DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

SERVICE AUTHORIZATION

Section: Clinical

Pages: 5

Subject: Service Authorizations

Effective Date: 02/16/2007

Revision Date: 02/12/2020

POLICY

Services provided by Davis Behavioral Health are prioritized as to population and scope according to statutory and contractual requirements. The delivery of services by an appropriate provider is prioritized as to 1) employee providers, 2) subcontracted providers, and 3) off-panel providers, respectively. Requests for the delivery of services are subject to authorization as specified in the following procedures.

PROCEDURE

A. AUTHORIZATION FOR SERVICE DELIVERY – EMPLOYEE PROVIDERS

1. A "second opinion" related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request at no cost to the enrollee.

B. AUTHORIZATION FOR SERVICE DELIVERY – SUBCONTRACTED PROVIDERS

1. Requests for authorization and service delivery by a subcontracted provider must be submitted to the off-panel coordinator either verbally or in writing. Prior to the authorization of service delivery by an off-panel provider, an initial clinical assessment (or reassessment for existing clients) must be completed by the requesting provider who must forward the evaluation and a treatment plan to the off-panel coordinator. The off-panel coordinator will present the documentation to the compliance officer, or designee, who must be a licensed mental health provider, for review and authorization. Individuals who refuse assessment or reassessment will be denied authorization for service provision by the subcontracted provider.

2. The Center will also mail the client a written Notice of Adverse Benefit at the time of the action affecting a claim if the denial reason is that: (1) the service was not authorized by the Center, as the client could be liable for payment if

the client gave advance written consent that he or she would pay for the specific service; (2) the client requested continued benefits (services) during an appeal or state fair hearing and the appeal or state fair hearing decision was adverse to the client; or (3) the client was not eligible for Medicaid when the services were provided.

3. The compliance officer or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and determine the appropriateness of an alternative provider based upon the following review criteria:

    a. Type of service requested;
    b. Amount, duration, and scope of service requested;
    c. Credentials, expertise, and capacity of Center staff;
    d. Credentials, expertise, and capacity of requested provider;
    e. History of previous treatment;
    f. Extenuating circumstances.

4. DBH will make a service authorization determination and provide notice of the decision to the subcontractor and the client as expeditiously as the client's condition may require, but no later than 14 calendar days from the date of receipt of the subcontractor's request for service authorization. This will be tracked on the off-panel request form.

5. The Center may extend the time frame for making a service authorization decision by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the Department of Health and the Center justifies that there is a need for additional information and that the extension is in the best interest of the client.

6. If the time frame for making a service authorization decision is extended, the Center will:

    a. Give the client written notice of the reason for the decision;

    b. Inform the client of his or her right to file a Grievance, and how to do so, if the client disagrees with the decision, and

    c. Carry out the service authorization determination as expeditiously as may be required by the client's health condition, however, no later than the date the extension expires.

7. The above time frames will apply unless the client's health or safety (as indicated by the subcontractor or determined by DBH) requires an expedited decision, in which case the assessment and authorization must

be accomplished and notice provided as expeditiously as the client's health condition requires, but no later than 72 hours from receipt of the request for service by the subcontractor.

8. The time frame for an expedited decision may be extended by up to 14 calendar days if the client or subcontractor requests an extension, or upon request by the Department of Health and the Center justifies that there is a need for additional information and that the extension is in the best interest of the client.

9. Failure to reach a service authorization decision within the time frames as indicated above will constitute an Action and require the Center to provide a Notice of Adverse Benefit to the client (written) as well as provide notice to the subcontractor (oral or written) by or on the date the time frame expires.

10. Any decision to deny a service authorization or to authorize a service in an amount, duration, or scope that is less than requested will be made by appropriately credentialed staff having clinical expertise in treating the client's diagnosed condition.

11. Any decision to deny a *service authorization request* (not a request for services from a specific provider), or to authorize a *service* in an amount, duration, or scope that is less than requested, including the type or level of service (with the exception of services that are not "covered" under the DHCF contract), constitutes an Action and requires the Center to provide a Notice of Action to the client (written) as well as provide notice to the subcontractor (orally or in writing).

12. A continuation of service delivery beyond any limits that may be specified must be re-authorized following the procedures outlined above, following a written request for continued authorization.

13. A "second opinion" related to the authorization of services, initial assessment, diagnosis, and/or available treatment options will be provided upon request.

C. AUTHORIZATION FOR SERVICE DELIVERY – OFF-PANEL PROVIDERS

1. Requests for authorization and service delivery by an off-panel provider must be made to the off-panel coordinator either verbally or in writing, prior to the authorization of service delivery by an off-panel provider, an initial clinical assessment (or reassessment for existing clients) must be completed as specified above, to determine the relevant treatment issues and service need. Individuals who refuse assessment will be denied authorization for service provision by an off-

panel provider.

2. Within a reasonable period of time following the clinical assessment, but not to exceed 30 days, the compliance officer or designee will review the assessment in consultation with the assessing clinician, consult with the requested provider if necessary, and determine the appropriateness of an off-panel provider based upon the following review criteria:

3. Clients will be notified either orally or in writing as to the determination for service delivery by an off-panel provider and such determination will be documented in the clinical record using an approved form.

4. Clients denied a request to see an off-panel provider shall be contacted directly to discuss options and alternatives. Clients approved for delivery of services by an off-panel provider will be subject to that provider's service delivery schedule in which case performance standards relative to initial face-to-face contact shall not apply.

5. If approved, the off-panel provider will be required to enter into a written subcontract with the Center and must meet all established guidelines for subcontractors as set by the local authority and as specified by Center contract with the Division of Health Care Financing.

6. Items 4 through 13 of Section B pertaining to subcontractor will apply to Section C off-panel providers.

D. GENERAL POLICIES AND PROCEDURE

1. DBH will produce and distribute a handbook to all enrollees who seek services. The handbook will provide information pertaining to the amount, duration, and scope of benefits available in sufficient detail to ensure that enrollees understand the benefits covered by DBH and how to access those services. Enrollee information will include the extent to which, and how, enrollees may obtain benefits from out-of-network providers and how, after hours and emergency coverage are provided, including what constitutes emergency medical condition, emergency services and post stabilization services.

2. DBH provides information on its process and procedures for obtaining emergency services, including use of the emergency telephone system. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract. DBH will inform enrollees of their right to use any

hospital or other setting for emergency care.

3. DBH will notify the Health Department of any intended change that would mean the information contained in the Medicaid Member Handbook would no longer be accurate and up to date.

4. The Health Department will determine if the change is a significant change.

5. DBH will give each enrollee written notice of any change that the Health Department defines as significant. The written notice will be 30 days before the intended effective date of the change.

6. DBH will make a good faith effort to give written notice of termination of a Subcontractor within 15 days of receipt or issuance of the termination notice, to each enrollee who was seen on a regular basis by the terminated Subcontractor.

7. If DBH is unable to provide necessary services covered under the contract to a particular enrollee, DBH will adequately and timely cover these services by using other out-of-network providers that offer the same level of care for as long as DBH is unable to provide them.

8. DBH will ensure compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue Medically Necessary Covered Services to any enrollee.

9. Davis Behavioral Health will provide Medically Necessary Covered Services in a manner that addresses:
   a. Prevention, diagnosis and treatment of mental health impairments.
   b. The ability of the client to achieve age-appropriate growth and development, and
   c. The ability to attain, maintain or regain functional capacity.

10. Davis Behavioral Health will provide, at a minimum, all appropriate Medically Necessary Covered Services in terms of amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. Services at DBH are available for CHEC enrollees.

11. Davis Behavioral Health may not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition. Davis Behavioral Health may place appropriate limits on a service on the basis of medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.