Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Community-Based Crisis, Urgent, and Emergency Services
PAGE: 1 of 7	**REPLACES:** NA
APPROVED DATE: 3-6-19	**RETIRED:**
EFFECTIVE DATE: 4-6-16	**REVIEWED/REVISED:** 10-22-14, 8-9-15, 3-1-16, 4-12-17, 5/3/17, 5/31/17, 12-18-17, 2-6-18, 12-18-18, 2-27-19
PRODUCT TYPE: Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff make level of care (LOC) determinations for Crisis, Urgent, and Emergency services and to describe the authorization process.

B. Policy

1. Clinical criteria for crisis services include:

- **1.1.** Behavior, or threats of behavior, posing imminent harm to self or others;
- **1.2.** Behavior not requiring psychiatric acute care hospitalization; and
- **1.3.** Behavior occurring at the time of crisis request.
- **1.4.** Clinical criteria supports diversion from ongoing evaluation and monitoring in an inpatientsetting.
- **1.5.** Crisis referral requests are initiated by:
  - **1.5.1.** Member's current mental health practitioner,
  - **1.5.2.** Treating or assessing physician/practitioner in an acute or urgent care setting,
  - **1.5.3.** Other mental health professional meeting with member at the time of referral request,
  - **1.5.4.** Member,or
  - **1.5.5.** Crisis service providers (Cahoots, police, Crisis Response Team (CRT) via phone or in-person.
- **1.6.** A Diagnostic and Statistical Manual of Mental Disorder (DSM) and International Classification of Diseases (ICD) covered diagnosis supported by behavioral health assessment information to make:
  - **1.6.1.** LOC determination based on:

1.6.1.1. Treatment history,

1.6.1.2. Degree of impairment,

1.6.1.3. Current symptoms,

1.6.1.4. Community supports, and

1.6.1.5. Medical appropriateness to support DSM and ICD covered diagnosis.

2. Appropriate available treatment environment characterized by:

2.1. The most normative,

2.2. Least restrictive,

2.3. Least intrusive,

2.4. Culturally and linguistically appropriate,

2.5. Evidenced based and/or evidence informed, and

2.6. Extent of family and community supports.

C. Procedure

1. Referrals:

1.1. Referred member must be enrolled in Trillium Community Health Plan.

1.2. Trillium members are able to access outpatient mental health assessment with an in-network provider without referral. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. For non-par provider services always requiring a PA, provider must submit, within two (2) business days of crisis respite (per respite care services billing code) admission:

2.1. PA request,

2.2. Evidence of a covered DSM and ICD diagnosis,

2.3. Summary completed within twenty-four (24) hours of admission including:

2.3.1. Current symptom presentation with impact upon functioning,

2.3.2. Safety concerns and related safety plan information,

2.3.3. Services or LOC to be provided,

2.3.4. Discharge/transition planning information, with

2.4. Clinical justification for requested services including summary of how service modalities would result in stabilization of acute behavioral symptom presentation.

3. Crisis respite and similar urgent service PA requests are determined within the seventy-two (72) hour urgent pre-service timeline if request is received prior to member admission to facility. Crisis respite and similar urgent service requests are determined within the twenty-four (24) hour concurrent timeline if request is received after member admission to facility or crisis center.

3.1. Concurrent requests will be processed within urgent concurrent timeline of twenty-four (24) hours.

4. When request is approved:

4.1. Continued stay requests for longer than three (3) calendar days based on submitted updated clinical justification including:

4.1.1. Ongoing risk of imminent danger to self or others,

4.1.2. Length of stay is medically appropriate, and

4.1.3. Measureable expected outcome.

5. When request is denied:

5.1. If the initial or concurrent review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

5.2. When the decision is to deny request, practitioner may request an expedited appeal if he/she disagrees with the determination.

6. For crisis psychotherapy and other crisis services provided within the array of outpatient mental health services, refer to criteria outlined in TBH Outpatient Mental Health Policy and Procedure.

7. For crisis psychotherapy and other crisis services provided within the array of outpatient substance use treatment services, refer to criteria outlined in TBH Outpatient Substance Use Disorders Treatment Services Policy and Procedure.

8. If member:

8.1. Continues to exhibit ongoing risk of imminent danger to self or others, or

8.2. Is unable to provide for basic needs and personal welfare due to their mental status, or

8.3. Member's impairment of judgment, impulse control, and/or perception arising out of an acute mental disorder, indicate the need for hospital level continuous monitoring and intervention or continued respite care services are necessary to stabilize, crisis services provider is expected to:

8.3.1. Coordinate transition to emergency room or an acute care facility, or

8.3.2. Refer to TBH Care Coordinator (CC) staff to:

8.3.2.1. Ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

9. TBH Licensed Utilization Management (UM) staff:

9.1. Review mental health assessment information,

9.2. Ensure DSM and ICD supported diagnosis, and

9.3. LOC.

9.4. Refer to TBH CC staff when necessary to ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

10. Expected Outcomes:

10.1. Improvement/stabilization of psychiatric symptoms,

10.2. Less restrictive LOC services are determined to be clinically appropriate, and

10.3. Prevention of psychiatric hospitalization.

11. When request is returned to sender:

11.1. Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

11.1.1. Member identifying information,

11.1.2. Requesting and Servicing Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number), including:

11.1.2.1. Medicaid Provider/DMAP number for non-par outpatient service requests,

11.1.3. Start date and end date for services,

11.1.4. ICD diagnostic code(s),

11.1.5. Billing code(s),

11.1.6. Number of units/visits/days for each billing code.

11.2. Upon review, no authorization is required per the ARQ for participating providers.

11.3. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

11.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

11.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster.

11.4.2. Mechanical or administrative delays or errors by the Contractor or State Office.

11.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

11.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number.

11.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered.

11.4.3.3. The provider submitted the request for authorization within 60 days of the date the eligibility was discovered (excluding retro-eligibility).

11.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

11.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium Medicaid member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. *Definitions*

Word / Term	Definition
Acute	Abrupt onset, short in duration, rapidly progressive, and in need of urgent care.
ARQ	Authorization Required Qualifier.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.

Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Crisis	Either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted by mental health symptoms and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental health, ability to maintain safe behaviors, and/or to prevent a significantly higher level of care.
Diagnostic and Statistical Manual of Mental Disorders (DSM)	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
Emergency Care	Health services from a qualified provider necessary to evaluate or stabilize an emergency medical condition, including inpatient and outpatient treatment necessary to assure within reasonable medical probability that the patient's condition is not likely to materially deteriorate from or during a client's discharge from a facility or transfer to another facility.
ICD	The International Classification of Diseases.
Level of Care (LOC)	The type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.
Level of Care Determination	The standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.
Licensed UM Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed health care professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Respite Care	Planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.
Urgent Care	Any request for behavioral healthcare or treatment where application of time periods for making non-urgent care determinations could result in the following circumstances: • Could seriously jeopardize the life or health of member or member's ability to regain maximum function, based on a prudent layperson's judgment; or, • In the opinion of the practitioner with knowledge of member's health condition, would subject member to severe pain not adequately managed without the care or treatment requested.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP Contract	Provision of Covered Service

	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	B.2.3.b.c.e
	Covered Services
	B.2.4.a.3.
	B.2.4.b.1
	B.2.4.b.2.(a-e)
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity
	E.23.
Current NCQA Health Plan Standards and Guidelines	UM 2:C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5:C,D Timeliness of UM Decisions
	UM 6:B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
Oregon Administrative Rules	309-019-0140
	309-019-0150
	309-019-0151
	410-120-1295
	410-141-3140
	410-141-3160
	410-141-3170
Oregon Regulatory Statutes	430.630
	430.644

F. *Related Material*

Name	Location
TBH Outpatient Mental Health Policy and Procedure	TBH Database
TBH Outpatient Substance Use Disorders Policy and Procedure	TBH Database

G. Revision Log

Type	Date
Merged policy and procedure into one document.	12-18-17
Updated Definition List	1-10-18
Added Return to Sender Language	1-10-18
Added CCO and CAK Contract Citations	2-6-18
Updated Treatment Plan Requirement Language	12-18-18

Update OARS	12-18-18
Updated Return to Sender Language	12-18-18
Added Contingent and Concurrent Information	2-27-19
Revised section 2	2-27-19