Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Feeding and Eating Disorders Treatment Services
PAGE: 1 of 11	**REPLACES:** NA
APPROVED DATE: 1-9-19	**RETIRED:** NA
EFFECTIVE DATE:9-16-15	**REVIEWED/REVISED:** 10-22-14, 8-9-15, 3-1-16, 4-12-17, 5-3-17, 5-31-17, 12-14-17, 1-31-18, 2-6-18, 12-10-18
PRODUCT TYPE: Medicare, 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 feeding and eating disorder treatment pre-service decisions and to describe the authorization process.

B. Policy

1. TBH considers evidence based and/or evidence-informed practice guidelines in making level of care (LOC) determination for feeding and eating disorder treatment.

2. Clinical criteria for feeding and eating disorder treatment services include:

2.1. A Diagnostic and Statistical Manual of Mental Disorder (DSM) and International Classification of Diseases (ICD) covered diagnosis of disordered eating supported by behavioral health assessment information and medical evaluation to make:

2.1.1. LOC determination based on:

2.1.1.1. Degree of Impairment,

2.1.1.2. Current symptoms,

2.1.1.3. Biopsychosocial information,

2.1.1.4. Weight as a percentage of healthy body weight,

2.1.1.5. Medical complications related to disordered eating that may be evidenced by:

4.1.1.1.1. Laboratory evaluations,
4.1.1.1.2. Echocardiogram,
4.1.1.1.3. Electrocardiogram (EKG),
4.1.1.1.4. Chest x-ray,
4.1.1.1.5. Computerized Tomography (CT) scan,

4.1.1.1.6. Magnetic Resonance Imaging (MRI),
4.1.1.1.7. Immune system abnormalities,
4.1.1.1.8. Radiography,
4.1.1.1.9. Bone scans,
4.1.1.1.10. Other medical evaluations evidencing complications due to coexisting medical conditions.

3. Appropriate available treatment environment characterized by:
3.1. The most normative,
3.2. Least restrictive,
3.3. Culturally and linguistically appropriate,
3.4. Evidence based and/or evidence informed,
3.5. Extent of family and community supports.

C. Procedure

1. Referrals:
1.1. Referred member must be enrolled in Trillium Community Health Plan (Trillium).
1.2. Trillium members are able to access Outpatient (OP) mental health assessments with an in-network provider without a referral.
1.3. If member is at immediate risk of acute medical care without intervention, member is directed to medical services.

2. For OP services not requiring a prior authorization (PA) based on Authorization Required Qualifier (ARQ), provider is able to submit claims.

3. For non-participating provider services always requiring a PA, prior to or on the first date of service, provider must submit:
3.1. PA request,
3.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,
3.3. A summary, completed within previous sixty (60) days, of:
3.3.1. Current symptom description with impact upon functioning,
3.3.2. Services or LOC to be provided,
3.3.3. Clinical justification for requested services including summary of how service modalities would meet treatment goals for current episode of care outside of currently available in-network services.

4. For initial Intensive Outpatient (IOP) and Partial Hospitalization(PHP), prior to or on the first date of service, provider must submit:
4.2. PA request,
4.3. Updated behavioral health assessment information or addendum completed by a Qualified Mental Health Professional (QMHP) within the previous sixty (60) days, including:
4.3.1. Evidence of a covered DSM and ICD diagnosis,
4.3.2. Behavioral presentation with current symptom description and impact upon functioning.
4.4. Service Plan conducted and/or updated within the last year reflecting:
4.4.1. Assessment,
4.4.2. LOC to be provided,

4.4.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan:
4.4.3.1. Include the participation of the individual and family members, as applicable,

4.4.3.2. Be completed and signed by qualified program staff.

4.5. Clinical justification for services requested, including:
4.5.1. How the member would benefit from requested LOC,

4.5.2. Why alternate services or LOC have been ruled out by provider/treatment team.

4.6. Medical documentation within the last thirty (30) days evidencing:
4.6.1. Body Mass Index (BMI) and/or weight as a percentage of goal weight,

4.6.2. Medical complications related to disordered eating, as applicable, may be evidenced by:
4.6.2.1.1. Laboratory evaluations,
4.6.2.1.2. Echocardiogram,
4.6.2.1.3. EKG,
4.6.2.1.4. Chest x-ray,
4.6.2.1.5. CT scan,
4.6.2.1.6. MRI,
4.6.2.1.7. Immune system abnormalities,
4.6.2.1.8. Radiography,
4.6.2.1.9. Bone scans,
4.6.2.1.10. Other medical evaluations evidencing complications due to coexisting medical conditions.

5. For concurrent IOP and PHP authorization requests, provider must submit concurrent authorization request with summary of:
5.1. Diagnostic, medical stability, or medication changes since last review,

5.2. Recent services/interventions, within past two-four (2-4) weeks, including:
5.2.1. Member/family participation in services,

5.2.2. Frequency of services,

5.2.3. Response to treatment,

5.2.4. Barriers to treatment progress,

5.2.5. Areas of progress.

5.3. Clinical justification for services requested, including:
5.3.1. Behavioral presentation with current symptom description and impact upon functioning,

5.3.2. Why alternate services or LOC have been ruled out by provider/treatment team.

5.4. Medical documentation within the last thirty (30) days evidencing:
5.4.1. BMI and/or weight as a percentage of goal weight,

5.4.2. Medical complications related to disordered eating, as applicable, may be evidenced by:
5.4.2.1. Laboratory evaluations,
5.4.2.2. Echocardiogram,
5.4.2.3. EKG,
5.4.2.4. Chest x-ray,
5.4.2.5. CT scan,
5.4.2.6. MRI,

5.4.2.7. Immune system abnormalities,
5.4.2.8. Radiography,
5.4.2.9. Bone scans,
5.4.2.10. Other medical evaluations evidencing complications due to coexisting medical conditions.

5.5. Discharge/transition planning information specific to remaining treatment goals.

6. For OP services requiring a contingent PA based on utilization:

6.1. Provider is able to submit claims for CPT codes based on ARQ without a PA up to the ARQ limits per member per calendar year.

6.2. Once claims have met a contingent authorization ARQ limit, provider must submit:

6.2.1. PA request,

6.2.2. Evidence of a covered DSM and ICD diagnosis and clinical justification for medically appropriate services,

6.2.3. Chart notes or session information from the most recent three (3) dates of service prior to PA submission,

6.2.4. Service Plan conducted and/or updated since most recent mental health assessment, reflecting:

6.2.4.1. Assessment,

6.2.4.2. LOC to be provided,

6.2.4.3. A safety plan when the assessment indicates risk to the health and safety of the individual or to others and be updated as circumstances change. The safety plan may be a separate document from the service plan:

6.2.4.3.1. Include the participation of the individual and family members, as applicable,

6.2.4.4. Be completed and signed by qualified program staff.

7. For OP concurrent (Recertification) for additional codes or units within current approved date range and/or an extended or new date range, additional clinical justification must be submitted, including:

7.1. Concurrent authorization request,

7.2. Updated behavioral health assessment information or addendum completed by a QMHP, within the previous sixty (60) days, including:

7.2.1. Evidence of a covered DSM and ICD diagnosis,

7.2.2. Behavioral presentation with current symptom description and impact upon functioning,

7.2.3. Service plan information completed within the past sixty (60) days,

7.3. Clinical justification for requested services, including:

7.3.1. How the member would benefit from requested services,

7.3.2. Why alternate services or LOC have been ruled out by provider/treatment team.

8. For initial residential services authorization requests, provider must submit:

8.1. PA request,

8.2. Updated behavioral health assessment information or addendum completed by a QMHP, within the previous two (2) weeks, including:

8.2.1. Evidence of a covered DSM and ICD diagnosis,

8.2.2. Behavioral presentation with current symptom description and impact upon

functioning,

8.2.3. Overview of recovery environment or support system,

8.2.4. Evidence member can be safely treated in a residential LOC with summary of level of structure and supervision needed.

8.3. Clinical justification for services requested, including:

8.3.1. How the member would benefit from requested LOC,

8.3.2. Why alternate services or LOC have been ruled out by provider/treatment team,

8.3.3. Continued care planning.

8.4. Medical documentation within the last thirty (30) days evidencing:

8.4.1. BMI and/or weight as a percentage of goal weight,

8.4.2. Medical complications related to disordered eating, as applicable, may be evidenced by:

8.4.2.1. Laboratory evaluations,

8.4.2.2. Echocardiogram,

8.4.2.3. EKG,

8.4.2.4. Chest x-ray,

8.4.2.5. CT scan,

8.4.2.6. MRI,

8.4.2.7. Immune system abnormalities,

8.4.2.8. Radiography,

8.4.2.9. Bone scans, or

8.4.2.10. Other medical evaluations evidencing complications due to coexisting medical conditions.

9. For concurrent residential services authorization requests, provider must submit concurrent authorization request with summary of:

9.1. Diagnostic, medical stability, or medication changes since last review, including:

9.1.1. BMI and/or weight as a percentage of goal weight,

9.1.2. Recent services/interventions within past five-seven (5-7) days, including:

9.1.2.1. Member/family participation in services,

9.1.2.2. Frequency of services,

9.1.2.3. Response to treatment,

9.1.2.4. Safety concerns,

9.1.2.5. Barriers to treatment progress,

9.1.2.6. Areas of progress.

9.2. Clinical justification for services requested, including:

9.2.1. Behavioral presentation with current symptom description within past five-seven (5-7) days and impact upon functioning,

9.2.2. Why alternate services or LOC have been ruled out by provider/treatment team.

9.3. Discharge/transition planning information specific to remaining treatment goals.

10. TBH Licensed UM Staff:

10.1. Determine clinical appropriateness and medical necessity of requested LOC for treatment, indicated by:

10.1.1. Review of clinical information submitted, including behavioral health assessment information and pertinent medical justification.

10.2. Offer TBH Care Coordination (CC) via UM approval notification of an initial OP contingent authorization, and/or

10.3. Upon determination of a concurrent OP contingent authorization, refer to TBH CC for member/provider outreach and/or,

10.4. 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.

10.5. Expected outcomes and discharge planning to lower level of care considers the following factors:

10.5.1. Stabilization/improvement of weight restoration,

10.5.2. Stabilization/improvement of restricting/purging/binging behaviors, or other pathogenic weight control measures,

10.5.3. Stabilization/improvement of medical complications,

10.5.4. Stabilization/improvement of daily functioning,

10.5.5. Prevention of higher LOC services, or

10.5.6. Less restrictive LOC services are determined to be clinically appropriate.

11. When request is approved:

11.1. For IOP, PHP, and residential services, initial and concurrent PAs will be authorized for appropriate length of stay as determined by InterQual Criteria Review. For IOP and PHP services, initial and concurrent PAs will not exceed six (6) months. For residential services, initial and concurrent PAs will not exceed thirty (30) days.

11.2. Determinations will be made according to the following timelines:

11.2.1. For initial youth IOP and PHP, review will occur within seven (7) business days,

11.2.2. For concurrent youth IOP and PHP, review will occur within fourteen (14) day pre-service timelines,

11.2.3. For initial and concurrent adult IOP and PHP, review will occur within fourteen (14) day pre-service timelines,

11.2.4. Initial residential PA requests are determined within the seventy-two (72) hour urgent pre-service timeline if request is received prior to member admission to facility. Residential authorization requests are determined within the twenty-four (24) hour concurrent timeline if request is received after member admission to facility.

11.2.5. For concurrent residential services, review will occur as urgent concurrent decisions within twenty-four (24) hours.

11.3 All initial (Certification) non-par OP and par OP contingent requests will be determined within the fourteen (14) day pre-service timeline. All initial (Certification) non-par OP and par OP contingent PA requests will not exceed twelve (12) months. Par OP contingent PA requests will not exceed twelve (12) months for a date range beyond the end of the current calendar year.

11.4 For codes subject to ARQ contingent limits, initial non-par and initial contingent requests will be authorized for up to:

11.4.1. 25 units for a combined grouping of 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, and T1006, or

11.4.2. 120 units for a combined grouping of H0004, H0005, H0006, H0036, H0038, H2014, H2027, H2032, and T1016.

11.5. Concurrent (recertification) authorization for additional codes or units within the current approved authorization date range or to extend the date range is based on additional clinical justification submitted, to include, as applicable:

11.5.1. Ongoing weight instability,

11.5.2. Ongoing risk of behavioral symptom escalation,

11.5.3. Treatment of comorbid disorders,

11.5.4. Risk of self-harm/suicidality,

11.5.5. Participation in current LOC,

11.5.6. Discharge planning,

11.5.7. Requested length of stay.

11.6. Provider must notify TBH UM staff of discharge plan in writing within forty-eight (48) hours of discharge.

12. When request is denied:

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

12.5. When the decision is to deny request, an expedited appeal may be requested if provider disagrees with the determination.

13. When request is returned to sender:

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

13.4.1. Member identifying information,

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

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

13.4.3. Start date and end date for services,

13.4.4. ICD diagnostic code(s),

13.4.5. Billing code(s),

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

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

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

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

13.7.1. 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,

13.7.2. Mechanical or administrative delays or errors by the Contractor or State Office,

13.7.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met, with documentation to show that:

13.7.3.1. The member refused or was physically unable to provide the Recipient Identification Number,

13.7.3.2. The provider can substantiate continual pursuit of reimbursement from the patient until eligibility was discovered,

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

13.8. 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.

13.9. 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
Adult	A person 18 years of age or older, or an emancipated minor. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for the purposes of these rules. Adults who are between the ages of 18 and 21, who are considered children for purposes of these rules, must have all rights afforded to adults as specified in these rules.
APA	American Psychiatric Association.
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.
Child	A person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.
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.
Contingent Prior Authorization	A blank ARQ alerting billing system an authorization could be required depends on whether member and category of service are covered by member's benefit plan.

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.
Feeding and Eating Disorders	Disorders characterized by a persistent disturbance of eating or eating-related behavior that result in the altered consumption or absorption of food that significantly impairs physical health or psychosocial functioning.
ICD	The International Classification of Diseases.
Intensive Outpatient (IOP)	Treatment consisting of at least three (3) days a week, nine (9) or more hours weekly.
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 Utilization Management (UM) Staff	Licensed Behavioral Health UM staff are: Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Medically appropriate	Services and medical supplies required for prevention, diagnosis or treatment of a physical or mental health condition, or injuries, and which are: (a) Consistent with the symptoms of a health condition or treatment of a health condition; (b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective; (c) Not solely for the convenience of an individual or a provider of the service or medical supplies; and (d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an individual.
Mental Health Assessment	A process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Outpatient	Treatment consisting of less than nine (9) hours per week.
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.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Qualified Mental Health Professional (QMHP)	An LMP or any other individual meeting the minimum qualifications as authorized by the Licensing Mental Health Authority or designee. Person demonstrating the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, conducting a mental status examination, complete a DSM diagnosis; conducting best practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a Service Plan; and providing individual, family or group therapy within the scope of their training. (a) QMHPs shall meet the following minimum qualifications: (A) Bachelor's degree in nursing and licensed by the State or Oregon;

	(B) Bachelor's degree in occupational therapy and licensed by the State of Oregon; € Graduate degree in psychology; (D) Graduate degree in social work; (E) Graduate degree in recreational, art, or music therapy; or (F) Graduate degree in a behavioral science field; or (G) A qualified Mental Health Intern.
Residential Treatment	A facility or a discrete part of a facility that provides a 24-hour therapeutically planned and professionally staffed group living and learning environment to live-in residents who require psychiatric care or substance abuse treatment, but do not require acute medical care.
Specialized eating disorder provider	Services provided in a specialized program, unit or facility for intensive outpatient, partial hospitalization, or residential levels of care for members diagnosed with feeding and eating disorders.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of clinical services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 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.
	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	309.039.0560
	309.039.0570
	410.120.1295

	410-141-3061
	410.141.3160
	410-172-0600

F. Related Material

Name	Location
Acute and Long Term Hospitalization Policy and Procedure	TBH Database
APA Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition	May 2006
InterQual Criteria 2017	TruCare Database
Outpatient Mental Health Policy and Procedure	TBH Database
Use of Out-of-Network Providers and Steerage	Trillium Database

G. Revision Log

Type	Date
Merged Policy and Procedure into one document	11-30-17
Updated section 2.1.1.5 and section 3.1.12 to include electrocardiogram (EKG)	11-30-17
Updated Definition List	12-1-17
Clarified review timelines for each line of service	12-14-17
Updated concurrent section to include Medicare terminology	12-14-17
Addition of InterQual Criteria	12-14-17
Added Return to Sender language	12-14-17
Addition of CCO CAK Citations	2-6-18
Updated Treatment Plan Requirement Language	12-10-18
Added Contingent and Concurrent Information	12-10-18
Updated Definitions	12-10-18
Update OARS	12-10-18
Updated Return to Sender Language	12-10-18