Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Intensive Service Array
PAGE: 1 of 11	**REPLACES:** NA
APPROVED DATE: 3-6-19	**RETIRED:** NA
EFFECTIVE DATE:11-5-14	**REVIEWED/REVISED:**11-4-15,1-27-16, 3-6-16, 3-15-17, 5-31-17, 1-16-18, 2-5-18, 12-28-18, 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 child behavioral health services and to describe Trillium Behavioral Health's (TBH) Intensive Service Array (ISA) authorization process.

B. Policy

1. Clinical criteria for Intensive Service Array (ISA) services include:

1.1. 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:

1.1.1. Level of care (LOC) determination based on:

1.1.1.1. Treatment history,

1.1.1.2. Degree of impairment,

1.1.1.3. Current symptoms,

1.1.1.4. Community supports, and

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

1.1.2. Appropriate available treatment environment characterized by:

1.1.2.1. the most normative,

1.1.2.2. least restrictive,

1.1.2.3. least intrusive,

1.1.2.4. culturally and linguistically appropriate,

1.1.2.5. evidenced based and/or evidence informed, and

1.1.2.6. extent of family and community supports.

1.1.3. Individualized ISA intensity level based on the Member and family's:
1.1.3.1. Unique needs;
1.1.3.2. Beliefs;
1.1.3.3. Strengths; and
1.1.3.4. Input from community-based child providers.

1.2. Referrals for authorization of ISA Services;
1.2.1. Intensive Treatment Service (ITS) including:
1.2.1.1. Psychiatric Day Treatment Services (PDTS);
1.2.1.2. Psychiatric Residential Treatment Services (PRTS);and/or
1.2.1.3. Subacute Psychiatric Care.

1.3. TBH shall ensure that the ISA is recovery focused, family guided, and time limited based on medically appropriate criteria.

C. Procedure

1. Referrals:
1.1. Referred member must be enrolled in Trillium Community Health Plan.
1.2. Referred member must be under the age of eighteen (18) years.
1.3. Trillium members are able to access OP behavioral health assessments with an in-network provider without a referral.
1.4. If member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. Participating and non-participating providers always require a prior authorization (PA) based on Authorization Required Qualifier (ARQ), prior to the first date of service.

3. For initial PDTS authorizations, provider must submit:
3.1. PA request,
3.2. Updated behavioral health assessment information or addendum completed by a Qualified Mental Health Professional (QMHP) within the previous sixty (60) days, including:
3.2.1. Evidence of a covered DSM and ICD diagnosis,
3.2.2. Behavioral presentation with current symptom description and impact upon functioning.
3.3. Service Plan conducted and/or updated within the last year reflecting:
3.3.1. Assessment,
3.3.2. LOC to be provided,
3.3.3. 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:
3.3.3.1. Include the participation of the individual and family members, as applicable,
3.3.3.2. Be completed and signed by qualified program staff.
3.4. Clinical justification for services requested, including:
3.4.1. How the member would benefit from requested LOC,
3.4.2. Why alternate services or LOC have been ruled out by provider/treatment team.

4. For concurrent PDTS authorization requests, provider must submit concurrent authorization request with summary of:
4.1. Diagnostic, medical stability, or medication changes since last review,

4.2. Recent services/interventions, within past two-four (2-4) weeks, including:
- **4.2.1.** Member/family participation in services,
- **4.2.2.** Frequency of services,
- **4.2.3.** Response to treatment,
- **4.2.4.** Barriers to treatment progress,
- **4.2.5.** Areas of progress.

4.3. Clinical justification for services requested, including:
- **4.3.1.** Behavioral presentation with current symptom description and impact upon functioning,
- **4.3.2.** Why alternate services or LOC have been ruled out by provider/treatment team.
- **4.3.3.** Discharge/transition planning information specific to remaining treatment goals.

5. For initial Psychiatric Residential Treatment Services (PRTS) authorization requests, provider must submit:

5.1. PA request,

5.2. Psychiatric or psychological assessment information conducted and/or updated within previous sixty (60) days,

5.3. Updated behavioral health assessment information or addendum completed by a QMHP, within the previous two (2) weeks, including:
- **5.3.1.** Evidence of a covered DSM and ICD diagnosis,
- **5.3.2.** Behavioral presentation with current symptom description and impact upon functioning,
- **5.3.3.** Overview of recovery environment or support system,
- **5.3.4.** Evidence member can be safely treated in a residential LOC with summary of level of structure and supervision needed.

5.4. Clinical justification for services requested, including:
- **5.4.1.** How the member would benefit from requested LOC,
- **5.4.2.** Why alternate services or LOC have been ruled out by provider/treatment team,
- **5.4.3.** Continued care planning.

6. For concurrent PRTS authorization requests, provider must submit concurrent authorization request with summary of:

6.1. Diagnostic, medical stability, or medication changes since last review, including:
- **6.1.1.** Recent services/interventions within past five-seven (5-7) days, including:
  - **6.1.1.1.** Member/family participation in services,
  - **6.1.1.2.** Frequency of services,
  - **6.1.1.3.** Response to treatment,
  - **6.1.1.4.** Safety concerns,
  - **6.1.1.5.** Barriers to treatment progress,
  - **6.1.1.6.** Areas of progress.

6.2. Clinical justification for services requested, including:
- **6.2.1.** Behavioral presentation with current symptom description within past five-seven (5-7) days and impact upon functioning,
- **6.2.2.** Why alternate services or LOC have been ruled out by provider/treatment team.

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

7. For PRTS requests, requesting provider shall make available for the Certification of Need (CON) process the following information about the referred child which will requested by TBH licensed UM staff, as needed, within initial PRTS authorization timeline:

7.1. A written psychiatric or psychological evaluation written evaluation completed within the previous sixty (60) days;

7.2. A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

7.3. Results of any direct recipient observation and assessment subsequent to the referral;

7.4. Other information from the referral source, other involved community agencies, and the family that are pertinent and appropriate to the admission procedure;

7.5. Level of Need Determination Process outcome including Child and Adolescent Service Intensity Instrument (CASII) score or Early Childhood Service Intensity Instrument (ECSII);

7.6. Identified care coordinator;

7.7. Identified Intensive Community Based Treatment Services (ICTS) provider;

7.8. Identified child and family team members;

7.9. Service Coordination Plan or expected date of completion;

7.10. Documentation regarding attempt or failure at lower level of care placement;

7.11. Letter from Community Mental Health Program (CMHP) approving the referral to this level of care;

7.12. Documentation that private insurance benefit will not fund stay.

8. A Certification of Need (CON) review must be completed by an OHA approved independent reviewer before a child or youth is placed in psychiatric residential treatment services.

9. For Subacute Psychiatric Care authorization requests, provider must submit:

9.1. PA request,

9.2. Updated behavioral health assessment information or addendum completed by a QMHP, within the previous seven (7) days, including:

9.2.1. Evidence of a covered DSM and ICD diagnosis,

9.2.2. Specific behavioral and/or psychiatric symptoms present within previous two to seven (2-7) days, including impact upon functioning,

9.2.3. Current treatment setting or treatment setting immediately prior to admission,

9.2.4. Overview of recovery environment or support system,

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

9.3. Clinical justification for services requested, including:

9.3.1. How the member would benefit from requested LOC,

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

9.3.3. Continued care planning.

10. For concurrent Subacute Psychiatric Case authorization requests, provider must submit

concurrent authorization request with summary of:

10.1. Clinical assessment information, which includes substance use evaluation, medical needs, and psychosocial information relevant to behavioral presentation,

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

10.2.1. Recent services/interventions within past seventy-two (72) hours, including:

10.2.1.1. Member/family participation in services,

10.2.1.2. Frequency of services,

10.2.1.3. Response to treatment,

10.2.1.4. Safety concerns,

10.2.1.5. Barriers to treatment progress,

10.2.1.6. Areas of progress.

10.3. Clinical justification for services requested, including:

10.3.1. Behavioral presentation with current symptom description within past seventy-two (72) hours and impact upon functioning,

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

10.4. Service Plan information, reflecting:

10.4.1. Multidisciplinary treatment goals,

10.4.2. Interventions to be provided within program setting,

10.4.3. 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:

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

10.4.3.2. Be completed and signed by qualified program staff.

10.5. Discharge/transition planning information and action steps initiated within 24 hours of admission specific to remaining treatment goals.

11. Trillium Behavioral Health (TBH) Licensed Utilization Management (UM) staff will:

11.1. Ensure DSM and ICD supported diagnosis;

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

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

11.2.2 Consideration of whether services fall within the definition of medical necessity per Oregon Administrative Rules (OARs);

11.2.3 CON determination by OHA independent review, for PRTS requests.

11.3. 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, in coordination with the Child and Family Team.

12. Children or Youth authorized for an ISA service are eligible for one of the following:

12.1. Psychiatric Day Treatment Service (PDTS); and/or

12.2. Psychiatric Residential Treatment Services (PRTS); and/or

12.3. Subacute Psychiatric Care.

12.4. When request is approved:

12.4.1. PDTS:

12.4.1.1. Initial and concurrent authorizations for PDTS will not exceed thirty (30) days.

12.4.1.2. Initial authorization determinations for PDTS occur within seven (7) business days.

12.4.1.3. Concurrent authorization determinations for PDTS occur within fourteen (14) day pre-service timelines.

12.4.2. PRTS:

12.4.2.1. Initial and concurrent authorizations for PRTS will not exceed fourteen (14) days.

12.4.2.2. Initial authorization determinations for PRTS occur within seven (7) business days. Authorization determinations for PRTS requests occur after CON process is completed.

12.4.2.3. Concurrent authorization determinations for residential services occur within the twenty-four (24) hour concurrent timeline.

12.4.3. Subacute Psychiatric Care:

12.4.3.1. Initial and concurrent authorizations for Subacute Psychiatric Care are authorized for appropriate length of stay as determined by InterQual Criteria Review.

12.4.3.2. Initial authorization determinations for Subacute Psychiatric Care occur within seventy-two (72) hours, if request is received prior to member admission to facility. Initial authorization determinations for Subacute Psychiatric Care occur within the twenty-four (24) hour concurrent timeline, if request is received after member admission to facility.

12.4.3.3. Concurrent authorization determinations for subacute services occur within the twenty-four (24) hour concurrent timeline.

13. Expected Outcomes:

13.1. Improvement/stabilization of psychiatric symptoms,

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

13.3. Prevention of psychiatric hospitalization.

14. When request is denied:

14.1. If the authorization is denied based on assessed clinical need, medically appropriate alternative treatment will be recommended.

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

14.3. When the decision is to deny request, practitioner may request an expedited appeal if they disagree with the determination.

14.4. Services continue to be delivered at medically appropriate LOC.

14.5. Members not determined as needing PRTS services are referred to other ISA services or to outpatient behavioral health services.

15. When request is returned to sender:

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

15.1.1. Member identifying information,

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

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

15.1.3. Start date and end date for services,

15.1.4. ICD diagnostic code(s),

15.1.5. Billing code(s),

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

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

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

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

15.4.1. 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.

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

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

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

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

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

15.5. 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.

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

D. Definitions

Word / Term	Definition
Acute Inpatient Hospital Psychiatric Care	Care within a psychiatric facility accredited by the Joint Commission on Accreditation of Health Care Organizations that is devoted to the provision of inpatient psychiatric care for persons under the age of 17 years and licensed as a hospital.
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.
Certificate of Need (CON)	A signed statement signed by a CONS team to certify that — (1) Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary; (2) Proper treatment of the beneficiary's psychiatric condition requires services on an inpatient basis under the direction of a physician; and (3) The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed.
Certificate of Needs (CON) Team	Team certifying need for CON services to include a physician and a Behavioral Health Care Coordinator.
Child and Adolescent Service Intensity Instrument (CASII)	Instrument to assist provider and others caring for children and adolescents in determining intensity of services need for children and adolescents ages 6-18 years.
Child and Family Team	Those persons who are responsible for creating, implementing, reviewing, and revising the service coordination section of the Service Plan in ICTS programs. At a minimum, the team must be comprised of the family, care coordinator, and child when appropriate. The team should also include any involved child-serving providers and agencies and any other natural, formal, and informal supports as identified by the family.
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.
Complex Care Management (CCM)	High-level of care management services for members with complex needs, including children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those non-adherent in less intensive programs; frail elderly, disabled, or end of life; experienced a critical event or have a complex diagnosis requiring oversight and coordination. Services include CM and CC for issues listed above, along with more frequent outreach to member to assess service plan compliance and progress toward goals. Key indicators of disease progress, e.g. HbaA1c levels and medication adherence will be monitored.
Complex Care Management (CCM) Staff	Licensed UM staff.
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

Word / Term	Definition
	components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
Early Childhood Service Intensity Instrument (ECSII)	Instrument to assist provider and others caring for young children in determining intensity of services need for infants, toddlers, and children from ages 0-5 years.
ICD	The International Classification of Diseases.
Intensive Treatment Services (ITS)	The range of services in the system of care comprised of Psychiatric Residential Treatment Services (PRTS) and Psychiatric Day Treatment, or other services as determined by the Division, that provide active psychiatric treatment for children with severe emotional disorders and their families.
Intensive Service Array (ISA)	The broad array of intensive treatment services beyond outpatient treatment including ICTS and ITS for children and adolescents, through and including age 17. These services target the population with severe mental or emotional disorders whose needs have not been adequately addressed in traditional settings.
Level of Care (LOC)	Range of available services provided from the most integrated setting to the most restrictive and most intensive in an inpatient setting.
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	The process of obtaining sufficient information, through a face-to-face interview to determine a diagnosis and to plan individualized services and supports.
Non-participating Provider	A provider that does not have a contractual relationship with Trillium and is not on their panel of providers.
Oregon Health Plan (OHP)	In Oregon, the Medicaid Program is called OHP.
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare 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.
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.
Psychiatric Day Treatment Services (PDTS)	The comprehensive, interdisciplinary, non-residential, community-based program consisting of psychiatric treatment, family treatment

Word / Term	Definition
	and therapeutic activities integrated with an accredited education program.
Psychiatric Residential Treatment Services (PRTS)	Services delivered in a PRTS facility to include 24-hour supervision for children who have serious psychiatric, emotional or acute mental health conditions that require intensive therapeutic counseling and activity and intensive staff supervision, support and assistance.
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; (C) 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.
Service Plan	A comprehensive plan for services and supports provided to or coordinated for an individual and his or her family, as applicable, that is reflective of the assessment and the intended outcomes of service.
Subacute Psychiatric Care	Services that are provided by nationally accredited providers to children who need 24-hour intensive mental health services and supports, provided in a secure setting to assess, evaluation, stabilize or resolve the symptoms of an acute episode that occurred as the result of a diagnosed mental health condition.
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.
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.
	Covered Services
	B.2.4.i.(1-4)

	B.2.4.i.2.f.
	B.2.4.k.3(a-h)
	B.2.4.l.3 (a-h)
	B.2.4.m.1(a-d)
	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 5: C, D Timeliness of UM Decisions
	UM 6: B Relevant Information for Behavioral Health Decisions
Oregon Administrative Rules	309.019.0165
	309-022-0105
	309-039-0560
	309-039-0570
	410-120-1295
	410-172-0680
	410-172-0690
	410-172-0730

F. Related Material

Name	Location
2018 CCO Contract	TBH Database
Outpatient Mental Health Services Policy and Procedure	TBH Database

G. Revision Log

Type	Date
Merged Policy and Procedure into one document.	11-30-17
Updated Referral Information (section 4)	11-30-17
Updated Definition List	1-10-18
Added CCO and OHA Contract Citations	2-5-18
Added Return to Sender Language	2-7-18
Updated Treatment Plan Requirement Language	12-28-18
Updated OARS	12-28-18
Updated Return to Sender Language	12-28-18
Restructured to include separate PDTS, PRTS, and Subacute sections	2-27-19
Updated authorization process and information	2-27-19