

Document Type: ¹	<input checked="" type="checkbox"/> Policy & Procedure	<input type="checkbox"/> Process Guideline	Adopted: 09/30/04
	<input type="checkbox"/> Plan	<input type="checkbox"/> System Description	Last Reviewed: 02/14/08
			Retired: _____

Revisions: 02/24/05, 11/19/05, 09/21/06; 04/05/07

Document Scope: (applies to Policy & Procedure only)

- The requirements herein apply only to the GCBH Central Office and its functions.
- X - The requirements herein apply, verbatim, to GCBH and its network providers².
- The requirements herein apply both to GCBH and its network providers². Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.

PURPOSE: To define processes for (1) authorizing/re-authorizing service for enrollees[†], (2) notifying enrollees of decisions affecting their care and of their right to appeal such actions, and (3) handling enrollee appeals.

DEFINITIONS

- I. Action – In the context of GCBH-funded service provision to Medicaid enrollees, this term includes (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the state; (5) the failure of GCBH or its formal designee to act within the timeframes provided in section 42 CFR 438(b); or (6) for a resident of a rural area with only one MCO, the denial of an enrollee’s request to exercise his or her right, under section 42 CFR 438.52 (b)(2)(ii), to obtain services outside the network.
- II. Adverse Action – A decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- III. Appeal – A request for review of an action, or an adverse action, as defined above.
- IV. Enrollee – A Medicaid recipient who is currently enrolled with GCBH. For a child under the age of thirteen, or for a child thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of enrollee includes parents or legal guardians. Additionally, for the purposes of this policy, references to enrollee notification, or to the filing of appeals, are understood to include an enrollee’s guardians and/or representatives, or the representative of a deceased enrollee’s estate.
- V. Fair Hearing – A hearing before the Washington State Office of Administrative Hearings. Also referred to as a “state administrative hearing.”
- VI. GCBH – For the purposes of this policy, GCBH refers to the central office in Kennewick, Washington.
- VII. Medical Necessity or Medically Necessary – A service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and

there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

- VIII. Mental Health Professional (MHP) – An individual who meets the criteria established by WAC 388-865-0150, or its successors.
- IX. Notice of Action – A written notice issued by GCBH or its formal designee, which communicates a decision not to authorize mental health services to an enrollee who meets medical necessity criteria, or to reduce, suspend or terminate previously authorized services.
- X. Notice of Determination - A written notice issued by GCBH or its formal designee, which communicates a decision to authorize mental health services or a decision that the person seeking services is not eligible to receive them. It includes a description of authorized services and time frames, if applicable, and notice of the individual's right to a second opinion and how to access it, if services beyond the intake or previously authorized benefit have not been determined to be Medically Necessary and no services are authorized by GCBH.
- XI. Information about the availability of other services under EPSDT for Enrollees under 21 and their legal representative
- XII. Service Authorization, Expedited – An accelerated process for responding to service requests when a provider determines that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
- XIII. Service Authorization, Standard – The process for responding to requests for initial and continuing authorizations of mental health services.
- XIV. Service Denial – A decision by a network provider not to offer an intake; a decision by GCBH or its formal designee not to authorize covered mental health services requested by a network provider for a Medicaid enrollee. Service denials do not include a decision made by a Mental Health Professional not to request an authorization for ongoing mental health services after an intake, based on a finding that an individual does not meet the medical necessity criteria.
- XV. Service Reduction – A decision by GCBH or its formal designee to decrease a previously authorized service. A provider's decision to decrease or change a covered service in the Individualized Service Plan is not a reduction.
- XVI. Service Suspension – A decision by GCBH or its formal designee to temporarily stop previously authorized services. A provider's decision to temporarily stop a covered service in the Individualized Service Plan is not a suspension

XVII. Service Termination – A decision by GCBH or its formal designee to stop a previously authorized service. A provider’s decision to stop a covered service in the Individualized Service Plan is not a termination.

POLICY

- A. GCBH contracts with a utilization management organization (UMO) to carry out authorization and notification processes for inpatient, residential and outpatient mental health services, including major diagnostic and therapeutic services directly related to the treatment of mental health disorders, for enrollees. Decisions to authorize or deny services are based on the *Level of Care and Authorization Criteria* established by GCBH. Decisions to deny services on the basis of medical necessity are approved by a qualified physician prior to issuance of written notification regarding the decision. Healthy Options Enrollees are not referred to the Enrollee’s Healthy Options managed care plan for mental health services if the Enrollee is determined to be eligible for RSN funded mental health services based on medical necessity and the *Access to Care Standards*.
- B. The GCBH Central Office manages all processes associated with responding to enrollee appeals of the UMO’s authorization decision, and is responsible for making the final determination. Appeals are addressed promptly, with the participation of those with authority to implement or compel corrective action relative to the determination
- C. GCBH does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. However, services may be limited on the basis of medical necessity or for the purpose of utilization control, provided the services authorized are sufficient in amount, duration, or scope to reasonably be expected to achieve their purpose. Determinations of what constitutes “medically necessary services” for given enrollees are no more restrictive than the State definition provided above, and are consistent with the extent to which GCBH is responsible for covering services related to: (1) The prevention, diagnosis, and treatment of health impairments; (2) The ability to achieve age-appropriate growth and development; and (3) The ability to attain, maintain, or regain functional capacity.
- D. GCBH and its network providers ensure that compensation to the UMO and to staff conducting clinical assessments for the purpose of determining appropriate service levels is not structured so as to provide incentive to deny, limit, or discontinue medically necessary services to any enrollee.
- E. GCBH maintains an Ombuds Service and provides interpreters to assist enrollees during the appeal process. Enrollees may also request the assistance or participation of providers or others of their choice in this process.
- F. A confidential record of each appeal is maintained for six (6) years following the completion of the appeal resolution process. At a minimum, such records include the enrollee’s name, dates and times of all milestones in the appeal process, the decision appealed, the provider involved, and the disposition of the appeal. Such records are maintained apart from the enrollee’s clinical record, and are not disclosed without the enrollee’s written permission, except as necessary to resolve the appeal or to DSHS if the enrollee requests a fair hearing.
- G. Staff members who regularly interact with enrollees are trained to the provisions of this policy and to their roles and responsibilities relative to the processes it articulates.

PROCEDURE

Authorization of Services

1. The authorization process begins with a face-to-face clinical intake assessment by an MHP. If the MHP believes the enrollee meets *GCBH Level of Care and Authorization Criteria*, a request for service authorization is faxed or sent electronically to the UMO. The request includes:
 - 1.1. The amount, duration and scope of each service requested.
 - 1.2. Clinical information supporting the service(s) requested.
 - 1.3. A request for expedited authorization if the MHP believes it necessary.
2. Requests made to the UMO are reviewed by an MHP, who authorizes them subsequent to review of the information provided and confirmation of financial eligibility. If the UMO has questions or concerns regarding the authorization of services, the decision is made in consultation with the provider and/or GCBH, as appropriate.
 - 2.1. **Standard Service Authorizations.** Except when a provider requests an expedited authorization process, decisions regarding the authorization of outpatient mental health services or voluntary inpatient hospitalization for psychiatric treatment are made, and notice given to the requesting provider and the enrollee, as expeditiously as the enrollee's condition requires and within fourteen (14) calendar days from receipt of the service authorization request, unless an extension is requested.
 - 2.1.1. Notice of service approval (i.e., Notice of Determination): Written notification is provided by the UMO to GCBH, the network provider and the Enrollee within the timeframe above.
 - 2.1.2. Notice of an "adverse action" decision (i.e., Notice of Action): Written notification is provided by the UMO to GCBH, the network provider and the Enrollee, within the timeframe above.
 - 2.2. **Expedited Service Authorizations.** When a provider determines that an accelerated authorization process is in the best interest of the enrollee, the authorization decision is made, and notice given to the requesting provider and the enrollee, as expeditiously as the enrollee's condition requires and within three (3) working days from receipt of the service authorization request, unless an extension is requested.
 - 2.2.1. Notice of service approval (i.e., Notice of Determination): Written notification is provided by the UMO to GCBH, the network provider and the Enrollee within the timeframe above.
 - 2.2.2. Notice of an "adverse action" decision (i.e., Notice of Action): Written notification is provided by the UMO to GCBH, the network provider and the Enrollee within the timeframe above.
 - 2.3. **Extensions.** For both Standard and Expedited service authorizations, the decision-making timeframe may be extended up to fourteen (14) additional calendar days if the enrollee or the provider requests it, or if GCBH justifies to the MHD, upon request, a need for additional information and how the extension is in the enrollee's interest.

- 2.3.1. If the timeframe is extended, the determination must be issued and carried out as expeditiously as the enrollee's health condition requires, and no later than the date the extension expires.
- 2.3.2. Extension requests made by enrollees[†] or providers are automatically granted. Extensions requested by the UMO must be approved by the GCBH Director, or his/her designee.
- 2.3.3. When an extension occurs at the request of GCBH or a provider, the UMO provides the enrollee[†] written notice of the reason for the extension and of his/her right to file a grievance if he or she disagrees with the delay.
- 2.3.4. The UMO tracks extension requests, monitoring for patterns in their use and reporting such patterns to the GCBH staff responsible for utilization functions, to be reported to the Quality Management Oversight Committee.
- 2.4. **Notification of MHD/Children's Administration re: "D" Coupon Enrollees.** If the Enrollee has a "D" coupon, the UMO provides a copy of the Notice of Action or Notice of Determination to GCBH, the network provider, MHD, and the Children's Administration Regional office, as the Enrollee's legal representative.
3. When, on the basis of an Intake Assessment, an MHP determines that medical necessity and access criteria are not met, the assessment and other relevant documentation or medical records are submitted to the UMO for review. If the UMO does not reverse the recommendation of the MHP, it initiates the Notice of Action process, described below.
4. The GCBH Children's Care Manager reviews initial intake evaluations of all enrollees under the age of 21 for medical necessity and makes Level I or Level II assignments, authorizing Level II services for children who are:
 - 4.1. involved with the Children's Administration, the Division of Developmental Disabilities, and/or the Juvenile Rehabilitation Administration/Department of Corrections in addition to mental health;
 - 4.2. diagnosed with substance abuse or addiction;
 - 4.3. receiving special education services; or
 - 4.4. have a chronic and disabling medical condition.
5. If an enrollee under the age of 21 receives the maximum services allowed under Level I and there is a request for additional services, the GCBH Children's Care Manager reviews the individual treatment plan and determines the appropriate level of care. Level II services are authorized when the enrollee meets the criteria in the preceding paragraph, or when services continue to be medically necessary after one re-authorization of Level I services.
6. The UMO maintains written records and a log of all denied requests for service.

Re-Authorization of Services

7. When a provider believes there is a need for continuation or re-authorization following the exhaustion of previously authorized services, the request to do so includes:
 - 7.1. An evaluation of the effectiveness of each service modality provided during the benefit period;

- 7.2. An evaluation of the progress the enrollee made towards recovery or resiliency;
 - 7.3. An identification of unmet goals in the individual service plan including those identified by the enrollee; and
 - 7.4. A determination of whether the enrollee has met discharge criteria.
- 8. The UMO's decision to re-authorize services is faxed to the provider, and includes the time period for which services are re-authorized.
 - 9. A request to extend services that were previously authorized as time-limited may be treated as a new request. However, if the provider presents the request as a necessary continuation of the original authorization and the request is denied, the denial is treated as a service termination which may be appealed by an enrollee.

Adverse Actions & Notices of Action

- 10. Notification of a decision to deny a service authorization request, or to authorize services in an amount, duration, or scope that is less than requested (i.e., an "adverse action"), is made via a Notice of Action form approved by GCBH, in the enrollee's primary language. The UMO mails this Notice to enrollees[†]. The form provides the following information:
 - 10.1. The date of the action;
 - 10.2. The action taken, and the reason(s) for it;
 - 10.3. An explanation of the enrollee's right to file an appeal or a state administrative ("fair") hearing, and how to do so;
 - 10.4. Definitions of denial, reduction, suspension and termination.
 - 10.5. A statement that the enrollee has twenty (20) days from the postmark date on the Notice of Action to file an appeal.
 - 10.6. A statement that the enrollee must file an appeal within (10) days of the postmark date if the action is in regards to previously authorized services which he/she wishes to continue receiving during the appeal process.
 - 10.7. The circumstances under which a 3-day expedited appeal process is available, and how to request it.
 - 10.8. Statements regarding the enrollee's right to have services continued pending resolution of the appeal, how to request continuation or reinstatement of services during the appeal, and the circumstances under which the enrollee may be required to pay for services received during the appeal process.
 - 10.9. The circumstances under which the enrollee may request a fair hearing.
- 11. For all adverse actions, a Notice of Action is mailed to the enrollee[†] within the timeframes noted below. The provider from which the enrollee receives outpatient services, and, if applicable, the facility providing inpatient services are also notified within these timeframes, though not necessarily in writing.
 - 11.1. **For termination, suspension, or reduction of previously authorized services –** At least ten (10) calendar days before the effective date of the action, except as noted below.
 - 11.1.1. A Notice of Action may be mailed not later than the date of action if:

- 11.1.1.1.GCBH has factual information confirming the enrollee's death;
- 11.1.1.2.GCBH has a clear written statement signed by the enrollee that he/she no longer wishes services, or that gives information that requires termination or reduction of services and indicates that the enrollee understands that this must be the result of supplying that information;
- 11.1.1.3.GCBH has learned that the enrollee has been admitted to an institution where he/she is ineligible for further services;
- 11.1.1.4.GCBH has no knowledge of the enrollee's whereabouts and returned mail has no forwarding address;
- 11.1.1.5.GCBH has knowledge that the enrollee has been accepted into another state's Medicaid program; or
- 11.1.1.6.GCBH has knowledge that the MHP treating the enrollee has prescribed a change in the level of services.

11.1.2. If GCBH has facts (verified through secondary resources, if possible) indicating that action should be taken because of probable fraud by the enrollee, the advance notice may be shortened to five (5) days.

11.2. For **denial of payment** – At the time of any action affecting the claim.

11.3. For **Standard and Expedited Service Authorization** decisions that deny or limit services – As expeditiously as the enrollee's condition requires, and **not longer than the notification timeframes established in the "Authorization of Services" section**, above.

11.3.1. For decisions to deny a request for voluntary Medicaid inpatient services, the Notice of Action is delivered on day the decision is made.

11.3.2. Failure to meet the timeframes for standard or expedited service authorization requests constitutes a denial and is thus an adverse action. In such instances, the Notice of Action must be mailed on the date the timeframe expires.

12. A copy of each Notice of Action issued is maintained at the GCBH central office.

Appealing an Action

13. Upon application for mental health services, enrollees[†] receive a copy of the GCBH *Mental Health Service Benefit Handbook*, which includes information relating to enrollees' right to appeal decisions and how to do so. As needed, explanation is provided through qualified interpreters for non-English speaking enrollees and those who are deaf or visually impaired. Additionally, enrollees are informed that the *Benefits Booklet* produced by the Mental Health Division (MHD), which also provides instructions regarding filing appeals, is available upon request, and a copy is provided if an enrollee requests one. Brochures from the GCBH Ombuds service are also available at network provider sites and the GCBH office.

14. When an enrollee indicates a desire to appeal an action relating to his/her care, appeal-related processes are reviewed with the enrollee, access to the Ombuds Service is facilitated if desired, and the enrollee is reminded of his/her right to involve others.

- 14.1. A staff member of a network provider may file an appeal on behalf of the enrollee if written consent is given by the enrollee, or a guardian or representative.
- 14.2. As needed, enrollees are provided interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
15. Appeals must be filed within twenty (20) calendar days of the postmark on the Notice of Action. If the enrollee wishes to continue receiving previously authorized services during the appeal process, the appeal must be filed within ten (10) calendar days of the postmark on the Notice of Action or the intended effective date of the action, whichever is later.
16. Appeals may be initiated either orally or in writing. Those initiated orally must be confirmed in writing and signed by the enrollee[†] within seven (7) calendar days unless an expedited resolution has been requested.
 - 16.1. Oral inquiries seeking to appeal an action are treated as appeals and the date of the inquiry becomes the filing date of the appeal.
 - 16.2. If an oral inquiry is not confirmed in writing, it will be considered incomplete. This does not preclude another filing within twenty (20) days of the date on the Notice of Action.
17. When an appeal is filed, the enrollee[†] is provided the following:
 - 17.1. Contact names and telephone numbers of the Ombuds Service, the involved network provider, and the GCBH Central Office.
 - 17.2. Information about the appeal process, including but not limited to timeframes for resolution and the enrollee's right to request a fair hearing at the state level (a) if the enrollee does not agree with GCBH's decision regarding the appeal, (b) if GCBH does not provide a written response within the required timeframes, or (c) if the enrollee believe there has been a violation of Washington State Department of Social and Health Services rules.
18. The Notice of Action form instructs enrollees to file their appeals directly with GCBH. However, because enrollees may request assistance from a network provider in filing an appeal, the first knowledge of an impending appeal may be at the network provider level, Accordingly, if an enrollee indicates to a network provider that he/she wishes to appeal a Notice of Action, the Director of the network provider (or his/her designee) notifies the GCBH Director:
 - 18.1. Within one (1) working day of receipt of this information for Standard appeals;
 - 18.2. Within the same day of receipt of this information for Expedited appeals.

Resolution of Appeals

19. The timeframe for resolution of an appeal depends upon whether the enrollee or his/her representative has requested a standard or expedited resolution process, and whether the process is extended, as allowed by law.
 - 19.1. **Standard Resolution of Appeal.** The appeal is resolved, and written notice provided by GCBH to the enrollee, within forty-five (45) days of its receipt, unless extended as noted below.
 - 19.1.1. GCBH attempts to acknowledge receipt of an appeal via a documented telephone call the working day following its receipt. A written acknowledgement

is provided to the enrollee[†] and the network provider within five (5) working days of receipt of the appeal.

19.2. **Expedited Resolution of Appeal.** An expedited process is provided when it is determined that the standard time for resolution would jeopardize the enrollee's ability to maintain or regain maximum functioning. In these cases, the appeal is resolved, and written notice provided by GCBH to the enrollee, with three (3) working days of its receipt, unless extended as noted below.

19.2.1. Requests for an expedited appeal resolution process are reviewed the day of receipt, and a decision as to whether an expedited process is warranted is communicated verbally by GCBH to the enrollee[†] no later the twenty-four (24) hours after receipt of the request.

19.2.2. If the request for an expedited resolution process is denied, GCBH provides written notice within two (2) calendar days. The appeal is then addressed in accord with timelines for the Standard Resolution process.

19.2.2.1. Denial of access to an expedited process is grounds for the filing of a grievance, if the enrollee[†] desires to do so.

19.3. **Extensions.** For both Standard and Expedited Resolution processes, the timeframe may be extended up to fourteen (14) additional calendar days if the enrollee[†] requests it, or if GCBH justifies to the MHD, upon request, a need for additional information and how the extension is in the enrollee's interest. If an extension occurs at the request of GCBH rather than the enrollee, written notice of the reason for the delay is provided to the enrollee[†].

20. The GCBH Director conducts a thorough review of each appeal, consulting with the GCBH Executive Committee and others, as needed, ensuring that those making the decision on the appeal were not involved in any previous level or review or decision-making in regards to it.

20.1. If the appeal is in regards to a denial based on lack of medical necessity, or involves clinical issues, the GCBH Director ensures that the final decision is made by a mental health professional with the appropriate clinical expertise in treating the enrollee's condition or disease.

20.2. The enrollee[†] is provided, before and during the appeal process, the opportunity to examine his/her case file, including medical records and any other documents and records considered during the appeal process.

20.3. The enrollee[†] is provided a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. When expedited resolution is requested, the enrollee is informed of the limited time available for this.

21. At the conclusion of both Standard and Expedited resolution processes, the GCBH Director provides the enrollee[†] a written notice of disposition. For expedited processes, the GCBH Director also makes reasonable efforts to provide an oral notice. The written notice includes:

21.1. The results of the resolution process and the date it was completed.

21.2. For appeals resolved not wholly in the enrollee's favor:

- 21.2.1. The right to request a state fair hearing, and how to do so;
 - 21.2.2. The right to request to receive benefits while the hearing is pending, and how to make the request; and
 - 21.2.3. That the enrollee may be held liable for the cost of those benefits if the hearing decision upholds GCBH's decision regarding the appeal.
22. GCBH ensures that no punitive action is taken against an enrollee[†] who requests an expedited resolution process or a provider who supports an enrollee's appeal.
23. When the Ombuds Service or other representatives requested by the enrollee have been involved, they are provided a copy of the notice of disposition.

Continuation of Benefits

24. GCBH continues an enrollee's benefits pending resolution of an appeal if all of the following conditions are met:
- 24.1. The appeal was filed within ten (10) days of the postmark on the Notice of Action or the intended effective date of the proposed action;
 - 24.2. The appeal involves the termination, suspension, or reduction of a previously authorized service;
 - 24.3. The services were ordered by an authorized provider;
 - 24.4. The original period covered by the original authorization has not expired; and
 - 24.5. The enrollee requests extension of benefits.
25. If, at the enrollee's request, benefits are continued or reinstated while the appeal is pending, they must be continued until one of the following occurs:
- 25.1. The enrollee withdraws the appeal.
 - 25.2. Ten (10) days pass after GCBH mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a state fair hearing with continuation of benefits until a hearing decision is reached.
 - 25.3. A state fair hearing office issues a decision adverse to the enrollee.
 - 25.4. The time periods or service limits of a previously authorized service has been met.
26. If the final resolution of the appeal is adverse to the enrollee, GCBH may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent the services were provided solely for continuation of benefits during the appeal process.

Reversed Appeal Resolutions

27. If GCBH reverses a decision to deny, limit or delay mental health services that were not furnished while the appeal was pending, the disputed services are authorized promptly, and as expeditiously as the enrollee's health condition requires.
28. If GCBH reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, GCBH must pay for those services in accordance with MHD policy and regulations.

Implementation of Recommendations:

29. The disposition of an appeal may include specific recommendations requiring action of a systemic nature on the part of GCBH or its network provider. Such recommendations are submitted to the GCBH Board of Directors for review and implementation.
30. The GCBH Regional Office, or its designee, monitors for timely completion of (a) the processes associated with authorizations, notices, and appeals, (b) the implementation of resolutions, and (c) the prevention of retaliatory actions against enrollees for accessing the appeal process. The GCBH Director reviews any allegations of retaliation, and takes action as needed.
31. On-site audits of network providers, conducted by GCBH, include checks for evidence of compliance with the provisions of this policy. When a need for corrective action is identified during such audits, network providers address compliance issues via their quality improvement processes and provide evidence of sustained improvement. GCBH staff review audit findings for trends requiring system level intervention, and report such to the GCBH Quality Management Oversight Committee for action.

APPROVAL

/S/ William Wilson

William Wilson, DrPH
Director

02/14/08

Date