Banner University Health Plan Out of Home Prior Authorization and Continued Care Training

May 18 & 20, 2021

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Today's Agenda

1. How to determine a member needs Out of Home (OOH) behavioral health treatment.
2. The Emergent Admission Process
3. Paths to OOH treatment.
4. Authorization Process/ Exclusionary Criteria
5. Expectations/Requirements for the OOH providers.
   a. BHIF
   b. BHRF
   c. TFC or ABHTH
6. Concurrent Review process
7. Discharge Planning
8. Denials
9. PYX

Today's Goals

1. Developing an appreciation for the source documents
2. Ensuring you know how to find documents and the provider manual.
3. Emphasizing the need for complete and timely submissions.
4. Creating an understanding of how information received allows Banner to render decisions based on Medical Necessity Criteria.

Tips for Success

- All processes and all forms are detailed on the BUHP website at www.BannerUHP.com
- All processes and ***medical necessity requirements*** are detailed in our Behavioral Health Comprehensive Provider Manual Supplement/ Chapter 8/Medical Management/ Securing Services and Prior Authorization
- To ensure approval and reimbursement, read, understand and follow the processes in the manual.
- Your first point of contact should be your **assigned reviewer** for all authorization issues.
- Your assigned reviewer's Manager/Associate Director is the second point of contact for authorization issues or issues with the assigned reviewer.

PART 1

Determining the need for out of home treatment

Determining the Need for Out of Home Treatment

- Out of Home (OOH) treatment includes BHRF, BHIF, TFC and ABHTH.
- Outpatient provider (behavioral health home) facilitates ART or CFT.
- The ART or CFT establishes consensus that outpatient behavioral health services are not meeting the member's needs and that OOH treatment is medically necessary.
- If there is no outpatient provider currently in place working with the member, the **admitting provider** is responsible to obtain the prior authorization OR admit on an "Emergent Admission" basis.

PART 2

The Emergent Admission Process

The Emergent Admission Process

- Developed to address the emergent needs of members stepping down from hospitalization. It was not intended for providers to use as a way to avoid the standard prior authorization process. An Emergent Admission must reflect the necessity for "emergent care".

- Providers using the "Emergent Admission" process must be clinically confident the member will meet the medical necessity criteria for admission as per **BUHP criteria.**

- If the member is admitted on Emergent basis and does NOT meet medical necessity, a denial will be issued. Typically, the member is discharged due to the denial and now a disruption in care has occurred.

More About the Emergent Admission Process

- A Quality-of-Care concern may be submitted to our Quality Management department, for further investigation, due to a provider's failure to apply the medical necessity criteria to justify an Emergent Admission. This puts our members at risk when they are admitted and then discharged without an appropriate discharge plan and/or coordination of care.
- Multiple substantiated Quality of Care concerns and/or failure to follow the BUHP processes can result in a Corrective Action Plan and/or contract termination.
- BUHP strives to contract with high performing providers that provide quality and clinically sound, evidence-based care to our members that meet medical necessity criteria.

Emergent Admission Process- Sunsetting

BUHP will be "sunsetting" the Emergent Admission process effective October 1, 2021. Members will not be permitted to emergently admit to OOH level of care after October 1, 2021.

Only specific specialty providers will be considered to continue the Emergent Admission process.

Look for further information about the sunsetting on our website, provider blast fax, provider forums and in our Comprehensive Behavioral Health Provider Manual Supplement.

PART 3

Paths to Out of Home Treatment Admissions

Paths to OOH Treatment

- Emergent admission
  - The member is admitted. The PA form, Notice of Admission, and OOH Application are due 2 business days from the member's admission.
- Prior authorization
  - The PA form and OOH Packet/Application are submitted, along with supporting documentation to justify medical necessity
  - If approved, the member admits, and Provider submits the Notice of Admission Form within 2 business days of the member's admission. *Late submittals will result in an Administrative Denial.*

While typically the outpatient provider completes the PA form and the OOH application, any provider can complete it. If a member admits to your OOH program, it is your responsibility to ensure that you either have a prior auth OR that the PA and application is submitted.

BHRF Admission as Step Down Process from Hospitalization

- For members who are receiving treatment at the inpatient level, the BUHP reviewer can step a member down from inpatient to BHRF and complete the BHRF authorization.
- The **hospital** can request the BUHP reviewer to determine if the member can be stepped down using the clinical received during the inpatient stay.
  - This step down auth will occur **only** if the BUHP reviewer agrees that the member meets criteria for BHRF.
  - No PA is required.
  - The BUHP reviewer will give the authorization number and last covered day to the hospital.
  - The member must discharge to a BHRF that is contracted with BUHP.
  - The BHRF must send in the Notice of Admission within 2 business days.

PART 4

Authorization Process and Exclusionary Criteria

Barriers to Approved Authorizations

Barrier	Correction
Lack of understanding of Banner's authorization process including incomplete forms	✓ Read, download and understand Securing Services and Prior Authorization Chapter 8 in the Behavioral Health Comprehensive Provider Manual ✓ Review materials on our website to stay updated on our processes ✓ Reach out to Provider Rep for assistance
Lack of SMART goals	✓ Understand how to write clinically sound goals and objectives with time frames and measurable outcomes to avoid a medical necessity denial.
Untimely submittal or failure to supply appropriate information for determination of medical necessity	✓ Develop a system to ensure that your submittals will meet our timeframes to avoid an Administrative Denial
Lack of discharge planning at admission	✓ Determine initial discharge plan at admission, updating as member progresses through care
Requesting a Peer to Peer Review and failure to have highest clinical lead to participate in review with Banner Medical Director	✓ Ensure that appropriate clinical staff with the most clinical information and clinical capacity participating in the Peer to Peer review with the physician.
Failure to follow through with Banner UM if submittal is sent and there is no response from Banner	✓ Monitor your submittals and timeliness of Banner response. Confirm that Banner received submittal.

Authorization process

- Whether using the emergent or regular PA process;
  - Forms are to be faxed to Banner using the fax number on the PA form.
    - Make sure your fax shows successful delivery.
    - There are some exceptions when the forms can be emailed.
  - Banner has 72 hours from receipt of the request to make a medical necessity criteria decision for BHRF, TFC and ABHTH.
  - Adopted children require a 72 TAT for every level of care
  - **All** criteria is published in the Behavioral Health Comprehensive Provider Manual found on the BUHP website.
  - If you have not heard from the Behavioral Health Utilization Management (UM) department within 72 hours of submitting a PA, you should contact us directly.
    - Please **do not** call customer service
    - Please have the member's AHCCCS ID number when you call.

Authorization process

- The requesting provider will receive either an approval, a Notice of Extension (NOE), or a denial.
- Approval forms are e mailed per the contacts indicated on the PA. If you want someone else cc'd, please note that on the PA form.
- If you have not sent in everything needed to make a determination, including needed clinical documentation, a Notice of Extension (NOE) may be sent.
- Reviewer will reach out to request additional information prior to sending an NOE, however, due to time frames, if you can't provide the information immediately, we will mail the NOE to the member and email a copy to the requesting provider and/or facility. This can potentially delay care.
- If a denial is being issued, you will receive an email from the reviewer. The denial form will be mailed to the member and faxed to the facility or the requesting provider by our denials department.

Authorization process/Approvals

- **For children's out of home authorizations**: The initial authorization form will include the number of days initially authorized. Once the member admits, this will be updated to include the specific date span authorized and when the concurrent review is due. This will be sent to both the outpatient provider and the OOH provider.

- **For adult members:** If we do not have the Notice of Admission (NOA) form, your approved authorization notice will show 1 day. Once you submit the NOA within the required time period, an updated authorization notice will be emailed showing the authorized date span. Late NOA's will result in an Administrative Denial.
- If the NOA is submitted with the application, the authorization notice will contain the full date span.

- As concurrent reviews are being completed telephonically, your approval notice may not show a concurrent review date. You will have scheduled times for review with your assigned reviewer.

BHIF Exclusionary Criteria (Children only):

1. An alternative to incarceration, preventative detention, or to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior including runaway behavior; or

2. The equivalent of safe housing, permanency placement, or

3. An alternative to parents'/guardian's or another agency's capacity to provide for the child or adolescent; or

4. An intervention when other less restrictive alternatives are available and not being utilized.

Exclusionary Criteria for BHRF (Adults and Children)

AHCCCS policy AMPM 320-V

Admission to a BHRF shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment.

3. A means of providing safe housing, shelter, supervision, or permanency placement.

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative, or

5. As an intervention for runaway behaviors unrelated to a Behavioral Health Condition.

Exclusionary Criteria for Therapeutic Foster Care (TFC, formerly called HCTC—Children Only)

Admission to a TFC shall not be used as a substitute for the following:

1. An alternative to detention or incarceration,

2. As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors,

3. As a means of providing safe housing, shelter, supervision or permanency placement,

4. As an alternative to parents'/guardians' or other agencies' capacity to provide for the member,

5. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/health care decision maker is unwilling to participate in the less restrictive alternative, or an intervention for member runaway behaviors unrelated to a behavioral health condition.

Exclusionary Criteria for Adult Behavioral Health Therapeutic Home (ABHTH):

In addition to the same exclusionary criteria for children's TFC admission, the following are also exclusionary for ABHTH:

1. Members with active substance abuse
2. Members that are Registered Sex Offenders
3. Members with a history of fire setting

Authorization criteria for ABHTH: Listed in the provider manual in section 8 Securing Services.

This is a rarely used level of care for adults.

PART 5

Expectations/Requirements for the Out of Home providers.

Expectations for BHIF facilities (children)

Banner University Health Plans require the following active treatment be demonstrated:

1. Psychiatric services, including BHMP visits at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs.
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24-hour skilled medical/nursing supervision.
3. Individual therapy a minimum of weekly.
4. Family therapy a minimum of weekly. If family therapy is not being provided weekly, rationale and efforts to engage the family in therapy must be documented in the clinical record.
5. Group therapy daily.
6. Active and individualized on going positive behavioral management.
7. School or vocational programming.

Additional Expectations for BHIF

1. Recertification of Need (RON) must be submitted to the UM reviewer every 30 days.
2. Discharge planning must begin at admission.
3. Discharge plan/summary must be sent to the health plan UM reviewer and to the outpatient behavioral health provider within 24 hours of discharge.

Expectations for BHRF Facility Providers

1. BHRF providers are required to notify the member's PCP and BH outpatient providers upon admission to and discharge from the BHRF.

2. A behavioral health assessment for a member is to be completed before treatment is initiated and within 48 hours of admission.

3. The CFT/ART is included in the development of the treatment plan within 7 days of admission.

Expectations for BHRF Facility Providers (cont.)

4. A comprehensive discharge plan is created during the development of the initial service plan and is reviewed and/or updated at each review thereafter.

5. BHRF staff are to participate in the CFT/ART process and review and modify the treatment plan at least monthly.

6. Behavioral Health Professionals (BHP) must sign off on treatment plans within 24 hours.

Expectations for BHRF Facility Providers (cont.)

7. The BHRF provider must have a process to actively engage family/guardians/designated representative in the planning process as appropriate.

8. For members under 18 years of age, individual and family therapy is required weekly. If family therapy is not being provided weekly, rationale and efforts to engage the family in therapy must be documented in the clinical record.

9. When a member is at a BHRF facility, additional therapy or behavioral coaching/skills development cannot be billed. The health plan expects that all these services are provided by the BHRF facility as part of the per diem rate. The only exception to that is if there is a specialty that the member needs that cannot be provided by the BHRF provider. This MUST be prior authorized.

Expectations for Providers related to SUD treatment American Society of Addiction Medicine (ASAM)

- BUHP requires providers serving youth and adults with substance use disorders to utilize the American Society of Addiction Medicine (ASAM) in assessing persons with substance use disorders and to train all staff conducting ASAM assessments. In addition, the Behavioral Health Home or other provider acting as the member's Behavioral Health Home must ensure that services are delivered by staff competent to assess and treat substance use disorders in individuals and families.
- All members seeking treatment for Substance Use Disorders must receive an ASAM assessment at intake and at least every six months during treatment.

Expectations for Providers related to SUD treatment American Society of Addiction Medicine (ASAM) (cont.)

Behavioral health residential facilities (BHRFs) providing substance use treatment must ensure length of stay is consistent with member's needs and meets medical necessity criteria. Treatment must remain individualized for each member, dependent upon ASAM placement criteria and treatment needs.

The ASAM is not a substitute for our admission criteria. The ASAM provides a recommended level of care, and we review the recommendation. We review the application and **all** clinical information provided. We compare the totality of the information to the **medical necessity criteria** in order to make a determination.

Expectations for TFC providers (children)

Some requirements have changed with the revision of **AMPM 320-W** that went into effect Oct. 1, 2020.

1. The TFC Treatment Plan shall:

    a. Be developed in conjunction with the CFT, and written as SMART goals. Specific, Measurable, Attainable, Relevant, Time Based

    b. Describe strategies to address TFC Family Provider needs and successful transition for the member to begin service with TFC Family Provider, including pre-service visits when appropriate as well as respite planning.

2. Discharge planning should begin upon admission and be discussed at every CFT.

Expectations for TFC providers (children)

3. The TFC family provider and agency provider are expected to review treatment plan, progress and discharge planning.

4. If member is not making progress, it is the expectation that interventions are adjusted.

5. Banner members are expected to be enrolled in and engaged in weekly family therapy. It is the TFC family provider's responsibility to ensure that child member attends family therapy sessions. It is the outpatient provider's responsibility to ensure that family therapy is available.

PART 6

Concurrent Review

Concurrent Review Process

Concurrent reviews have moved to telephonic started in March 2021.

The assigned reviewer(s) may have specific daily or weekly times scheduled for your facility or will schedule with your reviewer when the authorization is provided.

Facility reviewer should be ready to review during the scheduled time.

All reviews are based on the clinical presentation. The facility reviewer should be ready to provide specific clinical information to the Banner reviewer.

Concurrent Review Process (cont.)

The following criteria will be considered when determining continued stay:

1.The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition consistent with the criteria for admission.

2.Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

3.Member is making progress towards identified goals or if there is lack of progress the facility and treatment plan are revised resulting in the expectation of improvement.

4.The member is demonstrating marked improvement toward the one or more identified area of significant risk of harm that was identified during the admission/evaluation period.

Concurrent Review Process (cont.)

- Health Plan reviewers need to know if there has been a change in any court ordered treatment or for children, if there is DCS involvement.
- For children, we will be looking for dates of individual and family therapy to demonstrate weekly sessions for both individual and family therapy for all OOH levels of care.
- Health plan reviewers will ask for dates of psychiatric appointments and the date of the next appointment.
- Provider should be ready to list current medications, dosages and how often, date of recent changes in medications and any side effects to medications AND be ready to speak to member's adherence to medication regimen.
- Health Plan reviewers will ask what the current SMART goals are and progress toward the goals.

Concurrent Review Process (cont.)

- What goals have been successfully completed?
- For goals not completed, be prepared to provide specific examples of member's improvement on those goals.
- OOH providers should be ready to explain whether a significant risk of harm still exists and what those specific risks are.
- OOH providers should be ready to explain what functional impairments continue to exist and to provide specific examples.
- OOH providers need to be ready to list the names of the specific groups the member attends and how often. May ask for specific dates.
- Health Plan reviewers will ask what goals or specific treatment cannot be provided in a lower level of care.

Concurrent Review Process (cont.)

- OOH providers should be ready to describe any aggression, self-harm behaviors, deterioration in the member's mental health or other risky behaviors. Please be ready to provide the specifics including dates and what lead up to the behaviors.
- Next, be able to provide what action the OOH provider took and what action the outpatient clinic/provider took.
- OOH providers should be prepared to discuss any home visits the member may have had and the outcome.
- If member is refusing to participate in treatment or programming, how is this being addressed and what attempts have been made to engage member?
- Be prepared to report results of labs/urine drug tests.

Concurrent Review Process (cont.)

- For adolescent members, age 16.5 or older, the health plan reviewers are going to ask if services have been discussed for Transitional Age Youth.
- If member is 17.5 or older, has an SMI determination been discussed? If member may qualify for SMI, an SMI evaluation should be completed.
- OOH provider should be prepared to share who the member's natural supports are.
- If member is going to be stepping down to a lower level of OOH care, have coordinated efforts been made to send referral packets?
- If member is stepping down within the next 2 weeks, OOH provider should have the date and times for all step down appointments, including BHMP follow up if member has medications prescribed.

PART 7

Discharge Planning

Discharge Planning

- Discharge planning begins on day 1
- As an OOH Provider, are you thinking about the next steps (i.e., the discharge plan) upon admission?
- There MUST be a discharge plan on day 1.
  - What will be the member's living arrangements upon discharge? Specific address and phone number.
  - What specific services will be in place upon discharge?
  - There should be plans A, B, and C.
- Discharge planning is not optional. Every member should know and have been involved in the development of goals. They should know what reaching that goal will look like and what the next level of their treatment and care will be.

Discharge Planning

- Discharge planning.
  - The OOH providers will be asked what the DC plan is.
  - There should be plans A, B, and C. This is because sometimes the first and second discharge plan may not become fully realized. A third option is needed to ensure a safe discharge.
- OOH providers should be prepared to explain and describe what the specific barriers are to transitioning to a less restrictive level of care.
- OOH providers should be ready to describe how the barriers are being addressed.

PART 8

Denials

Denials

Administrative Denials-Banner issues Administrative Denials when information submitted is untimely or insufficient to apply medical necessity criteria after requests for information have been sent. Administrative Denials are not eligible for an Appeal.

Medical Necessity Denials - Banner issues Medical Necessity Denials when the information submitted does not meet the medical necessity criteria found in the Banner Behavioral Health Comprehensive Provider Manual/Chapter 8.

BUHP Reviewers for OOH care are licensed by the Arizona Board of Behavioral Health Examiners as behavioral health professionals. They are specially trained in the specific criteria and are tested yearly to ensure that they are applying the criteria reliably and consistently.

Denials

A Banner Medical Director is the only one that can determine a Denial for medical necessity.

Medical necessity denials are eligible for the Appeal process. If a denial process for a specific level of care is current (60 days) and an authorization request is received for the same level of care, the requesting provider MUST be able to convey the changes in the member's clinical status to justify the medical necessity that has been formally denied and Banner has not yet rendered a final decision for the Appeal.

Denial letters have the Appeal information on them. Follow the process.

PART 9

PYX

Banner
University Health Plans

Pyx Health & Banner Health Plan

Banner Health

Banner University Health Plans

Pyx

App for adults

Pyx Application

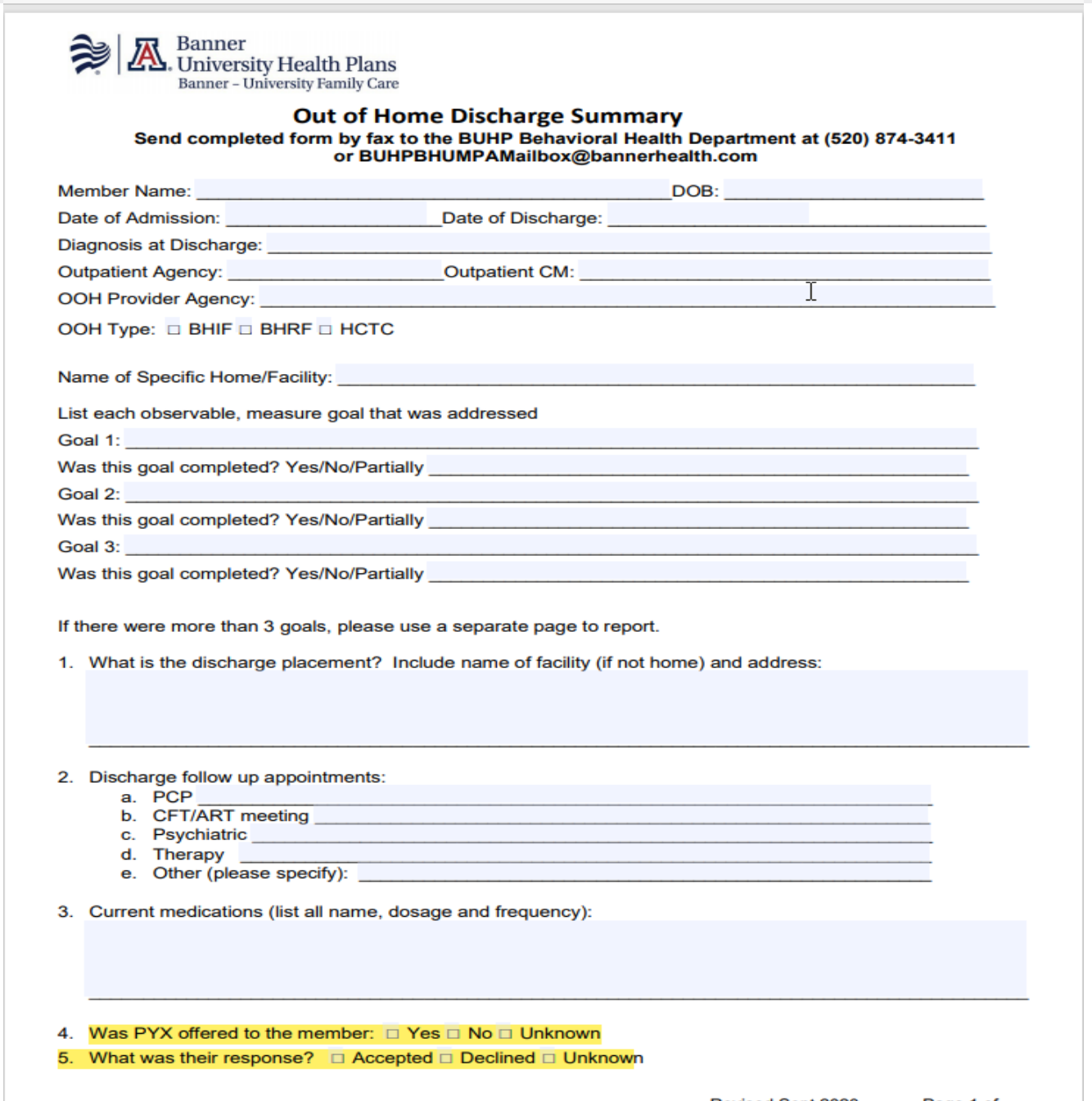
- Is an interactive app that is represented by a robot.
- Combats loneliness.
- Assists with social determinants of health (SDOH)
- Has geofencing around AZ hospitals and urgent care clinics, crisis centers
- Allows the member to identify circle of 5 people to contact if needed.
    - Case manager, family, friends
- Requires a smartphone
    - Android or iPhone
- Uses minimal data. Free/reduced rate, government support phones.
- Required introduction prior to discharge from BHRF.

OOH Discharge Form

Offering Pyx to adult members and documenting their response is required.

Provide the responses using our discharge form or yours.

Notification of discharge to the health plan is required within 24 hours of a member's discharge.



Banner University Health Plans
Banner – University Family Care

Out of Home Discharge Summary

Send completed form by fax to the BUHP Behavioral Health Department at (520) 874-3411 or BUHPBHUMPAMailbox@bannerhealth.com

Member Name: _____ DOB: _____

Date of Admission: _____ Date of Discharge: _____

Diagnosis at Discharge: _____

Outpatient Agency: _____ Outpatient CM: _____

OOH Provider Agency: _____

OOH Type: ☐ BHIF ☐ BHRF ☐ HCTC

Name of Specific Home/Facility: _____

List each observable, measure goal that was addressed

Goal 1: _____

Was this goal completed? Yes/No/Partially _____

Goal 2: _____

Was this goal completed? Yes/No/Partially _____

Goal 3: _____

Was this goal completed? Yes/No/Partially _____

If there were more than 3 goals, please use a separate page to report.

1. What is the discharge placement? Include name of facility (if not home) and address:

   _____

2. Discharge follow up appointments:
   a. PCP _____
   b. CFT/ART meeting _____
   c. Psychiatric _____
   d. Therapy _____
   e. Other (please specify): _____

3. Current medications (list all name, dosage and frequency):

   _____

4. Was PYX offered to the member: ☐ Yes ☐ No ☐ Unknown
5. What was their response? ☐ Accepted ☐ Declined ☐ Unknown

Thank You!

Contact information

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Thank you for attending today.

Lynda Crooms and Beth Pfile