OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
DEPARTMENT OF HUMAN SERVICES
PRIOR AUTHORIZATION REQUIREMENTS
FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE ORGANIZATIONS IN THE
BEHAVIORAL HEALTH HEALTHCHOICES PROGRAM

A. GENERAL REQUIREMENT

The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department of Human Services (Department) a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department's approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. The BH-MCO cannot require prior authorization for emergency services or emergency inpatient admissions. Authorization of emergency inpatient services must be consistent with Attachment 1. For each service to be prior authorized, the BH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below.
The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices Behavioral Health (HC BH) Agreement, including the Program Standards and Requirements (PSR), applicable policy in Medical Assistance General Regulations, Chapter 1101, and DHS regulations;
- ensure that behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court actions may require review of any previously approved prior authorization proposal. Any deviation from the Department's approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in the Department taking a corrective action.

The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:
a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

2. Medical Necessity Requirements:

a. The BH-MCO must describe the process to validate medical necessity for:
- covered care and services
- procedures and level of care
- medical or therapeutic items

b. The BH-MCO must identify the source of the guidelines used to review the request for prior authorization of services. The guidelines must be consistent with the HC BH PSR definition of medical necessity.

c. Medical necessity guidelines used by BH-MCOs must be approved by the Department and conform to Appendix S or T (as applicable) of the HC BH PSR.

For BH-MCOs, if the guidelines being used are:
- purchased and licensed, the BH-MCO must identify the vendor;
- developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
- based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
- based on the medical training, qualifications, and experience of the BH-MCO's Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the Member's condition or disease in accordance with CMS Guidelines, the HC BH PSR, and applicable legal settlements.

Requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the Member's condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or

- that the service or item is not medically necessary, after making a reasonable effort to consult the prescriber.

Additionally, if the Member is under 21 years of age, the reasonable efforts to consult with the prescriber must include a request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO. The BH-MCO may request either in writing or by telephone that the prescriber be contacted by the Member, parent, or authorized representative of the Member at the same time the BH-MCO is attempting to consult the prescriber. The BH-MCO's decision on whether to approve or deny the requested service cannot take into account whether the Member, parent, or the authorized representative chose to contact the prescriber. The BH-MCO must document its attempts to reach the prescriber, including its request that the Member, parent, or authorized representative of the Member, if the Member has an authorized representative, contact the prescriber to request that the prescriber contact the BH-MCO.

3. Administrative Requirements

A. The BH-MCO's written policies and procedure must demonstrate how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

B. The BH-MCO's written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO's overall Quality Management Plan.

4. Notification, Complaint, Grievance, and Fair Hearing Requirements

The BH-MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the Member notification requirements and the Complaint, Grievance, and Fair Hearing requirements of the HC BH PSR.

5. Requirements for Care Management/Care Coordination of Service(s)/Items(s) that do not require Prior Authorization

For purposes of tracking/care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify Providers of this notification requirement. This process may not be administratively cumbersome to Providers and Members. These situations need not comply with the other prior authorization requirements contained in this Appendix.

C. Prior Authorization Review and Decision Process:

1. Time frames for Notice of Decisions

a. The BH-MCO is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the Member is notified of the decision as expeditiously as the Member's health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made.

b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the Provider within forty-eight (48) hours of receipt of the request and allow up to fourteen (14) Days for the Provider to submit the additional information.

c. The BH-MCO must provide written notice to the Member that additional information has been requested on the date the additional information was requested using the Notice of Request for Additional Information template. The BH-MCO must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the request for additional information. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare. The BH-MCO may not modify the templates. The BH-MCO must also follow the instruction in the templates for including detailed, specific information related to the Denial.

d. If the requested information is provided within fourteen (14) Days, the BH-MCO must make the determination to approve or deny the service and notify the Member orally, within two (2) business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within two (2) business days after the decision is made. If the additional information is not received within fourteen (14) Days, the decision to approve or deny the service must be made based upon the available information and the Member notified orally within two (2) business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member and the prescribing Provider within (2) two business days after the decision is made.

In all cases, if the Member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) Days from the date the BH-MCO received the request, the service is automatically approved. To satisfy the twenty-one (21) Day time period, the BH-MCO may mail written notice to the Member and the prescribing Provider on or before the eighteenth (18th) Day from the date the request is received. If the notice is not mailed by the eighteenth (18th) Day after the request is received, then the BH-MCO must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

e. If the Member is currently receiving a requested service, the written notice of denial must be mailed to the Member at least ten (10) Days prior to the effective date of the denial of authorization for continued services. If probable Member fraud has been verified, the period of advance notice is shortened to five (5) Days. For acute inpatient services, the

effective date on a denial of a continuation of services must be at least one (1) Day after the date of the notice. If the Member wishes to have services continued as previously approved, the Member must file a Grievance before the effective date of the denial as indicated on the denial notice.

f. Advance notice is not required when the BH-MCO has factual information confirming the death of a Member; the BH-MCO receives a clear written statement signed by a Member that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the Member has been admitted to an institution where s/he is ineligible under the HC BH PSR for further services; the Member's whereabouts are unknown and the post office returns BH-MCO mail directed to the Member indicating no forwarding address; the Member has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the Member's physician.

2. Denial of Service:

A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

A. disapproves the request completely, or
B. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
C. approves provision of the requested service(s), but by a Network Provider, or
D. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
E. reduces, suspends, or terminates a previously authorized service.

NOTE: A denial of a request for service must be based upon one of the following five reasons, along with an explanation for the reason**,** which must be explicitly stated on the notice of action:

- The service requested is not a covered service.
- The service requested is a covered service but not for this particular Member (due to age, etc.)
- The provider is not a Network Provider
- The information provided is insufficient to determine that the service is medically necessary.
- The service requested is not medically necessary.

3. Authorization Decisions:

A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse

services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:

When a BH-MCO denies a request for services as defined in Section C.2. of this Appendix a written denial notice must be issued to the Member using the appropriate denial notice template. The BH-MCO must also include the Non-Discrimination Notice and Language Assistance Services templates when it sends the denial notice. The BH-MCO must use the templates supplied by the Department, which are available in DocuShare.

5. Denial Notice Reporting:

The BH-MCO must report denial of services to the Department via the denial log, as detailed in Appendix M.

6. Quality Review of Denial Notices

A. The Primary Contractor is responsible for ensuring the content and quality of the denial notices are consistent with the Department's requirements by implementing a formal monitoring process with documented procedures that include (but may not be limited to):
   - criteria used to review denial notices,
   - frequency of reviews,
   - percentage of denial notices to be reviewed,
   - selection process for the denial notices to be reviewed,
   - plan to ensure denial notices for various levels of care are reviewed,
   - plan to communicate review results to the BH-MCO,
   - individuals responsible for the review and dissemination of results of the review, and
   - process to ensure the BH-MCO incorporates recommendations from the review.

B. The Primary Contractor and BH-MCO are expected to comply with the Department's quality review of denial notices and the Department's efforts to ensure Primary Contractor oversight is adequate. The Department will specify a specific sample of denial notices that will be reviewed as part of the Department's quality review. The Department will review the denial notices to determine if the denial notices are compliant with federal and state regulations, policies, standards, and best practices.

ATTACHMENT 1

Emergency Inpatient Admission: Prior Authorization, Admission and Documentation

1. Prior authorization of psychiatric emergency inpatient admissions is not permitted. While prior authorization is not allowed for psychiatric emergency inpatient admissions, the BH-MCO may conduct a retrospective review, including review of the documentation by the physician at the emergency department verifying the medical necessity for emergency admission. Continued stay after stabilization of the emergency may be subject to concurrent review and prior authorization. The review procedures used by the BH-MCO shall not be inconsistent with the involuntary commitment processes set forth in the Mental Health Procedures Act, 50 P.S. §§ 7101 et seq.
2. If a request for continued stay after stabilization cannot be reviewed because it is uncertain if the individual is eligible for Medical Assistance, the BH-MCO must review the request within seven (7) days of the eligibility issue being resolved and no later than 180 days of the date of service.
3. The Primary Contractor and its BH-MCO may not refuse to cover emergency services based on the emergency department provider, hospital or fiscal agent not notifying the Member's BH-MCO of the Member's screening and treatment within 10 days of presentation for emergency services.
4. The BH-MCO must use the same time frame to review authorizations for continued stay for Network Providers and Out-of-Network Providers.
5. The Primary Contractor and its BH-MCO shall ensure that after stabilization of the emergency, the Provider completes an assessment and continues to document the Member's need for inpatient services to facilitate authorization for continued stay of the Member.