UnitedHealthcare Community Plan of Louisiana, Inc.	DEPARTMENT: **Clinical Operations – Behavioral Health**
	LINE OF BUSINESS: **UHC C&S Louisiana**
POLICY TITLE: **Utilization Management of Behavioral Health Benefits Addendum**	POLICY NUMBER:
EFFECTIVE DATE:	PAGE: **Page 1 of 11**
REVIEW DATE: ~~**11/20/2020**~~ **01/27/2021**	REVISION DATE: **01/27/2021**
REPLACES POLICY# / DATED:	~~AUTHORIZED BY~~ STATE APPROVAL: **08/07/2020**

I. SCOPE:

This addendum to the National Medicaid policy Management of Behavioral Health Benefits applies to members whose benefit coverage is provided through the Louisiana Medicaid plan and whose behavioral/mental health benefits are managed by UnitedHealthcare Community Plan of Louisiana (UHCCP LA).

II. PURPOSE:

National requirements as found in the Code of Federal Regulations (CFR), other applicable Federal regulations such as the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as the National Committee for Quality Assurance (NCQA) and URAC are reflected in the Government National Policy.

This addendum is to reflect unique requirements governing utilization management of behavioral health as described in the contract between the State of Louisiana Department of Health and Hospitals and UnitedHealthcare Community Plan of Louisiana ~~(UHCCP LA)~~ **(hereafter referred to as the Contract)**, regulatory requirements of the State of Louisiana, the Medicaid State Plan and waivers, and the court-ordered requirements, including but not limited to, United States v. State of Louisiana (DOJ Agreement- Case 3:18-cv-00608) of Chisholm v. Gee (Case 2:97-cv-03274).

III. DEFINITION(S)[1]:

- Medically Necessary Services – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:
  - deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

[1] Unless otherwise noted, definitions are from **Appendix B** of the Contract.

- those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

- Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiently of the use of health care services, procedures, and facilities. Utilization Management is inclusive of utilization review and service authorization.

- See the Government National Policy, *Medicaid and CHIP Managed Care – Policy Definitions List*.

- See also the All Lines of Business National Policy, *National Policy Definitions List*.

IV. POLICY[2]:

A General Provisions:

1 When an accrediting organization provides guidance that differs from State requirements, UCHCP LA may apply the accrediting organization's guidance when it is beneficial and/or less restrictive to the enrollee[3].

2 UHCCP LA has service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan. UHCCP LA's Clinical Criteria are disseminated to all affected providers, and upon request, to enrollees and potential enrollees.

[2] **Unless otherwise noted, policy provisions come from Appendix B of the Contract.**
[3] UHCCP Standard

3 UHCCP LA's Clinical Criteria are posted to its website. Posts for proprietary software that requires a license and which may not be posted publicly according to associated licensure restriction include the name of the software only. Upon request by an enrollee, their representative, or the Louisiana Department of Health (LDH), UHCCP LA provides the specific Clinical Criteria utilized to make a decision.

4 UHCCP LA identifies the source of the Clinical Criteria used for the review of service authorization requests and includes:

- a The vendor if the Clinical Criteria was purchased;
- b The association if the Clinical Criteria are developed/recommended or endorsed by a national or state health care provider association or society;
- c The Clinical Criteria source is identified if the criteria are based on national best practice guidelines; and
- d The individuals who make medical necessity determination if the criteria are based on the medical training, qualifications, and experience of UHCCP LA's medical director or other qualified and trained professionals.

5 UHCCP LA makes its decisions for utilization management, enrollee education, coverage of services, and other areas to which the Clinical Criteria apply in a manner consistent with the Clinical Criteria.

6 UHCCP LA makes decisions regarding medical necessity using LDH's definition of medically necessary services.

7 UHCCP LA has sufficient, appropriately qualified and trained clinical staff to apply service authorization Clinical Criteria.

8 UHCCP LA ensures that only clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease determine service authorization request denials or authorize a service in an amount, duration, or scope that is less than requested.

- a Individual(s) making these determinations have no history of disciplinary action or sanctions, including loss of staff privileges or participation

restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

b The individual making these determinations attests that no adverse determination is made regarding any medical procedure or service outside of the scope of such individual's expertise.

9 UHCCP LA has a plan for addressing the long-term stay of enrollees in emergency departments based on limited availability for necessary behavioral health services.

10 Upon request, UHCCP LA provides LDH with documentation supporting how it has placed appropriate limits on a service on the basis of medical necessity for individuals determined by LDH to need specialized behavioral health services.

11 UHCCP LA performs prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.

12 UHCCP LA ensures that inpatient psychiatric hospital and concurrent utilization reviews are completed by a Licensed Mental Health Profession (LMHP) for each enrollee referred for psychiatric admissions to general hospitals. UHCCP complies with the requirements set forth in state administrative rules.

13 A member or member's authorized representative may submit, orally or in writing, a service authorization request for the provision of services.

14 UHCCP LA does not deny authorization of higher-level services (e.g., inpatient hospital) for failure to meet medical necessity unless UHCCP LA can provide the service through an in-network or out-of-network provider for a lower level of care.

15 For the first 30 days of a newly enrolled member's linkage to the plan, UHCCP LA does not:

a Require authorization for the continuation of medically necessary covered services of a new member transitioning into UHCCP LA, regardless of the network status of the provider:

b Deny prior authorization solely on the basis of the provider being an out-of-network provider.

16 UHCCP LA does not require service authorization or referral for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.

B Coordinated System of Care (CSoC)

1 UHCCP LA conducts utilization management and review functions for the CSoC population, including:

a Applying initial risk screen for CSoC eligibility;

b When indicated, refer calls via seamless transfer to the contracted administrator of the CSoC program, who applies Brief CANS assessment tool to assess for CSoC presumptive eligibility; and

c Document in the child's health record:

i whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility;

ii when the child was referred to the Wraparound Agency;

iii the date on which the Freedom of Choice was signed;

iv if the child does not become enrolled in CSoC the reason:

- the youth and family refuse CSoC services; or
- the youth does not meet clinical eligibility based on the comprehensive CANS; or
- other reason.

d For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, UHCCP LA offers voluntary participation in

Case Management and/or other behavioral health services to meet the child and family's presenting needs.

C Court-Ordered Treatment

1 All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by UHCCP LA.

D Turnaround Time Requirements for Authorization and Non-Coverage Determinations

1 UHCCP LA makes 80% of standard service authorization determinations within 2 business days of obtaining appropriate medical information that may be required regarding a proposed ~~admission,~~ procedure, or service requiring a review determination.

2 All standard service authorization determinations are made no later than 14 calendar days following receipt of the request for service with the following exceptions:

a **Community Psychiatric Support and Treatment (**CPST**)** and **Psychosocial Rehabilitation (**PSR**)** service~~s~~ **authorizations** ~~for which the standard for determination is~~ **are made** within 5 calendar days of obtaining appropriate medical information; **and**

b All inpatient hospital service authorizations are made within 2 calendar days of obtaining appropriate medical information.

c Service authorization decision**s** may be extended up to 14 additional calendar days if:

i The member or the provider requests the extension; or

ii UHCCP LA justifies (to LDH upon request) the need for additional information and how the extension is in the member's interest.

3 UHCCP LA makes ~~95% of~~ concurrent **and expedited** review determinations within 1 ~~business~~ **calendar** day and ~~99.5% of concurrent review~~

~~determinations within 2 business days~~ of obtaining the appropriate medical information that may be required.

4 UHCCP LA makes post-service (retrospective) review determinations within 30 days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 days from the date of receipt of request for service authorization.

Table 1. Timeframes for Decisions and Notifications

Type of Request	Timeframe for Decision and Notification after obtaining appropriate medical information	Timeframe not to exceed for Decision and Notification after request	Possible Extension
Standard	**2 business days**	**14 calendar days**	**14 calendar days**
CPST and PSR services	**5 calendar days**	**14 calendar days**	**14 calendar days**
Inpatient Hospital Services	**2 calendar days**	**14 calendar days**	**14 calendar days**
Expedited	**1 calendar day**	**NA**	**NA**
Concurrent	**1 calendar day**	**NA**	**NA**
Post-service	**30 calendar days**	**180 days**	**NA**

5 UHCCP LA does not subsequently retract an authorization after services have been provided or reduce payment or an item or service(s) furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.

6 UHCCP LA does not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.

E Notice of Action

1 Approval

a For service authorization approval for a non-emergency admission, procedure or service, UHCCP LA notifies the provider verbally or as expeditiously as the enrollee's health condition requires, but not more than 1 business day of making the initial determination and provides written notification to the provider within 2 business days of making the determination.

b For service authorization approval or extended stay or additional services, UHCCP LA notifies the provider rendering the service, whether a health care professional or facility or both, and the enrollee receiving the service, verbally or as expeditiously as the enrollee's health condition requires, but not more than 1 business day of making the initial determination and shall provide written notification to the provider within 2 business days of making the determination.

2 Adverse Action

a UHCCP LA notifies the enrollee, in writing using language that is easily understood by the enrollee, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the *Enrollee Grievances, Appeals and State Fair Hearings* section in the contract. The notice of action to enrollees shall be consistent with requirements in 42 C.F.R. §438.404, §438.10 and §438.210, the *Marketing and Education* section of the contract for member written materials, and any agreements that the Department may have entered into relative to the contents of enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.

b UHCCP LA notifies the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested.

UHCCP LA provides written notification to the provider rendering the service, whether a health care professional or facility or both, within 2 business days of making the determination.

F Member Choice Form[4]

1 Members may only receive Mental Health Rehabilitation (MHR) services from one provider at a time with the following exceptions:

a A member is receiving tenancy support through the Permanent Supportive Housing Program.

b The UHCCP LA medical director makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each medical necessity review.

2 All members must complete and sign a Member Choice Form prior to the start of MHR services and when transferring from one MHR provider to another. UHCCP LA will notify the previous provider upon receipt of the new Member Choice form. The Member Choice Form is required to ~~be~~:

a **Be** submitted with the initial Level of Care Utilization System (LOCUS)/ Child and Adolescent Service Intensity Instrument (CASII)/ Early Childhood Service Intensity Instrument (ECSII);

b Be a part of the member's clinical record; **and**

c **Be** ~~and is~~ subject to audit upon request.

3 Providers must notify the member's health plan immediately if it is suspected that a member is receiving MHR services from more than one provider.

4 In most situations, during a transfer the initial provider is given a service end date while the new provider is given a start date to prevent a gap in

[4] **Louisiana Department of Health Medicaid Services Manual, Chapter 2: Behavioral Health Services Provider Manual, March 14, 2017, Section 2.3: Outpatient Services, Member Choice Form and Process**

services. UHCCP LA will monitor the duplication of services via prior authorization, ALERT and Practice Management.

VI. RELATED POLICIES:

- All Lines of Business National Policy. *National Policy Definitions List*
- Government Program Policies, *Medicaid – Management of Behavioral Health Benefits Addendum* Government National Policy, *Medicaid and CHIP Managed Care – Policy Definitions List*

X. APPROVED BY:

~~**10/9/2019**~~ ~~**11/07/2020**~~
01/21/2021

_____ _____

Jose Calderon-Abbo, M.D.
UHC Medical Director for Behavioral Health **Date**

P&P Revision Control Log

Revision Date	Summary of Revision(s) (Bullets what has changed, Include Page #)	Reason(s) for Revision
September 2016	Pages 38-39: added TAT requirements related to standard authorizations and denials.	Contractual requirement
October 2016	Table 3A on page 38	Contractual requirement

UnitedHealthcare Community Plan of Louisiana, Inc.	DEPARTMENT: **Clinical Operations – Behavioral Health**
	LINE OF BUSINESS: **UHC C&S Louisiana**
POLICY TITLE: **Utilization Management of Behavioral Health Benefits Addendum**	POLICY NUMBER:
EFFECTIVE DATE:	PAGE: **Page 11 of 11**
REVIEW DATE: ~~**11/20/2020**~~ **01/27/2021**	REVISION DATE: **01/27/2021**
REPLACES POLICY# / DATED:	~~AUTHORIZED BY~~ STATE APPROVAL: **08/07/2020**

Revision Date	Summary of Revision(s) (Bullets what has changed, Include Page #)	Reason(s) for Revision
November 2019	Addended to the Optum Management of Behavioral Health Benefits: Medicaid Removed non contractual and procedural elements and references pertaining to case management, Human Resources and Training Updated to align with current contract	Annual Review and Contractual Changes
August 2020	Header. Removed Subject to State Approval tag line.	State approval received August 07, 2020
November 2020	**Pages 6 and 7. Changed timeframes for standard, concurrent and expedited prior authorizations. Added Table 1. Timeframes for Decisions and Notifications**	**Annual Review and Contract Amendment # 3 mandated changes**
January 2021	**Pages 6 and 7. Changed timeframes for standard authorizations and added timeframe for inpatient hospital services.**	**Second issuing of Amendment #3**