

IV. Clinical Policies & Procedures



A. Introduction

The role of *ValueOptions* is to coordinate the delivery of clinical services. There are three parties to this care coordination process: the Enrollee, the Provider(s), and the clinical staff at *ValueOptions*' Texas Service Center. Each party has a significant role to play to assure that care is coordinated, Enrollees receive medically necessary and needed services within the scope of their eligibility, and Providers both deliver quality care and get reimbursed for the services they provide.

1. Roles of Enrollees and Their Families in Treatment

ValueOptions embraces the premise that to be maximally effective, behavioral health treatment needs to be an active process. This means that Enrollees and their families are expected and encouraged to be active participants in the treatment process to the full extent of their capabilities.

2. Roles of Providers

The Provider's role is to provide timely access for assessment and treatment services for enrolled consumers in the NorthSTAR program. Providers are responsible to involve Enrollees and their families in the treatment process, for coordination of care with other providers and human service agencies, for measuring treatment outcomes and satisfaction with care, and working collaboratively with *ValueOptions* to meet the needs of enrolled consumers.

3. Roles of *ValueOptions*' Care Managers

ValueOptions Care Managers assist consumers and Providers in assuring that Enrollees access the services they need at the most appropriate level and intensity of care, for the right amount of time. Care Managers work with Enrollees and Providers to authorize the delivery of medically necessary services. Care Managers also assure that Providers are performing comprehensive assessments, developing individual service plans, coordinating the delivery of care, and providing or referring Enrollees to additional services.

B. Referral Information

1. Access to Care

Access to care may occur through one of three processes:

- Referral sources may make referrals directly to an individual provider or agency within *ValueOptions* provider network.

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- Individuals or family members seeking help may also contact an individual provider or agency directly.
- Individuals or referral sources may contact *ValueOptions* ACCESS LINE to obtain a referral to an individual provider or agency.

ValueOptions maintains a clinical referral line, known as the *ValueOptions* ACCESS LINE - staffed by licensed clinicians, for the receipt of emergency, urgent, and routine calls on a 24-hour, seven-day a week basis.

When Enrollees call *ValueOptions* ACCESS LINE for entry into care, the clinicians conduct a brief screening to determine the clinical needs of the Enrollee and to confirm basic demographic information. Based on the information gathered from the Enrollee during this telephonic screening, the ACCESS LINE clinician refers the Enrollee to an appropriate network provider for a clinical and financial assessment.

2. Assessment Documentation

At a minimum, the following information must be documented for all initial assessments:

- Name
- Date of referral
- Date of Assessment
- Disposition following assessment, including reasons for terminating the referral, if no further services are offered
- Date of next appointment, if applicable
- STAR primary care physician's name, address, and telephone number
- Evidence of notification to the referral source of the outcome of the referral

3. Treatment for Ineligible Individuals

Indigent, non-Medicaid individuals who do not meet the clinical necessity criteria for NorthSTAR services may be treated by providers with alternative funds or may be referred to other community services.

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C. Authorization

1. Service Authorization Overview

In order to better serve our callers in crisis, we request that routine calls to our ACCESS LINE **1-888-800-6799** (i.e. those that are not urgent or emergencies) should be made during business hours, which are Monday through Friday, 8:00 am to 5:00 pm CST.

ValueOptions' ACCESS LINE provides authorization for all covered services. Authorization for most intensive levels of care (e.g., acute inpatient, residential, etc.) is provided by telephone. Providers contact *ValueOptions'* Care Managers, request authorization of services, present and discuss clinical information, and receive authorization to provide the requested care.

ValueOptions maintains a "Front Door Access System" for inpatient acute psychiatric care. If an adult non-Medicaid NorthSTAR member presents for acute inpatient admission at a non-designated front-door facility, the individual will be directed to a front-door facility for admission. The non-designated facility would contact a *ValueOptions'* Care Manager through *ValueOptions* ACCESS LINE for transport authorization to the most appropriate "Front Door Facility."

Authorizations for rehabilitative and supportive services which are delivered through the Specialty Provider Network (SPN) require the SPN to complete a WebCare Uniform Assessment and appropriate Texas Recommended Authorization Guidelines Scores (TRAG) with a treatment plan (if requested) to *ValueOptions*. More information regarding TRAG scoring can be found at: <http://www.dshs.state.tx.us>.

Authorization for outpatient care is required for outpatient services beyond 3 visits per year effective September 1 of every year. For outpatient authorizations which require additional clinical information, the Provider should submit the required treatment plan by fax to *ValueOptions* (1-877-888-6444).

2. Mental Health Outpatient Levels of Care - Review and Authorization

Consumers who meet criteria as target populations are eligible for the extended services. (Please see Section II: Eligibility, Enrollment, and Covered Services). Following the submission of the required assessment data through WebCare, *ValueOptions* Care Managers will review requests for services according to the resiliency and disease management model. *ValueOptions* Care Manager will authorize the requested services for up to twelve months, and an authorization letter will be sent to the SPN.

Outpatient services are authorized by *ValueOptions* in accordance with the DSHS MH Resiliency and Disease Management (R&DM) UM guidelines and in a way that does not inappropriately deny persons access to services. Following the referral to a provider, services

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may be automatically authorized depending on provider submission of appropriate documentation to *ValueOptions* UM department.

In some instances, if additional information is required to make an authorization determination, *ValueOptions* Care Manager may request submission of the complete treatment plan from the consumer's medical record.

One of *ValueOptions*' Care Managers is assigned to each of the SPNs in *ValueOptions* network. If assistance is needed in the development of a plan of care to meet the complex needs of a target population member, the Care Manager may be contacted to participate in the treatment planning.

3. Utilization Management Review

Upon receipt of all required information, including the WebCare Uniform Assessment, requests for authorization of services are reviewed by *ValueOptions*' Utilization Management staff in accordance with the following standards.

- Determination made within two business days
- Notification to provider of determination by telephone or electronic format within two business days of making the determination
- If electronic notification is not used, then written confirmation to provider of decision within three business days

4. Retrospective Review

- Determination made within 30 business days
- Written notification to provider of denial determinations within five business days of making the determination

5. Clinical Overrides and Exceptions:

a. Overrides

ValueOptions may authorize a clinical override to the TRAG Guidelines, which result in placement in a higher service package for the following reasons:

- **Consumer need:** A person has a medical need for services, evidenced by psychiatric inpatient admissions, which are included in a service package other than the one recommended by the TRAG.
- **Continuity of Care:** The TRAG recommends a lower service package but the person is maintained in the current service package for clinical reasons such as ensuring that improvements are maintained.

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- **Other:** A person presents for care and a clinician determines that an extenuating circumstance exists that requires the person to be served that is not captured in one of the other deviation reasons.

ValueOptions may authorize an override to the TRAG UM Guidelines which result in placement in a lower level service package for the following reasons:

- **Consumer Choice:** A person chooses not to receive services in the service package as recommended by the TRAG and wants to move to a less comprehensive package.
- **Provider lack of information or failure to validate reported TRAG dimension score on request from *ValueOptions*.**

b. Exceptions

ValueOptions may authorize an exception to the amounts of service within a service package for persons who have reached the maximum service unit limits of a level of care or for greater than it routinely authorizes, for the following reasons:

- **Consumer need:** A person in services and the clinician determine that an extenuating clinical circumstance exists that require the person to be served with an increased frequency or duration of services than is routinely authorized by *ValueOptions*

c. Requests for Clinical Overrides:

If, when applying the TRAG, the Licensed Professional of Healing Arts (LPHA) conducting the eligibility determination, determines that one of the approved conditions exist for granting a clinical override, the LPHA will do the following:

- Overrides for a higher service package – contact *ValueOptions* Care Manager, provide them with the necessary information and documentation to grant or deny the request
- Override for a lower service package – A provider can submit for a lower service package override by indicating such on their WebCare assessment
- Request for exceptions to the service intensity – authorization for additional units shall be submitted by providing an early request form to the Utilization Manager for review, with appropriate WebCare assessment information.

The exception and clinical override processes are not intended as mechanisms for appeal. These mechanisms are to ensure that individuals have access to clinically appropriate services.

d. Tracking, Reporting and Evaluation of Clinical Overrides:

The Utilization Management Committee (UMC) shall review aggregate data about the reasons for all exceptions and overrides quarterly. The UMC will ensure that periodically, an in depth

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analysis is conducted (which includes review of a sample of cases) and reviewed by the Committee.

ValueOptions will document the reasons for all clinical overrides and report them to the Quality Management Committee (QMC) on a quarterly basis. The information to be reported will include the following:

- Provider and individual's reason/clinical justification for the requested override
- *ValueOptions*' decision and reason for granting or denying the request for clinical override. NorthSTAR will monitor the number, nature and consistency of clinical overrides on a quarterly basis. The continued need for and impact of the clinical override process will be periodically evaluated by NorthSTAR using data and information provided by *ValueOptions*.

6. Service Authorization Grid

The following pages contain a **Service Authorization Grid** (which lists specific levels of care in several categories which are referenced in these procedures).

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Service Authorization Grid

Level of Care	Provided To:	Provided By:	Service Code	Pre-Authorization Required? *Pass through may apply	Pass through units available in the plan year	Authorization Process	Unit Value	Service Delivery Frequency Standards	Exclusions	Exception to Exclusions
Inpatient Services										
Acute (MH) Inpatient Hospitalization	Children & Adults	Licensed Facilities	100,114, 120,124	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	
Hospital-based Detoxification	Youth & Adults	Licensed Facilities	H0009	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily		
Sub-Acute (MH) Inpatient Hospitalization	Children & Adults	Licensed Facilities	190	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	
23 Hr Observation (Hospital-based)	Children & Adults	Licensed Facilities	762	Yes	No	Telephonic-Prior to Admission	Episode	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	
Crisis Stabilization										
Crisis Stabilization (Hospital-based, 1-3 days)	Children & Adults	Cred. Providers	154	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	
Crisis Stabilization (Community-based, 1-3 days)	Children & Adults	Cred. Providers	154	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	
Intensive Crisis Residential (1-14 days)	Children & Adults	SPN and Licensed Facilities	H0018	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	None
Residential Services										
Residential Treatment Centers	Children	Licensed Facilities	H0018, 1001	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily		
Level I Residential	Adults	SPN and Licensed Facilities	H2036	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily	ACT Members	None

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Level of Care	Provided To:	Provided By:	Service Code	Pre-Authorization Required? *Pass through may apply	Pass through units available in the plan year	Authorization Process	Unit Value	Service Delivery Frequency Standards	Exclusions	Exception to Exclusions
Medically Monitored 24- hr Residential Detoxification	Youth & Adults	Cred. Providers	H0010	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	None
Specialized Female Services- Residential	Youth & Adults	Cred. Providers	H2036	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	None
Placement Maintenance Services										
24- Hr Residential Rehabilitation Program	Youth & Adults	Cred. Providers	H2036	Yes	No	Telephonic-Prior to Admission	Day	24 h -daily	If assigned to an ACT team, ACT must be consulted prior to admission	None
Respite Housing	Children & Adults	SPN	H0045	Yes	No	Telephonic-Prior to Admission	Day	Constant Supervision	Non SMI/ SED	None
Supported Housing- Temporary Rental Assistance	SMI Adults & SED Youth (18-21)	SPN	H0044	Yes	No	Telephonic – Prior to Admission or Treatment Plan for continuance	Per diem	NA- must have plan in place with TRA ends	Non SMI/ SED	None
Personal Care Homes/ Assisted Living	SMI Adults	SPN	T1023	Yes	No	Telephonic – Prior to Admission or Treatment Plan for continuance	Per diem	24 h -daily	Non SMI	None
Therapeutic Foster Care	SED Children	SPN	S5145	Yes	No	Telephonic-Prior to Admission	Per diem	24 h -daily	Non SED	None
Adult Foster Care	SMI Adults	SPN	S5140	Yes	No	Telephonic-Prior to Admission	Per diem	24 h –daily	Non SMI	None
Pharmacological Maintenance Therapy	Adults	Cred. Providers	H0020	No	No	None	Day	210- daily, 211- 1X monthly		
Partial Hospital										
Partial Hospital	Children & Adults	Cred. Providers	H0035, H0047	Yes	No	Telephonic-Prior to Admission	Per diem	6 hours per day	ACT	None
Partial Hospitalization Rehabilitation Program	Children & Adults	Cred. Providers	T1008	Yes	No	Telephonic-Prior to Admission	Day	6 hours per day	ACT	None

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Level of Care	Provided To:	Provided By:	Service Code	Pre-Authorization Required? *Pass through may apply	Pass through units available in the plan year	Authorization Process	Unit Value	Service Delivery Frequency Standards	Exclusions	Exception to Exclusions
Day Services										
Day Treatment for Acute Needs-Rehabilitative	Adults	SPN	G0177	Yes	No	Telephonic – Prior to Admission or Treatment Plan for continuance	Hour	No more than 6 per day	ACT	None
Day Treatment CD	Adults	Cred. Providers	T1008	Yes	No	Telephonic-Prior to Admission	Day	20 hours per week	ACT	None
Intensive Outpatient										
Intensive Outpatient	Youth & Adults	Cred. Providers	H0047, 0905	Yes	No	Telephonic-Prior to Admission	Per diem	3 hours per day, 2-3 days a week	ACT	None
Intensive Outpatient Rehabilitative Program	Youth & Adults	Cred. Providers	H0047, 0905	Yes	No	Telephonic-Prior to Admission	Day	10 hours a week	ACT	None
Specialized Female Services- day only	Youth & Adults	Cred. Providers	H2035	Yes	No	Telephonic-Prior to Admission	Day	10 hours a week	ACT	None
Medically Monitored Outpatient Detox	Youth & Adults	Cred. Providers	H0012	Yes	No	Telephonic-Prior to Admission	Day	Daily		
Supportive Outpatient Program	Youth & Adults	Cred. Providers	H00474	Yes	20 units	Telephonic after initial units are utilized	Day	2 hours per week	ACT	None
Supportive Services										
Psychosocial Rehabilitation	SMI Adults	SPN	H2017	Yes	No	Uniform Assessment	15 min	Face to face	ACT Non-SMI or SED	
Skills Training (Rehabilitative)	SED Children & SMI Adults	SPN	H2014	Yes	No	Uniform Assessment	15 min	Face to face	ACT Non-SMI or SED	
Medication Trainings & Support	SED Children & SMI Adults	SPN	H0034	Yes	No	Uniform Assessment	15 min	Face to face	ACT Non-SMI or SED	
Supported Employment	SMI Adults	SPN	H2023	Yes	No	Uniform Assessment	15 min		ACT Non-SMI or SED	
Early Intervention	Children 3-5	SPN	T1027	Yes	No	Telephonic-Prior to Admission	Hour	Per service need and standards		
Respite- In/Out of Home	Children & Adults	SPN	S9125	Yes	No	Telephonic-Prior to Admission	Hour	Constant while in respite		
Case Management	SED Children & SMI Adults	SPN	T1017	Yes	No	Uniform Assessment	15 min	Face to face	ACT and Psychosocial Rehab	

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Level of Care	Provided To:	Provided By:	Service Code	Pre-Authorization Required? *Pass through may apply	Pass through units available in the plan year	Authorization Process	Unit Value	Service Delivery Frequency Standards	Exclusions	Exception to Exclusions
Assertive Community Treatment	Adults	SPN	H0040	Yes	No	Application for ACT services or Application for continued services	Month	3-7 times a week; with 70% in the community	All other NS services	Temporary Rental Assistance, Inpatient, Methadone Maintenance and Detox
Specialty Childrens' Program										
Specialty Program- Early Childhood Pre-School Day Treatment	Children (Ages 3-5)	Existing Specialty Provider Only	H2012	Yes	No	Telephonic-Prior to Admission	Week	Daily		
Specialty Program- Children and Youth Wrap Around	Children/ Youth (Ages 10-17)	Existing Specialty Provider Only	H2022	Yes	No	Telephonic-Prior to Admission	Week	Daily		
Specialty Program- Mental Health Services	Children (Birth to age 6)	Existing Specialty Provider Only	T1025	Yes	No	Telephonic-Prior to Admission	Week	3-5 times a week		
Specialty Program- Treatment Foster Care	Children	Existing Specialty Provider Only	S5145	Yes	No	Telephonic-Prior to Admission	Day	24 hour support		
Outpatient Services										
Outpatient Treatment Modalities- Diagnostic Interview/ Clinical Assessment- Individual/ Family/Group/ Multiple Family Group/ Narcosynthesis	Children & Adults	Cred. Providers	Standard CPT (0-20) Rehab codes for Counseling (21 and up)	Yes	3 units except Medication Management	Treatment Plan when initial units have expired	Per service unit	Face to Face	ACT	None
Medication Management	Children & Adults	Cred. Providers	Standard CPT	No	Yes- no limit	None	Per service	Face to Face	ACT	None
Walk-In Crisis Assessment	Children & Adults	Cred. Providers	Standard CPT	Yes	3 units with other TINs	Treatment Plan when initial units have expired	Per service	Face to Face	ACT	None
Home-Based and School Based Behavioral Health Treatment	Children	Cred. Providers	Standard CPT	Yes	No	Telephonic	Per service	Face to Face		
Psychological Testing/ Neurological Testing Battery	Children	Cred. Providers	Standard CPT	Yes	3 units Psychological testing only	Written request	Hour	Face to Face		

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Level of Care	Provided To:	Provided By:	Service Code	Pre-Authorization Required? *Pass through may apply	Pass through units available in the plan year	Authorization Process	Unit Value	Service Delivery Frequency Standards	Exclusions	Exception to Exclusions
Crisis Intervention Services	Children & Adults	Cred. Providers	H2011	No	Unlimited	None	Per episode	Face to Face	ACT	None
Transportation	Children & Adults	Cred. Providers	None	Varies	NA	Telephonic				

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7. Inpatient and Alternative Levels of Care

a. Pre-authorization

Pre-authorization is required for admissions to all levels of care except for the three units of pass through for traditional Outpatient Services and in cases of (life-threatening) emergencies.

Please note: there are three outpatient pass through units annually per member effective September 1.

After performing the assessment responsibilities according to the instructions contained in Section III (Enrollee Information), please follow these steps when requesting pre-authorization to acute levels of care:

- **Call the Service Center:** Contact *ValueOptions'* ACCESS LINE **1-888-800-6799** for pre-authorization of services for all eligible or enrolled consumers prior to their admission to these services. In emergency situations (i.e. those which require immediate care and treatment to avoid jeopardy to the life or health of the individual or harm to another person by the individual), authorization must be requested within 24 hours of delivering care.
- **Required Clinical and Demographic Information:** When you contact the ACCESS LINE to request pre-authorization, please be prepared to convey the clinical and demographic information that is requested in Section IV (Clinical Policies and Procedures) titled, "Information Required for Service Authorization". These instructions for providing clinical and demographic information to our Care Managers are presented in the order of the sequential screens of our on-line Managed Healthcare System (MHS), which is used by all *ValueOptions'* Care Managers. Presenting clinical information in this fashion to our Care Managers will result in timely, effective responses to your requests for authorizations.
- **Level of Care Criteria:** *ValueOptions'* Care Managers will evaluate authorization requests and the clinical information presented by providers according to our Level of Care Criteria (medical necessity criteria) included as an Addendum to this Manual. Please familiarize yourselves with these criteria so that both network providers and *ValueOptions'* Care Managers share a common framework for requesting and authorizing the delivery of care.

b. Concurrent Review

Providers **must** call *ValueOptions'* Service Center to request authorization of continued stays in inpatient and alternative levels of care. All requests for authorization of continued stays should be made far enough in advance of the expiration of the pre-authorization so that no lapse in services occurs. *ValueOptions'* Care Manager conducting the pre-authorization will provide specific instructions for concurrent review procedures.

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Please Note: It is up to providers to initiate telephone calls to the Service Center for requests for continued stays or concurrent reviews. Providers should make these telephone calls according to the instructions provided by the Care Manager during the pre-authorization process, and the procedures contained in our Provider Manual. *ValueOptions* does not routinely initiate calls to providers for continued stays and concurrent reviews. Failure to initiate concurrent review telephone calls by providers may result in non-payment of claims. Please follow these steps when requesting concurrent reviews or continued stays in inpatient and alternative levels of care:

- **Call the Service Center:** Contact *ValueOptions*' ACCESS LINE **1-888-800-6799** to request continued stays in inpatient and alternative levels of care (services listed under "telephonic authorization" in the grid within Section IV: Clinical Policies and Procedures). During the pre-authorization process, Care Managers provide specific instructions regarding concurrent reviews and how providers should initiate these. Please follow these instructions carefully. They include a specific date and time for you to call the Service Center, whom to ask for, and what clinical and demographic information to have available.
- **Required Clinical and Demographic Information:** When you contact the ACCESS LINE **1-888-800-6799** to request continued stays, please be prepared to convey the clinical and demographic information that is requested in Section IV (Clinical Policies and Procedures) titled, "Information Required for Service Authorization". Care Managers may also request specific information on the enrollee's signs and symptoms, progress made towards goals in the service or treatment plan, and discharge information.
- **Level of Care Criteria:** *ValueOptions* Care Managers will evaluate authorization requests and the clinical information presented by providers according to our Level of Care Criteria (medical necessity criteria) included as an Addendum to this Manual. Please familiarize yourselves with these criteria so that both network providers and *ValueOptions* Care Managers share a common framework for requesting and authorizing the delivery of care.

c. Discharge Planning:

- **Begins At Admission:** Discharge planning begins at the time of admission as a collaborative effort between the Care Managers and the treating provider. The intensity of the Care Manager's involvement in discharge planning will vary, depending upon the enrollee's needs and the level of care from which the enrollee is being discharged.
- **Updating the Discharge Plan:** Discharge plans should be updated throughout an enrollee's stay, and should be updated and revised as necessary according to the decisions reached in the concurrent review authorization process. Authorization for other levels of care will be based on clinical necessity, current treatment plan, and continuity-of-care issues.
- A critical component of discharge planning is the scheduling of the follow-up appointment. Per State requirements, outpatient services must be scheduled prior to a

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consumer's discharge from an inpatient (or other 24-hour) setting. Consumers must be seen within **seven (7) days** of discharge for mental health and within **five (5) days** for substance abuse/chemical dependency.

8. Expanded and Value-Added Services

***ValueOptions* expanded the continuum of services that will be available to NorthSTAR enrollees. These include the following services that require authorization and have procedure codes for reimbursement of claims. (See authorization section for details).**

- Sub-Acute Inpatient
- Crisis Stabilization (Hospital-based)
- Crisis Stabilization (Community-based)
- 23-Hour Observation and Treatment
- Residential (RTC) for Adults
- Focused Supportive Services

***ValueOptions* has also committed to supporting the development of additional “value-added” services that are available to all consumers, and do not require authorization. *ValueOptions* is currently working with consumer and provider groups to assess the need for geographic placement and expansion of these resources.**

- Consumer Run Drop-In Centers
- Minority and Specialty Populations Outreach
- Family Support Groups
- Peer Education Support and Counseling
- School-based Preventive Services
- Dual Diagnosis Support Groups
- Transportation for Non-Medicaid Consumers (*ValueOptions* has negotiated program rates that include payment for transportation to medically necessary services for uninsured enrollees).

9. Services Not Requiring Authorization

a. Data Analysis

Services that fall in this category on the Covered Services Authorization Table do not require authorization. *ValueOptions* will be monitoring access to and the delivery of these services by

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analyzing claims and other data. Do not call the Service Center for authorization of these Services, and do not attempt to register the delivery of these Services.

b. Payment for Services Provided to Enrollees

For these Services provided to eligible or enrolled consumers, submit claims, invoices, or requests for payment to *ValueOptions* according to the procedures contained in Section XI (Claim and Billing Information) and the provider agreement between your organization and *ValueOptions*. Payments will occur subject to eligibility or enrollment status, and the terms of the agreement in which a provider of these services has with *ValueOptions*. **Please note that providers are not permitted to bill TMHP for NorthSTAR enrollees after the NorthSTAR program begins for behavioral health services unless the reason for treatment (diagnosis) is due to developmental disability (MR/PDD/Autism).**

10. Information Required for Service Authorization

ValueOptions shares with providers the common goal of delivering care that is most appropriate given the severity of the illness and intensity of needed services. A review of current clinical data is required at all levels of care. The initial review should identify problems requiring treatment at the identified level of care, the treatment approach which will be used to resolve the current problem(s) and an identification of objectives by which to monitor progress, including length of stay. Further reviews should focus on a solution-oriented response to treatment, any revisions in the treatment plan and the discharge or follow-up plan. The Provider should be prepared to discuss the following with *ValueOptions* Care Manager to facilitate the process. The clinical records should contain the same type of information to facilitate the review process.

After obtaining basic demographic information on the enrollee (name, NorthSTAR identification number, etc) and the services requested, the following information, as relevant, will be gathered telephonically with as much detail as the provider is able to complete:

- Contact person
- Name/credentials of assessing/treating provider
- Date of Assessment
- Telephone number (contact person and/or assessment clinician)
- Date of Review
- Presenting problem
 - Detailed description of the problem, including severity of symptoms
 - Who prompted the call (e.g., family, consumer, etc)
 - Evaluation of precipitants
 - Stressors

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- Social Support
- Mental Status
 - Evaluate orientation x3/reality testing/thought process/content/affect/mood
 - Judgment/insight/intelligence/memory
 - Suicidal ideation, plan, history of attempts-details-including specific thoughts and plans
 - Homicidal ideation, plan, violence history – details
- Psychiatric History
 - Illness and previous treatment with outcomes
- Substance Abuse History
 - Enrollee’s current use pattern (particularly in the last week)
 - Prior use and treatments, if any (per substance)
 - Family history of substance abuse
 - Criminal history (current status)
 - Special needs/special services consideration
 - Treatment readiness
 - Obstacles for treatment access
- Medical History
 - Date of most recent physical exam
 - Current medical problems
 - Any current medical treatment
 - Coordination of care with medical provider (Primary Care Physician [PCP])
- Medications
 - All current Coordination of medications with PCP
- Family History (including pre-morbid functioning)
 - Include illness and treatment received by family consumers
 - Current family composition and any overt dysfunction
- Current Work Status of Enrollee
- Work/School History and Status
- Social Functioning

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- Community Support
- Risk Assessment
 - Ideation (Suicide/Homicide)
 - Plan (is there a current plan?)
 - Intent (will the Eligible enrolled individual contract for safety?)
 - Means
 - Dates of previous attempts
- Diagnosis
 - Axis I (Clinical Disorders)
 - Axis II (Personality Disorders/Mental Retardation)
 - Axis III (General Medical Condition)
 - Axis IV (Psychosocial and Environmental Problems)
 - Axis V (Global Assessment of Functioning – [GAF])
- Treatment Plan
 - Focus
 - Goals
 - Interventions
 - Estimated Length of Stay and Target Dates for Improvement
- Discharge
 - Discharge plan and anticipated discharge date
 - Transition Plan to the next level of care (who, where and when)
 - Placement, if relevant
 - Legal guardianship, if any
 - Resources needed to support compliance
 - Continuity related to established therapeutic relationships
 - Family/significant other involvement
- Review Outcome (decision on the Level of Care and length of authorization)
- Cite applicable Level of Care Criteria

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D. Peer Review and Medical Necessity Determination

During an authorization review, *ValueOptions* Care Manager requests clinical information about the enrollee's condition and response to treatment in order to assure that the requested level of service meets medical necessity. At times, the Care Manager may indicate that he/she cannot authorize the requested level of care due to the apparent lack of medical necessity. In these instances, the Care Manager may discuss alternative levels of care or treatment plans that could be authorized. If the provider does not feel that these recommendations are clinically appropriate, and that the requested level of care is the one that is required, the case will be referred to a Peer Advisor (Psychiatrist or a licensed Ph.D. Psychologist, with expertise in the area under review) for a Peer Review. Care Managers cannot deny level of care requests. Only a Peer Advisor can issue such a denial.

If a peer-to-peer review was not completed prior to the adverse determination, then reconsideration may be requested within 3 days. *ValueOptions* will perform a good faith effort to try to resolve any disagreements regarding non-authorization decisions in an expedient informal manner before proceeding to the appeals process. Please see Section VI (Appeals, Complaints, and Grievances) for a formal description of the State-approved NorthSTAR Appeal, Complaint, and Grievance policy.

E. Level of Care Criteria and Diagnosis-Based Treatment Guidelines

1. Development Process

For the NorthSTAR Program, *ValueOptions* recognized the need for level of care criteria that addressed the unique needs of individuals receiving publicly funded services. Our public sector clinical criteria were developed by our medical and clinical staff, in collaboration with community clinicians with expertise in the diagnosis and treatment of individuals with mental illness and/or addictive disorders, national experts, internal experts in a particular specialty, and standard clinical references. It was also particularly important to us to seek input from local providers and consumers in the refinement of our clinical criteria.

We convened an Ad Hoc meeting of our Clinical Advisory Committee to solicit provider feedback prior to completion of our criteria. After this initial development process, we submitted our Level of Care Criteria to the State for final review and approval. A complete set of the Level of Care Criteria that has been approved by the State, can be found online at <http://www.valueoptions.com/provider/contractspecific/northstar.htm>

2. Refinement/Alteration Process

We fully recognize that refinement, alteration, and development of our Level of Care Criteria and Treatment Guidelines will continue to be needed throughout the duration of the NorthSTAR Program. We will continue to use our Clinical Advisory Committee to assist us in this process.

IV. Clinical Policies & Procedures



3. Role of the Clinical Advisory Committee (CAC)

The CAC meet quarterly to address a variety of clinical and administrative issues, including the development, review, and implementation of clinical criteria and treatment guidelines, based on the State's requirements. These criteria incorporate both mental health and substance abuse levels of care. The CAC and its various subcommittees (Health Care Integration Subcommittee, Credentialing Subcommittee, and Utilization Management Subcommittee) ensure that all issues related to care for enrollees are addressed in an appropriate and timely manner.