UTLIZATION MANAGEMENT

The ValueOptions of California utilization management program encompasses management of care from the point of entry through discharge using objective, standardized, and widely-distributed clinical protocols and outlier management programs. Intensive utilization management activities may apply for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk. Participating providers are required to comply with utilization management policies and procedures and associated review processes.

Examples of review activities included in ValueOptions of California’s utilization management program are determinations of medical necessity, preauthorization, certification, notification, concurrent review, retrospective review, care/case management, discharge planning and coordination of care.

The ValueOptions of California utilization management program includes processes to address: (a) easy and early access to appropriate treatment; (b) working collaboratively with participating providers in promoting delivery of quality care according to accepted best-practice standards; (c) addressing the needs of special populations, such as children and the elderly; (d) identification of common illnesses or trends of illness; (e) identification of high-risk cases for intensive care management; and (f) screening, education and outreach. Objective, scientifically-based clinical criteria and treatment guidelines, in the context of provider or member supplied clinical information, guide the utilization management processes.

Prior to beginning a course of outpatient treatment and/or a non-emergency admission, providers/participating providers must contact ValueOptions of California to verify member eligibility and obtain authorization or certification (where applicable).

In order to verify member eligibility, the provider/participating provider will need to have the following information available: (i) the patient’s name, date of birth and member identification number; and should have available (ii) the insured or covered employee’s name, date of birth and member identification number; and (iii) information about other or additional insurance or health benefit coverage. Based on the most recent data provided by the employer/benefit plan, ValueOptions of California will: (1) verify member eligibility; (2) identify benefits and associated member expenses under the member’s benefit plan; and (3) identify the authorization or certification procedures and requirements under the member’s benefit plan. Note: Verification of eligibility and/or identification of benefits and member expenses are not authorization or certification or a guarantee of payment.

Health Plan Employer Data and Information Set (HEDIS®)

On an annual basis, ValueOptions of California participates with our clients in the collection of Health Plan Employer Data and Information Set (HEDIS) data. HEDIS is used by many of
American’s health plans to measure performance on important dimensions of care and service. HEDIS consists of 81 measures across five (5) domains of care and is maintained by the National Committee for Quality Assurance (NCQA). Only a few of these measures pertain to behavioral health, but over the last few years increasing attention has been paid to developing new measures for behavioral health.

Participating providers play a critical role in ValueOptions of California’s HEDIS measure performance. The behavioral health indicators primarily address either the number or the timeliness of visits following a diagnosis of certain behavioral health disorders or treatment at specific levels of care. Participating providers should be aware of the standards set by these measures and must document appropriately in members’ treatment records.

Beginning with HEDIS reporting year 2014, measurement year 2013, NCQA requires organizations to substantiate by documentation from the member’s health record all nonstandard supplemental data that is collected to capture missing service data not received through claims, encounter data, laboratory result files, and pharmacy data feeds. ValueOptions of California may request proof of service documentation from the member’s health record that indicates the service was received. All proof-of-service documents must include all the data elements required by the measure (e.g., Data elements include, but are not limited to: member name, DOB, practitioner type, date and place of service, procedure, prescription, diagnosis, date of test result, test result value or finding, and practitioner type). Requested proof-of-service documents must be mailed, faxed, or otherwise delivered by the member or provider to the entity contacting the member or provider for the information. Permitted examples are: super-bills, lab reports, radiology reports, sections of the member’s legal health record that show the service or assessment (documentation in the legal health record must be recorded, signed and dated by the provider).

Below is a brief description of the HEDIS measures that apply to the behavioral health field and the timeframes and numbers of sessions associated with each:

For detailed information regarding these measures, definitions and national averages, go to http://www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm

1. Follow-up after Hospitalization for Mental Illness

This measure is described as the percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within seven (7) and/or thirty (30) calendar days of discharge.

The critical pieces of this measure for providers/participating providers are:

- Inpatient facilities need to:
o Use accurate diagnoses when submitting claims for inpatient treatment. If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance use disorder, please use the substance use disorder diagnosis on the claim submitted at discharge.

o Assist in scheduling or ensure that follow-up visits are within seven (7) calendar days of discharge. **NOTE:** It is important to notify the provider/participating providers that the appointment is post hospital discharge and that an appointment is needed in seven (7) calendar days.

- **Outpatient providers/participating providers** need to make every attempt to schedule appointments within seven (7) calendar days for members being discharged from inpatient care. Providers/participating providers are encouraged to contact those members who are “no show” and reschedule another appointment. Claims for these visits should be submitted in a timely fashion.

2. **Initiation and Engagement of Alcohol and other Drug Use Treatment**

This measure calculates two (2) rates using the same population of members with Alcohol and Other Drug (AOD) Use:

**Initiation of AOD Use Treatment:** The percentage of adults diagnosed with AOD use who initiate treatment through either:

- An inpatient AOD admission, or
- An outpatient service for AOD (that can include an ER visit) AND an additional AOD service within 14 calendar days

**Engagement of AOD Treatment:** An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two (2) additional AOD services within 30 calendar days after the initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT 4 or revenue codes associated with substance use disorder treatment.

3. **Antidepressant Medication Management**

The components of this measure assess different facets of pharmacological management of depression.
Optimal Practitioner Contacts for Medication Management. This process measure assesses the adequacy of clinical management of new treatment episodes for adult members with a major depressive disorder.

The measure is defined as the percentage of members, eighteen (18) years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a non-mental-health practitioner or mental health practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase.

At least one of the three (3) follow-up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant or other practitioner with prescribing privileges).

Effective Acute Phase Treatment: This intermediate-outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

The percentage is determined by the number of members, eighteen (18) years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Effective Continuation Phase Treatment: This intermediate-outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen.

The percentage is determined by the number of members, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days (6 months).

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The following two rates in the measure assess follow-up care for children prescribed a medication to treat ADD or ADHD. Examples of the antidepressant medications included in this measure are:

- Tricyclic antidepressants (TCA) and other cyclic antidepressants
- Selective serotonin reuptake inhibitors (SSRI)
- Monoamine oxidase inhibitors (MAOI)
- Serotonin-norepinephrine reuptake inhibitors (SNRI), and
- Other antidepressants
Initiation Phase: Defined as the percentage of members, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication and who had one follow-up visit with practitioner with prescriptive authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Defined as the percentage of members, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication who remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within 270 calendar days (9 months) after the Initiation Phase ends.

5. Diabetes Screening for People with Bipolar Disorder or Schizophrenia Who Are Using Antipsychotic Medications (SSD)

This measure is described as the percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

6. Diabetes Monitoring for People with Diabetes and Schizophrenia Who Are Using Antipsychotic Medications (SMD)

This measure is described as the percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

7. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)

This measure is described as the percentage of members 18 – 64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

8. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

This measure is described as the percentage of members 19 – 64 years of age during the measurement year with schizophrenia who are dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

9. Plan All-Cause Readmissions (PCR)

For members eighteen (18) years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within thirty (30) days and the predicted probability of an acute readmission. Data are reported in the following categories:
1. Count of Index Hospital Stays (HIS) (denominator)
2. Count of 30-Day Readmissions (numerator)
3. Average Adjusted Probability of Readmission

New and Emerging Technologies

ValueOptions of California recognizes the need for knowledge of emerging technologies to provide access to optimum care for members. ValueOptions of California evaluates these technologies in terms of their overall potential benefits to members and in some instances recommends these technologies to clients for inclusion in their respective benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. ValueOptions of California has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in medical necessity decisions.

Treatment Planning

Providers/participating providers must develop individualized treatment plans that utilize assessment data, address the member’s current problems related to the behavioral health diagnosis, and actively include the member and significant others, as appropriate, in the treatment planning process. Clinical Care Managers (CCMs) review the treatment plans with the providers/participating providers to ensure that they include all elements required by the provider agreement, and at a minimum:

a. Specific measurable goals and objectives;
b. Reflect the use of relevant therapies;
c. Show appropriate involvement of pertinent community agencies;
d. Demonstrate discharge planning from the time of admission; and
e. Reflect active involvement of the member and significant others as appropriate.

Providers/participating providers are expected to document progress toward meeting goals and objectives in the treatment record and to review and revise treatment plans as appropriate.

Clinical Review Process

Provider/participating provider cooperation in efforts to review care prospectively is an integral part of care coordination activities. Subject to the terms of the member’s benefit plan and applicable state and/or federal laws and/or regulations, providers/participating providers must notify ValueOptions of California prior to admitting a member to any non-emergency level of care. The Mental Health Parity & Addiction Equity Act of 2008 requires that mental health and substance use disorder benefits, provided by group health plans with more than 50 employees, must be available on an
equivalent or better basis to any medical or surgical benefits. Some benefit plans, but not all, may fall under this guideline and do not require notification or authorization for standard outpatient services. Others may allow for a designated number of outpatient sessions without prior-authorization, certification, or notification. ValueOptions of California may request clinical information at various points in treatment to ensure the ongoing need for care and treatment that is appropriate and effective in improving health outcomes for members.

In all cases, providers/participating providers are encouraged to contact ValueOptions of California prior to initiating any non-emergency treatment to verify member eligibility and to clarify what the authorization or certification requirements are, if any, for the proposed treatment.

Coverage and payment for services proposed for and/or provided to members for the identification or treatment of a member’s condition or illness is conditioned upon member eligibility, the benefits covered under the member’s benefit plan at the time of service, and on the determination of medical necessity of such services and/or treatment. Overpayments made as a result of a change in eligibility of a member are subject to recovery.

Subject to verification of eligibility under the member’s benefit plan, upon request for authorization or certification of services, the Clinical Care Manager (CCM) gathers the required clinical information from the provider/participating provider, references the appropriate clinical criteria for the services and/or level of care, and determines whether the services and treatment meets criteria for medical necessity. The CCM may authorize or certify levels of care and treatment services that are specified as under the member’s benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). Authorizations or certifications are for a specific number of services/units of services/days and for a specific time period based on the member’s clinical needs and provider characteristics.

Prior to initial determinations of medical necessity, the member’s eligibility status and coverage under a benefit plan administered by ValueOptions of California should be confirmed. If eligibility information is not available in non-emergency situations, a CCM may complete a screening assessment and pend the authorization/certification awaiting eligibility verification. CCMs will work with members and providers/participating providers in situations of emergency, regardless of eligibility status.

If a member’s benefits have been exhausted or the member’s benefit plan does not include coverage for behavioral health services, the CCM, in coordination with the provider/participating provider as appropriate, will provide the member with information about available community support services and programs, such as local or state-funded agencies or facilities, that might provide sliding scale discounts for continuation in outpatient therapy.

When a provider/participating provider requests a retrospective review for services previously rendered, ValueOptions of California will first determine whether such a retrospective review is available under the member’s benefit plan and request the reason for the retrospective review (e.g.,
emergency admission, no presentation of a ValueOptions of California member identification card, etc.). In cases where a retrospective review is available, services will be reviewed as provided for in this handbook. In cases where a retrospective review is not available under the member’s benefit plan and/or where the provider/participating provider fails to follow administrative process and requirements for authorization, certification and/or notification, the request for retrospective review may be administratively denied. Subject to any client health benefit program and/or benefit plan specific requirements, the chart below references the standard timeframes applicable to the type of review request.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Urgency of Case</th>
<th>Timeframe to make decision</th>
<th>Timeframe to provide notification</th>
</tr>
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<tbody>
<tr>
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<td>Certifications</td>
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<tr>
<td>Prospective</td>
<td>Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds)</td>
<td>Seventy-two (72) hours after receipt of request for services</td>
<td>Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the determination on the same day.</td>
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<td>Cases meeting expedited definition (Knox-Keene)</td>
<td></td>
<td>Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for services.</td>
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<tr>
<td></td>
<td>Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)</td>
<td>Five (5) business days after receipt of request for services.</td>
<td>Telephonic or facsimile notification to provider on the same day the determination is made.</td>
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<tr>
<td>Concurrent (Continued Stay)</td>
<td>Urgent (e.g. Inpatient)</td>
<td>Twenty-four (24) hours after receipt of request for services if the concurrent review request defaults to an urgent prospective review request.</td>
<td>Telephonic notification or facsimile to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Written notice to member, provider, and facility within twenty-four (24) hours of request.</td>
</tr>
</tbody>
</table>
Non-urgent (e.g., RTC, Partial Hospitalization and Outpatient) | Five (5) business days after receipt of request for services | Telephonic or facsimile notification to provider within twenty-four (24) of the determination | Written notification to member, provider, and facility within two (2) business days of the determination

Retrospective | Non-urgent (all levels of care) | Thirty (30) calendar days after receipt of request for retrospective review | Written notice to member, provider, and facility within the overall time frame of thirty (30) calendar days of request for retrospective review | Written notice to member, provider, and facility within the overall time frame of thirty (30) calendar days of request for retrospective review

ValueOptions of California’s procedures for authorization, certification and/or notification apply to services and treatment proposed and/or previously rendered in instances where the member benefit plan administered by ValueOptions of California is primary and instances where the member benefit plan administered by ValueOptions of California is secondary.

ValueOptions of California, at times, may administer both primary and secondary benefit plans of a given member. To avoid possible duplication of the review process in these cases, providers/participating providers should notify ValueOptions of California of all pertinent employer and other insurance information for the member being treated.

Note: Failure to follow authorization, certification and/or notification requirements, as applicable, may result in administrative denial/non-certification and require that the member be held harmless from any financial responsibility for the provider’s/participating provider’s charges.

**Definition of Medical Necessity**

Unless otherwise defined in the provider agreement and/or the applicable member benefit plan, ValueOptions of California’s reviewers, Clinical Case Managers, Peer Advisors, and other individuals involved in ValueOptions of California’s utilization management processes use the following definition of medical necessity or medically necessary treatment in making authorization and/or certification determinations:

- Intended to treat, to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a Mental Health or Substance Use Disorder or Mental Disorder;
- To be considered effective for the individual’s illness;
- To be individualized, specific, and consistent with symptoms and diagnosis, and not in excess of individual’s needs;
To be consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance use disorder care professionals or peer reviewed scientific and medical literature;

To be reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available; and,

To not be primarily intended for the convenience of the recipient, caretaker, or provider/participating provider

Clinical Criteria

The clinical criteria used by ValueOptions of California to make admission, level of care and continuing treatment decisions reflect ValueOptions of California’s philosophy and clinical values. To determine the appropriate level of care during a review the CCM evaluates the pertinent clinical information relative to the levels of care criteria. These clinical criteria are assessed, revised where necessary and approved and/or adopted at least annually by the ValueOptions of California Board of Directors and Quality of Care Committee. Sources for various clinical criteria include:

- The American Psychiatric Association
- The American Psychological Association
- The American Academy of Psychiatrists in Alcoholism and Addictions
- The American Academy of Child and Adolescent Psychiatry
- The American Society of Addiction Medicine
- Tricare
- Consumer and family empowerment organizations (e.g., state-based Consumer Councils; National Mental Health Consumers’ Self-Help Clearing House; National Alliance for the Mentally Ill; Federation of Families for Children’s Mental Health)
- International Association of Psychosocial Rehabilitation Services
- InterQual
- State specific regulatory requirements
- The National Institutes of Health
- The National Institute on Alcohol Abuse and Alcoholism
- The National Institutes of Drug Abuse
- The Department of Health and Human Services’ Center for Substance Abuse Treatment
- Standard psychiatric texts and current publications in professional journals and books.
- Criteria from national peer organizations including managed care organizations (MCO) and behavioral health organizations (BHO)
- The Diagnostic and Statistical Manual 5
- The American Accreditation HealthCare Commission/URAC standards
- The American Society of Addiction Medicine standards (ASAM)
- The American Society of Addiction Medicine PPC-2R2R Criteria
- Health Management Strategies International Mental Health Review Criteria
- Discussions with senior consultants in the field
- Various criteria sets from other utilization management entities and third party payors

Clinical criteria may vary according to individual contractual requirements and benefit coverage. Access to current clinical criteria is available on the Beacon website at www.valueoptions.com/providers/Handbook/clinical_criteria.htm.

**Treatment Guidelines**

In addition to clinical criteria, ValueOptions of California has a set of Diagnosis-Based Treatment Guidelines. These guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by Clinical Care Managers (CCM) and Peer Advisors (PA) during reviews. ValueOptions of California seeks input from participating providers, consultants, and other expert clinicians to develop some of the guidelines; however in most instances ValueOptions of California adopts established and/or published guidelines such as those developed by the American Psychiatric Association (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and ECT). Information about and access to Treatment Guidelines used by ValueOptions of California is available on the Beacon website at www.valueoptions.com/providers/Handbook/treatment_guidelines.htm.

**ValueOptions of California's Care Management System**

Members and participating providers may access the ValueOptions of California care management system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct registration/certification of care through ProviderConnect for participating providers
- Direct authorization/certification of all levels of care through referral by a ValueOptions of California Clinical Care Manager (CCM)
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

If a call is received from a member requesting a referral and/or information about participating providers in the member’s location, CCMs may conduct a brief screening to assess whether there is a need for urgent or emergent care. Referrals are made to participating providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the participating provider holds and gender. Additionally, the member may require a clinician with a specialty such as treatment of eating disorders. In all cases, where available, the CCM will provide the member with the name, location and phone number of at least three participating providers.
Clinical Care Manager Reviews

ValueOptions of California Clinical Care Managers (CCMs) base reviews on established criteria adopted by ValueOptions of California and/or criteria developed by ValueOptions of California. CCMs are trained to match the needs of members to appropriate services, levels of care, treatment and length of stay, and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program seeks to provide that members who present for care are appropriately monitored and that comprehensive reviews of all levels of care are provided. Those cases that appear to be outside of best practice guidelines or appear to be treatment outliers are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, peer advisor review or more frequent CCM review.

CCMs obtain clinical data from the provider/participating provider or designee relating to the need for care and treatment planning. The CCM evaluates this information and references applicable clinical criteria to determine medical necessity of the requested level of care or service. Where appropriate, care is pre-certified for a specific number of services/days for a specific time period at a specific level of care, based on the needs of the member.

Except where disclosure of certain information is expressly prohibited by or contrary to applicable state or federal laws or regulations, participating providers must be prepared to provide ValueOptions of California with the following information at the time of the review, as necessary and appropriate:

- Demographics
- Diagnosis (current DSM or ICD)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including:
  - ideation
  - plan
  - intent
  - psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)
- Substance use history
  - type
  - amount
  - withdrawal symptoms
  - vital signs
  - date(s) of initial use and last use
  - date(s) of periods of sobriety
- Other presenting problem/symptomatology description, if applicable
- Progress since admission (if concurrent review)
- Medical problems
  - medical history
  - organic cause of psychiatric symptoms/behaviors
  - medical problems which exacerbate psychiatric or substance use symptoms/behaviors

- Current medications
  - types(s)
  - dosage(s)
  - date(s)
  - duration
  - response
  - provider(s)

- Primary care physician (PCP) interface, if applicable
- Other behavioral health care provider interface, if applicable
- General level of functioning
  - sleep
  - appetite
  - mental status
  - ADLs (Activities of Daily Living)

- Psychological stressors and supports
  - socioeconomic
  - family
  - legal
  - social
  - abuse, neglect, domestic violence (as appropriate)

- Response to previous treatment
  - previous treatment history, most recent treatment, past treatment failures
  - relapse/recidivism, motivation for treatment
  - indications of compliance with treatment recommendations

- Treatment plan
  - estimated length of stay
  - treatment goals
  - specific planned interventions
  - family involvement
  - precautions for specific risk behaviors
  - educational component for regulatory compliance and substance use disorder situations

- Discharge plan
  - aftercare required upon discharge
  - barriers to discharge

Inpatient or Higher Levels of Care
All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider’s/participating provider’s office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section. Prior to non-emergency admission and/or beginning treatment, the provider/participating provider must contact ValueOptions of California:

- For notification
- To confirm benefits and verify member eligibility
- To provide clinical information regarding the member’s condition and proposed treatment
- For authorizations or certifications, where required under the member’s benefit plan

ProviderConnect is available twenty-four (24) hours a day, seven (7) days a week (excluding scheduled maintenance and unforeseen systems issues) and should be utilized to confirm benefits, provide notification and clinical information as appropriate. Providers/participating providers can secure copies of the authorization/certification requests at time of submission for their records. The web portal can be utilized for concurrent reviews and discharge reviews as well as initial or precertification reviews.

Clinical Care Managers (CCMs) and/or Referral Line Clinicians are available seven (7) days a week, twenty-four (24) hours a day, three hundred sixty-five (365) days a year to provide assessment and referral and conduct authorization or certification reviews.

Where authorization, certification or notification is required by the member’s benefit plan and unless otherwise indicated in the provider agreement, providers/participating providers should contact ValueOptions of California within forty-eight (48) hours of any emergency admission for notification and/or to obtain any required authorization or certification for continued stay.

If prior to the end of the initial or any subsequent authorization or certification, the provider/participating provider proposes to continue treatment, the provider/participating provider must contact ValueOptions of California for a review and recertification of medical necessity. It is important that this review process be completed more than twenty-four (24) hours prior to the end of the current authorization or certification period.

Continued stay reviews: (a) focus on continued severity of symptoms, appropriateness and intensity of treatment plan, member progress and discharge planning; and (b) involve review of treatment records and discussions with the provider/participating provider or appropriate facility staff, EAP staff or other behavioral health providers and reference to the applicable clinical criteria. In instances where the continued stay review by a CCM does not meet clinical criteria and/or where questions arise as to elements of a treatment plan or discharge plan, the CCM will forward the case file to a Peer Advisor for review.
Note: For some benefit plans, authorization and/or certification requests (where required) for non-emergency admissions and/or higher levels of care is required to be done via a faxed document, the Inpatient Treatment Report (ITR) or via a request on ProviderConnect. When a provider/participating provider calls to request authorization or certification for non-emergency admissions and/or a higher level of care, ValueOptions of California will identify whether the member’s benefit plan is one that requires submission of the ITR or the use of ProviderConnect.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As a member is transitioned from inpatient and/or higher levels of care, the Clinical Care Manager (CCM) will review/discuss with the provider/participating provider the discharge plan for the member. The following information may be requested and must be documented:

- Discharge date
- Aftercare date
  - Date of first post-discharge appointment (must occur within seven (7) days of discharge)
  - With whom (name, credentials)
  - Where (level of care, program/facility name)
- Other treatment resources to be utilized: types, frequency
- Medications
  - Patient/family education regarding purpose and possible side effects
  - Medication plan including responsible parties
- Support systems
  - Familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed
  - Community resources/self-help groups recommended (note purpose)
- EAP linkage
  - if indicated (e.g., for substance use disorder aftercare, workplace issues, such as Return-to-Work Conference, enhanced wrap-around services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
  - Family illness education, work or school coordination, (e.g., EAP and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Case Management Services for select patients who meet high-risk criteria

As part of the case management program at ValueOptions of California, we offer assistance in:

- Discharge planning
- Assessment and integration of service for on-going needs
- Coordination with behavioral health services
- Collaboration with healthcare providers and care givers
- Providing information about what benefits might be available
- Medication education and monitoring

Hospitals may be asked for assistance in enrolling patients in case management during inpatient admissions.

When requested, please:

1. Have the patient complete the authorization form, with help if needed.
2. Send the authorization to ValueOptions of California by faxing it to the number on the form.
3. Schedule a discharge appointment within seven (7) days after discharge. If you need help with getting an appointment within seven (7) days, please contact ValueOptions of California.

Adverse Clinical Determination/ Peer Review

If a case does not appear to meet medical necessity criteria at the requested level of care, the CCM attempts to discuss the member’s needs with the provider/participating provider and to work collaboratively with the provider/participating provider to find an appropriate alternative level of care. If no alternative is agreed upon, the CCM cannot deny a request for services. Requests that do not appear to meet medical necessity criteria or present quality of care issues are referred to a peer reviewer for second level review. It is important to note that only a doctoral level peer reviewer can clinically deny a request for services. The peer reviewer considers the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary participating provider to discuss the case. Through this communication, the peer reviewer may obtain clinical data that was not available to the CCM at the time of the review. This collegial clinical discussion allows the peer reviewer the opportunity to explore alternative treatment plans with the provider/participating provider and to gain insight into the attending provider’s anticipated goals, interventions and timeframes. The peer reviewer may request more information from the provider/participating provider to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision and asked to notify the member. Written notification of an adverse determination is issued to the member, member representative, practitioner, and facility within decision timeframes. If an adverse decision is rendered, the provider/participating provider has the right to speak with the peer reviewer who made the adverse determination by calling ValueOptions of California at the toll free phone number of the member’s plan. For substance use disorder treatment and treatment of minors, ValueOptions of California follows federal and state guidelines regarding release of information in determining the distribution of adverse determination letters.
All written or electronic adverse determination notices include:

- the principal reason(s) for the determination not to certify,
- a statement that the clinical rationale (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request,
- information regarding how the member may file a grievance or appeal with ValueOptions of California,
- information regarding the member’s right to file a complaint with the Department of Managed Health Care,
- disclosures required by Sections 1368.01, 1368.02, (Grievance rights) and 1374.30 (Independent Medical Review process) of the Knox-Keene Act,
- the name and direct telephone number of the health care professional responsible for the denial, and
- the right of the provider to request a reconsideration within three (3) business days of receipt of the notice when a medical necessity denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a provider to respond to a request for Peer-to-Peer conversation within a specified timeframe.

**Lack of Information (LOI) Process**

When there is insufficient information to make a medical necessity determination, the PA may elect to make the decision based on the information that has been received, or may invoke the LOI process. If the decision is made based on available information, written notification is issued within the determination timeframe for the type of care request (e.g. urgent, non-urgent). If the PA invokes the LOI process, the provider is notified of the information needed within prescribed timeframes based on the type of care requested. A minimum period of time is given for the provider to furnish the necessary information. A Peer-to-Peer conversation may be initiated by either the PA or the provider in order to discuss the needed information. Once information is received, or the time period for furnishing the information has expired, the decision and notice must be issued within the specified timeframe for the type of care requested. See the LOI chart below for a listing of all relevant timeframes by type of request.

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Urgency of Case</th>
<th>Timeframe to make over all decision *</th>
<th>Timelines for reviews when there is a lack of information to make a decision(1)</th>
<th>Timeframe to provide notification</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Timeframe to notify provider/member that information is not sufficient to</td>
<td>Certification</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Timeframe to allow provider/member to provide information</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>When information obtained, timeframe to make decision</td>
<td>Non-Certification(2)</td>
</tr>
</tbody>
</table>

(1) Certification

(2) Non-Certification
<table>
<thead>
<tr>
<th>Conduct Area</th>
<th>Review Type</th>
<th>Timeframe</th>
<th>Timeframe</th>
<th>Timeframe</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds)</td>
<td>Seventy-two (72) hours after receipt of request for services</td>
<td>At least two (2) calendar days from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary information. The total process is to be completed within seventy-two (72) hours of the initial request for services.</td>
<td>Two (2) calendar days from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary information. The total process is to be completed within seventy-two (72) hours of the initial request for services.</td>
<td>Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day. Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for services.</td>
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<tr>
<td>Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)</td>
<td>Five (5) business days after receipt of request for services</td>
<td>Within five (5) business days after request for services</td>
<td>At least 45 calendar days after notification; time frame given must be documented</td>
<td>Five (5) business days from receipt of the required information.</td>
<td>Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day. Written notice issued to member, provider, and facility within two (2) business days of the determination.</td>
</tr>
</tbody>
</table>
| Continued Stay (Concurrent)          | Urgent                                                                       | Twenty-four (24) hours after receipt                                    | At least two (2) calendar days from receipt of the required information. | Twenty-four (24) hours from the determination                           | Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day. Written notice issued to member, provider, and facility within two (2) business days of the determination.
<table>
<thead>
<tr>
<th>Type</th>
<th>Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)</th>
<th>Retrospective (all levels of care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeframe</td>
<td>Five (5) business days after receipt of request</td>
<td>Thirty (30) calendar days after receipt of request for retrospective review.</td>
</tr>
<tr>
<td>Notice</td>
<td>Notice to member and provider within five (5) business days from request for services.</td>
<td>Notice to member and provider within fifteen (15) calendar days after request for services.</td>
</tr>
<tr>
<td>Timeframe</td>
<td>At least 45 calendar days after notification; time frame given must be documented.</td>
<td>At least 45 calendar days from notification; time frame given must be documented.</td>
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<tr>
<td>Documented</td>
<td>Five (5) business days from receipt or the request for services.</td>
<td>Fifteen (15) calendar days from the earlier of receipt of the required information, or the end of the period allowed to submit the necessary information.</td>
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<tr>
<td>Notice</td>
<td>Written notice issued to member, provider, and facility within twenty-four (24) hours of the determination.</td>
<td>Written notice issued to member, provider, and facility within the overall determination timeframe of thirty (30) calendar days from receipt or the request for review.</td>
</tr>
<tr>
<td>Timeframe</td>
<td>Written or electronic notice issued to member, provider, and facility within twenty-four (24) hours of receipt of the request for services.</td>
<td>Written notice to member, provider, and facility within the overall determination timeframe of thirty (30) calendar days from receipt or the request for review.</td>
</tr>
<tr>
<td>Action</td>
<td>If the request for services is denied, the provider must agree to notify the member of the decision on the same day.</td>
<td>If the request for services is denied, the provider must agree to notify the member of the decision on the same day.</td>
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</tbody>
</table>

*RTC*: Residential Treatment Center
*Partial Hospitalization*: Partial hospitalization is a level of care between inpatient and outpatient. It involves providing care in a hospital setting but for a limited time, allowing patients to continue their recovery while living at home.

The table outlines the timeframes and actions required for both Non-urgent and Retrospective services, ensuring that members and providers are informed in a timely manner.
(1) Extensions are one-time only per request for services (i.e. a concurrent review would constitute a new request for services). Lack of information extension is one type of extension. In addition, if a lack of information extension is not used; non-urgent claims may be extended by ValueOptions of California for "reasons beyond the control of the Plan" other than for lack of information (as shown above). Extensions are also subject to Knox-Keene requirements. ValueOptions of California must notify the member and provider before the end of the determination time frame of the reasons for the delay and the date by which the decision will be made.

*Example of notification time calculation: a non-urgent initial request must be decided within five (5) business days of receipt of request. ValueOptions of California may notify the member and provider on or before the 5th business day that it is extending the time-frame and why. The decision must then be made and a determination notice issued by the end of the five (5) business day of the extension, or twenty (20) days from receipt of the request for services (initial 5 business day determination date + the 15 day extension). For urgent care claims, there is no provision for extension other than for lack of information.

(2) Per Knox-Keene regulations-In the case of concurrent review, care shall not be discontinued due to a denial or a modification of service until the member’s treating provider has been notified of ValueOptions of California’s decisions and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

**Electroconvulsive Therapy**

Prior to conducting Electroconvulsive Therapy (ECT), providers/participating providers must contact ValueOptions of California for pre-certification of such therapy. All pre-certification requests for ECT are reviewed by a physician.

**Telehealth**

ValueOptions of California has adopted the American Telemedicine Association (ATA) Practice Guidelines for videoconferencing based telehealth. Providers/participating providers can reference the Telemental Health Guideline and Addendum for decision making on the appropriateness of ATA. Participating providers should contact ValueOptions of California for benefit coverage prior to providing this service.

**Outpatient Services**

Providers/participating providers should request any required authorization or certification for outpatient services by using the electronic method, ProviderConnect. If the electronic method, ProviderConnect is not available providers/participating providers should submit a ValueOptions of California Outpatient Review, or use the toll-free number for a telephonic review. In instances where a review does not meet clinical criteria and/or where questions arise as to elements of a treatment plan, the case file may be forwarded to a Peer Advisor for review.