SERVICE ACCESS AND AUTHORIZATION

The Bureau must prior authorize all requests for services to ensure that the medical necessity criteria are met. Services provided without prior authorization will not be reimbursed. Prior Authorization is a function performed through Service Access and Authorization (SAA). Requests for authorization are subject to review by the medical review psychiatrist. The review process may include a medical review conference. This conference is a face-to-face or telephone meeting with a recipient's psychiatrist for the purpose of reviewing clinical aspects of a recipient's care following an eligibility or reauthorization request.

Following the interim authorization period, ongoing services may be approved for up to ninety (90) days beginning with the service authorization date. Requests for reauthorization should be submitted fourteen (14) days prior to the expiration of the current authorization to avoid lapse in services and to assure timely processing of requests. All information sent to the SAA unit is date stamped and logged into Utilization, Tracking, Oversight, and Prior Authorization system (UTOPiA) the day it is received. If information is received after 3:00 pm, it is stamped and logged into UTOPiA the following business day.

Providers and recipients will receive written notification of approved, partially denied, and/or denied requests. A request for additional information will be sent to providers if required information is missing (such as Social Security number, address, signature page, etc.). The SAA staff will contact the provider for this information. The contact will be documented as a request for more information. If the additional information is not received by the fourteenth (14^{th}) calendar day after the receipt of the original request, the request will be denied.

Program eligibility is based on medical necessity criteria outlined on the screening form. Other factors including, but not limited to, effectiveness of interventions, recipient and family participation, and length of stay will be taken into consideration when the SAA unit reviews requests for authorization. Initial and reassessment activities include the rating of the LOCUS or CALOCUS, which are used to determine the recipient's level of care. If a recipient needs additional services during the authorization period, providers must submit a request for revision packet. The request must include a new LOCUS or CALOCUS rating as well as other documentation detailed below. LOCUS/CALOCUS ratings and the Client Data Sheet must be entered into MHRSIS and a data information file must be sent prior to submitting a request for authorization.

If it is determined at any point during the SAA process that the recipient does not qualify for services, the provider shall refer the recipient to his/her primary care physician, CMHC or other outpatient mental health clinic or to the appropriate medically necessary services with copies of all available medical and social information. The referral must be documented in MHRSIS.

The provider requesting authorization for a new recipient will follow phases one (1) through three (3). Providers requesting a reauthorization will follow phase four (4). There are seven (7) additional service access and authorization activities detailed below which require providers to submit information to the SAA unit. Providers must submit the required documentation with each request.

To obtain MHR forms and denial codes referenced below, visit the MHR website at www.mhrsla.org. If you need assistance, contact a network services representative at (225) 342-1203.

Service Access and Authorization Process

Phase One (1): Screening for MHR Eligibility

When a recipient requests services, an initial screening must be completed to determine whether the recipient meets the medical necessity criteria for services. Recipient data must be entered into MHRSIS.

Based on the results of the screening, the LMHP shall make one (1) of two (2) determinations:

1. The recipient does not meet medical necessity criteria and is referred to appropriate community resources. The referral must be entered in MHRSIS before the record is closed.
2. The recipient seems to meet eligibility criteria and will move onto phase two (2).

Phase Two (2): Determining Eligibility and Developing an Interim ISRP

If the recipient seems to meet medical necessity criteria, the provider continues the eligibility process, which may include, but is not limited to, the following:

1. Obtaining a Freedom of Choice form signed by the recipient ,
2. Opening the case in MHRSIS and completing a Client Data Form
3. Conducting the Initial Assessment (including rating the LOCUS or CALOCUS) ,
4. Developing an interim ISRP, which must address the recipient's immediate needs,
5. Review of the e-CDI data, if available. The treating psychiatrist and LMHP must review, sign, and date the printout,
6. Entering the LOCUS or CALOCUS rating into MHRSIS, and
7. Sending a data file.

Initial assessment data is collected and documented on the Initial Assessment form and must be completed within thirty (30) calendar days following the eligibility screening. Extensions beyond the thirty (30) day assessment period may be granted on a case-by-case basis, under exceptional circumstances at the discretion of the Medicaid Behavioral Health Section. Requests for extensions should be thoroughly documented and directly related to the reason for the delay. (Example: a fifteen (15) day extension is requested because the recipient was hospitalized for fifteen (15) days.).

To establish eligibility for the program, the following must be met to receive an interim authorization:

- Recipient/family agrees to receive services from the provider as indicated by a signature on the Freedom of Choice form;
- Recipient meets the medical necessity criteria;
- Recipient has a LOCUS or CALOCUS level of four (4) or above (level three (3) or above if returning to community living from structured residential settings under OCS or OJJ authority);
- Documentation indicates a thorough and accurate assessment which supports the diagnosis and LOCUS or CALOCUS level;
- Recipient has agreed to participate in the development of the interim ISRP as indicated by a signature on the ISRP (all children six (6) and older must sign plan);
- The crisis plan addresses areas in which the recipient is at risk of harm;
- The interim ISRP reflects the most urgent needs of the recipient;
- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number are present; and
- A record in MHRSIS must be opened and a data file submitted before an authorization request is submitted to SAA.

NOTE: This list is not all-inclusive.

Approval for Eligibility

If the request meets the established criteria the assessment is approved back to the date it was completed and signed by the LMHP, unless the provider fails to submit it within thirty (30) calendar days of the initial screening. The interim authorization begins on the date the assessment is completed and signed, and extends thirty (30) days forward from the date PA issues an approval. The interim authorization ends when the initial ISRP is approved or when the interim authorization period ends. The approval notice is sent electronically through MHRSIS to the provider. Recipients are mailed approval letters.

Denial for Eligibility

An eligibility request may be denied for one or more of the reasons listed in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. If the request is denied, the interim authorization will not be issued, including the unit for the initial assessment. The denial letter is mailed to the recipient and faxed to the provider.

Phase Three (3): Developing the Initial ISRP

During the interim authorization period**,** the provider will offer basic services including crisis intervention while developing the initial ISRP. The LMHP is responsible for preparing and submitting the ISRP. This plan should address the needs identified during the eligibility screen and the initial assessment. The plan should be recovery focused and written in language the recipient understands and that is consistent with his/her strengths and needs. The focus of the plan is recovery. Refer to Section 31.1 for details regarding the development of ISRPs.

The initial ISRP is submitted to the SAA unit and is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The recipient/family participated in defining recovery goals and objectives which are documented in the plan as indicated by; recipient/family signature (all children six (6) and older must sign plan);
- Requested services are age, cognitively, culturally or developmentally appropriate;
- Evidence based – best practice interventions are being provided;
- Symptoms, diagnosis and/or functional impairment matches services requested and/or CA/LOCUS score;
- Medication(s) prescribed are pursuant to best practices;
- The information on the assessment correlates to the diagnosis listed
- The services requested are based on the prioritized list of needs, the LOCUS or CALOCUS level and the recipient's resources, abilities and recovery goals;
- The objectives are written in SMART (Specific, Measurable, Action-Oriented, Realistic and Time Limited) format;
- Interventions must be specific and include the intervention method and frequency of contact;
- Risk management issues have been identified and addressed;
- The ISRP includes an individualized, recovery focused crisis plan and the initial discharge plan;

- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number, is present; and
- A data file is submitted.

NOTE: This list is not all-inclusive.

Approval for Initial Services

If the SAA unit approves the initial ISRP, the following authorization steps will be taken:

- SAA staff will input an end date for the interim authorization unless it has expired.
- SAA staff will input the initial authorization, which begins on the day after the review date and extends for up to ninety (90) days.

Approval letters are mailed to recipients. The approval notice is sent electronically through MHRSIS to the provider.

Denial for Initial Services

If the services differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider.

Phase Four (4): Conducting a Reassessment and Updating the ISRP

To request additional services, the provider must conduct a reassessment to determine if the recipient continues to meet the medical necessity criteria for services and to determine his/her level of care. The provider may be required to:

- Conduct a reassessment, including rating the LOCUS or CALOCUS
- Enter the LOCUS or CALOCUS rating into MHRSIS before submitting the authorization request.
- Update the ISRP. For a readmission or transfer, the provider will develop a new ISRP.

- Review, sign, and date the e-CDI printout (LMHP and psychiatrist).
- Ensure the request packet includes all of the required documentation and signatures.
- Submit a data file.

NOTE: This list is not all-inclusive.

The reauthorization request is submitted to the SAA unit. SAA staff reviews reassessment data and the ISRP to ensure services are delivered and that anticipated progress is made toward the established goals or the ISRP has been adjusted. This step allows the authorization staff to verify the medical necessity of ongoing care. The submitted information is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The current requested services, the previous authorization request, and the amount of services delivered in the previous authorization period reflect the ongoing need for the types and level of services;
- The total length of stay in the program;
- The number of crises or hospitalizations. A high number of crises may provide justification for a higher number of services and fewer crises may result in justification of a lower number of services;
- Symptoms and medication in comparison to the previous quarter;
- The LOCUS or CALOCUS level decreasing or there is an explanation as to why the level has not decreased;
- The current and previous ISRP goals, objectives, and interventions address the needs identified in the reassessment
- The provider has clearly documented changes in the recipient's status.
- The recipient/family participated in defining recovery goals and objectives which are documented in the plan as indicated by recipient/family signature (all children six (6) and older must sign plan);
- Requested services are age, cognitively, culturally or developmentally appropriate
- Evidence based – best practice interventions are being provided
- Symptoms, diagnosis and/or functional impairment matches services requested and/or CA/LOCUS score
- Medication(s) prescribed are pursuant to best practice
- The information on the reassessment correlates to the diagnosis listed
- The services requested are based on the prioritized list of needs, the LOCUS or CALOCUS level and the recipient's resources, abilities and recovery goals;
- The objectives are written in SMART (Specific, Measurable, Action-Oriented, Realistic and Time Limited) format;

- Interventions must be specific and include the intervention method and frequency of contact;
- Risk management issues have been identified and addressed;
- The ISRP includes an individualized, recovery focused crisis plan and the initial discharge plan;
- The request packet includes all of the required documentation and signatures;
- All identifying information such as Social Security number, address, Medicaid number is present; and
- A data file is submitted

Approval for Continued Services

If the request for authorization meets the requirements stated above, the request for services may be approved. Approval letters are mailed to recipients. The provider is sent the approval notice electronically through MHRSIS.

Denial for Continued Services

If the services approved, differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider.

Other Service Access and Authorization Activities

Request for Revision

If a recipient needs additional services prior to the end of the authorization period, a request to revise the authorization must be submitted to the SAA unit. The provider must:

- Complete a Request for Revision Form
- Update the ISRP
- Update the crisis plan
- Rate the LOCUS or CALOCUS
- Enter the rating into MHRSIS
- Ensure the request packet includes all of the required documentation and signatures
- Submit a data file

NOTE: A request for revision may not be submitted during the interim authorization period.

The revision request is submitted to the SAA unit and is reviewed according to authorization criteria that may include, but is not limited to, the following:

- The recipient is a danger to self or others, and is at risk for displacement (i.e. psychiatric hospitalization, therapeutic out of home placement, or incarceration);
- Two-thirds of the current/active units approved by SAA have been utilized;
- Referrals for the appropriate and medically necessary specialty services have been made but the service(s) are not available;
- The request packet includes all of the required documentation and signatures;
- The provider has clearly documented changes in the recipient's status;
- The recipient/family is actively participating in the treatment as indicated by signatures on the ISRP; The recipient is making progress towards meeting recovery goals; or the goals, objectives or intervention methods have been revised on the ISRP;
- The goals and objectives reflect the strengths, priorities and identified needs of the recipient and reflect a recovery/resiliency philosophy; and
- Risk management issues have been identified and addressed.

Approval for Revision

If the request for authorization meets the requirements stated above, the request for services may be approved. Approval letters are mailed to recipients. The provider is sent the approval notice electronically in MHRSIS.

NOTE: If the request for revision of PFII services is approved, the current authorization will be canceled. A new authorization for PFII services will be issued.

Denial for Revision

If the services approved, differ from those requested, the provider and the recipient will be notified regarding the denied services. The authorization request may be denied for any of the reasons identified in the MHR denial codes. The medical review psychiatrist may evaluate denied requests. The denial notice will include the recipient's appeal rights. The denial letter is mailed to the recipient and faxed to the provider.

Access to Emergency Services

To assure the quality and accessibility of services, a continuity of care procedure will be followed for recipients being discharged from any twenty four (24)-hour care facility when discharge is dependent upon the availability of follow-up mental health services.

This may include, but is not limited to, discharges from juvenile detention facilities, psychiatric hospitals or distinct part psychiatric units.

NOTE: No services may be billed while the recipient is a patient in a twenty four (24)-hour care facility except on the date of discharge. On the day of admission to a health care facility, providers may not bill for services.

New Recipients

The provider selected by the recipient must participate in discharge planning with the facility. The provider must complete phase one and phase two of the Service Access and Authorization Process. On the date of discharge from the twenty-four (24) hour care facility, the assessment packet, if completed, must be signed and dated by the LMHP and faxed to the SAA unit. The cover page must be marked, "Emergency PA" in black marker. The discharge instruction form from the twenty-four (24) hour care facility must be submitted to verify the date of discharge. The SAA unit will render a decision within one (1) working day.

Active Recipients

The provider must participate in discharge planning with the facility, taking care to note the expiration date of the existing authorization. The provider shall submit a new authorization request as outlined in phase four of the Service Access and Authorization Process or submit a request for revision on the date of discharge as appropriate. The cover page must be marked, "Emergency Authorization" in black marker. The discharge instruction form from the twenty-four (24) hour care facility must be submitted to verify the date of discharge. The SAA unit will render a decision within one (1) working day.

Recipient Transfer

When an active recipient selects a new provider during an authorization period, the current provider must send all requested documentation to the new provider upon receipt of the consent to release information form signed by the recipient within two (2) working days following the request. The provider may charge a reasonable fee to make copies. The recipient must be closed in MHRSIS and the closure form must be sent to the SAA unit.

The authorization for the current provider will be cancelled on the date the recipient notifies the SAA unit they wish to change providers. This confirmation may be provided to the SAA unit by the recipient in writing or by telephone.

For the new provider, if the last date of service with the previous provider was within the past twelve (12) months, the new provider must:

- Obtain a Freedom of Choice signed by the recipient
- Open the recipient in MHRSIS
- Send a data file before submitting the authorization request.

The new provider will be issued a thirty (30) day interim authorization. A sixty (60) day authorization will be issued if the provider receives five (5) or more requests for transfer at one time, such as when a neighboring provider closes.

During the interim authorization period, the new provider must complete phase four (4) of the Service Access and Authorization Process.

If the last date of service has been more than twelve (12) months, the recipient must be readmitted to the program. The provider must complete phase one (1) and phase two (2) of the Services Access and Authorization Process before requesting an authorization for services.

Recipient Readmission

If a recipient requests to re-enter the program and selects a provider who had previously provided services within the past twelve (12) months, the provider must complete phase four of the SAA process before requesting an authorization for services.

If the last date of service has been more than twelve (12) months, the recipient must be readmitted to the program. The provider must complete the phase one (1) and phase two (2) of the Services Access and Authorization Process before requesting an authorization for services.

NOTE: An Initial Assessment will only be issued if a recipient has not received MHR services within the past twelve (12) months.

Reconsideration

If the provider does not agree with the decision of the SAA unit, reconsideration may be requested. The provider must FAX the original denial letter with **RECON** written across the front, including additional information, to the SAA unit. The SAA Unit will render a decision on the reconsideration request. If the request is approved, it will not be backdated. The provider and recipient will be notified of the decision within fourteen (14) calendar days of the receipt of the request for reconsideration. If the request is denied, the denial notice will include the recipient's appeal rights.

Appeal Process

If the recipient continues to be dissatisfied with the decision, he/she may file an appeal through the Department of Health and Hospitals (DHH) appeals process. The recipient must send the request for a fair hearing to the DHH Bureau of Appeals within thirty (30) days of receipt of the denial notice.

Provider Closure

Prior to the voluntary closure, the provider will notify all recipients of the pending closure, provide a Freedom of Choice form to assist them in choosing another provider or other treatment resources. The provider should coordinate with the new treatment resource to ensure the recipient has sufficient medication. Upon the recipient's written consent, the provider must make copies of the recipient's record available. The provider must complete the MHRSIS Closure Form and submit it to the SAA unit. The SAA unit will monitor this procedure.

If the closure is involuntary, the provider shall assist recipients with transitioning to other mental health services. This shall include the development of a transition plan for each recipient.

NOTE: For more information regarding a provider closure, refer to Section 31.3 - Changes or Events That Must Be Reported.

Re-establishing Services to Displaced Recipients Due to Disaster

When a situation is deemed a disaster by DHH, procedures may be established in response to the disaster to ensure recipients have access to services which are medically necessary to maintain continuity of care. Any procedures established by DHH shall be consistent with program rules.