

Governing Body: Mid-Valley Behavioral Care Network (MVBCN)		Pages: 5 Date: 03/28/2011
Subject: Utilization Management	Prepared By: MVBCN Clinical Director	Approved By: Department of Human Services – Addictions and Mental Health Division

I. OUTPATIENT SERVICES

Management of outpatient mental health services to OHP members is delegated to each sub-region (county). Each sub-region has developed a Utilization Management policy and procedure which meets the requirements of the MHO Agreement and is specific to the design of the local provider system. These policies are reviewed by MVBCN and forwarded to AMHD for approval. The sub-regions are also responsible for responding to requests for out of panel or out of area outpatient services. Their policies outline the process for issuing Notices of Action when requested services are denied or limited, and for informing consumers of their Appeal rights.

- Each sub-regional Utilization Management process includes specific procedures to safeguard against unnecessary utilization.
- Each sub-region has developed written criteria for evaluating and documenting medical necessity and clinical appropriateness of services.
- Each sub-region outlines the authority and accountability for preauthorization, concurrent review, and discharge.

OHP members covered by the MVBCN are entitled to seek outpatient service from any MVBCN provider agency within the region. Any consumer who feels that the mental health clinician serving them is not meeting their needs has the right to request a Second Opinion. The program manager or clinical supervisor in the provider agency receives and responds to these requests. Second Opinions are provided at no cost to the member, from a qualified mental health practitioner at a provider agency contracted with MVBCN or from a non-participating provider if a qualified mental health practitioner is not available within the panel of contracted agencies.

II. SERVICES TO MEMBERS WITH OTHER MEDICAL CONDITIONS

Assessment: Each assessment shall identify any ongoing health care needs that require coordination between mental health treatment and medical services, or other care management. Such conditions include co-occurring substance use, physical health problems, chronic diseases, or other disabling conditions.

Treatment Planning: If the medical condition requires coordination with other health care services, the treatment plan is developed by the consumer and the mental health practitioner in consultation with any medical or other specialists providing care.

Access to Specialty Care: The outpatient provider agency is responsible to facilitate access to medically appropriate mental health specialists for treatment of the individual's condition and identified needs.

Original:	xxx	Revised:	10/01/2005	08/16/2007	03/14/2009	03/28/2011
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Coordination of Care: The outpatient mental health case manager or therapist is responsible for on-going communication and collaboration with the individual's primary care provider and other specialty medical providers. Coordination through the physical health plan's Exceptional Needs Care Coordinator is often helpful. Such coordination and sharing of information shall be conducted within Federal and State laws, rules, and regulations governing confidentiality.

Advance Directives: Individuals may request assistance from a mental health practitioner to develop an Advance Directive which documents their wishes regarding end of life care. Support in making end of life decisions is most likely to be needed in situations where the client does not have family or other support persons providing such assistance and when the individual's cognitive level and/or medical conditions suggest that assistance with this planning would be appropriate. Assisting the individual to approach their medical providers for help in thinking through these issues is an appropriate case management role.

III. CRISIS AND EMERGENCY SERVICES

Each MVBCN sub-region (county) is responsible for providing 24 hour crisis services. In addition, the Northwest Human Services Crisis Hotline provides member services support for MVBCN members and crisis intervention. Members whose conditions are likely to result in need for crisis or inpatient services are provided the opportunity to complete a Crisis Plan outlining their needs in these situations. Crisis respite and other crisis support services are available in the community to assist members to cope with crises.

MVBCN covers all medically appropriate emergency services provided in an acute care facility/setting due to an emergency mental health condition of a member, until the condition is stabilized. No prior authorization is required if a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual at risk of serious harm or impairment. MVBCN is responsible to pay for covered services provided as a post-stabilization service provided to maintain, resolve or improve the member's condition, as defined in the current MHO Agreement Part II, Section V, (B)(2)(d)(1-7).

The MVBCN Member Handbook and each BCN agency informs members of their right to assistance in completing a Declaration for Mental Health Treatment, which conveys the individual's preferences for future treatment at times when they are not able to make their own treatment decisions. The Declaration allows the individual to designate a representative to speak for them if a court or two physicians have determined that they are not capable of making decisions for themselves. Detailed instructions and forms are available at:

<http://www.oregon.gov/DHS/mentalhealth/services/planning.shtml>

MVBCN has created a less formal process to assist Members with planning in advance for crisis prevention and responsive crisis care. Clinical staff are expected to offer these materials to all clients for whom they may be helpful, and to assist in developing and updating a personalized plan. These are designed to meet the needs of a wide range of consumers including trauma survivors and persons who experience serious mental illness. Plans are kept by the client, in the clinical chart, and on file with the crisis service. Personal Action/Crisis Prevention Plans and suggestions to assist in writing one are on the MVBCN website at

IV. INPATIENT PSYCHIATRIC SERVICES

Inpatient Services -- Expected Practices

The MVBCN Inpatient Liaison is responsible for the authorization of payment for acute care psychiatric facilities and alternative placements. A face-to-face assessment by MVBCN staff or delegate is required prior to agreement to authorize payment for inpatient hospital care. (If an MVBCN member is admitted without prior screening, the hospital should request a screening immediately.) During business hours, the MVBCN Inpatient Liaison will consult with the county crisis staff or hospital mental health evaluator on the appropriateness of potential hospital admissions, advise that staff on specific alternatives to hospital care, and assist staff in arranging appropriate admissions to hospital or alternative care. After hours authorization of payment decisions are delegated to the county on-call supervisor. MVBCN is responsible for issuing any required Notice of Action related to inpatient services or alternatives.

Acute psychiatric care is appropriate to resolve a serious behavioral health problem, usually a crisis or severe and rapid deterioration in functioning. Treatment at a lower level of care has been tried or given serious consideration. Available alternative treatment is determined to be unsafe or ineffective. The clinical assessment must document that the emergency is a result of a mental condition (diagnosis included in current DSM) and that the inpatient care is medically appropriate (OAR 410-141-0000 (73)). The diagnosis and treated condition of admitted OHP members must be covered by the Oregon Health Plan in order to qualify for payment by MVBCN.

Emergency Admission Criteria – Adults

- A. A mental health evaluation of the member documents current symptoms consistent with a DSM Axis I or II psychiatric diagnosis that is covered by the Oregon Health Plan. This diagnosis must be the primary focus of the level of care requested; and,
- B. Acute inpatient treatment is likely to be effective for Either:
 1. The prevention of imminent, catastrophic deterioration caused by the mental disorder, or,
 2. The stabilization and/or improvement of the signs and symptoms produced by the mental disorder; and,
- C. Thorough consideration of lower levels of care and outpatient alternatives concludes those alternatives are unlikely to be effective, more likely to be intrusive, unavailable or too dangerous for the individual; and,
- D. Medical cause(s) of mental or behavioral symptoms have been ruled out or judged to be very unlikely given the clinical circumstances; and,

E. Either

1. Serious and imminent risk of harm to self or others due to the present psychiatric condition, as evidenced by, for example:
 - a. Current suicidal ideation with intent, realistic plan and/or available means, which cannot be managed safely at a lower level of care; or,
 - b. Other serious life threatening, self-injurious behavior, which cannot be managed safely at a lower level of care; or,
 - c. Current serious intent to harm another, with a realistic plan and/or available means, which cannot be managed safely at a lower level of care; or,

Or

2. Gravely disabled:
 - a. Serious and acute deterioration in functioning due to a psychiatric condition, which significantly interferes with the member's ability to safely care for themselves outside of an acute inpatient setting; or,
 - b. Impairment of judgment, impulse control, and/or perception due to an acute psychiatric disorder, which places the member at great risk and requires acute inpatient intervention to protect that member.

F. Exclusion Criteria:

1. Alcohol or drug intoxication is the primary cause of the signs and symptoms that indicate hospitalization (especially in the absence of a known psychiatric history); or,
2. Contact with patient's current community provider confirms patient can be safely maintained and clinically managed in a less intensive setting, even with the presence of the current symptoms; or,
3. Crisis providers state they are capable of maintaining and clinically managing the patient in a less intensive setting; or,
4. The primary problem is social or economic (e.g., alternative to incarceration, family conflict, lack of housing etc.), without concurrently meeting the psychiatric criteria for this level of care; or,
5. Inpatient services are contraindicated as described in Section G.

G. Consideration of Hospital Services for Trauma Survivors:

(With regard to the subpopulation of trauma survivors who are frequent users of police, hospital and emergency services and may be diagnosed with PTSD, DID or BPD)

1. For trauma survivors in the acute phase of the disorder, the function of suicidality is frequently to communicate distress, regulate and relieve emotional pain, and manage relationship issues of abandonment and intimacy.
2. A decision to hospitalize in these situations should be carefully weighed and will be evaluated by the MVBCN Inpatient Liaison. The best evidence available indicates that psychiatric hospitalization is usually not helpful and does not significantly reduce suicidal risk. It is essential, however, that necessary outpatient services be available to these individuals as the appropriate substitute for hospitalization.

3. Outpatient treatment must be available, consistent, timely and well coordinated. The necessary components include: crisis plans that are well developed with the consumers as partners and are shared with the crisis providers; crisis respite available 24 hours a day; and mental health services available the next business day.
4. Hospitalization may need to be considered when the situation is highly unpredictable. This would likely occur if crisis responders are not familiar with the individual or their patterns of behavior or there are significant disinhibitors present (factors that destabilize a person's behavior), such as active psychosis, mania, or the presence of brain injury.

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