

# **OPTUM<sup>TM</sup>**

## **By United Behavioral Health**

### **CARE ADVOCACY POLICY**

*State-Specific Policy: Indiana*

#### **Management of Behavioral Health Benefits**

**Effective Date: September 1987**

**Revision Date: April 2016**

**Last Review Date: April 2016**

#### **APPLICABILITY:**

- This policy applies to Optum<sup>TM</sup>\* members whose benefit coverage is provided through HMO and fully-insured plans issued in Indiana, regardless of where the member lives.
- This policy is based on the standard Care Advocacy policy titled, *Management of Behavioral Health Benefits*, and has been modified to reflect the specific regulatory requirements of the State of Indiana.

#### **PURPOSE:**

The purpose of this policy is to describe the mechanisms and processes designed:

- To promote consistency in the management of behavioral health benefits;
- To ensure that members receive appropriate, high quality behavioral health services in a timely manner; and
- To facilitate member engagement and empowerment.

#### **POLICY:**

- Optum has formal systems and workflows designed to process pre-service, concurrent and post-service requests for benefit coverage of services, for both in-network and out-of-network (OON) practitioners and facilities.
- **Entity-specific turnaround time requirements are followed when they are more restrictive than the standard turnaround time requirements outlined in this policy.**
- **Entity-specific requirements are followed when they are more generous/less restrictive to members and/or are less generous/more restrictive to Optum.**

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\* Optum is a brand used by United Behavioral Health and its affiliates.

Optum is responsible for adhering to all applicable state and/or federal laws governing activities within the scope of this policy, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, as well as the applicable requirements, standards and regulations as set forth by the Employee Retirement Income Security Act (ERISA), the Center for Medicare and Medicaid Services (CMS), the Department of Labor (DoL), and any applicable accrediting organizations.

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- **In situations in which there is a State of Indiana mandate requiring that Optum provide specific coverage or benefits, Optum complies with the requirements.**
- In situations in which there are state behavioral health parity laws, Optum complies with the state parity regulations. Otherwise, Optum complies with the Federal Mental Health Parity Act.
  - Optum Behavioral Policy & Analytics Committee (BPAC) vets all guidelines to ensure that guidelines are in compliance with applicable behavioral health parity requirements, at minimum that:
    - Behavioral health benefit limits (elements that operate to limit the scope or duration of benefits/treatment provided) are no more restrictive in plan design or operation than those applied to medical/surgical benefits.
    - Mental health and substance use disorders (MH/SUD) treatment programs are administered quantitatively and non-quantitatively on a basis that is equal to or similar to how medical/surgical benefits are administered.
  - Questions/challenges related to parity are referred to Optum's Parity Workgroup.

**PROCEDURAL GUIDELINES FOR POLICY IMPLEMENTATION:**

1. General Practices:
  - 1.1. Optum personnel make coverage determinations of requests for services within applicable timeframes, issue written notices (letters) of determinations and provide immediate notices, verbally or through electronic means – Secure Email (requests received through the provider portal) when required.
    - 1.1.1. **UBH encourages all providers requesting prior authorization to use the Indiana *Standard Prior Authorization Request Form for Health Care Services* form.**
    - 1.1.2. Members with limited English proficiency may request that the written notices of coverage determinations be translated. (See the standard Care Advocacy policy titled, *Language Assistance for Members with Limited English Proficiency*.)
  - 1.2. Optum does not withhold benefit coverage for an initial behavioral health evaluation.
  - 1.3. Optum does not withhold benefit coverage for emergency services in situations where a member obtained (and/or was directed by an authorized representative to obtain) emergency room services without notifying Optum or obtaining pre-approval, believing there was a true emergency.<sup>1</sup>
  - 1.4. When there are State or entity-specific requirements regarding post-stabilization services, Optum handles an initial pre-service request for inpatient services as a request for post-stabilization services when the member has an emergency medical condition and the member's emergency medical condition has been stabilized.
    - 1.4.1. Requests for services unrelated to an emergency are not considered post-stabilization care requests.
  - 1.5. Optum makes a determination and notifies the treating physician or designee of the determination by telephone within the State or entity-specific turnaround timeframe, when the pre-authorization request is for inpatient post-stabilization services at a contracted or non-contracted facility. Written notification is issued **within one (1) working day of the verbal notification.**

<sup>1</sup> NCQA MBHO Standard 2016: UM11A.

- 1.6. In accordance with State or entity-specific requirements, Optum is to be financially responsible for coverage of post-stabilization services that were administered to maintain, improve or resolve the member's stabilized condition, whether care is received from an in- network or out-of-network provider, up until a determination is made within the one hour (or shorter if required) turnaround timeframe, and also for coverage of post-stabilization services that are not pre-approved, if Optum does not respond to a request for pre-approval of post-stabilization services within the required turnaround timeframe; and as otherwise required by contract or state insurance laws.
  - 1.6.1. Optum's financial responsibility for post-stabilization services that are not pre-approved ends when a network provider assumes responsibility for the member's care through transfer or at the treating facility, or when Optum and the the treating physician reach an agreement concerning the member's care, or up until the member is discharged.
- 1.7. Unless entity-specific requirements are different, **Optum reviews a request to extend an initial authorization of post-stabilization services as an urgent concurrent review** according to the timeframe and other requirements described in this policy.
- 1.8. Optum allows at least 24 hours after an admission for a facility to request a pre-authorization, unless a longer period is required by contract or state-specific requirements.
- 1.9. Optum personnel do not reverse the approval of coverage unless it is determined that the information that was used to make the determination was incorrect or fraudulent.
  - 1.9.1. The time frame for issuing a notice begins at the time the determination was made to reverse the approval of coverage, if an approval of coverage is reversed.
- 1.10. Optum provides information in the determination notice (and upon request) about the proper procedure to request authorization or notification of services when the facility, practitioner, member or authorized representative does not follow the procedure required by the member's benefit plan.
  - 1.10.1. In accordance with Indiana insurance law, for non-urgent services, when Optum notifies a facility, practitioner, member or authorized representative of the proper procedure, the notification is by phone or in writing **within five (5) calendar days**, and for urgent services, the notification is by phone or in writing **within 24 hours**, and Optum records this transaction in the member's electronic record.
- 1.11. Optum offers the opportunity for practitioners to discuss coverage determinations with Optum Peer Reviewers.<sup>3 4</sup>
- 1.12. Optum personnel are available for members and practitioners seeking information about the Utilization Management process and the authorization of care.<sup>5</sup>
- 1.13. A member may bypass Optum's internal appeal review process and have the case reviewed through an applicable Independent External Appeal Review process if

<sup>2</sup> URAC HUM Standards: 4B and 27E (v. 7.3).

<sup>3</sup> NCQA MBHO Standard 2016: UM 7A.

<sup>4</sup> URAC HUM Standards: 15 and 16 (v. 7.3).

<sup>5</sup> NCQA MBHO Standard 2016: UM 3A.

Optum fails to make a determination and issue a notice within the timeframe requirements.<sup>6</sup>

- 1.14. A member may voluntarily agree to extend the decision-making timeframe requirement for a pre-service (urgent or non-urgent) or post-service review for reasons *other than a lack of necessary information* or for matters that are beyond Optum's control (e.g., to obtain an evaluation by a specialist).<sup>7</sup>

## 2. Role of Personnel Related to Managing Behavioral Health Benefits

- 2.1. Optum personnel identify themselves as Optum employees and provide their name and title when receiving, initiating or returning telephone calls.

**2.1.1. In accordance with the State of Indiana insurance law, Optum personnel provide the State of Indiana UR certification number, 31356, when discussing confidential member information with a practitioner or facility.**

- 2.2. Intake/Customer Service Personnel:<sup>8</sup>

2.2.1. Provide the names of outpatient in-network practitioners;

2.2.2. Authorize requests for routine outpatient services; and

2.2.3. Transfer calls to Care Advocates:

2.2.3.1. If the caller requests to speak to a Care Advocate about a non-urgent concern;

2.2.3.2. If the call requires evaluation or interpretation of clinical information; or

2.2.3.3. If the identified need is urgent/emergent; or

2.2.3.4. If the request is for a higher level of care.<sup>9</sup>

- 2.3. Care Advocates:

2.3.1. Care Advocates who perform Utilization Management activities, specifically case reviews and approval of service requests, are:

2.3.1.1. Nurses who hold a current, valid, unrestricted and active Registered Nurse credential in the United States with either an Associate's Degree (required) or a BSN Degree (preferred), and 2+ years behavioral health experience.

2.3.1.2. Mental health professionals are individuals who have at least a Masters' degree and who maintain a current, valid, unrestricted and active license for independent practice from an appropriate state-licensing organization in the United States. The licenses that are acceptable for this purpose are the same as those that are recognized by Network Services for inclusion in Optum's Behavioral Health credentialed clinician network.<sup>10</sup>

2.3.1.3. For detailed information on licensure requirements for Care Advocates, see the standard Care Advocacy policy titled, *Credentialing of Optum Clinical Personnel*.

<sup>6</sup> See the Indiana state-specific Care Advocacy policies: *Member Internal Appeals of Non-Coverage Determinations and Independent External Reviews of Non-Coverage Determinations*.

<sup>7</sup> NCQA MBHO Standard 2016: UM 5A.

<sup>8</sup> NCQA MBHO Standard 2016: UM 3A.

<sup>9</sup> URAC HUM Standards: 4 and 7 (v. 7.3).

<sup>10</sup> NCQA MBHO Standard 2016: UM 4A.

- 2.3.2. Respond to requests for service, including returning routine phone calls to members within one (1) business day;
- 2.3.3. Conduct clinical case reviews (at a frequency based on the severity or complexity of the member's condition, but not routinely on a daily basis);<sup>11</sup>
- 2.3.4. Collaborate with members and providers in treatment and discharge planning activities, including assisting in scheduling a follow-up appointment for the member when necessary<sup>12</sup>, to promote members' recovery, resiliency, wellness and well-being;
- 2.3.5. Make coverage determinations based on the consistent application<sup>13</sup> of appropriate clinical guidelines, approve the most appropriate level and type of care based solely on the current information available at the time of the review, and give verbal notice of determinations, when required; and<sup>14 15 16</sup>
- 2.3.6. Staff cases for which a coverage determination cannot be made to approve the requested service(s) with:
  - 2.3.6.1. A Peer Reviewer for clinical cases; or<sup>17 18</sup>
  - 2.3.6.2. A National Director or designee for an administrative review (based solely on the terms of the member's benefit plan).
- 2.3.7. Care Advocates conducting initial clinical review do not make non-coverage determinations.<sup>19</sup>
- 2.3.8. When the Care Advocate is informed of the determination by the Peer Reviewer or National Director of designee:
  - 2.3.8.1. The Care Advocate verbally informs the practitioner/facility, and requests that the facility inform the member/family of the non-coverage determination. (Telephone contact with a facility representative is considered a proxy for providing verbal notice to the member.)
  - 2.3.8.2. For a non-coverage determination based on clinical criteria, the Care Advocate offers the practitioner/facility information about available appeal/dispute options.<sup>20 21</sup>
  - 2.3.8.3. For a non-coverage determination based on administrative criteria, the Care Advocate offers the practitioner/facility the opportunity to appeal the determination.
  - 2.3.8.4. For a member admitted to an OON facility, when feasible and clinically appropriate, the Care Advocate issues an authorization for ambulance transport to a network facility.

## 2.4. Clinical Peer Reviewers

<sup>11</sup> URAC HUM Standard: 26 (v. 7.3).

<sup>12</sup> See the standard Care Advocacy policy: *Discharge Planning*.

<sup>13</sup> See the standard Care Advocacy policy: *Consistent Application of Level of Care Guidelines and Coverage Determination Guidelines*.

<sup>14</sup> NCQA MBHO Standard 2016: UM 2A and UM 5B.

<sup>15</sup> URAC HUM Standard: 1, 20 and 28 (v. 7.3).

<sup>16</sup> See the standard Care Advocacy policy: *Level of Care Guidelines, Coverage Determination Guidelines, Psychological and Neuropsychological Testing Guidelines, Best Practice Guidelines and Supplemental and Measurable Guidelines*.

<sup>17</sup> NCQA MBHO Standard 2016: UM 4A.

<sup>18</sup> URAC HUM Standards: 11, 13, 14 and 15 (v. 7.3).

<sup>19</sup> URAC HUM Standard: 12 (v. 7.3).

<sup>20</sup> See the Indiana state-specific Care Advocacy policies: *Member Internal Appeals of Non-Coverage Determinations and Independent External Reviews of Non-Coverage Determinations*.

<sup>21</sup> See the standard Care Advocacy policy: *Practitioner and Facility Disputes of Non-Coverage Determinations*.

- 2.4.1. Are clinical personnel who hold an active, unrestricted license within the United States or one of its territories, and board certification as a psychiatrist or addictionologist<sup>22</sup>, or an active, unrestricted license within the United States or one of its territories, as a doctoral-level psychologist, and are appointed by the Regional Medical Director or a senior clinical vice president/director to conduct peer reviews.
- 2.4.2. **Hold a license to practice medicine in the state where the member is receiving services, when required by state law. This requirement applies to situations in which a non-coverage determination is made based on a pre-service or concurrent review. This requirement does not apply to post-service reviews. NOTE: the states with “practice of medicine” requirements are Arizona, Minnesota, Missouri, New Mexico, and Texas.**
- 2.4.3. Provide consultation with Care Advocates related to making coverage determinations.
- 2.4.4. Conduct Peer Reviews when requested by the practitioner/facility.<sup>23</sup>
  - 2.4.4.1. Only physicians conduct peer reviews for requests for facility-based services, and for outpatient services by a physician.
  - 2.4.4.2. Doctoral-level psychologists conduct peer reviews for non-facility-based outpatient services, including Intensive Outpatient Programs (IOPs) and psychological and neuropsychological testing services, except when the request is made by a physician.
  - 2.4.4.3. Clinical Peer Reviews are conducted by Peer Reviewers within the United States or one of its territories.
- 2.4.5. A Peer Reviewer is to be available for a peer-to-peer review within a “reasonable” time frame.
  - 2.4.5.1. For urgent cases, allowing a two (2) to four (4) hour time frame for the treating practitioner to contact a Peer Reviewer is considered reasonable. However, the time period allotted for an urgent peer-to-peer review to take place is not to exceed the time remaining for making the determination within the turnaround time requirements.
  - 2.4.5.2. For non-urgent cases, in light of State of Indiana turnaround time requirements, Optum considers it reasonable to allow **two (2) working days** for the treating practitioner to contact a Peer Reviewer.
  - 2.4.5.3. If the treating practitioner does not contact Optum for the peer-to-peer review within the stated time period, the Peer Reviewer or designee is to make **at least two (2) attempts** to reach the practitioner by telephone prior to making a determination, and is to document the attempts to reach the treating practitioner as was scheduled, in the member’s electronic record.
  - 2.4.5.4. If the Peer Reviewer is unable to make contact with the attending practitioner after at least two (2) documented attempts to reach the practitioner, or if the practitioner, attending psychiatrist or facility declines the offer of a peer-to-peer review, the Peer Reviewer is to make a coverage determination based on available information.

<sup>22</sup> NCQA MBHO Standard 2016: UM 4A.

<sup>23</sup> URAC HUM Standard: 16A (v. 7.3).

2.4.6. When a practitioner/facility requests an opportunity to discuss a non-coverage determination, Optum is to make a Peer Reviewer available within one (1) business day of the request.

2.4.7. When the Peer Reviewer makes a determination to approve the requested services, the Peer Reviewer returns the case to a Care Advocate to resume the review process.

**2.4.7.1. In accordance with Indiana insurance law, every utilization review determination as to the medical necessity or appropriateness of an admission, service or procedure is reviewed by a licensed physician or determined in accordance with standards or guidelines approved by a physician.**

2.4.8. When the Peer Reviewer makes a non-coverage determination, verbal notification and the provision of information to the provider of appeal options, is to occur. The means by which this occurs depends on whether a peer-to-peer review has taken place prior to the non-coverage determination, and whether the Peer Reviewer is employed by Optum or is external to Optum.<sup>24</sup>

2.4.8.1. When a peer-to-peer review has taken place with an Optum-employed Peer Reviewer, it is the responsibility of the Peer Reviewer to provide verbal notification to the provider of the decision, and to provide information about requesting an appeal of the decision. The Peer Reviewer alerts the Care Advocate or designee to provide verbal notification to the facility Utilization Review contact.

2.4.8.2. When a peer-to-peer review has taken place with a Peer Reviewer not employed by Optum, and an Optum-employed Peer Reviewer has made a determination based on the external reviewer's review and recommendation, it is the responsibility of the assigned Care Advocate or designee to provide verbal notification to the provider or designee of the decision, and to provide information about requesting an appeal of the decision. Notifying the facility Utilization Review contact is considered a proxy for notifying the attending physician.

2.4.8.3. When a peer-to-peer review has NOT taken place prior to a non-coverage determination, it is the responsibility of the assigned Care Advocate or designee to provide verbal notification to the provider or designee of the decision, and to provide information about requesting an appeal of the decision. Notifying the facility Utilization Review contact is considered a proxy for notifying the attending physician.

2.4.9. The Peer Reviewer and/or assigned Care Advocate are to document the determination and other case activities so that a written notice can be issued within the appropriate timeframe.

### 3. Case Reviews

3.1. Case reviews are conducted in response to requests for coverage for all levels of treatment services. They may be urgent or non-urgent, and they may occur prior to a member receiving services (Pre-Service), during the course of a member receiving services (Concurrent), or following a member receiving services (Post-Service).

3.2. Case reviews are conducted in a focused and time-limited manner to ensure that the immediate treatment needs of members are met, to identify alternative services in

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<sup>24</sup> URAC HUM Standard: 16 (v. 7.3).

the service system to meet those needs; and to ensure the development of a person-centered plan, including advance directives.<sup>25</sup>

### 3.3. Pre-Service Reviews

- 3.3.1. A pre-service review is conducted in response to a request for care or services in advance of a member receiving the care or services.
- 3.3.2. A pre-service review may be requested on an urgent or non-urgent basis.

### 3.4. Concurrent Reviews

- 3.4.1. A concurrent review is conducted in response to a request for an ongoing course of treatment.
- 3.4.2. A concurrent review is always considered to be an urgent review.

### 3.5. Post-Service Reviews

- 3.5.1. A post-service review is conducted in response to a request for payment for services that have already been provided to a member.
- 3.5.2. A post-service review is always considered to be a non-urgent review.

## 4. Care Advocacy Review Process

### 4.1. Gathering Information

**4.1.1. In accordance with Indiana insurance law, a practitioner of record is to provide to Optum, within a reasonable time period, all relevant information necessary to authorize an admission, service, or procedure.**

4.1.2. For an emergency admission or procedure, the information is to be provided **within two (2) business days** after the emergency admission or procedure.

4.1.3. For an elective admission, procedure, or treatment, the information is to be provided **not later than two (2) business days** prior to the admission or the provision of the procedure or treatment.

**4.1.4. Optum personnel gather only the critical information needed (in compliance with any Indiana state-specific restrictions for the type of information that can be requested):<sup>26</sup>**

4.1.4.1. From reliable sources, such as the treating practitioner, facility personnel, the primary physician, and the member, or the authorized representative, as appropriate;<sup>27 28</sup>

4.1.4.2. To form a comprehensive, overall understanding of the member's situation (specific details involving interpersonal relationships that are not pertinent to making a coverage determination are not requested);

4.1.4.3. To determine if the behavioral health diagnosis is accurate and can be supported by the current symptoms and behaviors displayed by the member;

4.1.4.4. To assess for risk of suicidality, homicidality, domestic violence, child abuse and elder abuse, as indicated by a member's clinical presentation;

<sup>25</sup> See the *Vision Master Document*.

<sup>26</sup> URAC HUM Standards: 8, 10, 12, 27 and 28 (v. 7.3).

<sup>27</sup> See the standard Care Advocacy policy: *Gathering and Documentation of Information Used to Make Care Advocacy Decisions*.

<sup>28</sup> NCQA MBHO Standard 2016: UM 6A.

4.1.4.5. To collaborate with treatment and discharge planning; and

4.1.4.6. To make a coverage determination.

4.1.5. Medical records are not routinely requested, other than when additional information or corroboration is required. When medical records are needed, only relevant portions are requested, and reimbursement is made, unless otherwise stated in a contractual agreement.<sup>29</sup>

4.1.6. Requesting practitioners to numerically code diagnoses is not a routine part of the care review process.

4.2. Coverage Determination Types

4.2.1. The differentiation between whether a request will be reviewed against clinical or administrative criteria in making a coverage determination is important for two (2) reasons:

4.2.1.1. It determines the type of staff person who will perform the review:

4.2.1.1.1. Cases reviewed on the basis of clinical considerations are reviewed by a Peer Reviewer.

4.2.1.1.2. Cases reviewed on the basis of administration considerations are reviewed by a Clinical Operations Director/National Director or designee.

4.2.1.2. When a determination of non-coverage is made, it determines the information to be provided related to the options that are available to the member for appealing the determination.

4.2.1.3. Requests Requiring a Clinical Review and Determination

4.2.1.3.1. The requested service(s) require a determination of medical necessity;

4.2.1.3.2. The requested service(s) are considered experimental, investigational or unproven;

4.2.1.3.3. There is insufficient information to make a determination; or

4.2.1.3.4. The service is considered to be custodial, not acute.

4.2.1.4. Requests Requiring an Administrative Review and Determination

4.2.1.4.1. The member is not eligible for benefits; or

4.2.1.4.2. The member's benefits are exhausted.

4.2.1.5. Requests Requiring a Determination of whether the Review is Clinical or Administrative

4.2.1.5.1. The following table lists the request situations that require a consideration of whether the review is to be clinical or administrative.

Situation	Differentiation		Type of Review
<b>Lack of Prior Authorization within</b>	Claim that extenuating circumstances prevented timely pre-authorization.	Yes	Clinical

<sup>29</sup> URAC HUM Standard: 27D and E (v. 7.3).

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<b>the timeliness requirements</b>		No	Administrative
	Claim that the member's acute clinical condition (such as delusional thinking) resulted in a delayed request for prior authorization.	Yes	Clinical
		No	Administrative
<b>Request for OON services when the benefit plan provides no coverage outside the network</b>	Claim of a clinical need that cannot be met by any in-network practitioner/facility and that therefore requires the use of an OON practitioner/facility.	Yes	Clinical
		No	Administrative
<b>Request for an accommodation for OON services when the benefit plan provides a reduced benefit for coverage outside the network</b>	Claim of a clinical need that cannot be met by any in-network practitioner/facility and that therefore requires the use of an OON practitioner/facility.	Yes	Clinical
		No	Administrative
<b>Diagnosis excluded by the terms of the member's Benefit plan coverage</b>	There is a question about the accuracy of the diagnosis as stated, in that the member's condition, if accurately diagnosed, may not be among the excluded diagnoses.	Yes	Clinical
		No	Administrative
<b>Services excluded by the terms of member's Benefit plan</b>	The request for psychological testing for educational or legal purposes (for example, testing to rule out a learning disorder; or testing for a child custody case) and <b>IS ALSO</b> for the purpose of evaluation for treatment - establishing a diagnosis and making a recommendation for treatment services.	Yes	Clinical
		No	Administrative

4.3. Insufficient Information

- 4.3.1. Whenever possible, Optum personnel make a coverage determination using the available clinical information rather than initiating the formal Insufficient Information process.
- 4.3.2. A Care Advocate is to make at least two (2) attempts to gather information. If these attempts are unsuccessful, the Care Advocate is to initiate one of the formal Insufficient Information processes outlined below.
- 4.3.3. For both urgent and non-urgent requests, the required information is to be requested, a coverage determination is to be made, and notice to the member or authorized representative, the practitioner and/or the facility is to be provided in compliance with the turnaround time requirements for processing urgent or non-urgent requests for approval of benefit coverage (excluding any suspended time).
- 4.3.4. Time Requirements for Urgent Cases
  - 4.3.4.1. The Care Advocate is to telephone or fax a Request for Information letter to the member, authorized representative, practitioner or facility making the request within 24 hours of the request.

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- 4.3.4.2. The telephone call or fax is to outline the specific information that is required to complete the review.
- 4.3.4.3. The member or authorized representative has 48 hours from the receipt of the request for information to submit the requested information.
- 4.3.4.4. When a Request for Information letter has been sent, the time period for Optum to make a determination is suspended.
- 4.3.4.5. The suspension starts at the date and time the notice was sent.
- 4.3.4.6. The suspension ends at the date and time Optum receives the requested information, not to exceed 48 hours from the date and time the Request for Information letter was sent.
- 4.3.5. Time Requirements for Non-Urgent Cases
  - 4.3.5.1. The Care Advocate is to send a Request for Information letter by mail to the member or authorized representative and the treating practitioner within five (5) calendar days from the receipt of the request for benefit coverage, outlining the specific information that is required to complete the review.
  - 4.3.5.2. The treating practitioner, member or authorized representative has 45 calendar days from the issuance of the Request for Information letter to submit the requested information.
  - 4.3.5.3. When a Request for Information letter has been sent, the time period for Optum to make a determination is suspended.
  - 4.3.5.4. The suspension starts on the date the notice was sent.
  - 4.3.5.5. The suspension ends on the date Optum receives the requested information, not to exceed 45 days from the date the Request for Information letter was sent.
- 4.3.6. Upon receipt of the information, the Care Advocate is to make a coverage determination or is to forward the case to a Peer Reviewer.
- 4.3.7. If the information is not received, the case is to be forwarded to a Peer Reviewer to make a determination about whether there is sufficient information to make a coverage determination.
- 4.3.8. A determination is to be made based on the available information, if the Peer Reviewer determines that there is sufficient information to make a determination.
- 4.3.9. An NCD based on insufficient information is to be issued if the Peer Reviewer determines that clinical information is not sufficient to make a coverage determination.
- 4.3.10. It is not necessary to offer a peer-to-peer review prior to issuing an NCD based on insufficient information.
- 4.4. Management of Outpatient Services
  - 4.4.1. The Algorithms for Effective Reporting and Treatment (ALERT) program is used to manage individual outpatient services provided to members, using member-completed Wellness Assessments and/or claims data.
  - 4.4.2. The ALERT program identifies members with risk factors, atypical utilization patterns and/or atypical treatment responses.

- 4.4.3. Care Advocates conduct clinical reviews with outpatient practitioners for members identified by the ALERT algorithms.
- 4.5. Discharge Planning from Inpatient Levels of Care<sup>30</sup>
  - 4.5.1. Discharge planning focuses on a member's end-to-end experience by identifying opportunities to prevent the need for hospitalization and other out-of-home services.
    - 4.5.1.1. Effective discharge planning includes the member, the current treating practitioner or facility, the practitioner or facility at the next level of care, and, as appropriate, the member's family, the Primary Physician, and relevant community resources.
  - 4.5.2. Discharge planning may consist of a number of related activities coordinated by Care Advocates, including:
    - 4.5.2.1. Ongoing assessment of a member's clinical needs and the most effective means by which these needs can be met;
    - 4.5.2.2. Informing the member and, with the member's consent, the member's family, about the treatment process, beginning as early as possible and continuing throughout a course of treatment. This includes providing information pertaining to:
      - 4.5.2.2.1. The conditions that would result in the member's transfer to a lower or higher level of care;
      - 4.5.2.2.2. The alternatives to transfer to another level of care;
      - 4.5.2.2.3. The clinical basis for transfer to another level of care; and
      - 4.5.2.2.4. The anticipated need for and length of continued care following transfer to another level of care;
    - 4.5.2.3. Ensuring that the facility has scheduled for the member an outpatient appointment for follow-up care with an appropriately licensed outpatient practitioner within seven (7) days of discharge from the hospital, and, in the event that the facility has not done so, assisting the member, when necessary, with scheduling an appointment within seven (7) days of discharge;
    - 4.5.2.4. Ensuring that the facility communicates a discharge or transfer plan to the treating practitioner or facility at the next level of care and to the Primary Physician, as appropriate.
    - 4.5.2.5. Verifying post-discharge contact information for the member and/or representative;
    - 4.5.2.6. Identifying ancillary resources that may further promote the member's recovery, such as transportation;
    - 4.5.2.7. Ensuring that the facility develops a crisis plan and a medication adherence plan following discharge;
    - 4.5.2.8. Providing relevant information to the member and, with the member's consent, the member's family, as to how to further the member's recovery;

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<sup>30</sup> See the standard Care Advocacy policy: *Discharge Planning*.

- 4.5.2.9. Facilitating referral to Medical Case Management to meet medical health needs, as appropriate;
  - 4.5.2.10. Assisting and coaching the member to engage in behavioral health services following discharge, as appropriate; and
  - 4.5.2.11. Informing the member and the member's family, as appropriate, as to how to access additional community services, and coordinating services among community agencies as needed.
5. Post-Service (Retrospective) Reviews<sup>31</sup>
- 5.1. Practitioners and members have up to 180 days after the last date of service, unless otherwise required by state law or contract, to file a claim for services or request a post-service (retrospective) review of services that have already been delivered and for which a non-coverage determination has not been made. Examples include:
    - 5.1.1. A request for a review of services, or a claim for services, when there is no authorization on file;
    - 5.1.2. A claim for services by an OON facility or practitioner under a benefit plan that does not require preauthorization, but that requires a clinical determination; and
    - 5.1.3. A claim for services from an OON practitioner or facility when there are no OON benefits.
  - 5.2. A post-service request for coverage of services is processed as a non-urgent appeal/dispute review if a non-coverage determination has been made, including a non-coverage determination by the Claims Department on a claim for services.
  - 5.3. Unless the request is a claim for payment submitted directly to the Claims Department, a post-service request for coverage of services is to be processed through the CAC.
    - 5.3.1. Care Advocates conduct the initial post-service review and may authorize all of the care, if appropriate. However, if any part of the care cannot be authorized, a Peer Reviewer reviews the entire episode of care.
    - 5.3.2. Practice of medicine requirements do not apply to retrospective reviews of services already provided.
6. Requirements for Notifications
- 6.1. Verbal and/or Electronic Notice of Coverage Determinations
    - 6.1.1. When an immediate notice is required, the following information is provided verbally (as required by regulatory or other requirement) or by Secure Email (requests received through the provider portal):
      - 6.1.1.1. The date of the determination;
      - 6.1.1.2. The approval number, if applicable;
      - 6.1.1.3. The number of approved days, if applicable;

<sup>31</sup> For benefits provided under an ERISA plan: 29 CFR 2560.503-1, Benefit Claims Procedure Regulation establishes the minimum requirements for "reasonable procedures" (such as the timeframes within which claims must be decided) governing the processing of benefit claims for all employee benefit plans covered under ERISA. A claim for group health benefits includes "pre-service" claims, see § 2560.503-1(m)(2) and "post-service" claims, see § 2560.503-1(m)(3). The claims procedure rules when a claim for benefits is filed in accordance with the plan's reasonable procedures, and that claim is denied because the individual is not eligible for coverage under the plan, the coverage determination is part of a claim and must be handled in accordance with the claims procedures of the plan and the requirements of the regulation. (See 65 FR at 70255.) Note: The rules under 42 CFR 422 apply for Medicare enrollees.

- 6.1.1.4. The date range of the approval, if applicable;
  - 6.1.1.5. The total number of days approved to date, if applicable; and
  - 6.1.1.6. The date of admission or onset of services.
- 6.2. Requirements for Written Authorization Notices
- 6.2.1. The following elements are required for written notices of authorization for services:
    - 6.2.1.1. The authorization number;
    - 6.2.1.2. The type of service; and
    - 6.2.1.3. The date range of the authorization
- 6.3. Requirements for Written Non-Coverage Determination Notices
- 6.3.1. The following elements are required for written NCD notices:
    - 6.3.1.1. The determination and the specific level of care or service that is being denied.
    - 6.3.1.2. A statement that the member can obtain the diagnosis and diagnostic code and description and the treatment (procedure) code and description upon request.
    - 6.3.1.3. The rationale for the determination:
      - 6.3.1.3.1. For a clinical Non-Coverage Determination the rationale is to cite the *Level of Care (LOC) Guidelines*, the *Psychological and Neuropsychological Testing Guidelines*, and/or the *Coverage Determination Guidelines*, or other guideline required by contract or regulation, as appropriate, on which the non-coverage determination was based; and is to be written in language that is easily understandable to the member, and that addresses the member's specific clinical presentation.
      - 6.3.1.3.2. For an administrative Non-Coverage Determination the rationale is to cite the appropriate section in the member's relevant plan documents on which the non-coverage determination was based.
    - 6.3.1.4. Available Alternate Services (Clinical NCDs)
      - 6.3.1.4.1. A statement of alternative services that would be available and authorized.
    - 6.3.1.5. Information about requesting an appeal/grievance/dispute review
      - 6.3.1.5.1. A description and explanation of internal appeal/dispute rights, including urgent appeal/dispute rights, and any applicable time limits.
      - 6.3.1.5.2. Information that assistance related to appeals is available to members by the federal Employee Benefit Service Administration (EBSA) (for ERISA-governed plans) or the Department of Health and Human Services Health Insurance Assistance Team (for non-ERISA-governed plans), as applicable.

- 6.3.1.5.3. Information about state consumer assistance resources and programs through Indiana State Department of Insurance Consumer Services Division, if applicable.**
- 6.3.1.5.4. Information on the State of Indiana Department of Insurance external review process.**
- 6.3.1.5.5. The address for the Internet web site established by the Indiana Department of Insurance<sup>32</sup>**
- 6.3.1.5.6. A statement of the member's right to file a civil suit under section 502(a) of ERISA claims procedures, if applicable.
- 6.3.1.6. A statement of the right of the treating practitioner, facility, member or authorized representative to submit written comments, documents or records relating to the claim or request.
- 6.3.1.7. A statement of the right of the member, authorized representative and treating practitioner to request a copy, free of charge, of the relevant sections of the guidelines or the benefit plan provisions or other documents used in making the non-coverage determination;
  - 6.3.1.7.1. In accordance with Mental Health Parity and Addiction Equity Act (MHPAEA), Optum makes the criteria for mental health/ substance use disorder medical necessity determinations (and reasons for denials of coverage) available to current or potential participants, beneficiaries or providers upon request.<sup>33</sup>
- 6.3.1.8. Information about the reviewer, including:
  - 6.3.1.8.1. The name and title (and for clinical NCDs), the credentials of the reviewer.
  - 6.3.1.8.2. For clinical NCDs, the actual or an electronic copy of the signature of the clinical reviewer. For administrative NCDs, an actual or electronic signature of the reviewer is not required for the notice.
    - 6.3.1.8.2.1. When it is not physically possible for the actual or electronic copy of the signature of the Peer Reviewer to be affixed to the NCD notice, it is permissible, with the agreement of the clinical reviewer, for a designee to sign for the reviewer.
    - 6.3.1.8.2.2. When a clinical reviewer is external (not employed by Optum), the review results in a recommendation, rather than a determination. It is the responsibility of an Optum-employed clinical reviewer to make the determination and sign (or to authorize a designee to sign or affix an electronic signature to) the NCD notice.
    - 6.3.1.8.2.3. In a situation when two (2) clinical reviewers are required to review a service request, such as when a member is receiving treatment in a "practice of medicine" state, and when the state of governance of the member's plan is a different state and one that requires an in-state license and when the reviewer does not hold a license in both the

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<sup>32</sup> IC 27-1-3-33

<sup>33</sup> Mental Health Parity Act, §512(4).

“practice of medicine” and the applicable state of governance, then the two separate reviewers’ signatures are to appear on the notice.

## 7. Court-Ordered Treatment

**7.1. In evaluating requests for court-order treatment services, Optum considers the member’s acute symptoms and the precipitant for admission, the appropriateness of treatment, the terms of the member’s benefit plan, the stipulations of the court order, and applicable Indiana state law.**

7.2. The following process is to be followed if a determination to approve coverage is made:

7.2.1. A copy of the court order is to immediately be forwarded to the Legal Department if:

7.2.1.1. A member is mandated through court order to receive services, or is required to remain in a facility by a government entity; AND

7.2.1.2. The court order stipulates that Optum is responsible for the cost of care.

7.2.2. The Legal Department determines, within the timeframes required based on the urgency of the case, whether Optum is responsible for the cost of the services,

7.2.3. A non-coverage determination may be issued based on the requirements of the member’s benefit plan if the Legal Department determines that Optum is not responsible for the services.

## 8. Prudent Layperson Considerations

8.1. If a member seeks/sought benefit coverage for emergency room services without notifying Optum or obtaining pre-approval, believing a true emergency existed, benefit coverage for these services is not to be withheld.

8.2. If an authorized representative of the member or the health plan deems/deemed the situation to be/to have been urgent or emergent, benefit coverage for these services is not to be withheld.

8.3. Optum considers the member’s presenting symptoms when determining if the *prudent layperson* definition is met.<sup>34</sup>

## 9. OON Facilities<sup>35</sup>

9.1. An admission to an inpatient level of care at an OON facility when a member has no OON benefits is to be reviewed based on clinical considerations to determine if it was due to an emergency, or if the member was unable to access inpatient services at a network facility.

9.2. Optum’s policy is for the member to be transferred by ambulance to a network facility as soon as it is safe to do so.

## 10. COBRA Coverage

<sup>34</sup> NCQA MBHO Standards 2016: UM 11A

<sup>35</sup> See the standard Care Advocacy policy: *Authorizing Services for In-Network and Out-of-Network Practitioners/Facilities*.

- 10.1. Optum does not manage, or does not continue to manage, any alleged member's behavioral health services when our electronic eligibility records show that the subscriber is ineligible, or is no longer eligible, for coverage.
  - 10.1.1. Optum will retrospectively review claims for services rendered, if the qualified beneficiary subsequently elects COBRA coverage, makes the necessary premium payment within the grace period for payments and shows behavioral health benefit coverage that was active for the date/s on which the services were rendered.
- 11. Member Protected Health Information (PHI)
  - 11.1. Member PHI is to be kept confidential in accordance with Optum Integrity and Compliance policies and the standard Care Advocacy policy titled, *Confidentiality*.
  - 11.2. Optum personnel are only to request enough clinical information to determine if the behavioral health diagnosis is accurate and can be supported by the current symptoms and behaviors displayed by the member.
  - 11.3. The goal for obtaining clinical information is to have a comprehensive, overall understanding of the member's situation, as opposed to incident-specific detail, in order to make informed decisions that will produce safe and successful treatment outcomes.
  - 11.4. Specific details regarding symptoms are pertinent in assessing risk factors and creating discharge plans that meet members' needs in a comprehensive manner.
  - 11.5. Other pertinent information includes the nature of the symptoms, risk history, medications, response to current treatments and discharge planning.
- 12. Material Modification Filing
  - 12.1. Optum notifies the Indiana Department of Insurance of any material modifications made to policies and procedures **within 30 days of the change**.
- 13. Turnaround Time Requirements for Authorization and Non-Coverage Determinations
  - 13.1. The following tables outline the turnaround time and related requirements for processing requests for authorization of services Verbal and/or Electronic Notice of Coverage Determinations.
    - 13.1.1. Verbal notice to the member is not required when there is no member financial liability.
    - 13.1.2. For facility cases, telephone contact with a facility representative is considered a proxy for providing verbal notice to the member.

**Table 1A: Urgent Pre-Service Coverage Determinations (Authorizations)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	As soon as possible in consideration of the urgency of the member's situation, and in all cases <b>within two (2)</b>	From receipt of the request by any Optum behavioral health staff member.	N/A

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<b>Delivery of Immediate Notice – Verbal (as required by regulatory or other requirement) or by Secure Email when received through the provider portal (Required)</b>	<b>business days of receipt of the necessary information, not to exceed 72 hours.</b>		<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> </ul>
<b>Issuance of Written Notice</b>			<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>

**Table 1B: Urgent Pre-Service Non-Coverage Determinations (Denials)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	As soon as possible in consideration of the urgency of the member's situation, and in all cases <b>within two (2) business days of receipt of the necessary information, not to exceed 72 hours.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Verbal Notice (Required)</b>			<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>
<b>Issuance of Written Notice</b>			

**Table 2A: Urgent Concurrent Coverage Determinations (Authorizations)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within 24 hours.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Verbal Notice (as required by regulatory or other requirement) or by Secure Email when received through the provider portal (Required)</b>			<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> </ul>

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<b>Issuance of Written Notice</b>	As soon as possible in consideration of the urgency of the member's situation, and in all cases <b>within two (2) business days of the receipt of the necessary information, not to exceed 72 hours.</b>	From delivery of verbal notice.	<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>
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**Table 2B: Urgent Concurrent Non-Coverage Determinations (Denials)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within 24 hours.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Verbal Notice (Required)</b>			<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>
<b>Issuance of Written Notice</b>	As soon as possible in consideration of the urgency of the member's situation, and in all cases <b>within two (2) business days of the receipt of the necessary information, not to exceed 72 hours</b>	From delivery of verbal notice.	<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>

**Table 3A: Non-Urgent Pre-Service Coverage Determinations – Outpatient (Authorizations)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 10 calendar days.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Immediate Notice (Not Required)</b>	N/A	N/A	N/A
<b>Issuance of Written Notice (Open Authorizations)</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 10 calendar</b>	From receipt of the request by any Optum behavioral health staff member.	<ul style="list-style-type: none"> <li>• Member or authorized representative</li> </ul>

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<b>Issuance of Written Notice (Other than Open Authorizations)</b>	<b>days.</b>		<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>
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**Table 3B: Non-Urgent Pre-Service Non-Coverage Determinations (Denials)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 10 calendar days.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Verbal Notice (Not Required)</b>	N/A	N/A	N/A
<b>Issuance of Written Notice</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 10 calendar days.</b>	From receipt of the request by any Optum behavioral health staff member.	<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>

**Table 4A: Non-Urgent Post-Service Coverage Determinations (Authorizations)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 30 calendar.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Immediate Notice (Not Required)</b>	N/A	N/A	N/A
<b>Issuance of Written Notice</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 30 calendar days.</b>	From receipt of the request by any Optum behavioral health staff member.	<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>

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**Table 4B: Non-Urgent Post-Service Non-Coverage Determinations (Denials)**

Process Component	TAT Requirement	When the Clock Starts	Required Recipients
<b>Completion of Review and Determination</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 30 calendar.</b>	From receipt of the request by any Optum behavioral health staff member.	N/A
<b>Delivery of Verbal Notice (Not Required)</b>	N/A	N/A	N/A
<b>Issuance of Written Notice</b>	<b>Within two (2) business days of the receipt of necessary information, not to exceed 30 calendar.</b>	From receipt of the request by any Optum behavioral health staff member.	<ul style="list-style-type: none"> <li>• Treating practitioner</li> <li>• Facility</li> <li>• Member or authorized representative</li> </ul>

**RELATED POLICIES:**

- Care Advocacy policy: *Authorizing Services for In-Network and Out-of-Network Practitioners/Facilities.*
- Care Advocacy policy: *Confidentiality*
- Care Advocacy policy: *Consistent Application of Level of Care Guidelines and Coverage Determination Guidelines.*
- Care Advocacy policy: *Discharge Planning*
- Care Advocacy policy:
- *Documentation and Internal Communications Used to Make Coverage Decisions*
- Indiana state-specific Care Advocacy policy: *Independent External Reviews of Non-Coverage Determinations*
- Care Advocacy policy: *Language Assistance for Members with Limited English Proficiency*
- Care Advocacy policy: *Level of Care Guidelines, Coverage Determination Guidelines, Psychological and Neuropsychological Testing Guidelines, Best Practice Guidelines and Supplemental and Measurable Guidelines*
- Indiana state-specific Care Advocacy policy: *Member Internal Appeals of Non-Coverage Determinations*
- Care Advocacy policy: *Practitioner and Facility Disputes of Non-Coverage Determinations*

**APPROVAL HISTORY:**

- Policy and Procedure Committee review and approval: 07/28/2008
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- Policy and Procedure Committee review and approval: 07/22/2013
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