



## BEHAVIORAL HEALTH

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#### Introduction

'Ohana Health Plan's Clinical Services Program is designed to coordinate medically necessary care at the most appropriate level of service. The goal is to provide the right service in the right location at the right time to ensure that our members receive the highest quality of care.

Members experiencing both medical and behavioral conditions represent a significant proportion of all medical and psychiatric patients. 'Ohana (the Plan) is committed to improving health outcomes through improved access to and integration of behavioral health and primary care services.

Effective and timely communication and coordination of care among disciplines can bridge the gaps fragmenting health care delivery. Integration of care can positively affect member productivity, functional capacity and quality of life as well as decrease the potential for adverse drug interactions.

Behavioral health services may be provided by psychiatrists (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Psy.D. or Ph.D.), licensed clinical social workers (LCSW) or other licensed providers.

#### Behavioral Health Benefit Overview

'Ohana shall provide all medically necessary behavioral health services to QUEST Expanded Access (QExA) adults and child members. These services include:

- Twenty four-hour care for acute psychiatric illnesses
- Ambulatory services including 24 hours, seven-days-per-week crisis services
- Acute day hospital/partial hospitalization
- Methadone treatment services, which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient



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counseling services;

- Prescribed drugs including medication management and patient counseling
- Diagnostic/laboratory services including:
  - Psychological testing
  - Screening for drug and alcohol problems
  - Other medically necessary diagnostic services;
- Psychiatric or psychological evaluation;
- Physician services;
- Rehabilitation services;
- Occupational therapy; and
- Other medically necessary therapeutic services

No limits exist for medically necessary behavioral health services.

### **Exclusions and Limitations**

The Plan **will not** provide behavioral health services to those members:

- Whose diagnostic, treatment or rehabilitative services are determined not to be medically necessary by the health plan;  
or
- Who have been determined eligible for and have been transferred to the State of Hawai'i Department of Human Services' (DHS) Adult Mental Health Division (AMHD) for services, or behavioral health managed care (BHMC) plan, as described or the DHS's Child and Adolescent Mental Health Division (CAMHD).



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Members who have been criminally committed for evaluation or treatment in an inpatient setting under the provisions of Chapter 706, Hawai'i Revised Statutes, will be disenrolled from the behavioral programs and will become the clinical and financial responsibility of the appropriate state agency. 'Ohana will remain responsible for providing medical services to these members. However, room and board in special treatment facilities for adolescents is not covered by 'Ohana but the appropriate state agency.

#### **Authorization**

Utilization management is an activity that touches patients receiving more intensive services, including inpatient hospitalization, partial-hospital programming, and intensive outpatient services. The Plan will conduct timely utilization reviews in order to authorize member services to support quality of care.

Prior authorization is required for certain outpatient services or hospital/facility-based behavioral health services, except in an emergency. To request prior authorization for behavioral health services, please contact the Provider Hotline.

#### **Emergency Services**

Members experiencing an emergency behavioral health condition can receive medically necessary care without prior authorization from 'Ohana.

Emergency services include inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson's standard. The services must also be furnished by a provider that is qualified to furnish such services.

Providers rendering emergency services must notify 'Ohana as soon as possible, after the services are rendered and may be required to forward medical records to the Plan for utilization review.



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#### Medically Necessary Services

Medically necessary services shall be as defined in Hawai'i Revised Statutes (HRS) 432E-1.4 or health interventions that health plans are required to cover

within the specified categories that meet the criteria identified below, whichever is the least restrictive:

- The intervention must be used for a medical condition;
- There is sufficient evidence to draw conclusions about the intervention's effects on health outcomes;
- The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;
- The intervention's beneficial effects on health outcomes outweigh its expected harmful effects; or
- The health intervention is the most cost-effective method available to address the medical condition.

*Medical Condition:* a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

*Health Outcomes:* outcomes of medical conditions that directly affect the length or quality of a person's life.

*Sufficient Evidence:* considered to be sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes and is reproducible both within and outside of research settings.

*Health Intervention:* an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical condition. Activities that are primarily custodial, or part of normal existence, or undertaken



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primarily for the convenience of the patient, family or practitioner are not considered health interventions.

*Cost-Effective:* is cost-effective if there is no other available intervention that offers a clinically appropriate benefit at a lower cost.

#### **Medical Necessity Criteria**

‘Ohana follows criteria that serve as guidelines for determining the medical necessity and clinical appropriateness of all behavioral health services.

InterQual behavioral health criteria, developed by McKesson Health Solutions, include specific sets of guidelines for adults, children, adolescents, geriatric and for dual diagnosis and substance abuse services.

When appropriate, ‘Ohana also uses guidelines established by the American Psychiatric Association and American Academy of Child & Adolescent Psychiatry. In addition, the Plan adheres to all federal and state regulations and guidelines applicable to behavioral health services.

#### **Outpatient Psychiatric Referrals**

A referral to a psychiatrist should be made in the following situations:

- When it is believed medication management would assist in obtaining the best outcome of the therapeutic process either alone or in combination with outpatient psychotherapy;
- When a member is not improving during a course of outpatient psychotherapy due to continued symptoms of depression, anxiety or other complicating factors;
- When the member’s clinical status indicates there is the potential for danger to himself/herself, others or property;



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- When increased psychiatric symptoms are interfering with the member's ability for self care or to carry out normal activities of daily living;
- When a medical opinion is necessary after an initial evaluation or the member's primary care physician has requested a psychiatric consult because of the member's past psychiatric history and/or concurrent medical problems;
- When a member requires ongoing post-hospitalization monitoring of medication management;
- The diagnosis is unclear or treatment is ineffective.

Providers are encouraged to contact 'Ohana by telephone to coordinate and assist with all psychiatric referrals.

### **Inpatient Services**

Hospital and facility representatives must contact the 'Ohana utilization management department by telephone at (888) 505-1189 to initiate the precertification and authorization of inpatient services at the time of admission or, when emergency care dictates, within 24 hours of admission.

Authorization of emergency services is conducted by the Plan 24 hours a day, seven days per week. In addition to authorizing inpatient and other forms of intensive programming, licensed behavioral care managers arrange emergency evaluations during 23-hour observation periods, as well as inpatient and psychiatric consultations on medical units when indicated.

Discharge planning should begin at the time of admission. It is the responsibility of the provider to ensure that members have a follow-up appointment scheduled at the time of discharge to occur within five



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days of the discharge.

#### **Concurrent Review Process**

When a contracted facility has obtained authorization for an admission, a concurrent-stay review is required on a regular basis. The facility is responsible for contacting 'Ohana's concurrent review nurse with updated clinical information on the scheduled day of review. Concurrent review nurses collect only that information necessary to certify the requested service(s).

Concurrent review nurses may on occasion request copies of medical records and, when requested, only require the section of the medical record relevant to determine the need for ongoing medically necessary services. They determine if the data provided meets InterQual behavioral health criteria and, if so, an authorization will be granted for continued inpatient stay. The facility is verbally notified of all authorization and non-authorization decisions on the same business day.

#### **Physician-to-Physician Review**

If the Concurrent review nurse determines that further clinical information is necessary, the Concurrent review nurse and the facility UR staff will assist in coordinating an MD–MD review between 'Ohana's medical director or physician advisor (PA) and the attending physician. The Concurrent review nurse will arrange a telephone review (within one business day) with the attending hospital physician or licensed psychiatrist. The facility utilization reviewer will be notified of the date and time of the scheduled telephone review.

If the Concurrent review nurse determines that the information provided meets InterQual criteria for discharge, the case is referred to the medical director or physician advisor, who is then responsible for determining whether to provide authorization or non-authorization for continued care.



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**Member Grievance Process**

Please refer to the Appeals and Grievances section of the 'Ohana Provider Manual for detailed information on the member grievance process.

**Transitional Care for New Members***Transition of Care-Routine*

In the event a member entering the Plan is receiving medically necessary covered services in addition to or other than prenatal services the day before enrollment into 'Ohana, the Plan shall be responsible for the costs of continuation of such medically necessary services without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers.

The Plan shall provide continuation of such services for the lesser of:

1. Ninety days for all members receiving HCBS and all children under the age of 21, and
  2. One hundred and eighty days for all members living in a nursing facility and all members without a care plan;
- Or
3. Until members in these categories have had a health and functional assessment (HFA) from his or her service coordinator, had a care plan developed and have been seen by the assigned PCP who has authorized a course of treatment.



After the initial transition of care requirements are completed, providers are required to follow 'Ohana's prior-authorization or concurrent-review requirements.

If a provider receives an adverse claim determination that they believe was a transition-of-care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation of DHS/CMO approval for reconsideration. Refer to the **Quick Reference Guide** for the appropriate contact information.

#### **Provider Information and Quality of Care**

Quality of Care provider data is linked to the provider recredentialing process. 'Ohana collects and maintains a provider database that includes the following information:

- Access availability
- Over- and under-utilization
- Risk management and sentinel events
- Member satisfaction
- Member complaints
- Site reviews
- Medical record audits