



## **Behavioral Health (MAPSI) Utilization Management Program Components**

Payer Name: \_\_\_\_\_

Printed Name of Payer Representative: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this document applicable to all groups?  Yes  No  
*If no, please indicate specific group name and number.*

Group Number: \_\_\_\_\_ Group Name: \_\_\_\_\_

*A separate form is necessary for each group if services vary.*

To augment the behavioral health network of practitioners and facilities available to your group, MAPSI is pleased to offer an array of supplemental services. These services are designed to help payers keep track of utilization trends within their groups, and to ensure the most appropriate health care services are delivered in the most appropriate setting. Please carefully review the sections below, and select the services that your organization would like to purchase.

**I. Behavioral Health (MAPSI) Utilization Management and Case Management**  
*Please select each Utilization Management service requested by your organization.*

**A.  Inpatient Utilization Management**

Includes pre-admission review, concurrent review, retrospective review and discharge planning for the following behavioral health services: acute inpatient, substance abuse detoxification, psychiatric residential, and crisis residential.

1.  Rate negotiation for out-of-network or non-participating practitioners and/or behavioral health facilities
2.  Retrospective rate negotiation (on a case-by-case basis)
3.  MAPSI Exclusive Provider Organization (EPO)

**B.  Outpatient Utilization Management**

Includes pre-admission review, concurrent review, retrospective review and discharge planning for the following outpatient behavioral health services: partial hospitalization substance abuse/psychiatric; intensive outpatient substance abuse/psychiatric; outpatient psychotherapy; psychological/neuropsychological testing; outpatient electroconvulsive therapy (ECT); and psychiatric home care.

- Pre-certification for partial hospitalization
- Pre-certification for intensive outpatient services
- Pre-certification for psychotherapy
- Pre-certification for psychological/neuropsychological testing
- Pre-certification for outpatient ECT
- Pre-certification for MAPSI EPO
- Pre-certification for use of another PPO network outside the MAPSI service area

**C.  Case Management Services**

For payers that select MAPSI UM services, after-case compliance follow-up calls can be made to participants up to 90 days after inpatient and/or partial hospitalization. Duration of these services is based upon clinical complexity.

1.  Case management for inpatient and outpatient services

---

2. Does your organization use another PPO network outside the MAPSI network service area?

Yes       No

If yes, please provide the name of the network and the toll-free telephone number below.

---

---

---

3. If any of the services listed above are not covered benefits for your group members, please explain.

---

---

---

4. Does your organization have an Employee Assistance Program?     Yes       No

If so, please list the name and telephone number of an EAP contact.

---

---

---

**II. Utilization Reports**

All MAPSI payers receive the following standard reports:

- **Payer Report** – auto-generated to the payer for each approved or denied service, provides demographic information and details of approved/denied services for inpatient, outpatient and home health services.
- **External Referral Report** – generated from Case Management (CM) for each approved or denied case management service.
- **Denial and Appeal Report** – summary-level report to payers, sent quarterly and annually, containing summary-level data for all approved and denied services.

*In addition to the standard reports provided by MAPSI to all payers, the following report types may be available to your organization after discussions and confirmation of MAPSI Account Management. Please select the reports your organization would like to request.*

Inpatient Discharge Report (weekly)

Outpatient Discharge Report (weekly)

Home Health Care Discharge Report (weekly)

Re-admission Report (quarterly)

Utilization Management Report: includes inpatient, outpatient, home health and case management (quarterly and annually)

Case Management Savings Report (quarterly)

### III. Clinical Consultative Review

*After reading the following description, please check the box below if your organization elects to have clinical consultative review services provided by MAPSI.*

Clinical consultation review support services

MAPSI may be contacted by the payer for clinical consultation review support services, which include a formal recommendation – provided only to the payer. The recommendation will be based on the medical necessity clinical determination review performed by the Medical Director, or based on the use of standard criteria or guidelines by MAPSI.

All claims related administrative issues are handled by and referred to the payer or third party administrator. The payer assumes full responsibility for the initial denial process and all appeal processes related to MAPSI utilization management services. The payer assumes full responsibility for verbal and written notification to participants and physicians/health care practitioners, and utilization management service-related adverse benefit decisions and appeal rights.

### IV. Utilization Management-Related Denial/Non-Certification and First-Level Appeals

*After reading the following description, please check the box below if your organization elects to have MAPSI handle denials/non-certification and first-level appeals related to Utilization Management.*

MAPSI is responsible for the initial denial process and the first-level appeal process. As part of this process, MAPSI will send notification letters to participants, health care practitioners and payers. MAPSI will advise the participant, health care practitioner and payer when the clinical review appeal process is exhausted.

*(If this option is not selected, the payer retains oversight and is responsible for ensuring that the Utilization Management services-related denial and appeal processes are in compliance with all applicable state and federal regulations and accrediting agency standards. This includes meeting the established time frames, and identifying designated personnel to address, receive and respond to all Utilization Management-related clinical denial and appeal issues.)*

#### **Adverse Decision Process (Denial/Non-certification)**

MAPSI assumes responsibility for initial denial/non-certification letters written on behalf of the payer, group or third party administrator (TPA). These letters represent the first time MAPSI, on behalf of the payer, issues a notification of an adverse decision or an administrative denial. Letters are created and sent to the physician, health care practitioner and participant in accordance with state and federal laws and regulations, and accrediting agency standards. **All notifications occur in accordance with the Department of Labor (DOL) and state regulatory time frames and accrediting agency standards.**

#### **Non-Urgent Pre-admission/Pre-certification**

Decisions are made after receiving clinical information. When additional clinical information is needed to determine medical necessity, the participant, physician, vendor or health care practitioner is sent a request. To be considered, the additional information must be sent by the treating physician/health care practitioner, or the participant and his/her representative, and received by MAPSI within state, federal and accrediting agency time frames for the receipt of additional information. The

adverse decision is communicated to the participant or health care practitioner on behalf of the participant. The notice of adverse decision is provided in writing to the payer, requesting health care practitioner and participant.

### **Urgent/Emergent Pre-certification**

Urgent/emergent pre-certification is the expedited review of a case for health care services that are proposed but have not been delivered. The proposed services are necessary to treat a condition or illness that, without immediate medical attention, would (a) seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, (b) cause the participant to be a danger to self or others or (c) in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. If a request does not meet the criteria, it does not qualify as expedited review and is reviewed under the non-urgent review process.

With urgent reviews, decisions are made expeditiously and the requesting physician/health care practitioner acting on behalf of the participant is notified verbally of the decision. When MAPSI determines there is not enough information to complete the review of the urgent/emergent request, the treating physician/health care practitioner or the participant, is notified by telephone or fax of the specific information required. To be considered, the additional information must be sent by the treating physician/health care practitioner, or the participant and his/her representative, and received by MAPSI within state, federal and accrediting agency time frames for the receipt of additional information.

For pre-admission/pre-certification of an urgent/emergent request that results in an adverse decision, the decision is made and verbally communicated to the physician/health care practitioner acting on behalf of the participant. In addition, written or electronic mail confirmation of the decision is provided to the participant, payer and physician/health care practitioner according to state-specific adverse decision notification requirements.

### **Procedures for an Extended Stay in a Facility or Additional Health Care Services**

For an extended stay in a health care facility or additional health care services, decisions are made in accordance with state and federal regulations and accrediting standards. When the Medical Director determines that there is not enough information to complete the request, the treating physician/health care practitioner on behalf of the participant is notified expeditiously of the specific information required by telephone, electronic mail or fax. To be considered, the additional information must be sent by the treating physician/health care practitioner, or the participant and his/her representative, and received by MAPSI within state, federal and accrediting agency time frames for the receipt of additional information. For decisions that result in an adverse decision, the decision is verbally communicated to the physician/health care practitioner acting on behalf of the participant. In addition, written notice is sent to the participant and the physician/health care practitioner.

### **Procedures for Retrospective Review of Health Care Services**

When the review of medically necessary services and supplies is conducted after services have been provided to a participant, decisions are made in accordance with state and federal regulations and accrediting agency standards. If MAPSI determines there is insufficient information to complete the request, the health care practitioner, or the participant and his/her representative, are notified by mail, electronic mail or fax of the specific information required. To be considered, the additional information must be sent by the treating physician/health care practitioner, or the participant and

his/her representative, and received by MAPSI within state, federal and accrediting agency time frames for the receipt of additional information.

If the retrospective review of medically necessary services and supplies results in an adverse decision, the adverse decision will be verbally communicated to the health care practitioner acting on behalf of the participant. In addition, the notice of adverse decision will be provided in writing to the participant and the requesting health care practitioner.

Written notice of Utilization Management adverse decisions to the participants of self-funded, ERISA regulated groups and insurance carriers will contain the following information:

1. The detailed, specific, factual basis for the decision in clear, understandable language.
2. Reference to the specific criteria and standards, including guidelines, on which the decision was based, a statement of the decision that the participant is entitled to receive, upon request made to the payer and a written statement of the specific health benefit design provisions on which the decision was based.
3. A statement that a copy of the guidelines or criteria will be provided free of charge upon request.
4. The name, business address and business telephone number of the Medical Director or Associate Medical Director, as appropriate, who made the decision.
5. A statement that the Medical Director is available by telephone to discuss the decision with the physician/health care practitioner on behalf of the participant.
6. A statement that the participant, his or her representative, or a physician/health care practitioner on behalf of the participant has the right to file a grievance within prescribed state or federal regulatory time frames of receipt of a prospective, concurrent or retrospective adverse decision.
7. A statement referring the practitioner or participant to the payer for the written details of the participant's health plan benefit and eligibility summary plan.
8. A description of MAPSI's internal grievance process and procedures.
9. A description of the criteria for an emergency grievance and an explanation of the right to file an emergency grievance if the case meets these criteria.
10. A statement that the participant or health care practitioner filing a grievance on behalf of the participant may file a complaint with employer's benefit administrator in accordance with their benefit design plan.
11. A statement advising participants subject to ERISA of their right to file a civil suit.

### **First-Level Appeal**

At the time a participant and health care practitioner are notified in writing of an initial determination, instructions are provided for filing a first-level appeal. After receiving the appeal request, MAPSI sends an acknowledgement letter. The letter includes the name, address and telephone number of the MAPSI Coordinator, and the name and telephone number of the payer's benefit administrator contact

person. MAPSI processes both first-level appeals and first-level expedited appeals in accordance with state and federal regulations and accrediting agency standards. External consultant (specialty physician) opinions are used in accordance with state and federal regulations and accrediting agency standards. MAPSI notifies the participant, the physician/health care practitioner and the payer of the decision.

---

Payer Number: \_\_\_\_\_

Printed Name of Payer Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Payer Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of OneNet Account Manager: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of OneNet Account Manager: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of OneNet UM Liaison: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of OneNet UM Liaison: \_\_\_\_\_

Date: \_\_\_\_\_