

ALLIANCE BEHAVIORAL HEALTH UTILIZATION MANAGEMENT PROGRAM COMPONENTS

I. OPTIONS FOR BEHAVIORAL HEALTH UTILIZATION MANAGEMENT (MAPSI)

Check column titled “Yes” for each service component requested. If service is not a covered benefit, please note in comments section.

1. Inpatient Utilization Management: Includes pre-admission review, concurrent review and retrospective review and discharge planning for Behavioral Health services: Substance Abuse Detoxification/Rehabilitation Services, Psychiatric Services, Residential Services and Crisis Residential Services

Service Component	YES	NO	Comments
Inpatient Utilization Management			
Out of Network or Non Participating Facility Rate Negotiations Alliance Behavioral Health staff will facilitate negotiations with non participating providers and/or Behavioral Health facilities with the prior consent of the payor concurrently. Retrospective rate negotiations will occur on a case by case basis.			
MAPSI EPO			
Will payor utilize another PPO network outside the Alliance Network>			<i>(If yes, please indicate the name of the network and the 1-800 number)</i>
Payor EAP requires precertification by MAPSI Staff			<i>(If yes, please provide EAP point of contact and phone number)</i>

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2. Outpatient Utilization Management: Includes pre-admission review, concurrent review and retrospective review and discharge planning for outpatient Behavioral Health services: Partial Hospitalization Substance Abuse/Psychiatric, Intensive Outpatient Substance Abuse/Psychiatric; Outpatient Psychotherapy, Psychological/Neuropsychological Testing, Outpatient ECT(Electroconvulsive Therapy), and Psychiatric Home care.

	YES	NO	Outpatient Precertification Mandatory? Y/N		Comments
Partial Hospitalization					
Intensive Outpatient Psychotherapy					
Psychological/ Neuropsychological Testing					
Outpatient ECT					
MAPSI EPO					<i>(If yes, please indicate the name of the network and the 1-800 number)</i>
Will payor utilize another PPO network outside the Alliance Network?					<i>(If yes, please provide EAP point of contact and phone number)</i>

3. Case Management (CM) Services: After care compliance follow-up calls to the participant up to 90 days after Inpatient and/or Partial hospitalization for Groups that take MAPSI UM Services. Duration of these services is based on clinical complexity.

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Service Component	YES	NO	Comments
Case Management Services			

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II. UTILIZATION MANAGEMENT RELATED DENIAL/NON-CERTIFICATION AND FIRST LEVEL APPEALS

Check block if selecting service

- Alliance is responsible for the initial denial process and the first level appeal process, sends notification letters to participants, physicians/health care providers and payors. Alliance will advise the participant, provider and payor when the Alliance Clinical Review Appeal process has been exhausted.**

(If this option is selected, the payor retains oversight and is responsible for ensuring that the UM services-related denial and appeal process is 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 clinical UM-related denial and appeal issues).

Adverse Decision Process (Denial/Non-certification)

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

Non-Urgent Preadmission/Precertification

Decisions are made after receiving clinical information. Requests for additional clinical information are sent to participant, physician, vendor or health care provider when information is needed to determine medical necessity. For additional information to be considered, the treating physician/health care provider, or the participant and their representative, must provide the additional information requested within state, federal and accrediting agencies time lines from the date of their receipt of the request for the additional information. The adverse decision is communicated to the participant or health care practitioner action on behalf of the participant. The notice of adverse decision is provided in writing to the payor, requesting health care practitioner and participant.

Urgent/Emergent Precertification

Urgent/emergent precertification is the expedited review of a case for health care services that are proposed but have not been delivered; and 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, or (b) cause the participant to be

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in 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 and is reviewed under the non-urgent review process.

Decisions are made expeditiously and the requesting physician/health care provider acting on behalf of the participant is notified verbally of the decision. When Alliance determines that there is not enough information to complete the review of the urgent/emergent request, the treating physician/health care provider, or the participant, is notified by phone or facsimile of the specific information required. For additional information to be considered, the treating physician/health care provider, or the participant and their representative, must provide the additional information requested within state, federal and accrediting agencies time lines from the date of their receipt of the request for the additional information.

For preadmission/precertification of an urgent/emergent request that results in an adverse decision, the decision is made and orally communicated to the physician/health care provider acting on behalf of the participant. In addition, written or electronic mail confirmation of the decision is provided to the participant, payor and physician/health care provider 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 agency standards. When the Medical Director determines that there is not enough information to complete the request the treating physician/health care provider on behalf of the participant is notified expeditiously of the specific information required by phone, electronic mail or facsimile. For additional information to be considered, the treating physician/health care provider, or the participant and their representative, must provide the additional information requested within state, federal and accrediting agencies time lines from the date of their receipt of the request for the additional information. For decisions that result in an adverse decision, the decision is made and verbally communicated to the physician/health care provider acting on behalf of the participant. In addition, a written notice is sent to the participant and the physician/health care provider.

Procedures for Retrospective Review of Health Care Services

For retrospective review of medically necessary services and supplies that is conducted after services have been provided to a participant, decisions are made in accordance with state and federal regulations and accrediting agency standards. When Alliance determines that there is not enough information to complete the request the health care provider, or the participant and their representative, is notified of the specific information required by mail, electronic mail, or by facsimile. For additional information to

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be considered, the treating physician/health care provider, or the participant and their representative, must provide the additional information requested within state, federal and accrediting agencies time lines from the date of their receipt of the request for the additional information.

For retrospective review of medically necessary services and supplies that results in an adverse decision, the adverse decision is verbally communicated to the health care provider acting on behalf of the participant. In addition, the notice of adverse decision is provided in writing to the participant and the requesting health care provider.

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

1. The specific factual basis for the decision, in detail, in clear, understandable language.
2. Reference to the specific criteria and standards, including guidelines, on which the decision was based, and a statement that the participant is entitled to receive, upon request made to the payor, a written statement of the specific health benefit design provisions on which the decision was based.
3. A statement that a copy of the guideline or criterion 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. Statement that the Medical Director is available by telephone to discuss the decision with the physician/health care provider on behalf of the participant.
6. Statement that the participant, their representative or physician/health care provider on behalf of the participant has a right to file a grievance within proscribed state or federal regulatory timelines of receipt of a prospective, concurrent or retrospective adverse decision.
7. Reference the practitioner or participant to the payor for the written details of the participant's health plan benefit and eligibility summary plan.
8. Description of Alliance's internal grievance process and procedures.
9. Description of the criterion for an emergency case grievance and an explanation of the right to file an emergency case grievance if the case meets this criterion.
10. Statement that the participant or health care practitioner filing a grievance on behalf of the participant may file a complaint with the Employer's Benefit Administrator in accordance with their benefit design plan.
11. Statement for advising participants subject to ERISA of their right to file a civil suit.

First Level Appeal

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At the time a participant and health care practitioner/provider are notified in writing of an initial determination, instructions are provided for filing a first level appeal. Alliance sends an acknowledgement letter for receipt of the appeal after the receipt of the request. The letter includes the name, address and telephone number of the Alliance Appeals Coordinator and the name and telephone number of the payor's benefit administrator point of contact. Alliance processes both first level appeals and first level expedited appeals in accordance with state and federal regulations and accrediting agency standards. External consultants (specialty physicians) opinions are utilized in accordance with state and federal regulations and accrediting agency standards. Alliance notifies the participant, the physician, the health care provider and the payor.

III. CLINICAL CONSULTATIVE REVIEW

All claims related administrative issues are handled by and referred to the payor or TPA. The payor assumes full responsibility for the initial denial process and all appeal processes related to UM services. The payor assumes full responsibility for verbal and written notification of participants, physicians/health care providers and payors for UM service-related adverse benefit decisions and appeal rights.

Alliance may be contacted by the payor for clinical consultation review support services which include a formal recommendation to the payor only regarding the medical necessity clinical determination review performed by the Medical Director or by the utilization of standard criteria or guidelines by Alliance.

Check the box if selecting clinical consultation review services

Clinical consultation review support services

Alliance may be contacted by the payor for clinical consultation review support services which include a formal recommendation to the payor only regarding the medical necessity clinical determination review performed by a Medical Director or by the utilization of standard criteria or guidelines by Alliance.

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IV. REPORTS

STANDARD REPORTS

All payors receive the following standard reports:

1. Third Party Administrator (TPA) report – auto-generated to the payor for each approved or denied service, provides demographic information and details of approved/denied services for IP, OP and Home health services.
2. External Referral Report – generated from Case Management (CM) for each approved or denied CM service.
3. Denial and Appeal Report – summary level report to payors, sent quarterly and annually, containing summary-level data for all approved and denied services.

ADDITIONAL REPORTS

Additional report types may be available to payors after negotiation with Alliance Account Management.

REPORT TYPE	<i>Check for each report requested and Yes or No</i>	
Inpatient Discharge Report	Weekly	
Outpatient Discharge Report	Weekly	
Home Health Care Discharge Report	Weekly	
Readmission Report	Quarterly	
Electronic Precertification Report	Weekly	
UM Report (Inpatient, Outpatient, Home Health, DME, Outpatient Rehabilitation and Case Management)	Quarterly Annually	
Case Management Savings Report	Quarterly	

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Is this document is applicable to all groups?

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- 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.

Payor Number _____ Payor Name _____

Printed Name of Payor Representative _____

Signature of Payor Representative _____ Date _____

Printed Name of Alliance Account Manager _____

Signature of Alliance Account Manager _____ Date _____

Printed Name of Alliance UM Liaison _____ Date _____

Signature of Alliance UM Liaison _____ Date _____