Children and Family Treatment and Support Services

Utilization Management
Introduction & Housekeeping

- Slides and recording will be posted to ctacny.org.

- Please submit questions via the chat. Presenters will respond to questions at the end if time allows.

- Reminder: Information and timelines are current as of the date of this webinar.
Agenda

• Brief Overview of Children & Family Treatments and Supports Services (CFTSS)
• Overview of Key Concepts
• UM Requirements for Children & Family Treatments and Supports Services:
  • Other Licensed Practitioner Requirements
  • Community Psychiatric Treatment & Supports
  • Psychosocial Rehabilitation
• Strategies for Maximizing Utilization Management Outcomes
• Resources
Overview of CFTSS:

Other Licensed Practitioner
Community Psychiatric Treatment and Supports
Psychosocial Rehabilitation
Other Licensed Practitioner (OLP) Overview

• OLP services include: Licensed Evaluation/Assessment, Treatment Planning, Psychotherapy, Crisis Intervention Activities

• OLP services may be provided to children/youth in need of assessment for whom behavioral health conditions have not yet been diagnosed.

• These non physician licensed behavioral health practitioners (NP-LBHP) include
  • Licensed Psychoanalysts, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Mental Health Counselors, Licensed Masters Social Workers when under the supervision of licensed clinical social workers (LCSWs), licensed psychologists, or psychiatrists

• These practitioners must operate within a designated agency
Community Psychiatric Supports and Treatment (CPST) Overview

• CPST is intended to assist the child/youth and family/caregivers to achieve stability and functional improvement in daily living, personal recovery and/or resilience, family and interpersonal relationships in school and community integration. The family/caregivers is expected to have an integral role.

• Service Components: Intensive Interventions, Crisis Avoidance, Intermediate Term Crisis Management, Rehabilitative Psychoeducation, Strengths Based Service Planning, and Rehabilitative Supports
Psychosocial Rehabilitation (PSR) Overview

• PSR is designed to restore, rehabilitate and support a child’s/youth’s developmentally appropriate functioning as necessary for the integration of the child/youth as an active and productive member of their family and community

• Service Components: Building Personal and Community Competence through Social & Interpersonal Skills, Daily Living Skills, and Community Integration
For More Information:

- Please refer to the Children’s and Family Treatment and Support Services Manual
Overview of Key Concepts
State Plan services will become part of the Managed Care benefit on their implementation date.

### Children’s Implementation Timeline For Children & Family Treatment Support Services

<table>
<thead>
<tr>
<th>State Plan Service</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Other Licensed Practitioner</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Community Psychiatric Treatment and Supports</td>
<td>January 1, 2019</td>
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<tr>
<td>Family Peer Support</td>
<td>July, 1, 2019</td>
</tr>
<tr>
<td>Youth Peer Support and Training</td>
<td>January 1, 2020</td>
</tr>
<tr>
<td>Crisis Intervention State Plan</td>
<td>January 1, 2020</td>
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*draft dates pending CMS approval*
Goals For Children’s Design

• Provide a greater focus on prevention and early intervention and Identify needs early on in a child’s life.
• Allow interventions to be delivered in the home and other natural community-based settings where children/youth and their families live.
• Maintain the child at home and in the community with support and services.
• Prevent the onset or progression of behavioral health conditions and need for long-term and/or more expensive services.
• Be available to all Medicaid eligible children under the age of 21 who meet medical necessity criteria.
• Increase the delivery of services utilizing the six core principles.
Core Principles

- Child Centered
- Family Focused
- Community Based
- Multi-System
- Culturally Competent
- Least Restrictive/Least Intrusive
Key Points

• The new benefits are stand alone services, they are not programs nor are they part of any existing services (i.e. clinic).

• These services can be accessed individually or in a coordinated comprehensive manner when identified in the treatment plan.

• Services provided to children and youth must include communication and coordination with the family, caregiver and/or legal guardians.

• Coordination with other child-serving systems should occur to achieve the treatment goals.

• In order to be eligible to provide Children and Family Treatment and Support Services, an organization must become a designated provider by submitting an application.
Utilization Management Overview
What is Utilization Management?

• Definition:
  • Procedures used to monitor or evaluate clinical necessity, appropriateness, efficacy, or efficiency of behavioral health care services, procedures, or settings and includes ambulatory review, prospective review, concurrent review, retrospective review, second opinions, care management, discharge planning, and service authorization.

• Designated providers must have the ability to bill FFS and managed care, but today's presentation focuses on the managed care utilization management and authorization processes.
Types of Authorization Reviews

UM will occur at different points in the healthcare delivery cycle:

- **Pre-Service/Prior authorization:** provider must request permission from the MMCP before delivering a service in order to receive payment
  - NOT Required for OLP, CPST or PSR services

- **Concurrent review:** occurs during an ongoing course of treatment (such as inpatient hospital admission) to ensure that such treatment remains appropriate
  - Will be standardized process via a general form
Utilization Management: What are MMCPs looking for?

- Medicaid Managed Care Plans (MMCP) will use Medical Necessity guidelines approved by the State to determine appropriateness of new and ongoing services related to this transition.

- Medicaid Managed Care Plans (MMCP) should view each request for authorization for a specific service level within the larger context of the child’s needs.

- When a child no longer meets Medical Necessity for a specific service, the MMCP should work with providers to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the enrollee successfully transitions without disruption in care.
What is Medical Necessity?

• Medical necessity is the standard terminology that all healthcare professionals and entities will use in the review process when determining if medical care is appropriate and essential.

• New York State Department of Health requires the following definition of Medically Necessary:
  • Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap. (N.Y. Soc. Serv. Law, § 365-a).

Continuity of Care Requirements

- The MMCP may not conduct utilization management or require service authorization for a period of 90 days from the implementation date for all services newly carved into managed care for individuals under the age 21.

- Additionally, MMCPs are required to offer contract to all NYS-designated providers of Children’s Specialty Services, within the MMCP’s service area, who were formerly a provider of services for the 1915c waivers.
Utilization Management for Children & Family Treatment Support Services
Pathways to Care

- There are a variety of ways in which children/youth can access these services.
- The utilization of the Children’s Health and Behavioral Health Services is intended to be individualized to the needs of the child at any point in their developmental trajectory.
- A behavioral health need can be identified by multiple sources including parents and other caregivers, pediatricians, care managers, school personnel, clinicians, or the young person themselves.
- For the rehabilitative services anyone can make a referral for services, but the recommendation and service provision must be made by a licensed practitioner who can discern and document medical necessity.
Pathways to Care

• **Referral:** when an individual or service provider identifies a need in a child/youth and/or their family and makes a linkage/connection to a service provider for the provision of a service that can meet that need.

• **Recommendation:** when a treating Licensed Practitioner of the Healing Arts (LPHA) identifies a particular need in a child/youth based on a completed assessment and documents the medical necessity for a specific service, including the service on the child/youth’s treatment plan.
Pathways to Care: Recommendation Process

• The recommendation must be in writing, must be signed and dated, and must include an explanation of the medical need for the service.

• If the LPHA making the recommendation is not a member of the program/agency staff, the recommendation must include the LPHA license number, in addition to the above.

• If the LPHA making the recommendation is a member of the program/agency, the recommendation must include the identification of which components of the services are required to meet the child’s needs based on the completed assessment and include the components in the signed treatment plan.
Licensed Practitioner of the Healing Arts (LPHAs)

The following are LPHAs for CPST and PSR:

- Registered Nurse Professional
- Nurse Practitioner
- Psychiatrist
- Licensed Psychologist
- Licensed Master Social Worker*
- Licensed Clinical Social Worker*
- Licensed Marriage and Family Therapist*
- Licensed Mental Health Counselor*
- Physician
- Licensed Creative Arts Therapist
- Licensed Psychoanalyst*
- Physician's Assistant

*Note: these practitioners are also listed under OLP as NP-LBHPs, see OLP for additional information
Authorization Summary

• The first 3 service visits with OLP, CPST and Psychosocial Rehabilitation do not require authorization. However providers must notify MMCPs before providing services to ensure proper payment.

• If more services are needed and individual meets medical necessity, must perform concurrent review and MMCPs must provide a minimum of 30 service visits.

• 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.
Concurrent Review Process

• Provider submits concurrent authorization request to MMCP for medical necessity review. Provider has up to 3 visits before authorization is required for additional services.

• The MMCP reviews the authorization request with supporting documentation to evaluate medical necessity

• Process for Concurrent Review
  • State exploring standardized form for concurrent review

• A treatment plan will be required, but not for the purposes of obtaining authorization from MMCPs
Example of Obtaining Concurrent Authorization

- Referral
- Recommendation from LPHA with medical necessity documentation
- Up to 3 visits to determine the need for ongoing services
- Conducting concurrent review: Before the 4th visit, provider must request authorization from MMCP to continue providing services.
- If medical necessity is met, MMCP will authorize 30 visits.
  - MMCPs must make a service authorization determination and notify the provider/enrollee of the determination by phone and in writing no more than three business days after receipt of the request
MMCP Tips for Successful UM

• Make sure front line staff making the calls and submitting the documentation are aware of regulations.

• Providers should attend MMCP orientations, when available, to become more familiar with each Plan’s Process and Information.

• When Calling Identify yourself as a Provider:
  • Caller name
  • Name of treating Provider/Facility
  • Provider Tax ID # or Provide Plan ID if one is given by the plan

• It is important to have client/member information available when calling MMCP. This usually includes Member ID and DOB.
Other Licensed Practitioner
Medical Necessity: Admission Criteria

Criteria 1 or 2 must be met:

The child/youth is being assessed by the NP-LBHP to determine the need for treatment. The NP-LBHP develops a treatment plan for goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits that:

1. Corrects or ameliorates conditions that are found through an EPSDT screening; OR

2. Addresses the prevention, diagnosis, and/or treatment of health impairments; the ability to achieve age-appropriate growth and development, and the ability to attain, maintain, or regain functional capacity.
OLP Authorization Requirements
Pre-Services

• A child in need can be referred for “Other Licensed Practitioner” from a variety of routine sources such as schools, pediatricians, etc., or may be a result of self-identification by a parent/caregiver at which time a licensed practitioner will make a determination for the provision of the service.

• Services are initiated upon the first visit and the OLP will complete an assessment to identify needs that will guide treatment planning.

• To access Other Licensed Practitioner (OLP) the child/youth does **not** require a behavioral health diagnosis.
OLP Authorization Requirements
Pre-Services

• Services are able to be provided both on and off site.
• Services may be provided to individuals, families, groups.
• Providers bill the following:
  • Medicaid fee-for-service rate code
  • Valid CPT code(s)
  • CPT code modifiers (as needed)
  • Units of service

No Prior Authorization Required
OLP Authorization Requirements

Concurrent Review

• Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits.

• The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child’s treatment plan and/or Health Home plan of care.

Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.

There are no annual claim limits associated with any of the crisis services inclusive in the OLP service category.
Community Psychiatric Treatments & Supports
Medical Necessity: Admission Criteria

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM OR the child/youth is at risk of development of a behavioral health diagnosis; AND

2. The child/youth is expected to achieve skill restoration in one of the following areas:
   a. participation in community activities and/or positive peer support networks
   b. personal relationships;
   c. personal safety and/or self-regulation
   d. independence/productivity;
   e. daily living skills
   f. symptom management
   g. coping strategies and effective functioning in the home, school, social or work environment; AND
Medical Necessity: Admission Criteria
Continued

3. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, AND

4. The services are recommended by the following Licensed Practitioners of the Healing Arts operating within the scope of their practice under State License: Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Creative Arts Therapist, Licensed Marriage and Family Therapist, Licensed Psychoanalytist, Licensed Psychologist, Physicians Assistant, Psychiatrist, Physician, Registered Professional Nurse OR Nurse Practitioner
CPST Authorization Requirements
Pre-Services

• A child in need can be referred for Community Psychiatric Supports & Treatment from a variety of routine sources however, the determination for access (“recommendation”) and service provision must be made by a licensed practitioner who can discern and document medical necessity.

• To access CPST the child/youth must be at risk for the development of or have a behavioral health diagnosis
CPST Authorization Requirements
Pre-Services

- Services are able to be provided both on and off site.
- Providers bill the following:
  - Medicaid fee-for-service rate code
  - Valid CPT code(s)
  - CPT code modifiers (as needed)
  - Units of service

No Prior Authorization required
CPST Authorization Requirements
Concurrent Review

• CPST services must be part of the treatment plan, which includes goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.

• Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits.

• The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child’s treatment plan and/or Health Home plan of care.

Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.
Psychosocial Rehabilitation
Medical Necessity: Admission Criteria

All criteria must be met:

1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM; AND

2. The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms; AND

3. The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or supporting a child/youth’s functional level to facilitate integration of the child/youth as participant of their community and family AND

4. The services are recommended by the Licensed Practitioners of the Healing Arts (LPHAs) operating within the scope of their practice under State License
PSR Authorization Requirements

Pre-Services

• Services are able to be provided both on and off site.
• Providers bill the following:
  • Medicaid fee-for-service rate code
  • Valid CPT code(s)
  • CPT code modifiers (as needed)
  • Units of service

No Prior Authorization required
PSR Authorization Requirements

Concurrent Review

- PSR services must be part of the treatment plan, which includes goals and activities necessary to correct or ameliorate conditions discovered during the initial assessment visits.
- If the child is not yet diagnosed, a referral must first be made to a Licensed Practitioner who has the ability to diagnose in the scope of his/her practice.
- Where the MMCP has determined continued services are medically necessary, the authorization period following the initial 3 visits must be inclusive of at least 30 service visits.
- The MMCP will review services at reasonable intervals thereafter as determined by the MMCP and consistent with the child’s treatment plan and/or Health Home plan of care.

Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit.
Strategies for Maximizing Utilization Management Outcomes

What can providers do today to prepare for UM?
Top 10 things to consider

‣ Understand medical necessity criteria per service

‣ Documentation is consistent, complete, accurate, and timely

‣ Examine LOS per service, identify outliers

‣ Reference EBTs/Best Practices

‣ Be able to provide a concise clinical presentation demonstrating how service requested is needed and will be used as well as at which frequency, scope and duration
Top 10 things to consider

‣ Proactively staff cases of concern/high risk and have practical, individualized crisis plans that are up to date

‣ Participate in any MMCP workgroups

‣ Have fully functional IT systems for reports and tracking

‣ Be prepared for appeals, & know how to staff a case

‣ Bump up any concerns!
UM Strategies: Prepare Your Agency Staff

- Understand any requirements or qualifications for staff delivering the services and address any gaps in staff preparedness

- Review and fully understand medical necessity criteria

- Understand MMCP expectations for the review process

- Understand and embrace the MMCP language tied to UM

- Practice reviews with Case Studies to gain comfort with the process
UM Strategies: Effective Agency Practices

- Develop internal workflows with responsibilities clearly designated for staff members

- Develop population level reporting strategies to identify outliers by program by staff and client level

- Routinely monitor the quality of the service being provided and look for improvement opportunities.

- Seek feedback (degree of satisfaction) from those individuals receiving the services
UM Strategies: Effective Staffing for UM

- The Agency’s Utilization Management staff member:
  - Is a member of the treatment team and a part of the conversation
  - Effectively communicates MMCP concerns to the team
  - Understands MMCP terminology, treatment volume caps and effectively communicates with the MMCP.
  - Understands the treatment being provided and is not just extracting information from a client note or record
The Agency’s Utilization Management staff member:

- Is familiar with all covered services under the Plan: OMH/OASAS Inpatient, Outpatient, clinic, PROS, HCBS, etc..
- Well informed of treatment modalities being utilized including medications
- Tracks the success of the individual in the service being provided and can articulate the success to the MMCP
- Able to articulate the long term services plan developed to move the individual towards recovery and how the current service supports the long term plan.
Next Steps

- Standardized Concurrent Review Form
  - State developing
- Follow up Office Hour for Billing and Utilization Management Questions in November
  - More information coming soon.
- Q&A Document will be developed and posted
- Appeals and Grievances Webinar
  - More information coming soon
Resources & Links
Questions and Feedback

Please include Kid’s system/managed care in the subject line:

NYS OMH Managed Care Mailbox
OMH-MC-Children@omh.ny.gov
Additional Resources

RESOURCES TO STAY INFORMED:

• Subscribe to children’s managed care listserv
  http://www.omh.ny.gov/omhweb/childservice/

• Subscribe to DOH Health Home listserv
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm

• Health Home Bureau Mail Log (BML)
  https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action
Additional Resources

Children’s Managed Care Design:  

Trainings on Children’s System Transformation

• Children and Family Treatment and Support Services- Service Review  
  https://ctacny.org/training/children-and-family-treatment-and-support-services-training

• Children and Family Treatment and Support Services Billing and RCM Training  
  https://ctacny.org/training/billing-childrens-system-transformation
Questions and Discussion

Please send questions to: mctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources.