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Memorandum

To: Managed Care Plan Liaisons to NYS

From: Thomas Smith, MD, Medical Director, NYSOMH Division of Managed Care
Charles Morgan, MD, Medical Director, NYSOASAS
Pat Lincourt,

Date: August 21, 2015

Re: MCO Behavioral Health Guidance memo and Attachment 1.
Prior and concurrent authorization for ambulatory behavioral health services

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NYS is updating prior guidance regarding utilization management for ambulatory behavioral health (BH) services issued May 14, 2015. The following clarifies expectations of Medicaid Managed Care Organizations and Health and Recovery Plans (collectively referred to as Plans) related to utilization management of routine behavioral health outpatient office and clinic care.

Note that:

1. *Prior Authorization Request* is a Service Authorization Request by the Enrollee, or a provider on the Enrollee's behalf, for coverage of a new service, whether for a new authorization period or within an existing authorization period, made before such service is provided to the Enrollee.

2. *Concurrent Review Request* is a Service Authorization Request by an Enrollee, or a provider on Enrollee's behalf for continued, extended or more of an authorized service than what is currently authorized by the Contractor within an existing authorization period.

NYS expects Plans to use the following utilization management and quality improvement approaches to oversee behavioral health outpatient office and clinic services:

1. *Clinical triggers for individual case reviews*. Examples include: XX outpatient visits for treatment of depression with no claims for antidepressant medications; multiple detox admissions for an individual with opioid dependence but no pharmacy claims for medication assisted treatment; no changes in intensity of outpatient services despite multiple inpatient readmissions; or claims suggesting quality of care concerns, e.g., a service type or frequency that clearly does not match an established evidence-based practice.

2. *Provider profile triggers for provider QA and education interventions*. Examples include: >XX% of clinic cases with specific diagnosis above the mean # sessions/year for all plan providers; or % cases with SUD and no mediation assisted treatment exceeds XXth percentile for all plan providers.

At this time, NYS will not define specific clinical or provider profile triggers that Plans must use. OMH and OASAS Plan oversight staff will be available for consultation around development of specific triggers and request that Plans submit their trigger definitions upon implementation.

Utilization management and quality improvement interventions should include recommendations for providers to review their practices and policies and should not involve retroactive utilization review. Providers will be expected to participate in Plan reviews of specific cases and provider profile data, and Plans may deny services if providers fail to participate or make adequate efforts to address identified concerns.

In addition to the above recommended utilization management and provider education interventions, note that:

1. NYS will allow Plans to require concurrent review requests for outpatient mental health office and clinic services following the 30th visit per calendar year as described in the enclosed attachment.

2. UM Policies for outpatient substance use disorder services (including opioid clinics) must be approved by OASAS. Thirty-fifty visits per year are within an expected frequency for OASAS clinic visits and 150-200 visits per year are within an expected frequency for opioid treatment clinic visits. OASAS encourages plans to identify individual and/or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization. OASAS will issue further guidelines regarding use of the LOCATDR to support utilization management decisions for substance use disorders.

As stated in the prior guidance, Plans will not be allowed to deny payment for ambulatory BH services based upon failure of the provider to notify the Plan that an episode of ambulatory BH care has been initiated. NYS will work with Plan leadership to support alternative approaches to ensuring provider adherence to contracted notification requirements.

Please let us know if you have any questions.

CC: Robert Myers, OMH
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Attachment 1. Ambulatory mental health services for adults for which Mainstream Managed Care and Health and Recovery Plans may require prior and/or concurrent authorization of services.

Service	Prior Auth	Concurrent Review Auth	Additional guidance
Outpatient mental health office and clinic services including: initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy, and Licensed Behavioral Practitioner (LBHP) services (off-site clinic services)	No	Yes	MMCOs/HARPs must pay for at least 30 visits per calendar year without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law. Note: the 30-visit count should not include: a) FFS visits or visits paid by another MMCO/HARP; or b) psychiatric assessment and medication management visits. Multiple services received on the same day shall count as a single visit (and must be delivered consistent with OMH clinic restructuring regulations).
Outpatient mental health office and clinic services: psychiatric assessment; medication treatment	No	No	
Psychological or neuropsychological testing	Yes	N/A	
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: • Clinical Treatment; • Intensive Rehabilitation (IR); or • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.
PROS Active Rehabilitation	Yes	Yes	Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Mental Health intensive outpatient *(note: Not State Plan)*	Yes	Yes	
Mental Health partial hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Attachment 2. Ambulatory substance use disorder services for adults for which Mainstream Managed Care and Health and Recovery Plans may require prior and/or concurrent authorization of services.

Service	Prior Auth	Concurrent Review Auth	Additional guidance
OASAS-certified Part 822 clinic services, including off-site clinic services	No	Yes	See OASAS guidance regarding use of LOCATDR tool to inform level of care determinations. OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 30-50 visits per year are within an average expected frequency for OASAS clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
Medically supervised outpatient substance withdrawal	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
OASAS Certified Part 822 Opioid Treatment Program (OTP) services	No	Yes	OASAS encourages plans to identify individual or program service patterns that fall outside of expected clinical practice but will not permit regular requests for treatment plan updates for otherwise routine outpatient and opioid service utilization; 150-200 visits per year are within an average expected frequency for opioid treatment clinic visits. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
OASAS Certified Part 822 Outpatient Rehabilitation	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame. The contractor will allow enrollees to make unlimited self-referrals for substance use disorder assessment from participating providers without requiring prior authorization or referral from the enrollee's primary care provider. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.