LPS UTILIZATION MANAGEMENT PLAN
FISCAL YEARS 2019-2020

The primary purpose of the Utilization Management (UM) Program is to assure the highest quality services are provided to eligible individuals in the most cost effective manner. Integral to this cause is the concept of continuous quality improvement with a focus on progressively improving administrative and clinical efficiencies as well as outcomes of care and services. Since performance of important organizational functions significantly affects service outcomes of care and customer satisfaction, the UM and Quality Management (QM) Programs primary focus is to achieve these goals by monitoring, analyzing, evaluating, reporting and recommending improvements in the organizational functions of LifePath Systems and it's contracted providers for mental health and substance use disorders.

The Utilization Management staff and the Utilization Management Committee will identify and monitor patterns of over-utilization, under-utilization and other utilization problems that compromise care from inappropriately utilized resources. This may include weekly, monthly and quarterly monitoring of the performance measures outlined in the most current performance contract notebook for mental health and substance use disorder services, billing issues, clinical outcomes and barriers to access. Based on the findings, UM staff and the UM Committee will recommend and participate in interventions to make utilization of services more efficient and consistent with contractual requirements and the local planning processes. On a regular basis the interventions and recommendations by the UM committee to providers will be monitored for outcome improvement.

This plan is based on compliance with the Texas Resilience & Recovery (TRR) Utilization Management Program Manual, the Mental Health, Substance Use Disorder (SUD) Contracts, and the Texas Administrative Code.

Required Utilization Management Personnel

UM Physician: Board eligible psychiatrist who possesses a license to practice medicine in Texas.
Job Functions Include: Oversight of the UM process and approving of all policy and procedures related to UM; clinically supervises the Utilization Manager; is responsible for providing consultation on all adverse determinations upon request of UM, and for reviewing all first level appeals of adverse determinations; resolves conflicts that may arise regarding the authorization of services that are not resolved through usual procedures; is a member of the UM Committee; provides physician-to-physician review as indicated.

UM Manager: An RN, RN-APN, PA, LMSW-ACP, PhD Psy, LPC, or LMFT licensed in the State of Texas who has at least 5 years of experience in direct care of persons with a serious mental illness and/or children and adolescents with serious emotional disturbance, which may include experience in an acute care or crisis setting; at least 5 years of experience participating as a member of a treatment team that develops and monitors treatment plans for individuals with chronic and serious mental illness; has demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience within the past 3 years; has one year experience in program oversight of mental health care

services; and has demonstrated competence in performing UM and review activities.
Job Functions Include: Conducting utilization review and granting and denying authorizations for all Levels of Care (LOC) and services as part of the HHSC UM Guidelines; conducts prospective, concurrent, and retrospective reviews for authorization of LOCs/services for individuals; conducts reviews using clinical information submitted by providers, direct contact with providers, review of medical necessity records, and contact with the individual and family members when needed and appropriate; makes initial adverse determinations and all clinical overrides and exceptions to the UM Guidelines, in consultation with the LBHA UM physician when indicated; monitors service delivery and outcomes to ensure services are not over-utilized or under- utilized; reviews data to detect outliers and unusual patterns of utilization and recommends interventions to the UM Committee; informs individuals and providers relative to appropriate treatment alternatives and community resources; performs Utilization Care Management for those individuals with special circumstances needing special authorization by an LBHA representative; participates in provider training on the UM process, monitors provider adherence to UM Guidelines, and provides consultation when needed.

Utilization Management Committee

The primary function of the UM Committee is to monitor utilization of clinical and fiscal resources to ensure that clinical resources are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance, and availability of high quality care through the evaluation of clinical practices, services, and supports delivered by the covered providers using clinical, encounter and administrative data and performance measures. Based on review of utilization data, the committee makes recommendations for improvements in provider practices and agency processes. The UM Committee will meet at least quarterly and may meet more frequently as needed. All activities of the UM Committee are under the supervision of the UM Physician. Minutes will be kept for each committee meeting. In addition to any other current issues the committee will review the following:

- Appropriateness of Eligibility Determinations
- Use of Exceptions and Overrides to service authorization ensuring rationale is clinically appropriate and documented administratively and clinically
- Over and Under Utilization
- Appeals and Denials
- Fairness and Equity
- Cost Effectiveness of all services provided
- Outcomes in relationship to services provided

The Composition of the Utilization Management Committee includes at a minimum:

- Medical Director/Utilization Management Physician
- Utilization Management Representative
- Quality Management Representative
- Financial Services Representative

Training Members of the Utilization Management Committee:
LifePath Systems will ensure that all UM Committee members receive appropriate training to fulfill the responsibilities of the committee. Training will be conducted at least annually, when needed, or when a new member is added. LifePath Systems will provide to each member of the UM committee a copy of the "UM Program Plan," the current HHSC UM Guidelines and other information necessary to perform their function. The UM Physician, or his/her designee, will discuss with each new member of the committee:

- the role of the UM Committee;
- types of cases;
- data and information reviewed by the committee; and
- clarification of the UM program and processes.

All participants in the Utilization Management process are subject to strict confidentiality practices, as defined by federal, state and other applicable rules.

Review of UM Committee Activities:
The Utilization Committee is responsible for the continuous review of procedures and protocols related to utilization management. Using reports available via MBOW, CARE and internal reports the committee will monitor the appropriateness and effectiveness of the UM processes at LifePath Systems. The UM Committee will evaluate this data and recommend improvements to the UM process to the Behavioral Health Management Team. The committee also will annually conduct an evaluation of UM activities. This annual review will appraise the past year's effectiveness of UM in its role of ensuring that the center meets the performance measures established in the contract for services delivered and for UM effectiveness as per UM Performance Measures outlined in section 7 of the HHSC UM Program Manual. As per the PCN the UM plan will be reviewed and updated in conjunction with the quality management plan on a biennial basis.

Provider Profiling

Provider profiles, to include review of data and relevant methodology will be used for the purpose of evaluating a provider's performance in relation to the use of resources and compliance with utilization review guidelines.

LifePath Systems will assess utilization through the use of provider utilization profiles. Profiling may be defined as; gathering data and using relevant methodology, for the purpose of describing and evaluating a provider's mental health practice performance in relation to the use of resources. Profiles will be used to identify areas in need of improvement in the effectiveness and efficiency of the delivery of care and services rendered by providers. The primary objective of profiling is to encourage high-quality service delivery, which includes appropriate utilization of resources and results in improved client satisfaction and positive outcomes. Profiles will be employed for informational purposes for LPS and providers including information concerning factors that influence utilization rates and outcomes. Providers who advocate for necessary and appropriate mental health care and services for clients will not experience retaliation by LPS. LPS will not terminate, demote or refuse to compensate a provider

because the provider advocates in good faith for a client, seeks reconsideration of a decision denying a service, or reports a violation of law to an appropriate authority.

The development of provider profiles may include but is not limited to the following data:

- length of stay (LOS)
- readmission or recidivism rates to identified services
- number of requests for special or support services
- prescription charges
- number of inpatient bed days
- number of outpatient service days
- use of crisis services & emergency room visits
- lab tests
- individual achievement of clinical outcomes
- number of adverse determinations
- number of appeals

UM Responsibilities

Utilization Reviews and Authorization of Services

Services will be authorized for all levels of care as per the Performance Contract, current utilization management guidelines, payer standards, uniform assessment, diagnosis, additional clinical information submitted and clinical judgment.

Authorization is required prior to delivery of services, with the exception of crisis services. Behavioral Health routine authorization requests must be received the same day the face to face uniform assessment (UA) was completed but no later than 3 business days from the date of assessment. SUD service authorization requests must be submitted within 3 business days of the begin service date. Requests submitted outside of the 3 business days of completion must be accompanied with written justification for the delay of the submission and will be considered by the UM department and authorized accordingly.

Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested will be reviewed by either the utilization manager or board certified or board eligible psychiatrists of the same or similar specialty as the services being denied.

Utilization Review:

Under the direction of the UM Physician, the Utilization Manager will monitor the Utilization Review process. Utilization Review entails the protocols and procedures involved in the determination of eligibility and delivery of services. The Utilization Manager will ensure that business practices guiding the UR process are in compliance with the current Mental Health and Substance Use Disorder contracts and the various manuals, guidelines and administrative codes that provide protocols, policies and procedures of the delivery of behavioral healthcare. For substance use disorder

services the following Texas Department of Insurance (TDI) criteria will be utilized for care management and utilization review determinations; Title 28, Part 1, Chpt 3, Subchapter HH, Rules 3.8001-3.8030.

1) **Prospective Review:**

- This is a pre-admission review for appropriateness of admission into services prior to receiving services.
  Preauthorization for outpatient services is required to document medical necessity and determine appropriate level of care. Preauthorization can be made only by the UM physician and UM staff not involved in the providing of services. Prospective review is determined no later than 2 business days, based on information gained via the ANSA/CANS, Clinical Management for Behavioral Health Services (CMBHS) SUD Assessment and the initial eligibility interview. Crisis services do not require preauthorization however must be authorized within 2 business days after the provision of the crisis service.

2) **Concurrent Review:**

- A routine review by a utilization manager or a utilization reviewer, during the course of a patient's treatment to determine if continued treatment is medically necessary.
- A concurrent review process will be used to identify, evaluate and coordinate appropriate clinical and cost effective treatment. The UM staff is responsible for the authorization of services. Determination of concurrent reviews will be made within 1 business day after receipt of request. Notification will be available to the provider through CMBHS within two business days of making the determination.

3) **Retrospective Review:**

- A review following service provision to assess the appropriateness, necessity, quality and reasonableness of health care services provided, usually conducted on a case-by-case or aggregate basis.
- The Utilization Manager will monitor the individual clinic's activities within the utilization review process to ensure consistency in the UR process throughout LifePath Systems and its provider network. Retrospective review will take place within 30 days of determination of the need for a retrospective review. Specifically, UM will monitor:
  - Determination, authorization and documentation of medical necessity for services
  - Level of Care Assignment
  - Inpatient admissions and discharge planning
  - Effectiveness of services
  - Provider productivity
  - Service capacity
  - Clinical overrides
  - Outlier data

Authorization of Services:
As the LBHA LifePath Systems will complete service authorizations per each provider for TRR Non Managed Care Organization (MCO) clients, substance use disorder clients and monitor the authorization process for MCO clients as follows:

1) **Authorization Procedure for TRR Non-MCO Clients:**

- Assessing staff will complete the Uniform Assessment (UA).
- The Utilization Manager will review the assessments within 2 business days for prospective reviews and 1 business day for concurrent reviews and make a determination to authorize, deny, or modify requested service. The Utilization Managers are Licensed Professionals of the Healing Arts (LPHA) that do not function as service providers.
- Services are authorized for the length of time specified by the current UM Guidelines for each level of care.
- In the event that the requested service is at capacity, a lesser level of care may be offered or the client may be placed on a waiting list, unless the client is receiving Medicaid. Clients with Medicaid may not be placed on a waiting list for a Medicaid service.
- With appropriate clinical justification, the Utilization Manager may override the recommended level of care and approve an alternate level of care. Documentation of authorization will be signed by the Utilization Manager and placed in the clinical record.
- In the event that a client is not authorized for a requested level of care, the Utilization Manager will notify the responsible staff person.
- Authorization of crisis services will take place within 2 business days of service delivery.

2) **Authorization Monitoring Procedure for TRR MCO Clients:**

- Assessing staff will enter the Uniform Assessment into CMBHS.
- The designated LPHA will review the uniform assessment for medical necessity within 2 business days for prospective reviews and 1 business day for concurrent reviews and submit to the MCO to authorize a requested level of care according to current UM Guidelines.
- With appropriate clinical justification, the LPHA may request that the MCO override the recommended level of care into an alternate level of care.
- Final service authorizations are made by MCO UM staff in accordance with UM Guidelines for each level of care.
- In the event that a client is not authorized for a requested level of care by the MCO, the MCO will notify the provider in accordance with UM guidelines.
- Utilization Managers will serve as the primary points of contact for the MCO UM staff.

3) **Authorization of Substance Use Disorder General Revenue Clients:**

- Assessing staff will enter diagnostic, clinical assessment and request for authorization into CMBHS
- Prospective and concurrent reviews for detoxification and residential services will be completed by the Utilization Manager within 1 business day of receiving all necessary clinical information and make a determination to authorize, deny, or modify requested service.

- For outpatient services prospective reviews will be completed by the utilization manager within 2 business days and concurrent reviews will be completed within 1 business day.
- Services are authorized for the length of time in accordance with current American Society of Addiction Medicine (ASAM), TDI criteria, Texas Administrative Code (TAC) criteria, clinical presentation and contractual specifications relevant to each episode of care.
- In the event that the requested service is at capacity and it is clinically appropriate, a lesser level of care may be offered or the client may be placed on a waiting list.

Making Adverse Determinations:

The UM department will make adverse determinations and denials in an objective manner. Unless otherwise indicated the following processes and guidelines apply to mental health and substance use disorder services. An adverse determination (i.e. a decision to deny, reduce or terminate a service) applies to those individuals requesting services that are denied and those individuals who are receiving services who no longer meet UM criteria for that service(s) and for whom the provider and individual request additional authorization. The initial recommendation to deny authorization for continued stay is made by the Utilization Manager. Upon appeal the UM Manager and, as appropriate, the UM Physician conducts a review of all necessary information.

- Denial of services based on an administrative determination, such as failure to comply with contractual authorization procedures, may be made by the Utilization Manager or the UM physician. At the time of the decision to deny further authorizations, UM staff assigned to the case verbally notify the appellant and the individual or their Legally Authorized Representative (LAR) requesting or receiving services (if different), and his/her provider. Within 4 business days of the decision, a Denial of Authorization letter is mailed to the appellant and individual requesting or receiving services (if different) and his/her provider. The appeal process does not go further for an administrative denial.
- Referral of an individual to his/her third party coverage in accordance with Title 25, Texas Administrative Code (TAC), Chapter 412, Subchapter C (relating to Charges for Community Services) may only be made by the Utilization Manager, if available, or the UM physician. At the time of the decision, UM staff assigned to the case will verbally notify the individual or his/her LAR receiving services and his/her provider of the proposed action. Within 4 business days of the decision, a notification letter will be mailed to the individual receiving services and his/her provider.
- Denial of services based on a clinical determination may only be made by the Utilization Manager or UM Physician and a final denial of services based on failure to meet clinical criteria may only be made by a physician. At the time of the decision to deny further authorizations, UM staff assigned to the case verbally notifies the appellant and individual or their LAR requesting or receiving services, if different, and his/her provider. Within 3 business days of the decision, a Denial of Authorization letter is mailed to the appellant and individual or their LAR requesting or receiving services, if different, and his/her provider.
- A proposal to reduce or terminate services based on a clinical determination that non-payment is not related to the individual's mental illness and the proposed action would not cause the individual's mental or physical health to be at imminent risk of serious deterioration may only be made by the Utilization Manager or UM Physician. This proposal is not applicable for individuals for whom the LBHA is identified as responsible for providing court-ordered outpatient services. At the time of the decision to reduce or terminate

services in accordance with Title 25, TAC Chapter 412, Subchapter C (relating to Charges for Community Services) UM staff assigned to the case verbally notifies the individual or his/her LAR receiving services and his/her provider of the proposed action. Within 3 business days of the decision, a notification letter will be mailed to the individual receiving services or his/her LAR and the individual's provider. The LPS will not take the proposed action while an appeal of the proposed action is pending.

Maintaining an Appeals Process:

LifePath Systems UM Department will maintain an appeals process that will assure notification of adverse determinations to the person receiving or requesting services and his/her provider and will include information on how to file an appeal. LPS will ensure individuals' have access to an objective appeals process when services are denied, reduced or terminated. Individuals funded by Medicaid are also afforded access to the Medicaid Fair Hearing Process. LPS will ensure that all providers and individuals are provided information about the right to appeal and the process to do so.

Appeals:

The appeals process provides a mechanism for individuals requesting or receiving services, their LAR, individuals advocating on the individual's behalf, and providers to challenge utilization management (UM)/resource allocation decisions with which they disagree. The individual requesting or receiving services, his/her LAR, his/her provider or someone else acting on the individual's behalf has **30 calendar days** after receipt of written notification of an adverse determination to initiate a request for appeal. Individuals requesting or receiving services may notify the UM department of their decision to appeal an adverse determination either in writing or verbally. An individual's LAR, appeals representative or the individual's provider will then submit the request for appeal of an adverse determination in writing. The appealing party will have the opportunity to submit, in writing, good cause for having a particular type of specialty provider review the case. In such circumstances, the appeal will include a review by a provider in the same or similar specialty as typically manages the specialty condition, procedure, or treatment under review. All requests to appeal an adverse determination will be sent to the UM department.

This process is separate and distinct from the process that allows a person with Medicaid coverage the right to request a Medicaid fair hearing. In accordance with Uniform Fair Hearing Rules outlined in Title 1, TAC chapter 357, Subchapter A, LPS will afford persons an opportunity to a fair hearing in any Medicaid case for an individual whose claim for services is denied or not acted upon promptly or LPS takes action to suspend, terminate or reduce services, including a denial of prior authorization request for Medicaid-covered services. Although the Medicaid fair hearing process is distinct from the appeal processes, similar activities may be synchronized.

Routine Appeal Process:

- The individual has **30 calendar days** after receipt of written notification of an adverse determination to initiate a request for an appeal. The LBHA Program Administrator, or his/her designee, will when requested, assist the appellant, LAR and/or provider, as needed to meet required time frames in the appeal process, assistance in collecting additional information from UM staff, the individual requesting services or receiving services, the LAR and /or provider to obtain any additional information as needed to submit the appeal.
- As soon as all necessary information is received UM has **2 business days** to make a

determination. The UM representative submits the individual's chart and other data necessary to review the adverse determination decision to a designated individual who was not involved in the original authorization decision. The individual reviewing the appeal may obtain additional information including but not limited to, interviews with the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for him/her and the individual's provider.

- Review of the appeal shall be complete within **20 business days** of receipt of notification to appeal unless the chief executive officer of the LifePath Systems grants an extension of the timeframe. The final denial of services based on failure to meet clinical criteria may only be made by a physician.
- Following the appeal decision, UM staff assigned to the case verbally, in person or by telephone, will notify the appellant and individual requesting or receiving services, if different, and his/her provider of the decision.
- Within **3 business days** of the decision, UM staff assigned to the case will mail written notification of the decision (an Appeal Resolution letter) to the appellant and individual requesting or receiving services, if different, and his/her provider. The letter includes information about making a complaint to the Health and Human Services Commission (HHSC) Individual Services and Rights Protection Division (1-800-252-8154) if they are not satisfied with the appeal decision.

Expedited Initial Appeal Process:

- Denial of admission or continued stay for mental health inpatient services or substance use disorder detoxification (detox) or residential treatment requires an expedited appeal process. Within **1 hour** of making the adverse decision, for admission or continued stay for inpatient services, designated LifePath Systems UM staff will notify the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for him/her, or the individual's provider of the adverse decision.
- Once notified of a denial of detox, residential treatment, inpatient services or continued stays for hospitalization, the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for him/her, or the individual's provider will have **1 business day** to request an appeal through the UM Department. However, if notification of the denial is made at 5:00 PM or later, they will have until 8:30 AM the next business day to make the request.
- A LifePath Systems physician who was not involved in the original authorization decision will review the appeal. The expedited appeal is completed based on the immediacy of the condition and no later than **1 calendar day** from the date that all information necessary to complete the review is received by UM Department staff.
- Within **1 calendar day** of the decision, UM staff assigned to the case verbally, in person or by telephone, as well as certified mail (Appeal Resolution letter), notifies the appellant and individual requesting or receiving services, if different, and his/her provider of the decision.

Expedited Second Level Appeal Process:

- Once notified of an appeal resolution the appellant and person requesting or receiving services, if different, and his or her provider have one business day to request a second review of the appeal through the UM Department. However, if notification of the appeal decision is made at 5:00 PM or later, they will have until 8:30 AM the next business day to make the request.

- A UM representative will gather all necessary data and forward it to an external physician reviewer. The physician reviewer will then conduct a review and make a determination regarding the appeal. The expedited second level appeal will be completed based on the immediacy of the condition and no later than one calendar day from the date that all information necessary to complete the review is received by UM Department.
- Within one business day of the decision, the UM staff assigned to the case will verbally, in person or by telephone, as well as by certified mail (Appeal Resolution letter), notify the appellant and person requesting or receiving services, if different, and the person's provider explaining the resolution of the appeal.

At any time, the appellant and individual requesting or receiving services, or their LAR, may contact the HHSC Office of Individual Services and Rights Protection (1-800-252-8154) for further review of their concern about the appeal decision and any proposed action.

Waitlist

TRR Services:

The Utilization Management team in compliance with Texas Resilience and Recovery Waiting List Maintenance requirements and state performance contracts will determine capacity levels for each level of care and will maintain waitlists for services as necessary. UM will triage and prioritize the service needs of the individuals determined eligible for services, but for which LPS has reached or exceeded capacity to provide services. If a wait list is implemented, designated authority staff will utilize MBOW and CMBHS on a regular basis to monitor both individuals waiting for all services and underserved due to resource limitations to ensure any person who becomes eligible for Medicaid, after being placed on a wait list, is promptly identified and placed into the appropriate LOCR within **60 days** of the Medicaid recipients effective (date benefit begins) or certification date (date of notification of benefit), whichever is later.

In accordance with performance contract Info Item R guidelines for TRR, to ensure clients on the wait list are not deteriorating, still have a desire and need for services and can be located, type and frequency of monitoring will be as follows:

- For LOC-A 8 with an LOC-R of adult LOC 3 or 4 and all children on the wait list will be monitored every **30 days**
- For LOC-A 8 with an LOC-R of adult LOC 1S or LOC 2 will be monitored every **90 days** from date of placement.
- For both of the above timeframes staff will utilize a brief clinical screening (see Attachment A) to assess for current urgency of need. If it is determined the individual is in need of crisis services these will be provided otherwise individuals will remain on the wait list until capacity is available.
- Staff will attempt to contact and document at least 2 different efforts either via phone, letter or home visits to reach the client within the above noted timeframes. If a client cannot be reached after these efforts the client will be removed from the wait list but no sooner than **30 days** prior

to the preceding contact.
- Clients on the waiting list will be reassessed at least every 180 days using the CANS or ANSA

For clients placed on the wait list with limited financial resources a screening for benefits assistance will be provided.

Inpatient Care Waitlist:
Pursuant to TAC Title 25, Part 1, Chapter 412 Subchapter G pertaining to Access to Mental Health Community Services and Standards of Care, LPS shall utilize the Inpatient Care Waitlist (ICW) through CMBHS within **1 business day** of the LMHA determination that a client requires inpatient services, and there are no resources available in the local service area, (i.e., no Private Psychiatric Beds available locally or at Terrell State hospital).

Substance Use Disorder Services:
The Utilization Management team in compliance with state performance contracts, will monitor capacity for each level of care and will maintain waitlists for services as necessary. Priority for admission will follow priority population guidelines admitting pregnant injecting individuals within 72 hours, injecting users within 14 days and DFPS referrals within 72 hours. In the event that LPS reaches capacity HHSC will be notified. As per contractual guidelines interim services will be provided to the priority population by the regional Outreach, Screening and Referral (OSAR) provider. If a client cannot be admitted who is at risk for dangerous withdrawal the contractor shall ensure that an emergency medical care provider is notified. In accordance with contractual guidelines daily capacity will be reported as follows:

- Residential detoxification, intensive residential and supportive residential treatment providers will report daily LPS client census to LPS UM staff Monday through Friday via encrypted email by 9:30 a.m. Central Time.

- For residential detoxification, intensive residential, or supportive residential treatment services daily available capacity will be reported by LPS UM staff Monday through Friday in CMBHS by 11:00 a.m. Central Time.

- For ambulatory detoxification, outpatient treatment, or co-occurring psychiatric and substance use disorders the previous day's attendance may be reported in the daily capacity report the next day Monday thru Friday through the HHSC CMBHS by 11:00 a.m. Central Time. For example: Monday's daily attendance may be reported on Tuesday and Friday's attendance may be reported on the following Monday.

- Ambulatory detoxification and outpatient treatment providers previous day's attendance will report daily LPS client census to LPS UM staff Monday through Friday via encrypted email by 9:30 a.m. Central Time. For example: Monday's daily attendance may be reported on Tuesday and Friday's attendance may be reported on the following Monday.

- If a pregnant woman or an injecting substance user is on the waiting list this shall be confirmed

in the Daily Capacity Management Report.

For individuals who are not on the wait list for capacity reasons the following removal procedure shall apply; the individual will be removed from the waitlist upon admission to treatment; upon notification from the individual that they are no longer interested in services, the individual no longer meets the criteria for a certain level of care or if the individual has not had face to face contact with the OSAR and cannot be contacted for a period of 14 days, with a minimum of 3 unsuccessful documented attempts via phone and/or mail.

YES Waiver

The Youth Empowerment Services (YES) Waiver provides comprehensive home and community-based mental health services to youth (ages 3-19th birthday) at risk of institutionalization and/or out-of-home placement due to a serious emotional disturbance (SED). The program provides flexibility in the funding of intensive community-based services and supports for youth and their families.

YES Authority Requirements:

The UM Department monitors compliance with LPS' YES Waiver Work Plan. As per the YES Waiver Policy Manual July 2016, 2000.3, an individual is required to obtain and maintain Medicaid in order to receive YES Waiver services.

To facilitate management of timely and appropriate YES service utilization, the LPS coordinates the flow of information between the YES single point of entry and the UM program.

- Access to UM staff is consistent throughout each business day.
- UM staff is available throughout the business day to review clinical information needed to make authorization decisions.
- The Center will provide a twenty-four hours a day seven days a week telephone answering system and FAX machine through which authorization request messages may be received.
- Upon receipt of all required information, requests for authorization of services are reviewed by the UM staff in accordance with the YES Waiver standards.
- Information about the right of persons requesting or receiving services to express concerns, dissatisfaction, or appeal an adverse determination decision will be posted at all service sites. The information will include an easily understood explanation of the appeal process.
- Process for clinical eligibility determination (CED):
    - Inquiry List calls will be returned or answered within one 1 business day by LBHA (includes completing assessing demographic eligibility).
    - Within seven 7 business days of the initial demographic eligibility determination, and if LPS has enrollment capacity, an LPHA must

complete the Clinical Eligibility Determination-assessment (completion of a TRR UA).

- If it is determined the youth meets clinical eligibility as per the YES Waiver Policy Manual the UM department will then authorize the individual into an LOC-YES.

  NOTE: Authorization for TRR services through LOC–YES occurs independently from enrollment into the YES Waiver. An LOC-YES authorization is 90 days.

- Following CED by HHSC then LPS will complete the enrollment process for Waiver services or if denied will complete the process to get the individual into the appropriate TRR LOC other than LOC-YES as applicable. A CED authorized by HHSC is valid for 365 days from the CED date in CMBHS.

- Process for service authorization:
  - All service authorization requests (initial, review and annual renewals) must be entered into CMBHS and placed in "Ready for Review" status within 5 business days of the completion of the Individual Plan of Care (IPC) for HHSC's review.
  - HHSC will make an authorization determination within 5 business days of the IPC being submitted to CMBHS. Clarification or questions regarding the service authorization request from the HHSC authorizer are placed in the 'Note' section and the request is placed into 'Draft' status (not authorized).
  - Changes to the request must be communicated to HHSC prior to authorization or denial of the request. Any changes made by the Facilitator must be placed back in 'Ready for Review' status within five business days of the request being placed into 'Draft' status by HHSC.
  - Transition Planning and service coordination begins at least six (6) months prior to the Waiver participant's 19th birthday.

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ATTACHMENT A

LPS Wait List
Brief Clinical Screening Assessment

Do you understand that you are on the waiting list for all services at this time?

Since the last contact:
Are the mental health problems you were seeking services for still present?

Has the client found anyone in the community to provide services to address these needs?

Have those problems gotten better, worse, stayed the same, or caused a crisis?

Has the client expressed any suicidal/homicidal ideation? (noticed any increased risk of harm to self or others?)

Have there been any psychiatric hospitalizations?

Did client report any alcohol or drug use? If yes describe.

Would you like or have you already been given any counseling referrals?

Do you have a family doctor that can be seen if needed?

Have there been any recent arrests?

Has client's phone number, address or living situation changed since the last contact?

Have you gained Medicaid since last contact?

Conclusion: Waiting list status following assessment (indicate all that apply):
Remove from waitlist by client choice:

Remove from waitlist; services elsewhere:

Referred for emergency services:

Remain on waiting list:

ATTACHMENT B

Denial of Authorization Based on Administrative Determination

Request Date_____ **Decision Date**_____

Name of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Services		

Reason for Authorization Denial	

Please be informed that you have the right to make a complaint regarding this decision. In order to make a complaint you may contact one or more of the following:

LBHA Individual Rights Coordinator:
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

Texas Health and Human Services Commission (HHSC)
Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, Texas 78714-9347
MC: 2019
1-800-252-8154

Disability Rights, Texas
2222 West Braker Lane
Austin, Texas 78758

1 (800) 252-9108
1 (512) 454-4816(Voice)
1 (512) 323-0902(Fax)
1 (866) 362-2851(Video Phone)

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

Linda Miller, LPC, Director of UM
7308 Alma Drive, Plano, TX 75025
Phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

ATTACHMENT C

Denial of Authorization Based on Clinical Determination

Request Date_____ **Decision Date**_____

Name of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		

Reason for Authorization Denial	

Please be informed that you have the right to appeal this decision. In order to appeal the authorization decision, you must contact the Utilization Management Department by telephone at 972-422-5939, by email at bhumqm@lifepathsystems.org, in person or by mail at the following address LifePath Systems 7308 Alma Drive, Plano, TX 75025 within 30 days of receipt of this notice. Afterwards, you will receive a letter from the UM department acknowledging your request to appeal. You may request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal. Prior to a decision, you have the right to meet with the individual/s who will be deciding the appeal. Within 20 business days of your request to appeal, UM will notify you in person or by telephone of the decision. If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department
7308 Alma Drive, Plano, TX 75025
phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

The appeal for authorization may be requested by:

- You
- Your legally authorized representative
- Your Provider
- Your actively involved adult relative, friend, or advocate (with your written consent)

ATTACHMENT D

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Appeal Procedure for Indigent Community Mental Health or Substance Use Disorder Services

Your Right to Appeal

If one of these decisions is made about your services, and you do not agree with the decision, you have the right to appeal it **(staff circles applicable reason)**:

- a decision that you are not eligible for services during intake process
- a decision to reduce your services and supports based on a clinical determination
- a decision to deny your request for a service or support that is not clinically indicated
- a decision to terminate your services and supports based on a clinical determination

How to Begin

- Call the Utilization Department 972-422-5939 and say that you want to appeal a decision. He/she will assist you. Or, you may tell your provider that you want to appeal, and your provider will assist you.
- You must start your appeal no later than thirty (30) days from the time you are notified of the decision.

The Appeal Process

1. Once LPS receives notice of your appeal, an Appeal Acknowledgement letter will be mailed to you. You should receive the letter within one week of your notice to appeal.
2. You may be asked to provide additional information.
3. Within twenty business days after the date that all necessary information is received by LPS, a decision shall be made.
4. Within one business day of the decision, the Utilization Management staff assigned to your case shall notify you in person or by telephone of the decision.
5. Within three business days, the UM staff assigned to your case shall mail an Appeal Resolution letter to you to inform you of the decision and offer additional information. The Appeal Resolution letter will include notice that the decision is final.
6. If you disagree with the decision, you will have ten calendar days to request a review of your concerns by contacting the HHSC Office of Individual Services and Rights Protection at 1-800-252-8154.

Date:_____ Client ID:_____ Client Name:_____

Staff Name (print):_____ Staff Signature:_____

If you have Medicaid, this appeal process does not preclude you from requesting a Medicaid Fair Hearing. If you have questions or need help with your appeal, call the Rights Coordinator:

LBHA Individual Rights Coordinator:
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

Report any problems or complaints with the appeal process to:

Texas Health and Human Services Commission
Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, Texas 78714-9347
MC: 2019
1-800-252-8154 (toll free)

ATTACHMENT E

Request to Appeal Denial of Authorization

Date of Denial_____ Request Date_____ Decision Date_____

Name of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		

Reason for Authorization Denial	

Reason for Request of Appeal	

I am aware that I have the right to appeal the above mentioned decision. I am submitting this appeal to the Utilization Management Department within 30 days of receipt of denial. I am aware I will receive a letter from the Utilization Manager acknowledging my request to appeal. I may also request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal. Prior to a decision, I have the right to meet with the individual/s who will be deciding the appeal. Within 20 business days of my request to appeal, the utilization management department will notify me in person or telephone of the decision.

Client Signature: _____ Date: _____

Submit this completed form to the following contact:

LifePath Systems
Utilization Management Department:
Linda Miller, LPC, Director of UM
7308 Alma Drive, Plano, TX 75025
phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

ATTACHMENT F

Appeal Acknowledgement

Request Date_____ **Date of Notification** _____

Name of Individual Requesting/Receiving Services		**Record #**
Name of Individual		
Requested Service(s) for which Authorization Denied		

Reason for Appeal	

Your request to appeal a decision to deny authorization for service(s) is acknowledged. Please be informed of the following:

- You have the right to meet with the individual/s who will be deciding the appeal.
- You may also provide additional information (in writing, in individual, by telephone, or through your representative) for the individual/s who will be deciding the appeal as long as it is received by LifePath Systems within 10 business days of the date of this notification.
- Within 20 business days of your request to appeal, LifePath Systems will notify you in person or telephone of the decision.

- The denied service(s) will not be initiated or re-instituted until the appeal process is complete and only if the decision is in your favor.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Linda Miller, LPC, Director of UM
7308 Alma Drive, Plano, TX 75025
phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

ATTACHMENT G

Appeal Resolution

Request Date_____ **Decision Date**_____

Name of Individual Requesting/Receiving Services		Record #
Name of Individual		
Service(s) Requested/Denied		

Decision	
Clinical Basis for the Decision	
Specialization of Consulted Providers	

Please be informed that if you disagree with the decision, you will have ten calendar days to request a review of your concerns by HHSC Office of Individual Services and Rights Protection at 1-800-252-8154.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Linda Miller, LPC, Director of UM
7308 Alma Drive, Plano, TX 75025
phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

If you would like to make a complaint, you may contact one or more of the following:

LBHA Individual Rights Coordinator
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

HHSC
Office of Consumer Services/Rights Protection
PO Box 149347
Austin, TX 78714-9347
MC: 2019
1-800-252-8154

Disability Rights
2222 West Braker Lane
Austin, TX 78758
1-800-252-9108
1-514-454-4816 (voice)
1-512-323-0902 (fax)
1-866-362-2851 (video phone)

ATTACHMENT H

Modification or Reversal of Appeal Resolution

Request Date _____ **Decision Date**_____

Name of Individual Requesting or Receiving Services		Record #
Name of Individual		
Requested Service(s) for which Authorization Denied		

Decision	
Clinical Basis for the Decision	
Specialization of Consulted Providers	
Plan to Initiate or Re-Engage Services	

Please be informed that the decision to deny authorization for service(s) has been modified or reversed. Linda Miller, LPC or her designee will contact you within 20 business days for a routine appeal or 2 calendar days for expedited appeal to discuss the plan to initiate or re-engage in the requested services.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Linda Miller, LPC, Director of UM
7308 Alma Drive, Plano, TX 75025
phone 972-422-5939 fax 214-871-3328
bhumqm@lifepathsystems.org

If you would like to make a complaint, you may contact one or more of the following:

LBHA Individual Rights Coordinator

Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

HHSC
Office of Consumer Services/Rights Protection
PO Box 149347
Austin, TX 78714-9347
MC: 2019
1-800-252-8154

Disability Rights
2222 West Braker Lane
Austin, TX 78758
1-800-252-9108
1-514-454-4816 (voice)
1-512-323-0902 (fax)
1-866-362-2851 (video phone)

ATTACHMENT I

Denial of Authorization Based on Clinical Determination for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential Treatment

Request Date_____ Decision Date_____

Name of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		

Reason for Authorization Denial	

Please be informed that you have the right to appeal this decision. In order to appeal the authorization decision, you must contact the Utilization Management Department by telephone at 972-562-9647 x 1429 or encrypted email at lfondren@lifepathsystems.org and BHCOC@lifepathsystems.org **within 1 business day** of receipt of this notice. If notification of the denial is made at 5:00 pm or later, you will have until 8:30 am the next business day to make the request. Afterwards, you will receive notice either by phone, fax or encrypted email from the UM department acknowledging your request to appeal. You may request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal. If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Leanne Fondren, LPC-S, Utilization Manager
1515 Heritage Drive, Suite 105, McKinney , TX 75069
phone 972-562-9647 x 1429 fax 972-895-2334
lfondren@lifepathsystems.org and BHCOC@lifepathsystems.org

Signature of UM Staff:_____ Date:_____

The appeal for authorization may be requested by:

- You
- Your legally authorized representative
- Your Provider
- Your actively involved adult relative, friend, or advocate (with your written consent)

ATTACHMENT J

Expedited Appeal Procedure for Denial of Authorization for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential Treatment

Request Date_____ **Decision Date**_____

Name of Individual Requesting or Receiving Services		**Record #**
Name of Provider		
Requested Service(s) for which Authorization Denied		

Decision	
Clinical Basis for the Decision	
Specialization of Consulted Providers	

Within **1 hour** of making the adverse decision, for admission or continued stay for inpatient services, detoxification or residential treatment the designated LifePath Systems UM staff will notify the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for him/her, or the individual's provider of the adverse decision. If an appeal is requested by the individual please submit this completed form to LPS Utilization Management Department via fax or encrypted email to contact information noted below, within **1 business day** of notification of denial of authorization. If notification of the denial is made at 5:00 pm or later, you will have until 8:30 am the next business day to make the request. If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Leanne Fondren, LPC-S, Utilization Manager

1515 Heritage Drive, Suite 105, McKinney , TX 75069
phone 972-562-9647 x 1429 fax 972-895-2334
lfondren@lifepathsystems.org and bhumqm@lifepathsystems.org

If you would like to make a complaint, you may contact one or more of the following:
LBHA Individual Rights Coordinator
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

HHSC
Office of Consumer Services/Rights Protection
PO Box 149347
Austin, TX 78714-9347
MC: 2019
1-800-252-8154

Disability Rights
2222 West Braker Lane
Austin, TX 78758
1-800-252-9108
1-514-454-4816 (voice)
1-512-323-0902 (fax)
1-866-362-2851 (video phone)

ATTACHMENT K

Initial Appeal Resolution Notice for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential

Request Date_____ **Decision Date**_____

Name of Individual Requesting/Receiving Services		Record #
Name of Provider or Hospital		
Service(s) Requested/Denied		

Decision	
Clinical Basis for the Decision to Uphold Denial Or Reverse or Modify Denial & Additional Days Authorized	
Specialization of Consulted Providers	

Please be informed that if you disagree with the decision, you will have ten calendar days to request a review of your concerns by HHSC Office of Individual Services and Rights Protection at 1-800-252-8154.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Leanne Fondren, LPC-S, Utilization Manager
1515 Heritage Drive, Suite 105, McKinney , TX 75069
phone 972-562-9647 x 1429 fax 972-895-2334
lfondren@lifepathsystems.org and BHCOC@lifepathsystems.org

UM Staff:_____ Date:_____

If you would like to make a complaint, you may contact one or more of the following:

LBHA Individual Rights Coordinator
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

HHSC
Office of Consumer Services/Rights Protection
PO Box 149347
Austin, TX 78714-9347
MC: 2019
1-800-252-8154

Disability Rights
2222 West Braker Lane
Austin, TX 78758
1-800-252-9108
1-514-454-4816 (voice)
1-512-323-0902 (fax)
1-866-362-2851 (video phone)

ATTACHMENT L

Second Level Review - Appeal Resolution Notice for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential

Request Date_____ **Decision Date**_____

Name of Individual Requesting/Receiving Services		Record #
Name of Provider or Hospital		
Service(s) Requested/Denied		

Decision	
Clinical Basis for the Decision to Uphold Denial Or Reverse or Modify Denial & Additional Days Authorized	
Specialization of Consulted Providers	

Please be informed that if you disagree with the decision, you will have ten calendar days to request a review of your concerns by HHSC Office of Individual Services and Rights Protection at 1-800-252-8154.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

LifePath Systems
Utilization Management Department:
Leanne Fondren, LPC-S, Utilization Manger
1515 Heritage Drive, Suite 105, McKinney , TX 75069
phone 972-562-9647 x 1429 fax 972-895-2334
lfondren@lifepathsystems.org and BHCOC@lifepathsystems.org

UM Staff: _____ Date: _____

If you would like to make a complaint, you may contact one or more of the following:

LBHA Individual Rights Coordinator
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

HHSC
Office of Consumer Services/Rights Protection
PO Box 149347
Austin, TX 78714-9347
MC: 2019
1-800-252-8154

Disability Rights
2222 West Braker Lane
Austin, TX 78758
1-800-252-9108
1-514-454-4816 (voice)
1-512-323-0902 (fax)
1-866-362-2851 (video phone)

ATTACHMENT M

Family Partner Target: Codes and Service Descriptions

2250	Engagement Activity	F	0.25	H0025 HATS
5022	Family Partner Support	F, T	0.25	H0038, HA
5021	Parent Support Group	F	0.25	H0025-HAHQ
5023	Family Training Inv and Grp	F	0.25	H2019, HA H2019, HAHQ

PCN Information Item G:

Engagement Activities: Short-term planned activities with the youth and caregiver to develop treatment alliance and rapport. Activities include, but are not limited to: enhancing the youth and/or caregiver's motivation to participate in services, explaining recommended services, and providing education regarding value of services. Adherence to the recommended LOC and its importance in recovery are also explained. This service should not be provided in a group, and should be provided in accordance with confidentiality requirements.

Family Partner Supports: Peer mentoring and support provided by Certified Family Partners to the primary caregivers of a child who is receiving mental health community services. This may include introducing the family to the treatment process; modeling self-advocacy skills; providing information, making referrals; providing non-clinical skills training; assisting in the identification of natural/non-traditional and community supports. Family Partners are the parent or LAR of a child or youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system (e.g. mental health, juvenile justice, social security, special education) as the LAR to that child or youth. (TAC Title 25 Part 1 Chapter 412 Subchapter G Division 1)

Parent Support Group: Routinely scheduled support and informational meetings for the individual's primary caregivers.

Family Training: Training provided to the individual's primary caregivers to assist the caregivers in coping and managing with the individual's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training.

ATTACHMENT N

Youth Empowerment Services (YES) Waiver
Denial of Eligibility

Date:	
Local Mental Health Authority:	
Child or Youth Name (Last, First, MI):	
Date of Birth:	**Age:**
Medicaid Number:	**CMBHS Number:**
Legally Authorized Representative Name: (Last, First, MI):	

Dear _____:

The local mental health authority reviewed your child or youth's eligibility for the YES Waiver program and has determined that services in the YES Waiver program are ☐ denied ☐ suspended ☐ terminated for your child or youth because the following eligibility criteria were not met:

Demographic Criteria

☐ County of Residence

☐ Age

☐ Place of Residence

Clinical Criteria

☐ Child and Adolescent Needs and Strengths (CANS)

☐ Inpatient Criteria

Financial Criteria

☐ Medicaid Eligibility

Other

☐ Specify:

If you disagree with the local mental health authority's decision to ☐ deny ☐ suspend ☐ terminate YES Waiver services, you have the right to request a fair hearing to appeal this decision.

To request a fair hearing, you must submit a written request to the Department of State Health Services on or before: _____. You may lose the right to appeal if the request is not received by this date.

At a fair hearing, you may: 1) represent your child or youth; or 2) choose, at your expense, an authorized representative, such as a relative, friend, lawyer or other spokesperson, to represent your child or youth. If your child or youth is currently receiving YES Waiver services, he or she may eligible to continue to receive those services while the hearing is pending.

Youth Empowerment Services (YES) Waiver
Denial of Eligibility

To request a fair hearing:

Complete the enclosed form and mail to:	***Or***	*Call:*
Texas Department of State Health Services		Texas Department of State Health Services
Office of Consumer Services and Rights Protection		Office of Consumer Services and Rights Protection
P.O. Box 149347		Toll Free Number: 1-800-252-8154
Mail Code 2019		Relay Texas, TTY: 1-800-735-2989
Austin, Texas 78714-9347		

If you have questions about any of the information in this letter, please contact:

LBHA Individual Rights Coordinator
Dr. Jim Barr
P.0. Box 828
McKinney, TX 75075
1 (972) 562-0190

Sincerely,

Enclosure

ATTACHMENT O

Youth Empowerment Services (YES) Waiver
Denial of Eligibility

My local mental health authority has informed me that Youth Empowerment Services (YES) Waiver services for my child have been ☐ denied ☐ suspended ☐ terminated. I wish to appeal the ☐ denial ☐ suspension ☐ termination of YES Waiver services for my child.

_____

Signature

_____

Date

You are entitled to representation, at your own expense, at any time during the fair hearing process. Provide the contact information for additional witnesses or representatives (attorney/legal counsel, family members, etc.), if you have the information available at the time you are requesting a fair hearing.

Name	Address	Phone Number

Return this form to:

Texas Department of State Health Services

Office of Consumer Services and Rights Protection

P.O. Box 149347

Mail Code 2019

Austin, Texas 78714-9347

Office of Consumer Services & Rights Protection

Toll Free Number: 1-800-252-8154