CORPORATE POLICY & PROCEDURE

	Policy Name: Payment and Authorization of Hospital Admissions
Department: Clinical Engagement	Policy Number: CE22
Version: 6	Creation Date: 9/29/2014
Revised Date: 8/30/18, 10/5/19, 7/23/20, 8/9/20, 3/1/21	Review Date:
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek	☐ Umpqua Health Management ☐ Umpqua Health Network
Signature:  Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 3/1/2021

POLICY STATEMENT

Umpqua Health Alliance (UHA) covers inpatient hospital admissions and psychiatric services when services are rendered in an in-network facility, psychiatric inpatient facility or a non-inpatient facility certified by the Oregon Health Authority (OHA). Payment of claims are subject to applicable eligibility, coverage, referral, authorization, notification requirements, and medical necessity and medical appropriateness of services. Related information can be found in policies CE05 – Medical and Pharmacy Review, CE11 - Out of Network Services, CE12 - Prior Authorization, and in the CCO Contract Exhibit B Part 2, Section 2(c)(1-8) and Exhibit M.

PURPOSE

Define the process UHA follows for determination of authorization and payment for hospital admissions.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Involuntary Psychiatric Care: Emergency psychiatric holds consistent with ORS 426.130 and alternatives to involuntary psychiatric care when a less restrictive voluntary service will not meet the medically appropriate needs of the member and the behavior of the member meets legal standards for the use of emergency psychiatric hold.

Medical Inpatient Hospital Admissions: Items and services furnished to an inpatient stay, including room and board, nursing care and related services, diagnostic and therapeutic services, and medical and surgical services.

Long Term Psychiatric Care (LTPC) is inpatient psychiatric services delivered in an Oregon State operated hospital after usual and customary care has been provided in an acute inpatient hospital psychiatric care setting or in a residential treatment facility for children under age 18 and the individual continues to require a hospital level of care.

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Psychiatric Facility: Acute care facility for persons with mental health disorders, a facility specializing in the treatment of serious mental disorders, such as major depressive disorder, schizophrenia and bipolar disorder.

Warm Handoff: The process of transferring a patient from one provider to another, prior to discharge from an acute care psychiatric hospital, that involves face-to-face meetings with the patient, either in person or through the use of telehealth, and that coordinates the transfer of responsibility for the patient's ongoing care and continuing treatment and services. A warm handoff shall be offered to individuals with SPMI, defined in OAR 309-032-0860(22), as part of the discharge planning process.

PROCEDURES

General Requirements

1. The minimum health record requirements for all hospitals are as follows:
    a. Identification of the member;
    b. Physician name;
    c. Date of admission;
        i. If applying for Medicaid benefits after admission, the dates of application for and authorization of benefits';
    d. The plan of care (as required under 45 CFR §456.180 for mental hospitals or 45 CFR §456.80 for hospitals);
    e. Initial and subsequent continued stay review dates;
    f. Reasons and plan for continued stay, if the attending physician believes continues stay is necessary;
    g. Other supporting material that the hospital's utilization review committee believes appropriate to be included; and
    h. For non-mental hospitals only:
        i. Date of operating room reservation; and
        ii. Justification of emergency admission, if applicable.

Medical Admissions

1. Scheduled, non-emergent, elective admission for inpatient services require appropriate prior authorization (PA).
    a. Provider of services will submit request no less than 7 days before admission. To include:
        i. Patient demographics;
        ii. Medical justification for services;

iii. Supporting documentation and applicable medical records;
iv. Planned date of service;
v. Expected length of stay; and
vi. Diagnoses.

2. Scheduled, non-emergent, elective admission for inpatient services require appropriate prior authorization (PA).
    a. Provider of services will submit request no less than 7 days before admission. To include:
        i. Patient demographics;
        ii. Medical justification for services;
        iii. Supporting documentation and applicable medical records;
        iv. Planned date of service;
        v. Expected length of stay; and
        vi. Diagnoses.
3. For unplanned or emergency admission, including admissions from the emergency department or observation unit, the hospital must provide notification to UHA of admission as soon as practical, but no more than 48 hours after the admission.
    a. All hospital admission request must include:
        i. Member identification and patient demographics;
        ii. Admitting and attending physician name;
        iii. Date of admission;
        iv. Plan of care (as required under 42 CFR 456.80);
        v. Initial and subsequent continued stay review dates (described under 42 CFR 456.128 and 456.133);
        vi. Reasons and plan for continued stay if applicable; and
        vii. Medical records supporting need for admission and continue stay.
4. For extended stay and concurrent review, if a hospital anticipates that a patient will remain hospitalized or otherwise need services beyond those authorized, it shall provide the following information to UHA as soon as practical, but no later than 48 hours after learning of the need to exceed any authorization:
    a. A request for additional authorization clearly stating the scope of the requested authorization;
    b. UHA authorization reference number or numbers for all prior authorizations relevant to the request, preferably on the cover sheet or first page;
    c. The member's health plan number;
    d. The relevant diagnoses code or codes; and

e. All new relevant medical records.

5. UHA shall not have the right to restrict coverage for any hospital length of stay following a normal vaginal birth to less than forty-eight (48) hours, or less than ninety-six (96) hours for a cesarean section. An exception to the minimum length of stay may be made by the physician in consultation with the mother, which must be documented in the Clinical Record.
6. UHA shall consider all requests for authorization and either approve, partially approve, or deny the request within the time frames set. With the exception to in-network facilities, UHA requires a prior authorization to be submitted for all inpatient hospitalizations.
7. Members who are readmitted for inpatient services within thirty (30) days of original inpatient discharge for the same or related condition for which they were treated during the original admission may be reviewed. If it is determined that the member is being treated for the same or a related condition as the original admission, the readmission can be retracted.
8. Notification of admissions are received, along with supporting documentation, to UHA by fax at (541) 677-5881 or by mail to the attention of its Medical Management Department at 500 SE Cass Ave. Suite 101, Roseburg, OR, 97470.

Psychiatric Admissions

1. UHA requires notification of psychiatric hospital admission from the facility within two (2) business days of admission.
2. In addition to the above minimum health record notification, per 42 CFR §§ 456.111 and 456.211, notifications will include:
    a. The plan of care, including, but not limited to:
        i. Diagnosis, symptoms, complaints, and complications indicating the need for admission;
        ii. A description of the functional level of the individual;
        iii. Any orders for:
            1. Medications;
            2. Treatments;
            3. Restorative and rehabilitation services;
            4. Activities;
            5. Social services; and
            6. Diet.
        iv. Orders and activities must be developed in accordance with the physician's instructions.

v. Orders and activities must be reviewed and revised as appropriate by all personnel involved in the care of an individual.
vi. A physician and other personnel involved in the beneficiary's case must review each plan of care at least every 60 days.
vii. Modifications to the initial plan of care;
viii. Plans for discharge, as appropriate;

b. If the attending physicians determine the member will remain hospitalized or otherwise needs services beyond those authorized, the hospital will provide the following information to UHA as soon as practical, but no later than 48 hours after learning of the need to exceed any authorization.
c. A request for additional authorization clearly stating the scope of the requested authorization;
d. UHA authorization reference number or numbers for all prior authorizations relevant to the request, preferable on the cover sheet or first page;
e. The member health plan number;
f. The relevant diagnosis code(s);
g. All new relevant medical records to support continued stay;
h. Any other supporting material the submitter believes appropriate to include.

3. UHA applies InterQual® guidelines to each admission to assess medical necessity and medical appropriateness of initial and continued stay in accordance with 42 CFR § 438.210 and OAR 410-141-3835.
4. UHA will make a prior authorization determination within three (3) days of a request for non-emergent behavioral health hospitalizations or residential care.
5. UHA will not require members to obtain approval of a primary care physician in order to access to behavioral health assessment and evaluation services. Members will have the right to refer themselves to behavioral health services from the provider network.
6. UHA shall consider all requests for authorization and either approve, partially approve or deny the request within set time frames. Letters of approval will be faxed and or mailed to the address provided upon notification of admission. Denials will be processed per UHA's policy CE21 - Adverse Benefit Determination and in accordance with the CCO Contract between UHA and the OHA, OAR 410-141-3875 through OAR 410-141-3915 (fka 410-141-3230 through 410-141-3255), and 42 CFR §§ 438.400 through 438.424.
7. UHA will cover and reimburse inpatient psychiatric services, not including Substance Use Disorder treatment, at an Institution for Mental Disease, as defined in 42 CFR 435-1010, provided:
8. Facility is a hospital providing inpatient psychiatric services;

9. Length of stay is no more than 15 days during the period of the monthly capitation payment;
10. Provision of inpatient psychiatric treatments in an Institution for Metal Disease meets the requirements for in lieu of services at 42 CFR § 483.3(e)(2)(i-iii); and
11. UHA offers the member option to access the covered state plan services in accordance with OAR 410-141-3860(10)(c)(B).

Oregon State Hospital

1. UHA shall be financially responsible for members on the waitlist for Oregon State Hospital (OSH) beginning in contract year 2022.
2. UHA will share financial risk for members in OSH beginning in contract year 2022.
3. UHA will in accordance with OAR 309-091-0000 through 309-091-0050;
    a. Coordinate with applicable subcontractors as needed regarding discharges for all adult members with severe persistent mental illness (SPMI);
    b. Coordinate care for members during discharge planning for the return to home provider or the receiving CCO if member will be discharged into a different service area when member has been deemed ready for transition;
    c. Arrange for both physical and behavioral health care services care coordination;
    d. Provide case management services, care coordination and discharge planning for timely follow up to ensure continuity of care;
    e. Coordinate with OHA regarding members who are presumptively or will be retroactively enrolled in Oregon Health Plan (OHP) upon discharge;
    f. Arrange for all services to be provided post-discharge in a timely manner; and
    g. Provide access to evidence-based intensive services for adult members with SPMI discharged from OSH who refuse Assertive Community Treatment (ACT) services.
4. Discharges from OSH shall not be to secure residential treatment facility unless medically appropriate. No member shall be discharged to a secure residential treatment facility without the expressed prior written approval of the Director of OHA or the Director's designee.
5. UHA will ensure a member discharged from OSH who is determined not to meet the level of care for ACT shall be discharged with services appropriate to meet member's needs.

Involuntary Psychiatric Care

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1. UHA will make a reasonable effort to provide covered services on a voluntary basis and consistent with current Declaration for Mental Health Treatment as provided at http://www.oregon .gov/oha/amh/forms/declaration.pdf in lieu of involuntary treatment.
2. UHA will employ the use emergency psychiatric holds consistent with ORS 426.130 and alternatives to involuntary psychiatric care when a less restrictive voluntary services will not meet the medically appropriate needs of the member and the behavior of the member meets legal standards for the use of an emergency psychiatric hold.
3. UHA will only use psychiatric inpatient facilities and non-inpatient facilities certified by OHA under OAR 309-033-0200 through 309-033-0740.
4. UHA will comply with ORS chapter 426 and OAR 309-033-0200 through 309-033-0740 for involuntary civil commitment of those members who are civilly committed under ORS 426-130.
5. UHA will ensure that any involuntary treatment provided under this CCO Contract is provided in accordance with ORS Chapter 426 and OAR 309-033-0200 through 309-033-0440 and shall coordinate with the Community Mental Health Provider (CMHP) Director in UHA's services area in assuring that all legal requirements are met. UHA will work with the CMHP Director in assigning a civilly committed member to any placement and participate in circuit court hearings related to planned placements, if applicable.
6. Contractor shall work with secure residential treatment facilities to expeditiously move civilly committed adult members with SPMI who no longer need placement in a secure residential treatment facility (SRTF) to a community placement in the most integrated setting appropriate for that person. Discharge shall be to housing consistent with the member's treatment goals, clinical needs, and informed choice. The member's geographic preferences and housing preferences (e.g., living alone or with roommates) shall be reasonably and medically accommodated in light of cost, availability and the other factors stated above.

<u>Long Term Psychiatric Care</u>

1. UHA will be financially responsible for long term psychiatric care (LTPC) benefit for members after contract year 2021, with a timeline to be determined by OHA.
2. For a member age 18 or older:
    a. If UHA identifies a member, age 18 to age 64, with no significant nursing care needs due to a general medical condition, acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, UHA will request a LTPC determination from the applicable Health Services Division (HSD), Adult Mental Health Services Unit, as described in the procedure for LTPC

determinations for members 18 to 64, available on the CCO Contract Forms Website https://www.oregon.gov/oha/HSD/OHP /Pages/CCO-Contract-Forms.aspx.

i. HSD Adult Mental Health Services Unit will respond to UHA no more than three (3) business days follow the date HSD receives a completed request for LTPC determination for member 18-64.

b. If UHA identifies a member, age 65 and over, or age 18 to age 64 with significant nursing care needs due to a general medical condition, acute medical condition or physical disorder of an enduring nature, is appropriate for LTPC, UHA will request a LPTC determination from the Oregon State Hospital-NTS, Outreach and Consultation Services (OCS) Team as described in procedure for LTPC determination for member requiring neuropsychiatric treatment, available on the CCO Contract Forms Website https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx .

i. OCS team will respond to UHA's request no more than three (3) business days following the date the OCS team receives a completed request for LTPC determination for member requiring neuropsychiatric treatment.

c. A member is appropriate for LTPC when:

i. Member needs either intensive psychiatric rehabilitation or other tertiary treatment in a state facility or extended care program or extended and specialized medication adjustment in a secure or otherwise highly supervised environment; and

ii. Member has received all usual and customary treatment, including, if medically appropriate, establishment of a medication management program and use of a medication override procedure.

d. OHA will cover the cost of LTPC of members age 18 to 64 determined appropriate for such care beginning on the effective date specified below and ending on the date the member is discharged from such setting, until such time that OHA transfers this financial responsibility to UHA.

e. If a member is ultimately determined appropriate for LTPC, the effective date of such determination will be any one (1) of the following:

i. Within three (3) business days of the date HSD Adult Mental Health Services Unit staff receives a completed request for LTPC determination for persons' age 18-64;

ii. The date the state facility - NTS OCS team receives a completed request for LTPC determination for persons requiring state hospital-NTS;

iii. In cases where OHA and UHA mutually agree on a date other that as identified in (i) or (ii) above, the date mutually agree upon; or
iv. In cases where the clinical reviewer determines a date other than a date described above the date determined by the clinical reviewer.

f. In the event UHA and HSD Adult Mental Health Service Unit staff disagree about whether a member 18 to 64 is appropriate for LTPC, UHA may request, within three (3) business days of receiving notice of the LTPC determination, review by an independent clinical reviewer. The determination of the clinical reviewer will be deemed the determination of OHA for purposes of the CCO Contract. If the clinical review ultimately determines that the member is appropriate for LTPC, the effective date of such determination will be the date specified in subparagraph 2 (g) of this policy. The cost of the clinical review will be divided equally between UHA and OHA.
g. UHA will work with the appropriate OHA team or designee in managing admissions, discharge and transitions from LTPC for members who require LTPC at a state facility, to ensure that member are served in and transition into the most appropriate, independent, and integrated community-based setting possible.
h. For members, including those in long term neuropsychiatric care at the state facility, UHA will work with the member to assure timely discharge and transition from LTPC to the most appropriate, independent and integrated community-based setting possible consistent with member choice.

3. For a member age 17 or younger;
   a. If UHA identifies a member who is age 17 or younger is appropriate for LTPC referral, UHA will request a LTPC determination from the applicable HSD Child and Adolescent Mental Health specialists; as described in procedure for LTPC determinations for members 17 and under, available on the CCO Contract forms website https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx.
   b. The HSD Child and Adolescent Mental Health specialist will respond to UHA no more than seven (7) business days following the date HSD receives a completed request for LTPC determination for member 17 and under.
   c. UHA will work with HSD Child and Adolescent Mental Health specialist in managing admissions and discharges to LTPC Secure Children's Inpatient Program (SCIP) and Secure Adolescent Inpatient Program (SAIP).
   d. The member will remain enrolled with UHA for delivery of SCIP and SAIP services. UHA will be responsible for care coordination for the entire length of

stay, including admission determination and planning, linking the child and family team and intensive outpatient services and supports provider, services provided by LTPC service provider and transition and discharge planning. This should include collaborative relationships with all systems partners to achieve continuity of care. UHA will ensure that utilization of LTPC is reserved for the most acute and complex cases and only for the period of time necessary and medically appropriate to remediate symptoms that led to admission.

e. For the member and the parent or guardian of the member, the care coordinator and the child and family team will work to assure timely discharge and transition from a psychiatric residential treatment facility to the most appropriate, independent and integrated community-based setting possible.

Acute Inpatient Hospital Psychiatric Care

1. UHA will provide acute inpatient hospital psychiatric care for members who do not meet the criteria for LTPC and for whom it is medically appropriate.
2. UHA will submit required data through the acute care reporting database as instructed by OHA.
3. A medication override procedure is considered a "significant procedure" as defined in OAR 309-033-0610. UHA may perform a medication override procedure only after the member has been committed, there is good cause as described in OAR 309-033-0640, and the requirements of OAR 309-033-0640 have been met.
4. UHA will develop and implement and individualized management plan for contacting and offering services to each member who has two (2) or more readmissions to an acute care psychiatric hospital in a six-month period.
5. UHA will ensure all members discharged from acute care psychiatric hospitals are provided a warm hand off to a community case manager, peer or other community provider prior to discharge, and that all such warm handoffs are documented.
6. UHA will ensure that all members discharged from acute care psychiatric hospitals have linkages to timely, appropriate behavioral health and primary care in the community prior to discharge and that all such linkages are documented, in accordance with OAR 309-032-0850 through 309-032-0870.
7. UHA will ensure all adult members receive a follow-up visit with a community behavioral health provider within seven (7) days of their discharge from an acute care psychiatric hospital, or three (3) days if members are involved in intensive care coordination services.

8. UHA will coordinate with system community partners to ensure members who are homeless and who have two (2) or more readmissions to an acute care psychiatric hospital in a six-month period are connected to a housing agency or behavioral health agency to ensure these members are linked to housing in an integrated setting, consistent with the member's treatment goals, clinical needs and informed choice.
9. UHA will work with OHA and the CMHP to ensure that members who are discharged from acute care psychiatric hospitals are discharged to housing that meets the individuals immediate need for housing and will work with acute care psychiatric hospitals in the development of each individual's housing assessment. The housing assessment will be documented in a plan for integrated housing that is part of the individual's discharge plan, and will be based on the member's treatment goals, clinical needs, and informed choice. UHA will notify, or require acute care psychiatric hospital to notify the community provider to facilitate the implementation of the plan for housing.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	UM & Service Authorization Handbook		8/9/20	1