



TEXAS

Department of State Health Services

**COMMUNITY MENTAL HEALTH
and
SUBSTANCE ABUSE SERVICES**

RESILIENCY & DISEASE MANAGEMENT

**LMHA
UTILIZATION MANAGEMENT
PROGRAM MANUAL**

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FOREWORD

The Utilization Management Program Manual is a technical assistance document, formulated and revised to help the [LMHAs](#) develop and monitor their Utilization Management (UM) programs and processes. Taking into consideration the various strengths, challenges and complexities inherent in developing programs in the diverse communities served, the Department of State Health Services has given considerable latitude to the LMHAs in developing their processes, within the structure of applicable regulatory and contractual requirements. The processes within this manual are offered as “best practice” models and in some cases may exceed the actual requirements. Any mandated requirements are to be found in the current version of the [DSHS Performance Contract](#), [Texas Administrative Code \(TAC\)](#), the current edition [Texas Laws Relating to Mental Health](#), and other applicable laws.

The Utilization Management Program Manual was originally prepared to assist the LMHAs with the implementation of changes in service provision that were introduced in the [MH Resiliency and Disease Management \(RDM\)](#) model. This document will periodically be updated in order to assist in the clarification of Utilization Management issues.

The most current version of this manual may be found on-line at the following address:
<http://www.dshs.state.tx.us/mhprograms/RDMUMProcess.shtm>

SECTION 1. INTRODUCTION

MENTAL HEALTH RESILIENCY AND DISEASE MANAGEMENT UTILIZATION MANAGEMENT OVERVIEW

[Utilization Management](#) is the vehicle through which a [Local Mental Health Authority \(LMHA\)](#) ensures that people receive [quality](#), cost effective services in the most appropriate treatment setting, and in a timely manner. The LMHA must have an effective mechanism to manage the [utilization](#) of clinical resources. By implementing UM activities, the LMHA strives to achieve a balance between the needs and well-being of persons in need of mental health services and the demand for services and availability of resources. UM is a critical component of the DSHS MH Resiliency and Disease Management (RDM) initiative.

Each LMHA is responsible for maintaining an infrastructure which supports the implementation and maintenance of key UM processes and functions, and for incorporating UM data and information into management decisions. Key UM processes include the facilitation of access and [referral](#) to services, promotion of the most effective use of resources, and the ongoing exchange of clinical information between the LMHA and [providers](#), as illustrated in the [LMHA UM FLOWCHART](#). The LMHA maintains a comprehensive [UM Program Plan](#), provides an adequate number of qualified UM staff to implement it, and supports the activities of a UM Committee.

To be effective, it is recommended that the LMHA Utilization Management program:

- recognize the evolutionary nature of Utilization Management;
- acknowledge the efficiencies that will be gained as managers improve their ability to use data and providers gain trust in UM as a process to facilitate access to care rather than create barriers to care;
- use data to identify patterns of [utilization](#), work with clinicians to determine if the patterns and variations are desirable or not; and work with providers to make needed improvements;
- ensure that clinically qualified persons make decisions to authorize or deny payment for services;
- limit the use of [prior authorization](#) to only the highest risk, highest cost services where the need for prior authorization has been demonstrated;
- reduce prior authorization and [concurrent review](#) requirements for providers who demonstrate a consistent ability to follow the [UM Guidelines](#) and submit appropriate documentation;
- capitalize on information management technology and oversight activities which will allow [Automatic Authorization](#) for some services based on provider submission of appropriate clinical data;
- conduct [retrospective reviews](#) in conjunction with other LA functions such as [Quality Management \(QM\)](#), Claims Management and Data Verification to maximize the use of staff resources ;
- integrate utilization data into various local authority functions to include strategic and local planning; and
- be designed to use the least possible resources, require limited infrastructure and be amenable to contracting with an [Administrative Services Organization \(ASO\)](#) or other LMHA for this service if unable to maintain appropriate staffing.

UTILIZATION MANAGEMENT OVERSIGHT

Oversight of LMHA UM Process and Results: DSHS will monitor LMHA data entered into WebCARE and CARE on a routine basis to determine compliance and performance, including the outcomes of service delivery. This will include data that reflects patterns of current service [utilization](#) and the clinical assessment decisions used by the LMHA to make UM decisions. When [outliers](#) or trends are detected which reflect unusual or unexpected results, contact with the LMHA will be initiated and the causes explored. DSHS and the LMHA will collaborate on a series of activities to ensure that necessary oversight and improvement occurs in a manner that is the least resource intensive and provides necessary information for management decision making. On an “as needed” basis and through routine sampling, DSHS will monitor the following:

- **TRAG (Adult & Child):** Oversight of the implementation of the TRAG will be conducted to ensure uniformity of implementation and reliability of results.
- **UM Clinical Guidelines (Adult & Child):** DSHS will use data from WebCARE, CARE and [MBOW](#) (MR and Behavioral Health Outpatient Warehouse - formerly Data Warehouse-Business Objects) to monitor compliance with the UM Guidelines to ensure consistent application and to obtain information to be used in improving the guidelines on the state level.
- **Complaints, Appeals and Overrides:** The LMHA will monitor the number and nature of complaints and appeals of adverse determinations, to ensure that [individuals'](#) rights are protected and access to due process is ensured. In addition, information obtained from WebCARE and MBOW about clinical overrides will be critical to the future development and evolution of the UM Guidelines.

SECTION 2. LMHA UTILIZATION MANAGEMENT PROGRAM

OVERVIEW

[Utilization Management](#) is a dynamic process that provides timely, accurate and relevant information to facilitate fact-based decision making by the LMHA and results in positive outcomes for persons receiving services and improved provider practice. The LMHA Utilization Management staff and the Utilization Management Committee identify and monitor patterns of [over-utilization](#), [under-utilization](#) and other [utilization](#) problems that compromise care or that inappropriately utilize resources. Based on their findings, UM staff and the UM Committee recommend and participate in interventions to make utilization of services more effective, efficient and consistent with contractual requirements and the local planning processes.

LMHA UM Responsibilities include:

- developing, implementing and improving the LMHA Utilization Management Program so that it meets the needs of people receiving services, the community, the LMHA and DSHS;
- conducting prospective, concurrent and retrospective reviews to authorize services using the DSHS Utilization Management Guidelines and ensuring that people are receiving and benefiting from services;
- applying objective criteria when making adverse determinations;
- ensuring notification of adverse determinations to the person requesting or receiving services and his/her provider, including information on how to file an appeal or Fair Hearing;
- managing appeals in a timely manner according to established procedures;
- Implementing [Utilization Care Management](#) for persons with special circumstances and needs to ensure their access to needed services;
- collaborating with other LMHA functions such as Quality Management, Financial Services and Network Management in the use of UM data and with providers in planning interventions to improve provider practice;
- coordinating and supporting the activities of the UM Committee; and
- participating at the state level with DSHS in the future development and evolution of the DSHS UM Guidelines.

[UTILIZATION MANAGEMENT PROGRAM PLAN](#)

The LMHA Utilization Management Program Plan describes the UM program and is written to be consistent with the goals identified by the LMHA and applicable regulatory and contractual requirements.

The LMHA Utilization Manager (or UM Director, if applicable), under the direction of a UM psychiatrist and in consultation with the UM Committee, assumes the responsibility for execution of the UM Program Plan. The procedures, authority, and accountability outlined in the UM Program Plan are designed to ensure effective implementation of the LMHA's UM program and to meet DSHS rule and contractual requirements. The LMHA UM Program Plan must include a description of how the Utilization Management program's [effectiveness](#) in meeting goals will be evaluated; how improvements will be made on a regular basis; and the oversight and control mechanism to ensure that utilization management activities meet required standards when they are delegated to an [ASO](#) or a DSHS-approved entity. The LMHA is responsible for distributing

the UM Program Plan and for training network providers on the Plan's relevant aspects. It is recommended that the UM Program Plan be reviewed and updated at least annually to ensure compliance with the most current rules and contractual requirements.

LMHA UM FUNCTIONS

All of the functions listed below must be incorporated into the LMHA's UM program. The LMHA is required to staff a minimum of two positions: a UM Physician and a Utilization Manager. With the exception of physician oversight, all of the UM functions listed below may be fulfilled by either or both of these positions, or other qualified LMHA Authority staff under the supervision of the Utilization Manager.

1. **Physician oversight of UM processes.** This function must be carried out by a board eligible psychiatrist who possesses a license to practice medicine in Texas. The oversight function includes approval of all policies and procedures related to Utilization Management, to include changes based on new technology and availability of resources
2. **Consistent application of the [UM Guidelines](#) and processes.** This is accomplished through ongoing supervision of LMHA staff and management of UM operations.
3. **Utilization reviews and authorizations for all [service packages](#)** as indicated by the DSHS UM Guidelines.
4. **Collection, analysis, and documentation of utilization information.** This information is to be used in ongoing analysis of systemic issues that may support clinical and management decisions.
5. **[Utilization Care Management](#).** This function exists to accommodate unusual circumstances where telephonic and documentation review might not be sufficient to make an appropriate authorization decision. This function includes coordinating services for persons with special circumstances and needs, and facilitating authorization where it cannot be effectively conducted through the usual processes, necessitating direct contact with the provider, the individual and/or family members.
6. **[Utilization Management Committee](#).** The primary function of the UM Committee is to monitor utilization of the LMHA's clinical resources to ensure they 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 LMHA and its contracted providers using clinical, encounter and administrative data and performance measures. At a minimum, the UM Committee must consist of the LMHA UM Physician, LMHA UM and QM staff, and LMHA financial/fiscal staff. The UM Committee may also include mental health professionals, information management staff, or other LMHA staff and professionals.
7. **[Provider Submission of Documentation and Request for Continued Stay Review](#).** The LMHA will develop a process for provider submission of clinical information which will include at minimum, telephonic and/or electronic submission and will ensure that information specific to an individual that is gathered for utilization review remains [confidential](#) in accordance with all applicable laws and is shared only with those that have the need for and authority to receive it.
8. **[Adverse Determinations](#).** An adverse determination (i.e. a decision to deny, reduce or terminate a service) applies to those persons requesting services that are denied and those persons 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 recommendations to deny authorization for continued stay is made by the Utilization Manager who then refers it to the LMHA UM Physician, who will make a final decision based on all

available data. The final denial of services based on failure to meet clinical criteria may only be made by a physician.

9. **Appeal of Adverse Determinations.** The LMHA must ensure individuals' 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. The LMHA will ensure that all providers and individuals are provided information about the right to appeal and the process to do so.
10. **LMHA UM Data Submission to DSHS.** The LMHA will submit utilization data to DSHS according to the DSHS Performance Contract. If the LMHA delegates any UM activities to an external entity (to include an ASO or other LMHA), the LMHA will have a written contract with the UM Contractor that is consistent with all applicable regulatory and contractual requirements. The LMHA will maintain its UM Committee or designate another appropriate LMHA committee to:
 - review the reports produced by the UM Contractor,
 - make improvements in LMHA processes that impact utilization of resources; and
 - evaluate the [effectiveness](#) of services to improve provider practices.

UTILIZATION REVIEW ACTIVITIES

Evaluating the adequacy, appropriateness and [quality](#) of services provided to persons receiving services is a component of all Utilization Management review processes. Although specified services are routinely reviewed, all LMHA mental health services are subject to review when indicated, without regard to payment source. Decisions made by the LMHA's UM staff and UM Committee are based on objective and valid criteria and standards approved by DSHS.

Utilization reviews are conducted for the following purposes:

1. **Service Package Authorization:** oversight of initial and subsequent level of care (LOC) assignments to ensure consistent application of DSHS UM Guidelines.
2. **Outlier Review:** retrospective and concurrent review of data to identify outliers followed by review of individual cases to determine need for change in level of care assignment or service intensity. May result in referral for [peer review](#) or other oversight activities.
3. **Inpatient Admission and Discharge Planning:** prospective or concurrent review of inpatient admissions to ensure most clinically effective and efficient Length of Stay. Review of discharge plans to ensure timely and appropriate treatment following an inpatient stay.
4. **Administrative Review:** review of clinical and administrative documentation for timeliness and adequacy of UM processes to include reimbursement, corporate and contract compliance, and data verification.

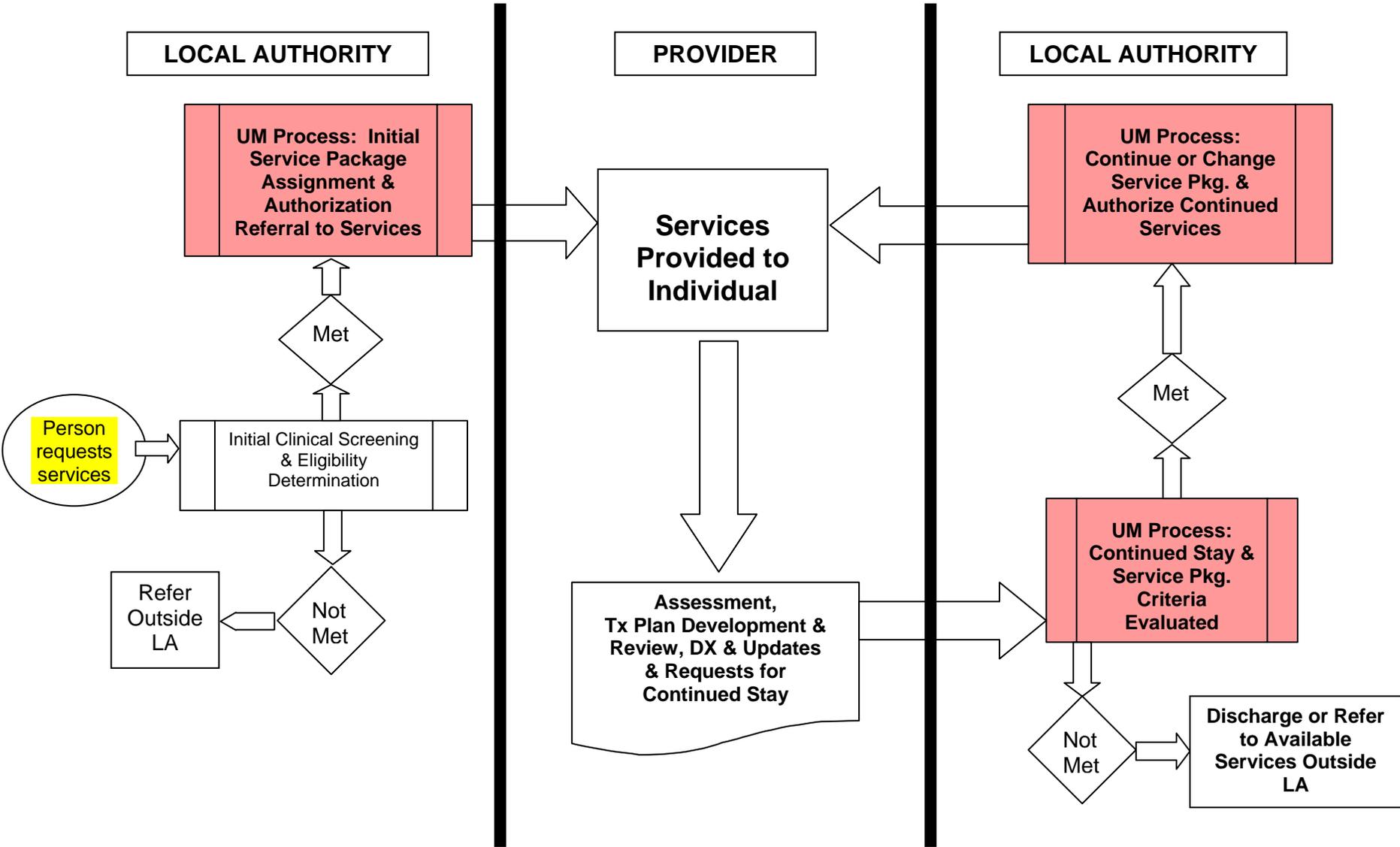
INTRA-AGENCY INTERFACE

Utilization Management should be committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Much of the LMHA Utilization Management function overlaps or is reliant on coordination with, Quality Management, Provider Relations, Claims/Reimbursement, Management of Information Services and other service management functions.

Successful interface among the various [authority](#) functions of the LMHA is essential for effective and efficient management of resources, identification of gaps in service delivery and resolution of

over- and under-utilization of services and resources. Interface between Utilization Management and other authority functions occurs through exchange of data, information and reports, joint participation in a variety of committees and collaboration in planning, projects and operational initiatives.

DSHS LMHA UTILIZATION MANAGEMENT FLOWCHART



SECTION 3. LMHA UTILIZATION MANAGEMENT POLICIES AND PROCEDURES

UTILIZATION MANAGEMENT COMMITTEE

Purpose:

The primary function of the UM Committee is to monitor utilization of the LMHA's clinical resources to assist the promotion, maintenance and availability of high quality care in conjunction with effective and efficient utilization of resources.

Objectives:

- assure the overall integrity of the LMHA Utilization Management process to include timely and appropriate assignment of Mental Health [Levels of Care](#) based on the DSHS UM Guidelines;
- assure that LMHA staff involved in the UM process are qualified to fulfill their functions and that [inter-rater reliability](#) is being maintained;
- approve the process used to review and authorize the provision of mental health services, including an appeal system for adverse determination decisions;
- analyze utilization patterns and trends to include gaps in services, rates of no shows for appointments and services, billing issues, underdeveloped frequently requested services, existing services that are [under-utilized](#) and [over-utilized](#), and barriers to access;
- establish mechanisms to report quantitative and qualitative information on service utilization and service delivery to LMHA management and staff, the LMHA Board, providers and other interested persons in a timely manner;
- provide a mechanism to identify potential [quality](#) issues and to forward them to the Quality Council, Committee or Quality Management Department;
- assist in the ongoing modification of [screening](#) criteria, standards, and review methods under the control of the LMHA and provide relevant feedback to DSHS; and
- prepare and arrange educational programs to address deficiencies noted by review findings.

Procedures:

The UM Committee operates according to established guidelines. Guidelines are located in the current contract in the Authority Attachment.

<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>

Authority:

The Utilization Management Committee receives its authority from the Board of Trustees of the LMHA and reports to the UM Physician designated to oversee the UM Program.

Appointing Members to the Utilization Management Committee:

All UM Committee members are appointed by the LMHA Executive Director/CEO. These members demonstrate leadership in their designated areas, provide data analysis and information as needed, conduct reviews as requested and effectively communicate information and committee findings to stakeholders. As needed, the UM Committee consults with physicians, providers and others from appropriate specialty areas to ensure processes and decisions are accurate and consistent.

Composition of the Utilization Management Committee:

Required membership includes:

- LMHA UM Physician
- Utilization Management Staff Representative
- Quality Management Staff Representative
- Fiscal/Financial Services Staff Representative

Participation by others may be indicated depending on the nature of issues under consideration.

Examples include:

- LMHA Clinical staff
- Contracts Management
- Network Development
- Information Systems
- Medical Records
- Clients' Rights Officer
- Providers
- Intake and [eligibility](#) staff

Training Members of the Utilization Management Committee: The LMHA will ensure that all UM Committee members receive appropriate training to fulfill the responsibilities of the committee. The LMHA should provide each member of the UM committee a copy of the LMHA's [UM Program Plan](#), the current DSHS Utilization Management Guidelines and other information necessary to perform their function. The Utilization Management Physician, or his/her designee, should discuss with each new member of the committee: the role of the UM Committee, type of cases, data and information reviewed by the committee, and clarify the LMHA UM program and processes. All participants in the Utilization Management process are subject to strict [confidentiality](#) practices, as defined by DSHS and other applicable rules.

Conflict of Interest: No UM committee member may participate in the review of a case in which he/she has a conflict of interest (e.g. has been professionally involved, has a personal or financial relationship with the provider or individual, etc.) Since current DSHS policy allows the UM Physician to function in a provider role, if a conflict occurred, the LMHA would need to arrange for a non-involved physician to review the case. This could include an agreement with a different LMHA to provide this service. The LMHA will identify other potential conflict of interest situations and include such situations in training for UM staff and UM Committee members.

Meetings: UM Committee meetings must be held at least quarterly and may be held more frequently as needed at a designated time and at the call of the UM Committee Chairman.

Minutes: The UM Department is responsible for taking, distributing, and storing documentation of oversight and follow-up activities.

CONTACT WITH AND RECEIPT OF INFORMATION FROM PROVIDERS

Purpose:

To ensure appropriate contact between the Utilization Manager and providers to include receipt of information.

Procedure:

- **Initial Contact:** UM will work with designated providers when routine information about eligibility and services is needed. In no event shall this preclude a LMHA representative from contacting a provider or others in his/her employ where a review might otherwise be unreasonably delayed or where the person designated is unable to provide the necessary information or data requested by the LMHA.
- **Collection of Information:** The provider must submit clinical documentation to the LMHA as specified in the LMHA provider manual and/or their contract, consistent with applicable laws on [confidentiality](#). When conducting routine utilization review activities, the LMHA shall collect only the information necessary to authorize the admission, procedure, or treatment, and/or length of stay, such as, identifying information about the person receiving services, clinical information regarding the diagnoses of the person receiving services, medical history relevant to the diagnoses, the person's prognosis, and the treatment plan prescribed by the treating provider along with the provider's justification for the treatment plan. Personnel employed by, or under contract with the LMHA who obtain information regarding an individual's specific medical condition, diagnosis, and treatment options or protocols directly from the physicians, shall be qualified according to DSHS guidelines (see LMHA UM Functions).

CONFIDENTIALITY AND PROPER USE OF IDENTIFYING INFORMATION
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Purpose:

To ensure confidential and proper use of identifying information gathered for the purpose of utilization management and review.

Procedure:

All activity that involves use of or access to confidential information related to an individual will be conducted in a manner that safeguards confidentiality and prevents the LMHA liability in connection with disclosures of confidential information. All LMHA staff will be responsible for safeguarding the confidentiality rights of [individuals](#). Disclosure will be made only within the limits of informed consent of the parties involved or as required by applicable federal and state law.

The LMHA Utilization Management activities are part of the internal [Peer Review](#) Process and are subject to confidentiality regulations. All physician and non-physician participants in the UM process are expected to protect confidentiality as required by HIPAA and LMHA policies. All UM committee members shall sign a confidentiality statement prior to participation on the committee.

The LMHA will ensure that identifying information gathered for the purpose of utilization review will be used solely for the following purposes:

- Utilization Review
- [Utilization Care Management](#)
- [Discharge Planning](#)
- Claim Management
- Quality Assurance/Improvement
- Auditing for Contractual Purposes
- Review by DSHS or an Independent Review Organizations, when applicable

Identifying information obtained during the process of utilization review is shared only with those agencies and persons that have the authority to receive such information.

ACCESS AND [REFERRAL](#) TO SERVICES

Purpose:

Utilization management reviews ensure that UM processes and procedures do not create a barrier to timely provision of appropriate services. In addition to authorizing services, utilization review serves to ensure that individuals are receiving and benefiting from the services they need. For those individuals who may be under-served or those experiencing barriers to access, utilization review provides the LMHA the opportunity to offer additional services.

Procedure:

Utilization Management authorization reviews are conducted according to the following:

[Crisis Services](#): Mental Health community services provided to individuals in crisis. The definition of crisis includes both Emergent and Urgent care services.

- **Emergent Services.** Emergent care services are those services necessary to screen and stabilize individuals in cases where a prudent layperson, acting reasonably, would have believed that an emergency psychiatric situation existed. **Emergency services do not require prior authorization**; however, the authorization must be completed within two business days after the provision of the crisis intervention service.
- **Urgent Services.** Authorization of urgent services is determined by the Utilization Manager and/or [Eligibility](#) Determination staff as determined by the LMHA. Notice of authorization and adverse determination will be made verbally and immediately to the provider.
- **Routine Outpatient Services.** Routine outpatient services are authorized by the LMHA in accordance with the DSHS MH RDM UM Guidelines and in a way that does not inappropriately deny persons access to services. Following the LMHA referral to a provider, services may be automatically authorized depending on provider submission of appropriate documentation to the LMHA UM department. While routine outpatient services may also be reviewed by UM staff for authorization, the [Automatic Authorization](#) method is more cost effective.

EXCEPTIONS TO UM AUTHORIZATION REVIEW:

- **[Automatic Authorization](#):** This is a formal process that allows an authorization to be given without UM staff review, when there is a written agreement, LOC-R = LOC-A and staff have demonstrated [competence](#) in the [Uniform Assessment](#). It is recommended that no high risk populations be automatically authorized, as these individuals merit more in-depth review. An Automatic Authorization may be used for initial or continued stay determinations.
- **[Extended Review](#) Period Requested:** By checking the Extended Review Period Requested box on the Uniform Assessment, an extension of the time frame of reassessment of the TRAG from 90 to 180 days is created. This field may be completed for the small number of highly stable, ongoing adult clients who have a current LOC-R 1 = LOC-A 1 and a preceding LOC-R 1 = LOC-A 1, or child/adolescent clients who have a current LOC-R 4 = LOC-A 4 and a preceding LOC-R = 4 and LOC-A 4. These are individuals who, because of their stability, are not scheduled to see a prescribing professional during the first 90 days of the authorization. The Extended Review renders the assessment valid for up to 180 days. This field *cannot* be completed for clients receiving their first Uniform Assessment at Intake.
- It is important to note the date range of the corresponding authorization so they both are in effect to cover the extended time frame.
- The Extended Review does not alleviate the need for Treatment Plan updates every 90 days.

Both Automatic Authorization and Extended Review should be monitored through mechanisms to be determined by the LMHA (e.g. trending, random oversight, etc.)

PROVIDER ACCESS TO UTILIZATION MANAGEMENT

Purpose:

To ensure that the Utilization Management system facilitates timely access to services and that the safety of persons requesting or receiving services is not compromised.

Procedure:

- The LMHA coordinates the flow of information between the crisis response system, single point of entry and the Utilization Management program.
- Access to Utilization Management staff is consistent throughout each business day. After hours, there is a back-up system to accept and record messages for non-emergent or urgent care and to refer callers back to the crisis system, if needed. Message recorders have time- and date-received capability, and non-urgent recorded messages are returned within two business days when sufficient information for a return call is provided. A toll-free telephone number is available for long distance calls made within the LMHA service area.
- UM staff is available throughout the business day to review clinical information needed to make authorization decisions.
- For potential adverse determination decisions, psychiatric consultation is available twenty-four hours a day through the crisis response system.
- The LMHA will provide a twenty-four hours a day, seven days a week telephone answering system and confidential fax machine through which authorization request messages may be received.
- If the provider has any concerns about the case (e.g. that any of the admission criteria are not met, the authorized LOC is incorrect, or the individual refuses some or all of the services) the provider must contact UM to document and discuss the case.

UTILIZATION REVIEW

Purpose:

To ensure timeliness of service authorization reviews, determinations, and notification of determinations

Procedure:

Upon receipt of all required information, requests for authorization of services are reviewed by the LMHA's Utilization Management staff in accordance with the following standards.

Prospective Review (Initial Determination)

- Determination made no later than two business days after receipt of request.
- Notification to provider of determination by telephone, facsimile, or other means, no later than two business days of making the determination.
- If verbal format was used, then written confirmation to provider of decision mailed within three business days of the verbal notification.

Concurrent Review

- Determination made within one business day after receipt of request.

- Notification to provider of determination by telephone, facsimile or by other means within two business days of making the determination.
- If verbal format was used, then written confirmation to provider of decision mailed within two business days of the verbal notification.

Retrospective Review

- Determination made within 30 business days.
- Written notification to provider of denial determinations within five business days of making the determination.

PERSONS WITH SPECIAL CIRCUMSTANCES AND NEEDS

Purpose:

To ensure that Utilization Management criteria are applied in such a way that persons with special circumstances and needs receive the services they need and ensure linkage with needed services external to the LMHA's [provider network](#).

Procedure:

The LMHA will ensure identification of individuals with special circumstances and needs so that the LMHA can be flexible in the application of UM Guidelines and in making authorization decisions to ensure needed access to appropriate care.

Upon identification of a person with special circumstances, the Utilization Manager will review the details of the case and may fulfill the [Utilization Care Management functions](#) or refer to other UM staff assigned to that function.

“Special circumstances” may include, but are not limited to, a person who in addition to their psychiatric needs has at least one of the following:

- a physical disability
- an acute health condition, life-threatening or terminal illness
- mental retardation or a developmental disability
- a woman who is pregnant

CLINICAL OVERRIDES AND EXCEPTIONS

Purpose:

To ensure that:

- The LMHA has a mechanism to override the Utilization Management Guidelines and [Texas Recommended Authorization Guidelines \(TRAG\)](#) when there is the need. All Overrides should be based on Medical Necessity criteria.
- The LMHA has a process to make Exceptions to and manage the number of units of service authorized for an individual.

Procedure:

Clinical Overrides:

1. The LMHA may authorize a clinical override to the DSHS UM Guidelines which result in placement in a higher [service package](#) for the following reasons:

- **Individual need:** A person has a medical need for services that is included in a service package other than the one recommended by the TRAG.
 - **Continuity of Care:** The TRAG recommends a lower service package but the person is maintained in the current service package for clinical reasons such as ensuring that improvements are maintained.
 - **Other:** A person presents for care and a clinician determines that an extenuating circumstance exists that requires the person to be served for reasons not captured in one of the other deviation reasons.
2. The LMHA may authorize an override to the DSHS UM Guidelines which result in placement in a lower level service package for the following reasons:
- **Individual Choice:** A person chooses not to receive services in the service package recommended by the TRAG and wants to move to a less comprehensive package.
 - **Resource Limitations:** Capacity for the TRAG recommended service package is not available. This option is applicable to non-Medicaid eligible individuals only. There is one deviation from this rule. If a person has an LOC-R4 and can be given the same amount and type of Medicaid-covered services (additional units of Case Management and Rehab Services to equal those of the ACT Team) in LOC-A3, an Override can be given with the reason of Resource Limitation. This is not a violation of Federal law.

Exceptions:

The LMHA may authorize an Exception to the amounts of service within a service package for persons who have reached the maximum service unit limits of a [level of care](#) or for amounts of service greater than it routinely authorizes, for the following reasons:

- **Individual need:** A person in services and their clinician determine that an extenuating circumstance exists that requires the person to be served with an increased frequency or duration of services than that which is routinely authorized by the LMHA.

Requests for Clinical Overrides:

At Admission: If, when applying the DSHS UM Guidelines and the TRAG, the LPHA conducting the initial [eligibility](#) determination, determines that one of the approved conditions exists for granting a clinical override, the LPHA will do the following:

- **Overrides for a higher or lower service package** – ensure that an opening is available in the desired service package by either contacting the LMHA UM staff per procedure or through use of the LMHA automated system which ensures that the service capacity for this individual is available, and provide them with the necessary information and documentation to grant or deny the request.

During the Course of Treatment: If, after completion of the TRAG, the provider determines that one of the approved conditions exists for granting a clinical override or exception, the provider will do the following:

- Contact the LMHA Utilization Manager and provide them with the required clinical information and documentation. This must be accomplished through means consistent with written agreements with the LMHA, applicable laws on [confidentiality](#) and any DSHS requirements.
- The exception and clinical override processes are not intended as mechanisms for appeal. These mechanisms ensure individuals' access to [medically](#) necessary services.

Note: *It is strongly recommended that only the LMHA Utilization Manager and/or UM Physician should grant a clinical override which places a person into a higher [level of care](#).*

All clinical overrides must be clinically and administratively documented as required by DSHS and the LMHA.

The LMHA may develop time frames for the process for granting [exceptions](#) and clinical overrides, considering availability, demand, LMHA service capacity and other relevant factors.

Granting Clinical Overrides and Exceptions:

- Upon request or identification of a person meeting the criteria for an override or exception, the LMHA Utilization Manager or UM Physician will evaluate the mental health treatment needs of the individual, additional information about his/her history, current special needs and/or circumstances and the provider's documentation of special accommodations needed to provide the indicated mental health service.
- The LMHA Utilization Manager or UM Physician, or a designee under their supervision, will ensure that they have the necessary clinical information to make the exception or clinical override decision. This may include contact with the provider, the person requesting or receiving services and family members.
- The Utilization Manager and/or UM Physician or a designee under their supervision, shall document the reasons for all exceptions and overrides.

Tracking, Reporting and Evaluation of Exceptions and Clinical Overrides:

The Utilization Management Committee shall review aggregate data about the reasons for all exceptions and overrides at every meeting. The UM Committee will ensure that periodically, an in depth analysis is conducted and reviewed by the Committee. This will include review of a sample of cases as well as aggregate and individual data available through WebCARE and MBOW applications.

ADVERSE DETERMINATIONS

Purpose:

To ensure that all adverse determinations (i.e. a decision to deny, reduce or terminate a service) are objective and based on the DSHS Utilization Management Guidelines, rules and regulations.

Procedure:

Service authorization denials/adverse determinations apply to persons who are requesting [eligibility](#) for services, are presently receiving services but no longer meet criteria for that service(s), or who no longer meet the eligibility requirements of the LMHA and for whom the provider continues to request authorization for that service(s).

Adverse determinations are service authorization denials that may be appealed, and include those in which persons seeking services:

- are found ineligible for services during the eligibility determination process;
- who, based on clinical determination, have been terminated from services;
- who, based on clinical determination, have had an involuntary reduction in their services;
- who, based on clinical determination, have been denied access to a service/support they request to receive;
- who, based on clinical determination that non-payment is not related to the person's mental illness and that the proposed action would not cause the person's mental or physical health to be at imminent risk or serious deterioration, may experience an involuntary reduction or

termination of services (does not apply to persons for whom the LMHA is identified as responsible for providing court-ordered outpatient services); or,

- are referred to their third-party coverage.

The LMHA will respond to adverse determinations in accordance with the following framework:

- The Utilization Manager, and as appropriate the UM Physician, will conduct 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, the Utilization Management staff assigned to the case shall verbally notify the [appellant](#) and the individual or their Legally Authorized Representative (LAR) requesting or receiving services, if different, and his/her provider. Within four 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, 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, the Utilization Management staff assigned to the case shall verbally notify the individual or their LAR receiving services and his/her provider of the proposed action. Within four business days of the decision, a Notice of Proposed Action letter is 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. At the time of the decision to deny further authorizations, the Utilization Management staff assigned to the case shall verbally notify the appellant and individual or their LAR requesting or receiving services, if different, and his/her provider. While the TAC states that within ten 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; it is strongly recommended that the timeframes parallel those of the Medicaid Fair Hearing procedure by sending the letter within three business days.
- 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 that 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 LMHA 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) the Utilization Management staff assigned to the case shall verbally notify the individual or their LAR receiving services and his/her provider of the proposed action. Within three business days of the decision, a Notice of Proposed Action letter is mailed to the individual receiving services or his/her LAR and the individual's provider. The LMHA may not take the proposed action while an appeal of the proposed action is pending.

RIGHT TO MAKE A [COMPLAINT](#) AND RIGHT TO [APPEAL](#)

Purpose:

To support the right of individuals to express concerns or dissatisfaction with the Utilization Management process or to appeal an adverse determination decision. It is the right of an individual requesting or receiving services to be informed of the results of appeals and the reason for upholding, modifying or reversing an adverse determination decision.

Procedure:

Information about the right of individual requesting or receiving services to express concerns or dissatisfaction or appeal an adverse determination decision will be posted at all service sites and included in the Client Rights Handbook. The information will include:

- An easily understood explanation of the appeal process;
- How the individual may receive assistance in requesting an appeal;
- The individual's right to meet with the person(s) who will be deciding the appeal;
- Time frames for the appeal review; and,
- Method used to inform the individual of the outcome of the appeal review.

At intake, the LMHA will review the Client Rights Handbook with the individual receiving services and/or his/her LAR, who signs a statement indicating receipt of this information. Each year, the service provider shall review the information with the persons receiving services and/or their LAR. Additionally, individuals requesting or receiving services and/or the LAR are informed that they may contact the DSHS Client Services and Rights Protection Office at any time regarding any concern or complaint and are given the toll free number (1-800-252-8154).

[PROVIDER](#) OBLIGATION TO ASSIST THE [APPEAL](#) PROCESS

Purpose:

To inform service providers of their obligation to assist persons requesting or receiving services in appealing adverse determination decisions.

Procedure:

The LMHA informs and educates providers regarding their obligation to, upon request, assist a person requesting or receiving services in appealing an adverse determination decision, as well as inform the provider of their obligation to, upon request, file an appeal on the person's behalf. The LMHA informs and educates providers about these obligations as follows:

- in the RFP (if applicable);
- at the time of contracting;
- annually with LMHA service providers;
- in writing as part of the LMHA's policies and procedures or provider manual; and,
- at the time of contract renewal.

If the LMHA receives a [complaint](#) that a provider did not facilitate access to the appeals procedure, a person designated by the LMHA will investigate the provider's procedures. At any time, the individual may access the LMHA's Client's Rights staff. If they are not currently involved in the determination of the complaint, they may advocate for the individual. Additionally, the LMHA informs providers of the right of individuals requesting or receiving services and/or their LAR to

contact the DSHS Client Services and Rights Protection Office at any time regarding a concern or complaint and is given the toll free number (1-800-252-8154). The provider is given this toll free number to post at all service sites.

APPEALS OF ADVERSE DETERMINATIONS

Purpose:

The LMHA will establish an appeals process in accordance with T.A.C. 401.464. (Rule Governing Notification and Appeals Process). The appeals process of the LMHA provides a mechanism for persons requesting or receiving services, their legally authorized representative (LAR), persons advocating on the individual's behalf and providers to challenge Utilization Management/resource allocation decisions with which they disagree. In addition, the appeals process serves to:

- facilitate the request for review and reconsideration of adverse determination decisions;
- allow the identification and resolution of ongoing service problems through the analysis of appeal trends and feedback to appellants; and,
- allow the LMHA to prospectively evaluate and take appropriate action on potential risk issues.

In accordance with Title 25, TAC Chapter 419, Subchapter G relating to [Medicaid Fair Hearings](#), the LMHA is required to 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 the LMHA 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.

http://www.dshs.state.tx.us/mhcontracts/FY07Contract/Info_Item_Q_Fair_Hearing_Procedures.doc

The UM appeals processes described here are also separate from those appeal processes applicable to the Benefits Plan, as defined in Information Item I of the FY2006 Performance Contract.

http://www.dshs.state.tx.us/mhcontracts/FY07Contract/Info_Item_I_Local%20Service%20Area_Benefits_and_Plan_Diversion_Action_Plan.doc

Procedure:

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. Appeals are submitted as follows:

- Individuals requesting or receiving services may appeal an adverse determination decision either in writing or verbally.
- The LMHA may request that the individual's LAR, an [appeal representative](#) or the individual's provider submit the request to appeal an adverse determination decision in writing.
- The adverse decision written notification must also allow the appealing party an opportunity to submit, in writing, good cause for having a particular type of specialty provider review the case. In such circumstances, the appeal shall 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 decision will be routed to a central point of contact designated by the LMHA.

The LMHA's procedure for appeals shall be reasonable and shall include the following provisions:

Routine Appeal Process

- If an individual requesting or receiving services requests assistance in completing a written appeal, the LMHA will provide such assistance.
- As soon as all necessary information is received by the LMHA, the UM representative will submit 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 **twenty business days** of receipt of notification to appeal unless the CEO of the LMHA grants an extension of the timeframe.
- Following the appeal decision, the Utilization Management staff assigned to the case shall verbally, in person or telephone, notify the appellant and individual requesting or receiving services, if different, and his/her provider of the decision.
- Within **three business days** of the decision, the Utilization Management staff assigned to the case shall 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 will include information about making a [complaint](#) to the DSHS Client Services and Rights Protection Division (1-800-252-8154) if they are not satisfied with the appeal decision.

Expedited Initial Appeal Process

- It is recommended that the LMHA have an expedited appeal process based on the immediacy of the condition. Denial of admission or continued stay for inpatient services requires an expedited appeal process. Within **one hour** of making the adverse decision, the LMHA 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 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 **one business day** to request an appeal through the LMHA's Utilization Management 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.
- An LMHA 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 **one calendar day** from the date that all information necessary to complete the review is received by the LMHA.
- Within **one calendar day** of the decision, the Utilization Management staff assigned to the case shall verbally, in person or telephone, as well as certified mail (Appeal Resolution letter), notify the appellant and individual requesting or receiving services, if different, and his/her provider of the decision.

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

The LMHA staff designated to manage appeals may also be responsible for:

- Coordinating and facilitating the appeal process;

- Assisting the appellant/LAR/provider, as needed, to meet required timeframes;
- Collecting additional information from UM staff, the individual requesting or receiving services, LAR, and/or provider, as appropriate;
- Maintaining an appeals log categorized by cause and disposition including length of time for resolution of each appeal;
- Maintaining a record of the appeal for a minimum of six years;
- Collecting, trending, and analyzing appeal data to identify service problems or potential risk issues; and
- Sharing relevant appeals data with the UM Committee, [Quality Management](#) and other appropriate management staff.

NOTIFICATION LETTERS

Purpose:

To provide clear, concise, and timely written communication of LMHA Utilization Management decisions to individuals receiving or requesting services, their LAR, other persons acting on their behalf, and/or a provider.

Procedure:

Notification letters shall be sent in a timely manner in accordance with a determined notification schedule, and shall contain content that clearly explains the Utilization Management decision and all recourses available.

Notice of Proposed Action

When the LMHA proposes to involuntarily reduce or terminate services based on a clinical determination that non-payment is not related to the individual's mental illness and that the proposed action would not cause the individual's mental or physical health to be at imminent risk or serious deterioration or refer the individual to his/her third party coverage, a Notice of Proposed Action letter is mailed to the individual receiving services or the individual advocating on the individual's behalf and the individual's provider. In addition to the reason for the decision, the letter must include information relative to the right to appeal the proposed action, as well as:

- An easily understood explanation of the appeal process;
- How the individual requesting or receiving services may receive assistance in requesting an appeal;
- Time frames for the appeal review;
- Method used to inform the appellant of the outcome of the appeal review; and,
- Include a copy of the Title 25, TAC Chapter 412, Subchapter C relating to Charges for Community Services.

Denial of Authorization

When a service is denied based on **administrative determination** (i.e., lack of capacity in the specified level of care, failure to comply with contractual authorization procedures, request of a duplicate service, use of an out-of-network provider, etc.) a Denial of Authorization Letter is mailed to the individual requesting or receiving services or the person advocating on their behalf and the provider. The letter must include the reason for the decision as well as information relative to the right to make a [complaint](#) and the process.

When a service is denied based on **clinical determination**, a Denial of Authorization Letter is mailed to the individual requesting or receiving services or the person advocating on their behalf and the provider. In addition to the reason for the decision, the letter must include information relative to the right to appeal, as well as:

- An easily understood explanation of the appeal process;
- How the individual requesting or receiving services may receive assistance in requesting an appeal;
- The appellants right to meet with the person(s) who will be deciding the appeal;
- Time frames for the appeal review; and,
- Method used to inform the appellant and the individual requesting or receiving services, if different, and the provider of the outcome of the appeal review.

Appeal Acknowledgement

In response to a request to appeal of an adverse determination decision, to include a proposed action, the LMHA will mail an Appeal Acknowledgement letter to the appellant or individual requesting or receiving services if different or his/her LAR.

The letter must include:

- The date of the LMHA's receipt of the appeal;
- A unique file or identification number to be assigned to the complaint;
- A description of the appeal procedures and time frames;
- An opportunity for the appealing party to submit the reason for the appeal;
- Information on how the appellant may provide additional information (in writing, in person, by telephone, or through an authorized representative) to the file for the reviewer who will be making the appeal decision and the date by which all information must be submitted to the LMHA;
- Notification that the appellant has the right to meet in person with the reviewer who will be deciding the appeal; and
- Notification that the denied services, supports, or treatment will not be initiated or re-instituted until the appeal process is complete and only if the decision is in the appellant's favor.

Appeal Resolution

Following review of an appeal of an adverse determination, an Appeal Resolution letter is sent to the appellant and individual requesting or receiving services, if different, and his/her provider as notification of the decision. In all cases, the Appeal Resolution letter shall contain:

- the decision;
- the principle reason for the decision;
- the specialization of providers consulted; and
- the description of the appeal and/or complaint process
- the DSHS Client Services and Rights Protection Office address and toll free number.

In all cases when an adverse determination decision is modified or reversed by the LMHA, the Appeal Resolution letter will also include:

- the plan to re-engage the individual into services.

DELEGATION OF THE UTILIZATION MANAGEMENT FUNCTION

Purpose:

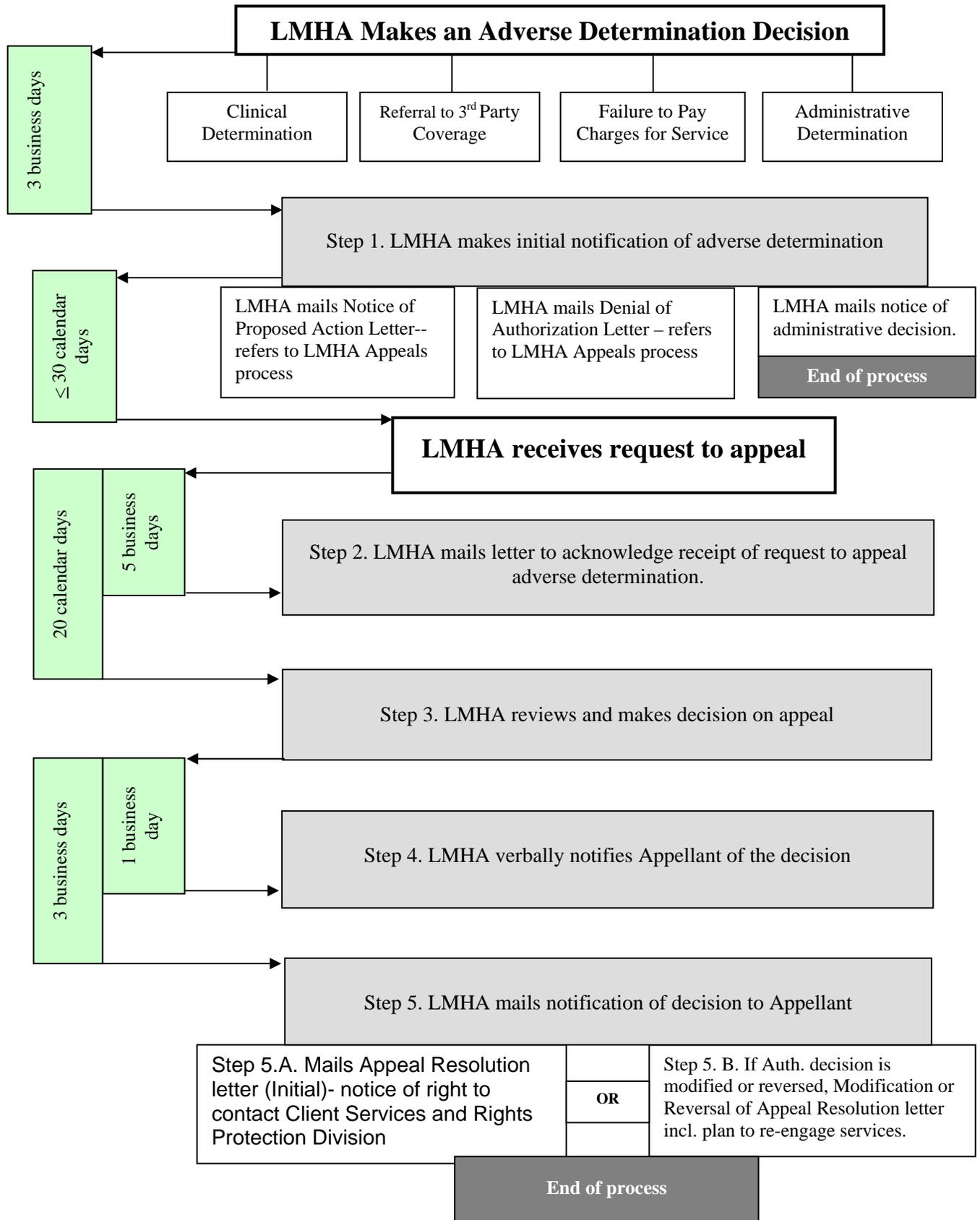
To ensure that if the LMHA delegates the Utilization Management function to an ASO or other LMHA, that sufficient controls are in place to ensure that all DSHS and LMHA contractual requirements are met, including the TAC 412G Mental Health Community Services Standards, §412.313. (b).

Procedure:

If the LMHA delegates any UM activities to an external entity, the LMHA will ensure the following:

- A written contract between the LMHA and the external entity defines review and reporting requirements of the entity consistent with this guide and any sections of the TAC 412G and the current Performance Contract related to delegation of authority functions.
- Results and analyses of all delegated UM activities will be reported to the LMHA at least quarterly, and an annual summary will be provided to coincide with the LMHA's annual local planning and management review processes.
- The LMHA will evaluate at least annually the external entity's performance of the delegated UM processes as defined in the written contract.
- If the LMHA contracts with an external entity to perform UM, the LMHA either maintains a UM Committee or designates another appropriate LMHA committee to review the reports produced by the UM Contractor, make improvements in LMHA processes and provider practices and address undesirable patterns of utilization. The LMHA will maintain involvement of a physician in UM related activities as needed.

ROUTINE (NON-EXPEDITED) APPEAL PROCESS FLOWCHART



Section 4. Utilization Review (UR) and Authorization Process

LMHA UR AND AUTHORIZATION PROCESS FOR ADULT MH SERVICE PACKAGES (SP)
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SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
SP 1	<p>An individual enters into this service package when:</p> <ol style="list-style-type: none"> New individual is referred through the eligibility determination process or Current individual is stepped down from a more intensive service package <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<ol style="list-style-type: none"> For individuals being admitted, services may be authorized by UM staff or by automatic authorization for 365 days contingent upon: <ul style="list-style-type: none"> TRAG indicates a LOC-R 1 and All other admission criteria are met and All required data is entered into WebCARE and A slot with an SP1 provider is available. For individuals who do not meet admission criteria but do meet criteria for clinical override, UM must be contacted for prior authorization. If there is no slot available with a SP1 Provider, and the individual does not meet criteria for an override, he/she is placed on the Waiting List (LOC-8). (Not applicable to Medicaid-eligible individuals who must be served.) 	<ol style="list-style-type: none"> Prior to the expiration of 365 days, one of the following will occur: <ul style="list-style-type: none"> The individual is discharged if clinically appropriate The individual is moved to a higher SP Additional units of service may be re-authorized by UM staff or automatically re-authorized for another 365 days if: <ul style="list-style-type: none"> TRAG indicates a LOC-R 1 and All SP1 admission criteria are still met and All required data is entered into WebCARE and SP1 provider slot is available. Special considerations may be met While the LMHA may choose to have UM staff authorize this SP, automatic authorization is an appropriate option since an individual's placement in this SP does not require concurrent review unless: <ul style="list-style-type: none"> Clinical concerns are identified by the provider or Utilization Manager Data analysis identifies service delivery characteristics as an outlier For individuals who do not meet admission criteria but do meet criteria for clinical override, UM must be contacted for prior authorization. <p>If an individual is being under-served in SP 1, (LOC-R greater than 1 and LOC-A is 1 because of lack of capacity) the LMHA has the obligation to move him/her to the appropriate LOC-R SP when a slot is available.</p>	<ul style="list-style-type: none"> Data analysis and identification of outliers is important for this SP to determine if automatic authorization is working as intended Outliers identified through data analysis may be reviewed at any time and/or additional documentation requested from the provider. Retrospective reviews for UM, QM, Claims, etc. may also be conducted as needed for any service package The LMHA may require prior authorization for reauthorization of SP1 for new providers, based on the results of provider profiling or for other reasons as needed
Add on SP 1	<p>An individual receiving SP1 is eligible for add on services when the UM guideline criteria are met.</p>	<ol style="list-style-type: none"> Add on Services - add on services may be authorized if: <ul style="list-style-type: none"> The individual meets the criteria and The LMHA has the capacity. (Not applicable to Medicaid-eligible individuals who must be served.) The LMHA will develop a process to equitably authorize these services for eligible individuals. 	<ol style="list-style-type: none"> Add on Services - add on services may be reauthorized if: <ul style="list-style-type: none"> The individual meets the criteria and The LMHA has the capacity. (Not applicable to Medicaid-eligible individuals who must be served.) The LMHA will develop a process to equitably reauthorize these services for eligible individuals. 	

SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
SP 2	<p>An individual may enter this service package only from another service package (usually SP1).</p> <p>This criterion is not subject to clinical override.</p> <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<p>1. For individuals currently in a SP (usually SP1), services may be authorized by UM staff or automatically authorized for 180 days contingent upon:</p> <ul style="list-style-type: none"> All SP2 admission criteria are met and TRAG indicates a LOC-R 2 and All required data is entered into WebCARE and SP2 provider slot is available <p>2. If there is not a slot available with a SP 2 provider, the individual is remains in their current SP until a slot is available. (Not applicable to Medicaid-eligible individuals who must be served)</p>	<p>1. Prior to the expiration of 180 days, one of the following will occur:</p> <ul style="list-style-type: none"> the individual is moved to SP1 <i>(or in rare cases another SP)</i> or the individual is discharged, if clinically appropriate or Additional units of service may be re-authorized or automatically re-authorized, if all SP2 admission criteria are still met and the TRAG indicates a LOC-R 2 <p>2. For individuals who do not meet the criteria for reauthorization but do meet criteria for clinical override, UM must be contacted for prior authorization.</p>	<ul style="list-style-type: none"> Data analysis and identification of outliers is important for this SP to determine if automatic authorization is working Outliers may be reviewed at any time Retrospective reviews for UM, QM, Claims, etc. may also be conducted as needed for any service package The LMHA may require prior authorization for reauthorization of SP2 for new providers, based on the results of provider profiling or for other reasons as needed.
Add on SP 2	<p>An individual receiving SP2 is eligible for add on services when the UM guideline criteria are met.</p>	<p>1. Add on Services - add on services may be authorized if:</p> <ul style="list-style-type: none"> All SP2 Add on services admission criteria are met and All required data is entered into WebCARE and <p>SP2 Add on provider slot is available (Not applicable to Medicaid-eligible individuals who must be served)</p> <p>2. The LMHA will develop a process to equitably authorize these services for eligible individuals.</p>	<p>1. Add on services may be re-authorized if:</p> <ul style="list-style-type: none"> The individual continues to meet the criteria and The LMHA has the capacity to provide additional services. (Not applicable to Medicaid-eligible individuals who must be served) <p>2. The LMHA will develop a process to equitably re-authorize these services for eligible individuals.</p>	

SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
SP 3	<p>An individual enters into this service package when:</p> <ol style="list-style-type: none"> 1. New individual is referred through the eligibility determination or 2. Current individual in a lower SP moves to a higher SP or 3. Current individual is stepped down from a more intensive service package <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<ol style="list-style-type: none"> 1. For all individuals, it is strongly recommended that entry into SP3 should be prior authorized by a Utilization Manager. The LMHA may choose to allow the Utilization Reviewer to authorize entry into SP3; however, Utilization Reviewers must be carefully supervised by the Utilization Manager regardless of whatever decisions an LMHA makes regarding Utilization Reviews. It is recommended that initial entry into SP3 not be automatically authorized. 2. Authorization is based on: <ul style="list-style-type: none"> • TRAG indicates a LOC-R 3 and • All other admission criteria are met and • All required data is entered into WebCARE and • A slot with an SP3 provider is available. 3. If there is not an opening with a SP3 provider, the individual is: <ol style="list-style-type: none"> A. Considered underserved and should be moved to the appropriate SP as soon as possible B. Is placed in a lower SP or C. Remains in their current SP <p>(Not applicable to Medicaid-eligible individuals who must be served)</p> 4. For individuals who do not meet admission criteria for SP 3 but do meet criteria for clinical override, UM must be contacted for prior authorization. 5. If an individual is being under-served in this SP, (LOC-R 4 and LOC-A is 3 because of lack of capacity) and are underserved, they are to be reviewed for movement to the LOC-4 as part of routine Utilization Management. 	<ol style="list-style-type: none"> 1. Prior to the expiration of 180 days, one of the following will occur: <ul style="list-style-type: none"> • The individual is discharged if clinically appropriate • The individual is moved to a higher SP • The individual is moved to a lower SP • Additional units of service may be re-authorized by UM staff or automatically re-authorized for another 180 days if: <ul style="list-style-type: none"> ➢ The TRAG indicates a LOC-R 3 ➢ SP3 admission criteria are met 2. For individuals who do not meet reauthorization criteria for SP 3 but do meet criteria for clinical override, UM must be contacted for authorization to maintain the individual in this SP. 3. If an individual is being under-served in this SP, (LOC-R 4 and LOC-A is 3 because of lack of capacity) and are waiting for treatment in SP 4, they are to be reviewed for movement to the LOC-4 as part of routine Utilization Management. 	<ul style="list-style-type: none"> • The LMHA may reduce the frequency of reviews for this service package for providers that demonstrate compliance with the UM clinical guidelines, timely submission of documentation, demonstrate good outcomes as determined through provider profiling. • Updated diagnostic and assessment data continues to be submitted and reviewed aggregately for outliers and trends.

SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
Add on SP 3	An individual receiving SP3 is eligible for add on services based on medical necessity and when the UM guideline criteria are met.	<p>1. Add on Services – may also be authorized if:</p> <ul style="list-style-type: none"> The individual meets the criteria and The LMHA has the capacity. (Not applicable to Medicaid-eligible individuals who must be served) <p>2. The LMHA will develop a process to equitably authorize these services for eligible individuals.</p>	<p>1. Add on services may be re-authorized if:</p> <ul style="list-style-type: none"> The individual continues to meet the criteria and The LMHA has the capacity to provide additional services. (Not applicable to Medicaid-eligible individuals who must be served) <p>2. The LMHA will develop a process to equitably re-authorize these services for eligible individuals.</p>	
SP 4	<p>An individual enters into this service package when:</p> <p>1. An individual who is not currently admitted (new) is referred through the eligibility determination process or</p> <p>2. An individual in a lower SP moves to a higher SP</p> <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<p>1. For all individuals, it is strongly recommended that entry into SP 4 should be prior authorized by a Utilization Manager. The LMHA may choose to allow the Utilization Reviewer to authorize entry into SP4; however, Utilization Reviewers must be carefully supervised by the Utilization Manager regardless of whatever decisions an LMHA makes regarding Utilization Reviews. Initial entry into SP4 may not be automatically authorized.</p> <p>2. Authorization is based on:</p> <ul style="list-style-type: none"> All SP 4 admission criteria are still met TRAG indicates a LOC-R 4 or The individual meets the criteria for a clinical override All required data is entered into WebCARE SP 4 provider slot is available <p>3. If an individual is eligible for SP 4 but there is not an opening with a SP 4 provider, the individual is underserved and should be moved to SP4 as a part of routine Utilization Management when capacity is available. (Not applicable to Medicaid-eligible individuals who must be served)</p>	<p>1. Prior to the expiration of 180 days, one of the following will occur:</p> <ul style="list-style-type: none"> The individual is discharged if clinically appropriate The individual is moved to a lower SP if clinically appropriate The individual remains in SP 4 and additional units of service are re-authorized for another 180 days if: <ul style="list-style-type: none"> The TRAG indicates a LOC-R 4 SP 4 admission criteria are met 	<ul style="list-style-type: none"> The LA may reduce the frequency of reviews for this service package for providers that demonstrate compliance with the guidelines, timely submission of documentation, demonstrate good outcomes, etc., as determined through provider profiling

SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
Flex Benefit 1 A. Spot Rental B. Partial Rental Subsidy C. Respite D. Utilities E. Emergency food F. House-wares G. Residential Services H. Clothing I. Start up Deposits	<p>Any individual who meets the admission criteria is eligible for one or more of these Benefits, based on medical necessity.</p> <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<p>This benefit is limited to a total \$500 per person per month</p> <p>1 month</p> <p>3 months and a maximum of one year</p> <p>1 month</p> <p>up to 2 months</p> <p>1 time</p> <p>1 time</p> <p>1 month</p> <p>1 time</p> <p>1 time (first and last month's rent)</p>	<p>1. Flex Benefit 1 may be re-authorized if:</p> <ul style="list-style-type: none"> The individual continues to meet the criteria and The LMHA has the capacity to provide additional services. (Not applicable to Medicaid-eligible individuals who must be served if the service is Medically Necessary) <p>2. The LMHA will develop a process to equitably re-authorize these services for eligible individuals.</p>	
Flex Benefit 2 Transportation	<p>An individual in any service package that meets the admission criteria is eligible for this service</p>	<p>1. This is a temporary service usually received one time however longer term assistance may be needed.</p> <p>2. These are funds of last resort</p> <p>3. This benefit is limited to a total of \$100 per person per month</p>	<p>1. Flex Benefit 1 may be re-authorized if:</p> <ul style="list-style-type: none"> The individual continues to meet the criteria and The LMHA has the capacity to provide additional services. (Not applicable to Medicaid-eligible individuals who must be served if the service is Medically Necessary) <p>2. The LMHA will develop a process to equitably re-authorize these services for eligible individuals.</p>	<p>Efforts should be made to assist the individual in accessing other transportation resources.</p>
Crisis Services	<p>Any individual that meets the admission criteria is eligible for this service</p> <p>UM Guidelines: http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm</p>	<ul style="list-style-type: none"> Crisis services do not require prior authorization; however, the authorization must be completed within two business days after the provision of the crisis intervention service. <p>For all individuals, this service is authorized for 7 days contingent upon:</p> <ol style="list-style-type: none"> TRAG indicates the individual is in crisis, and Medical Necessity criteria is met 		

SP	ENTRY INTO SERVICES	INITIAL AUTHORIZATION	RE-AUTHORIZATION & UTILIZATION REVIEW	ADDITIONAL INFORMATION
		<p>and documented</p> <p>3. all other admission criteria are met, and</p> <p>4. all required data is entered into WebCARE.</p>		
<p><u>Crisis</u> Follow-up</p>	<p>Individuals in SP 1 – 4 are not eligible for this service</p>	<p>1. Brief services for those individuals discharged from crisis services or hospitalization that are not eligible for other services.</p> <p>2. Prior authorization should not be required in order to facilitate access to this brief service</p>	<p>1. This service may be reauthorized by the Utilization Manager</p>	
<p>In-patient Hospitalization (Acute or sub-acute)</p>	<p>Includes all psychiatric hospitalizations in state and community psychiatric hospitals.</p>	<p>1. Prospective review is conducted at the time of referral for hospitalization whenever possible</p> <p>2. If not prospectively reviewed, concurrently reviewed by the Utilization Manager within two working days.</p>	<p>1. Due to the intensity of in-patient hospitalization, concurrent Utilization Review should be conducted frequently as needed and at least every 5 days.</p>	<p>UR conducted through review of hospital medical records faxed, submitted electronically or telephonically. LMHA must maintain some form of documentation of authorization and reauthorization of inpatient admissions to state and community psychiatric hospitals.</p>

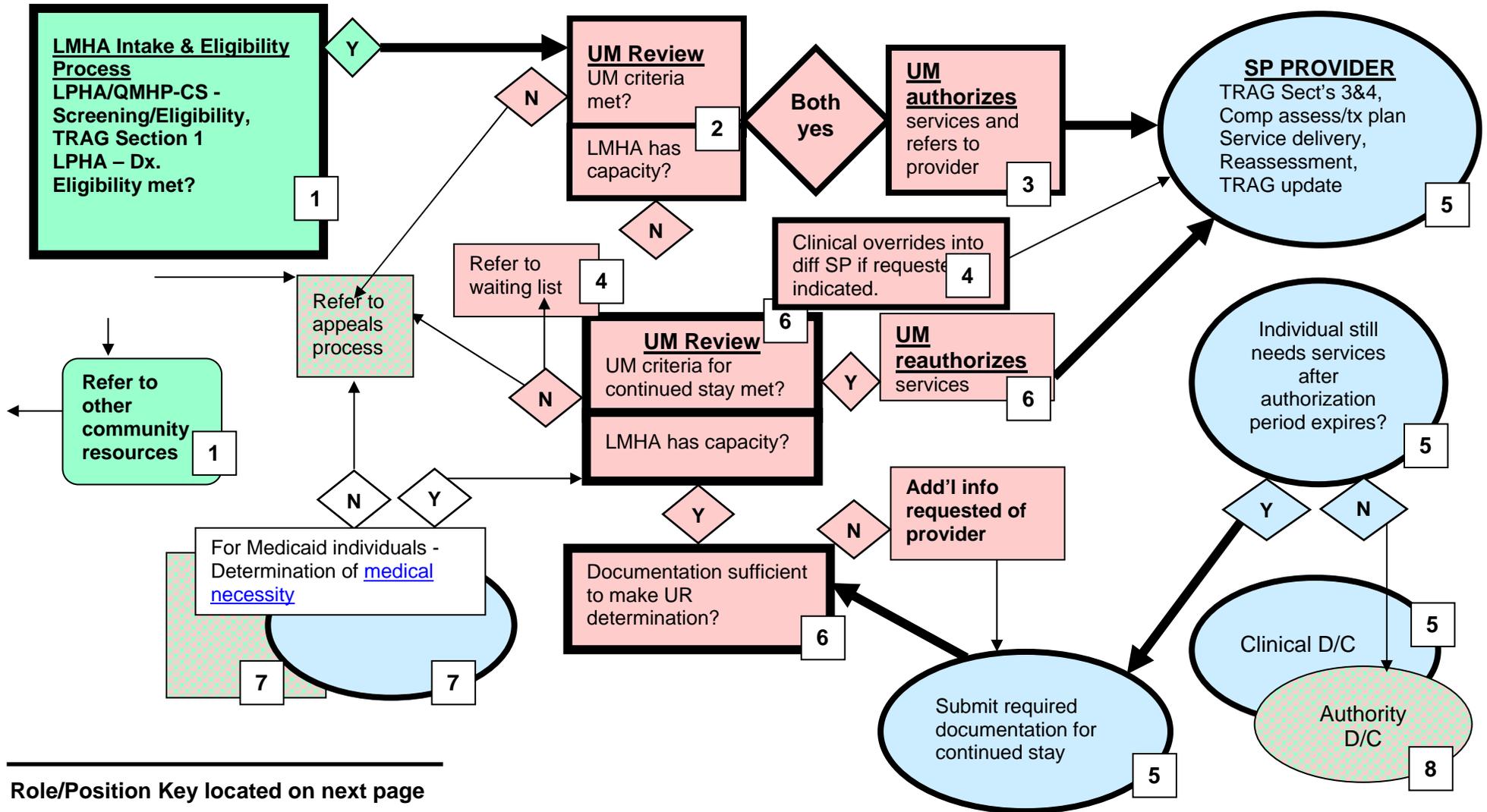
LMHA RESILIENCY AND DISEASE MANAGEMENT PROCESSES

LOCAL MH AUTHORITY

Service Entry Processes

UM Processes

Provider Processes



Role/Position Key located on next page

Role/Position Key

1. LMHA [QMHP-CS](#) or LPHA for screening, eligibility, [TRAG](#) Sect 1. LPHA gives Dx. No Dx needed for Crisis LOC 0.
2. It is recommended that for initial tx and TRAG LOC-R =SP1 or 2, UM staff (QMHP-CS or LPHA) reviews criteria and capacity. If TRAG LOC-R=SP 3-4, it is recommended that the Utilization Manager (LPHA) reviews.
3. Use Utilization Manager or Utilization Reviewer if SP 1-2. Utilization Manager recommended if LOC-R is SP 3-4. UM staff reviews TRAG, and issues authorization. Alternatively, Automatic Authorization may be used if formal agreement is in place and criteria are met.
4. Utilization Manager
5. Any provider qualified to provide services per UM Guidelines.
6. It is recommended that either the Utilization Manager or Utilization Reviewer may authorize if SP 1-2. It is recommended that the Utilization Manager authorize if LOC-R is SP 3-4. UM staff reviews TRAG, and issues authorization. Alternatively, Automatic Authorization may be used if formal agreement is in place and criteria are met.
7. Either LMHA or provider LPHA
8. Utilization Manager or Utilization Reviewer reviews TRAG, and if d/c criteria are met per UM Guidelines, closes services in WebCARE.

UR AND AUTHORIZATION FOR CHILDREN'S [SERVICE PACKAGES](#) (SP) (RESERVED)

LMHA [WAITING LIST](#) PLACEMENT AND MANAGEMENT

Purpose:

To facilitate service provision according to priority of need, based on LMHA capacity, and to provide accurate, ongoing information for LMHA and DSHS management and resource allocation decisions.

Procedure:**Initial Intake and Placement on the Waiting List - LOC 8 (Waiting for All Services.)**

The LMHA must provide intake within 14 days of request for MH services. Following the intake assessment, the individual may be placed on a waiting list if the LMHA does not have the capacity to provide services in the recommended Level of Care. When service capacity is exceeded, the LMHA will use established guidelines and criteria for placing people on the waiting list. This does not include individuals who are currently being underserved due to lack of capacity in the most appropriate Service Package. Those individuals should be moved to the correct Service Package as soon as there is an available slot. These criteria will include procedures for triage and prioritization based on urgency of clinical need.

NOTE: Individuals who are [Medicaid Eligible](#), (i.e. currently have Medicaid benefits) may not be placed on a waiting list.

The waiting list will identify individuals who have not been admitted into services due to lack of capacity in all levels of care.

Monitoring and Management of the Waiting List

- Current service capacity information will be maintained by the LMHA and made accessible to LMHA staff responsible for eligibility determination, level of care assignment and authorization.
- The waiting list is monitored in accordance with Contract requirements by the LMHA Utilization Management Department at least every 30 days for consideration in LMHA resource management and allocation decisions.
- Individuals on the waiting list for admission into services or the most appropriate level of care as indicated by the [TRAG](#) are contacted at a frequency sufficient to determine and prioritize their needs and in accordance with the current contractual requirements. Contacts determine whether the services for which the individual is waiting are still desired by the individual.
- Individuals on the waiting list for admission into services will be authorized and referred to appropriate providers as soon as service capacity allows.
- People will be removed from the waiting list once they are admitted into services or when it is determined that they either no longer need or desire services.
- Service capacity and procedures used to manage the waiting list are routinely reviewed by the UM Committee and adjusted as needed.
- The LMHA will monitor the waiting list according to the criteria in their performance contract with DSHS on a monthly basis.

SECTION 5. LMHA UTILIZATION MANAGEMENT PERSONNEL

LMHA FUNCTIONS, CREDENTIALS AND REQUIRED POSITIONS

NOTE: It is essential to use accurate terminology when discussing who may authorize services, for example, neither a QMHP-CS nor an LPHA can authorize services unless they are qualified as UM staff. In addition, it is a requirement that all UM staff must be Authority staff may not provide any direct services, including crisis services, with exception of the UM Physician. Due to staffing limitations, it is currently allowable for an LMHA provider physician to also be the UM Physician as long as he/she meets all the qualification for that position and is able to fulfill the duties. Arrangements must be made to avoid conflict of interest regarding UM decisions for services provided by the UM Physician. Qualified UM staff may have responsibilities for other Authority functions such as hospital liaison, QM, etc.

TITLE/FUNCTION	CREDENTIAL REQUIRED TO PERFORM FUNCTION	DESCRIPTION OF DUTIES	POSITION REQUIRED
Utilization Management Physician - (Required) Physician oversight of the UM program	M.D. - Fully trained (board eligible psychiatrist) and possesses a license to practice medicine in Texas.	<ul style="list-style-type: none"> • Primary function is to oversee the Utilization Management process and approve all policies and procedures related to Utilization Management. • Clinically supervises the Utilization Manager and Utilization Management Director (if applicable). • Is responsible for providing consultation on all adverse determinations upon request of the Utilization Manager, 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 Utilization Management Committee. • Provides physician-to-physician peer review as indicated. 	Yes (May be part time - determined by LMHA)
Utilization Management Director Administrative supervision of UM process and operations	RN, RN-APN, PA, PhD psychologist, LCSW (LMSW-ACP), LPC, or LMFT and is licensed in Texas. Has at least 3 years of clinical experience in the treatment of persons with mental illness or chemical dependency.	<ul style="list-style-type: none"> • Primary function is to ensure consistent application of the Utilization Management Guidelines and process through supervision of the Utilization Managers, Utilization Reviewers and Utilization Care Managers and management of UM operations. • Works under the supervision of the Utilization Management Physician & ensures effective communication regarding UM operations, performance and problems. • Ensures the annual update and changes as needed to the LMHA UM Program Plan. • If the Utilization Management Director does not meet the qualifications for a Utilization Manager, they can administratively but not clinically oversee the Utilization Management program and functions. • May function as a Utilization Reviewer or Utilization Care Manager with the same limitations regarding denials and prospective authorizations. • May function as a Utilization Manager only if all credentials and requirements are met and documented. 	No
Utilization Manager – (Required) Utilization Management	RN, RN-APN, PA, PhD psychologist, LCSW (LMSW-ACP), LPC, or LMFT licensed in Texas and found by the LMHA to be fully qualified to perform all LMHA UM functions and has: <ul style="list-style-type: none"> • at least 5 years experience in direct care of 	<ul style="list-style-type: none"> • Primary function is utilization management, conducting utilization review and granting and denying authorizations for all MH service packages and services as per the DSHS Utilization Management Guidelines. • Conducts prospective, concurrent and retrospective reviews for authorization of service packages/services for individuals; • Conducts reviews using clinical information submitted by providers, direct contact with providers, review of medical 	Yes

TITLE/FUNCTION	<u>CREDENTIAL</u> REQUIRED TO PERFORM FUNCTION	DESCRIPTION OF DUTIES	POSITION REQUIRED
	<p>persons with a serious mental illness, including experience in an acute care setting, and</p> <ul style="list-style-type: none"> at least 5 years experience participating as a member of a treatment team that develops and monitors treatment plans for persons with chronic & serious mental illness, and documented training within the past 3 years in psychopharmacology, medical/psychiatric co-morbidity and complications of serious mental illness, and at least one year's experience supervising MH providers, and demonstrated competence in performing Utilization Management and review activities. 	<p>records and contact with the individual and family members when needed and appropriate.</p> <ul style="list-style-type: none"> Makes initial adverse determinations and all clinical overrides (CORP) and exceptions to the UM Guidelines, in consultation with the LMHA UM physician when indicated. Monitors service delivery and outcomes to ensure that 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 a LMHA representative. Participates in provider training on the UM process, monitors provider adherence to UM Guidelines and provides consultation when needed. This position can fulfill all UM functions except provide physician oversight for the LMHA UM process 	
<p>Utilization Reviewer</p> <p>Utilization Review</p>	<p>Qualified Mental Health Professional-Community Services (QMHP-CS)</p> <p>Minimum qualifications as defined in the current DSHS Mental Health Community Services Standards and has at least 3 years clinically appropriate experience in treatment of persons with mental illness & chemical dependency.</p>	<ul style="list-style-type: none"> Primary function is to collect, analyze and document information from medical records and providers to be used by the Utilization Manager in prospective reviews, authorization or in making initial adverse determinations. Conducts retrospective reviews and review of data to detect outliers. May conduct utilization review and grant authorization decisions limited to continued stays, including overrides and add-on services, for individuals who are already receiving authorized services from the LMHA when the request is complete, accurate, and clearly falls within the DSHS UM Guidelines. Any requests for authorization that do not clearly meet the guidelines must be reviewed by a Utilization Manager. Does not conduct prior authorizations for service packages or hospitalization May assist the Utilization Care Manager if the UR staff possesses required credentials. The Utilization Manager supervises and approves the work of the Utilization Reviewer. 	No
<p>Utilization Care Manager</p> <p>Utilization Care Management Functions</p> <p>(Note: this is not a service provided to individuals. It is an authority function that ensures individuals receive services they need & that UM does not function as a barrier to access)</p>	<p>Qualified Mental Health Professional-Community Services (QMHP-CS)</p> <p>Minimum qualifications as defined in the current version of the DSHS Mental Health Community Services Standards and has at least 3 years of clinically appropriate experience in the treatment of persons with mental illness and chemical dependency.</p>	<ul style="list-style-type: none"> Primary function is to accommodate <i>unusual</i> circumstances where telephonic and documentation review are not sufficient to make an appropriate authorization decision. Individuals with Special Circumstances and other persons with special needs may be followed by a Utilization Care Manager until authorization and special monitoring is complete. Monitors services delivered to people where there are specific quality or utilization issues that require special LA oversight. Educates providers about services available to the individual, community alternatives and negotiates with providers to facilitate the individual's access to needed services when there are unusual barriers to access. May visit providers and individuals at service delivery sites or participate in treatment team meetings to collect information or to provide information about benefits and community alternatives etc. May conduct utilization review and grant authorizations decisions limited to continued stays for individuals who are 	No

TITLE/FUNCTION	<u>CREDENTIAL</u> REQUIRED TO PERFORM FUNCTION	DESCRIPTION OF DUTIES	POSITION REQUIRED
		<p>already receiving authorized services from the LMHA and when the request is complete, accurate, and clearly falls within the DSHS UM Guidelines. Authorizations that do not clearly meet guidelines must be granted by a Utilization Manager.</p> <ul style="list-style-type: none"> • Does not conduct prior authorizations for service packages or hospitalization. 	
Utilization Management Committee – (Required)	Per Contract, the UM Committee includes LMHA UM physicians, LMHA utilization and quality management staff, and fiscal/financial management staff. May also include mental health professionals, information management, and other LMHA staff as indicated.	<p>The Utilization Management Committee must meet at least quarterly to ensure effective management of clinical resources, fiscal resources, and the efficiency and ongoing improvement of utilization management processes. The committee must review:</p> <ul style="list-style-type: none"> • appropriateness of eligibility determinations; • use of exceptions and overrides to service authorization ensuring rationale is clinically appropriate and documented in the administrative and clinical record; • over- and under-utilization; • appeals and denials; • fairness and equity; and • cost-effectiveness of all services provided 	Yes

PROFESSIONAL CONDUCT FOR UM STAFF

Purpose:

Utilization Management functions shall be conducted in a manner which upholds ethical principles, prevents conflict of interest, supports collaborative relationships between the LMHA and providers, and demonstrates professional behavior.

Procedure:

The LA shall develop and implement policies and procedures to ensure ethical behavior and to maintain appropriate and professional relationships with providers including the following:

Ethics/Conflict of Interest:

- Addition or reduction of any form of compensation or condition of employment or contract agreement shall not be contingent on the volume of services delivered by providers or the number of authorizations or adverse determinations made by the UM staff.
- There shall not be any personal or professional financial relationship between UM staff and providers subject to UM service authorization and denial processes.

Appropriate and Professional Relationships should ensure that:

- UM staff notify providers at least one business day in advance of an on-site contact, and schedule the visit during the provider's routine office hours at a mutually agreeable time.
- UM staff present photo identification and shall wear name tags indicating their position and agency when making on-site visits to providers.
- UM staff communicate with the contact person designated by the provider, to request documentation and to schedule reviews. UM staff will present themselves to the contact person upon arrival, will review the documentation in the area designated by the provider, will not move documentation to another area without informing the designated contact person, and will not disrupt the office operations or service provision while on site.
- UM staff only request documentation necessary for making the UM determination, and shall reimburse the provider a reasonable charge as defined in their contract for transmitting and/or reproducing copies of documentation. The reasonable charges will not exceed copying costs set by the TX Workers' Compensation Commission.
- Documentation containing client-identifying information is managed, protected, and maintained according to the same rules, policies, and procedures for [confidentiality](#) and medical record storage and security that are applied to all LA documentation, including consistent application of HIPAA requirements.
- Medical record or other documentation that is already available within the LA outside the UM department will not be requested again from the provider.
- UM staff shall not request to observe, participate, or otherwise be present during service provision unless agreed upon by the individual and provider and shall not request the provision of psychotherapy process notes (*notes maintained by the provider outside of the medical record*) via any mode of transmission.
- UM staff will make a timely [referral](#) to the appropriate LMHA department when they become aware of complaints by a provider, individual, or family, or observe [quality](#) issues.

SECTION 6. UTILIZATION MANAGEMENT DATA AND INFORMATION

LMHA UTILIZATION MANAGEMENT REPORTS

Utilization information from various data sources (e.g. CAM, encounter data, CARE, etc.) is available to LMHAs via MBOW and other programs. MBOW reports are created in an evolving and ongoing process, and variations of the following data configurations will be available as they are created. LMHAs will also have the capability to create some customized reports in MBOW. Data-based information illustrates numerous aspects of service utilization, and can be shared across LMHA functional areas for management decisions.

UM REPORT DESCRIPTIONS

For a detailed list and description of all current reports available, follow this link to [MBOW](#). Log in, go to CA Utilization Mgmt. Pick the category of your choice and toggle between “View List” and “View Details” to see the titles of, or a detailed description of all current reports available for that category.

SECTION 7. LMHA UM PROGRAM EVALUATION AND IMPROVEMENT

UM PERFORMANCE MEASURES

As with any LMHA functions, the UM program is evaluated on a regular basis (e.g., annually) to determine its [effectiveness](#) in facilitating access, managing care, improving outcomes, and providing useful data for resource allocation, [quality improvement](#), and other management decisions. Examples of [indicators](#) that may be used to measure how well specified UM processes are accomplished include the following:

- Turnaround time for routine authorization requests
- **90% turned around within 2 business days of receipt of complete request**

- Turnaround time for urgent authorization requests
- **95% within 1 business day of receipt of complete request**

- Inpatient admissions reviewed frequently in first 2 weeks
- **90% of admissions reviewed every 4 days for the first 2 weeks**

- Inpatient admissions reviewed weekly after 2nd week
- **90% of admissions with LOS over 2 weeks reviewed weekly**

- Resolution of client and provider appeals
- **90% resolved within 45 days**

- Number of UM [complaints](#) per 1,000 clients
- **< 14 per 1,000 clients**

- Number of UM appeals per 1,000 clients
- **< 15 per 1,000 clients**

- Percent of appeal decisions over turned
- **equal to or less than 15% of all appeals**

INTER-RATER RELIABILITY

Consistent application of valid and reliable criteria across all service settings is an important aspect of the UR process. Scheduled checks of inter-rater reliability assess how consistently and timely all UM staff apply criteria across all levels of care subject to UR decisions. This section applies to LMHAs that have more than one UM staff making determinations on Utilization Management reviews, and more than one physician making decisions about denials of inpatient care and appeals of adverse determinations.

Only a Board certified or eligible psychiatrist can make the determination to deny authorization of inpatient care. It is recommended that consistent application of criteria be monitored in the following manner:

- On an annual basis, a random sample of a minimum of five (5) cases of denials made by each physician are selected by the Utilization Manager or designee for review by another physician not involved in the case. The Utilization Manager or designee will also select a random sample of a minimum of ten (10) cases reviewed by each UM staff, representing the array of [service packages](#) reviewed. This will include staff making [eligibility](#) determinations at the entry to the LMHA service system.
- All physicians reviewing appeals of adverse determinations or making denial decisions will have a sample of their decisions audited by another physician, but physicians will not audit their own cases. Audits for inter-rater reliability will be assigned equitably to all participating physicians, depending on caseloads and other duties.
- UM staff will be assigned to audit at least 10 cases initially reviewed by their UM peers. One common case will be assigned to all reviewers. UM staff will not audit their own cases, and distribution of cases will ensure the widest cross-validation among UM staff.
- For each case selected for inter-rater reliability testing, the auditing physician or UM staff will review the same documentation available to the physician or UM staff who made the initial denial or authorization decision, applying clinical criteria and guidelines established by the LMHA.
- The Utilization Manager or designee will calculate scores for presentation to the UM Committee and UM Medical Director.
- A benchmark of 80% inter-rater reliability is set.
- Scores falling below 80% will be required to participate in biannual tests until his/her score achieves 80% or higher.
- Physicians' scores falling below 80% inter-rater reliability during an annual or biannual test will be addressed by the LMHA's Medical Director, and these scores for UM staff will be addressed by the Utilization Manager or designee.
- The LMHA UM Medical Director or Utilization Manager or designee will maintain all scores, corrective action plans, and resolution, and will report this information annually to the Utilization Management Committee and Director of QM.
- The Utilization Manager or Director, if available, will maintain all individual and group scores, corrective action plans, and resolution. The UM Committee will review this information also.
- The Utilization Manager or Director, if available, will include a Summary of Actions and Improvements for inter-rater reliability testing of all UM staff, including physicians, in the annual evaluation of the UM program.

UM PROGRAM SELF-ASSESSMENT

The UM program is assessed annually to evaluate adherence to the written UM Program Plan. The following is a sample program assessment instrument:

Staff Conducting Review: _____

Date of Review: _____

Program Element	Element Present		Document/ Section	To Be Revised		Date of Revision
	Yes	No		Yes	No	
UM Program Plan						
The UM Program Plan describes the UM program.						
The UM Program Plan is reviewed, evaluated and updated annually.						
All providers are knowledgeable of relevant aspects of the UM Program Plan.						
UM Functions/Personnel						
A Physician provides oversight of the UM program. (Required)						
A qualified Utilization Manager conducts UM, UR, and authorizations for services as per the DSHS UM Guidelines, and provides oversight for other delegated UR functions as indicated. (Required)						
Inter-rater reliability is monitored for all UM staff and physicians, with a benchmark set no lower than 80%.						
UM Committee						
Analyzes utilization patterns and trends to include gaps in services, rates of no show for appointments/services, billing issues, under- and over-utilization of existing services, underdeveloped or frequently requested services, clinical outcomes, and barriers to access.						
Reports information on service utilization to LMHA Board, management staff, providers and other interested parties						
The composition of the committee demonstrates the required membership as defined in the Performance Contract.						
Each member of the UM Committee has received training and materials necessary to fulfill the responsibilities of the committee.						
The UM Committee meets quarterly or more frequently.						
Utilization Review						
Eligibility Determination - prospective screening is conducted by an LPHA to determine eligibility for admission to services and initial Service Package assignment using DSHS criteria.						

Program Element	Element Present		Document/Section	To Be Revised		Date of Revision
	Yes	No		Yes	No	
Service Package Assignment - retrospective oversight of initial and subsequent level of care assignments is conducted to ensure consistent application of DSHS UM Guidelines.						
Authorization for Continued Stay - concurrent reviews are conducted to establish need for continued services or review of automatic authorizations .						
Outlier Review - retrospective and concurrent review of data is conducted to identify outliers followed by review of individual cases to determine need for change in level of care assignment or service intensity.						
Inpatient Admission and Discharge Planning – prospective or concurrent review of inpatient admissions is conducted to ensure most clinically effective and efficient length of stay. Review of discharge plans to ensure timely and appropriate treatment following an inpatient stay.						
Administrative Review-review of clinical and administrative documentation for timeliness and adequacy of UM processes to include reimbursement, corporate and contract compliance, data verification and rehabilitation plan oversight.						
UM Procedures						
The LMHA 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.						
For potential inpatient denials, psychiatric consultation is available twenty-four hours a day through the crisis response system.						
Prospective Review						
<ul style="list-style-type: none"> UM makes a review decision within two business days of the initiation of the Utilization Management process 						
<ul style="list-style-type: none"> Notification to provider of determination by telephone within one business day of making the determination. 						
<ul style="list-style-type: none"> Written or electronic confirmation to provider of decision within three business days. 						
Concurrent Review						
<ul style="list-style-type: none"> UM issues a decision within one business day of the initiation of the UM process 						
<ul style="list-style-type: none"> Notification to provider of determination by telephone within one business day. 						
<ul style="list-style-type: none"> Written or electronic confirmation to provider of decision within one business day of the telephone notification. 						
Retrospective Review						
<ul style="list-style-type: none"> Determination made within 30 business days. 						
<ul style="list-style-type: none"> Notification to provider of denial determinations in writing within five business days of making the determination. 						

Program Element	Element Present		Document/Section	To Be Revised		Date of Revision
	Yes	No		Yes	No	
Authorization for continued hospitalization or services include:						
• The number of extended days or units of service;						
• The next anticipated review point;						
• The new total number of days or services approved; and						
• The date of admission or onset of services						
Adverse Determination						
Denial of services based on an administrative determination are made by the Utilization Manager/Director or the UM physician.						
A proposal to refer the person to his/her third party coverage in accordance with Title 25, TAC Chapter 412, Subchapter C relating to Charges for Community Services) is made by the Utilization Manager/Director or the UM Physician.						
A denial of services based on a clinical determination is made by the Utilization Manager or the UM Physician.						
A proposal to reduce or terminate services based on a clinical determination that non-payment is not related to the person's mental illness and that the proposed action would not cause the person's mental or physical health to be at imminent risk or serious deterioration may be made by the person's team, however, the final determination is made by the Utilization Manager or the UM Physician.						
At the time of the adverse determination decision, the UM staff assigned to the case will verbally notify the appellant and person receiving or requesting services, if different, and his/her provider.						
Within three business days of the adverse determination decision, a Denial of Authorization letter is mailed to the appellant and person receiving or requesting services, if different, and his/her provider						
Appeals of Adverse Determination Decisions						
Routine Review Process:						
• The person receiving or requesting services, his/her LAR, his/her provider or someone else acting on the person's behalf has 30 calendar days after receipt of written notification of an adverse determination to request an initial appeal.						
Requests to appeal an adverse determination decision are routed to the LMHA Utilization Management Department.						
If a person requesting or receiving services requests assistance in completing a written appeal, the LMHA will provide such assistance.						
Review of the appeal shall be complete within twenty business days of receipt of notification to appeal unless the CEO of the LMHA grants an extension of the timeframe.						

Program Element	Element Present		Document/Section	To Be Revised		Date of Revision
	Yes	No		Yes	No	
<p>The expedited initial/second appeal procedure</p> <ul style="list-style-type: none"> • Process is completed based on the immediacy of the condition and no later than one calendar day from the date that all necessary information is received by the LMHA. • Within one business day of the decision, the Utilization Management staff assigned to the case shall verbally, in person or telephone, as well as certified mail, notify the appellant and person requesting or receiving services, if different, and his/her provider of the decision. 						
An appeals log categorized by cause and disposition including length of time for resolution of each appeal is maintained by the UM Department and shared with Quality Management and other appropriate management staff.						
Right to Make a Complaint/ Appeal an Adverse Determination Decision						
At intake, the LMHA will review the Client Rights Handbook with the person receiving services and/or Legally Authorized Representative (LAR) who sign a statement indicating receipt of this information.						
Information about the right of persons requesting or receiving services to express concerns or dissatisfaction or appeal an adverse determination decision will be posted at all service sites and included in the Client Rights Handbook. The handbook contains information about how to make a complaint to the DSHS Client Services and Rights Protection Division (1-800-252-8154).						
Provider Manual						
Prior to referring anyone to a provider, the LMHA ensures that the provider has a Provider Manual and has been trained on requirements for participation in the LMHA's provider network .						
Provider utilization profiles are used to describe and assist evaluation of a provider's practice performance.						
Miscellaneous						
The LMHA implements and monitors UM program improvement strategies as appropriate.						
Identifying information gathered for the purpose of UM/UR is kept confidential.						
If the LMHA delegates the utilization management function to an ASO or other LMHA, sufficient controls are in place to ensure that all DSHS and LMHA contractual and regulatory requirements are met.						

SECTION 8. LMHA PROVIDER OVERSIGHT

PROVIDER PROFILING

F. Oversight of Authority and Provider Functions

Contractor shall:

1. Objectively monitor and evaluate service delivery and provider performance including providing oversight information to the Contractor's Board.

One means of assessing utilization is 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." Proper utilization of mental health resources is also an important aspect of [quality assessment](#).

Use of Provider Utilization Profiles:

The primary objective of profiling should be to encourage high-quality service delivery, which includes appropriate utilization of resources and results in improved client satisfaction and outcome. Although some measures used for provider profiling may lack precision, profiling has educational validity for the LMHA and providers. Depending on the degree of reliability of measures, provider utilization profiles may also be used for calculating payment and making contract decisions. The profiling report must consider factors that influence utilization rates and outcomes in order to enable providers to educate themselves and allow an LMHA a fair basis for payment or termination decisions.

Providers who advocate for necessary and appropriate mental health care and services for individuals must be protected from retaliation by LMHAs. An LMHA must not terminate, demote, or refuse to compensate a provider because the provider advocates in good faith for an individual, seeks reconsideration of a decision denying a service, or reports a violation of law to an appropriate authority.

The following should be considered in using provider profiles for various purposes:

- **Provider education.** A provider may be cost-effective in one aspect of his/her practice and not in another. Data on a provider should be classified by the LMHA in order to evaluate and educate a provider, in terms of services provided, referral practices, etc. Profiles should inform the provider about cost effective management of client sub-populations. Data can illustrate a provider's cost effectiveness in managing specific types of clients.
- **Basis for compensation.** An LMHA may elect to provide higher reimbursement to those providers who care for more acute or more complex individuals or achieve service productivity levels.
- **Retention of providers.** A contract termination decision should never be based exclusively on a provider's profile unless:
 - the problem is ongoing;
 - the provider has been informed of the problem and given sufficient time to correct the behavior;
 - with respect to termination for [over-utilization](#), the provider's client population has been carefully considered and appropriately risk adjusted (evaluation of case mix).
- **Credentialing and recredentialing.** Provider profiles may be considered but should not be determining factors in credentialing decisions.

- **Improving practice patterns & the profiling process:** [Quality management](#) processes may be used to identify best practices, ineffective practices, productivity, or to develop a better profile instrument.

Provider Data Which May Be Used For Profiling:

Certain aspects of providers' practices can be profiled reliably, but others cannot. Provider attributes for which validated objective measures are nonexistent, should not be profiled or used.

Attributes that can be objectively quantified and reliably measured may include:

- length of stay (LOS);
- readmission or [recidivism](#) rates to identified services
- number of requests for special or support services;
- prescription charges;
- # days inpatient;
- # days outpatient;
- use of crisis services & emergency room visits;
- appropriate use of TIMA scales and
- individual achievement of clinical outcomes
- # of adverse determinations
- # of appeals
- data accuracy

Sources of Data:

LMHAs should ensure their data sources are accurate, and have an awareness of the limitations of certain data sources as follows:

- Claim Forms may be insufficient to determine performance results because they do not capture clinical characteristics about individuals; outcome of the care provided or detailed information on the severity of the individual's condition.
- Coding may hamper data accuracy and reliability related to unclear definitions of diagnosis, condition or treatment or inaccurate coding.
- Medical Records may be incomplete or imprecise. Providers may err in their documentation not directly related to reimbursement.

Potential Profile Focus:

- **Provider** – Tracking fidelity to treatment models, outcomes and costs by diagnosis and treatment
- **Hospital or facility-** Track recidivism rate, length and duration of services provide comparisons to hospitals with similar demographics, track short and long-term outcomes and charges.
- **Client** - Comparisons of normative data prior to and post treatment. Measure medical interventions for cost and outcomes.

Methods of Profiling:

A profile that is constructed to answer specific questions and uses appropriate statistical methods may differentiate providers with a degree of reliability. Before providers are profiled, however, the LMHA should involve them in selection of measures and to identify complicating factors such as case mix.

The provider utilization profile must be designed to answer a concise question and be clearly interpretable. Data sources for utilization profiles range from claims databases maintained by the LMHA to individual client records kept in providers' offices and at service sites.

A profile should be based on a scientifically drawn sample of eligible subjects or on a complete census. LMHAs should not formulate a profile until enough data are acquired to render the profile statistically useful. To attain statistical validity, adequate amounts of data need to be collected over a sufficient time period or data may need to be pooled with other sources.

Cautions in Use of Utilization Data:

Comparing utilization review patterns to detect deviations above and below the norm are frequently conducted. Penalizing a provider for exceeding utilization rates may be inappropriate unless rates are risk adjusted for the client population. Comparison of utilization patterns should only be between providers of the same services with control for as many variables as possible.

PROVIDER MANUAL CORE ELEMENTS

To inform all providers of the requirements for participation in the LMHA's [provider network](#), it is recommended that the LMHA should develop a manual for providers and deliver a provider manual to each provider prior to referring any individuals to that provider. In addition, the LMHA should afford each provider an opportunity to obtain training on the contents of the manual, and should designate a contact person to assist providers in complying with the requirements for participation. The manual should include but not be limited to the elements below.

Recommended Provider Manual Core Elements:

1) Protection of Client Rights

- Annual review of Client Rights Handbook
- Notification of right to make a complaint/ appeal an adverse determination decision
- Obligation to Assist Access to Appeals Process

2) [Confidentiality](#) of Information

- Applicable rules and Laws
- Procedures for Release of information

3) [Utilization Management](#)

- LMHA [Eligibility](#) Determination and [Level of Care](#) Assignments
- LMHA Process for [Referrals](#) to Providers
- Provider Assessment & Initial Treatment Planning
- Administrative and Clinical Documentation
- Outpatient Treatment Reports (OTR)
- Authorization Processes & Utilization Review
- Documentation of No Shows & Cancellations

4) [Quality Management](#)

- LMHA Quality Management Program
- Provider Participation in [Quality Improvement](#) Projects and Teams
- Evaluating and Improving Program Fidelity
- [Peer Review](#)

5) Claims

- Claim Submission Requirements (e.g. "clean claims")
- Claims Appeals Process
- Sample Forms/Instructions

6) [Credentialing](#)

- Overview of process

- Application
- Timeframes
- Notification
- Appeal of Decisions

7) Network/Contract Management

- Provider Procurement
- Communication with Providers
- Technical Assistance and Training
- Contracts
- Penalties and Sanctions

8) Rules & Standards Applicable to Provider

SECTION 9. UTILIZATION MANAGEMENT RESOURCES

SAMPLE PROVIDER PROFILE

Provider Name <i>(Group or Individual)</i>	Provider 1	Provider 2	Provider 3
Provider Type			
Case Mix Measure			
Average time in service			
# Served			
# New admissions			
# Discharges			
# Planned discharges			
# of Encounters			
Average time per encounter			
# individuals receiving crisis services			
# of ER visits			
# of hospitalizations			
Average days hospitalization			
# of incarcerations			
Adequate UM Documentation			
# requests for clinical override			
# of appeals requested			
# of claims submitted			
# of claims returned			
# of claims paid			
Most frequently prescribed medication/s (Physicians)			
Average medication cost (Physicians)			
TIMA Compliance Measure (Physicians)			

SAMPLE NOTIFICATION LETTERS

Denial of Authorization Based on Administrative Determination

Request Date _____

Decision Date _____

Name of Person 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:

LMHA Client Rights Coordinator:
(insert phone number and address)

**Texas Department of State Health Services
Office of Client Services and Rights Protection:**
P.O. Box 12668
Austin, Texas 78711-2668
1-800-252-8154

Advocacy, Inc.
7800 Shoal Creek BLVD., Suite 171-E
Austin, Texas 78757
1-800-252-9108 (voice and TDD)

If there is any part of this notice that you do not understand or if you need further assistance, please contact (insert LMHA designated UM staff name and title, LMHA address and contact information.)

Utilization Manager and/or UM Physician

Date

Denial of Authorization Based on Clinical Determination

Request Date _____

Decision Date _____

Name of Person 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 of (insert name of the LMHA) by telephone, in person, or by mail within 30 days of receipt of this notice.** Afterwards, you will receive a letter from (insert name of the LMHA) 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 person/s who will be deciding the appeal. Within 20 business days of your request to appeal, (insert name of the LMHA) will notify you in person or 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

LMHA Name
Utilization Management Department
Name and Title of Utilization Management Staff
LMHA Address
LMHA fax and phone number

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)

Utilization Manager and/or UM Physician

Date

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Appeal Procedure for Community Mental Health 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:

- a decision that you are not eligible for services
- a decision to reduce your services and supports
- a decision to deny a service or support that is not clinically indicated
- a decision to terminate your services and supports

How to Begin

- Call _____ 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 the LMHA 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 two business days after the date that all necessary information is received by the LMHA, 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 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 the DSHS Office of Client Services and Rights Protection at 1-800-252-8154.

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 ().

Report any problems or complaints with the appeal process to:

**Texas Department of State Health Services
Office of Client Services and Rights Protection
P.O. Box 12668, Austin, Texas 78711-2668
1-800-252-8154 (toll free)**

Appeal Acknowledgement

Request Date _____

Date of Notification _____

Name of Person Requesting/Receiving Services		Record #
Name of Person Requesting Appeal		
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 person/s who will be deciding the appeal.
- You may also provide additional information (in writing, in person, by telephone, or through your representative) for the person/s who will be deciding the appeal as long as it is received by (insert name of the LMHA) within 10 business days of the date of this notification.
- Within 20 business days of your request to appeal, (insert name of the LMHA) 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

LMHA Name
Utilization Management Department
Name and Title of Utilization Management Staff
LMHA Address
LMHA fax and phone number

Utilization Manager and/or UM Physician _____

Date _____

**NAME OF LMHA
Appeal Resolution**

Request Date _____

Decision Date _____

Name of Person Requesting/Receiving Services		Record #
Name of Person Requesting Appeal		
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 DSHS Office of Client 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

**LMHA Name
Utilization Management Department
Name and Title of Utilization Management Staff
LMHA Address
LMHA fax and phone number**

**If you would like to make a complaint, you may contact one or more of the following:
LMHA Client Rights Coordinator
(insert phone number and address)**

**Texas Department of State Health Services
Office of Client Services and Rights Protection
P.O. Box 12668
Austin, Texas, 78711-2668
1-800-252-8154**

**Advocacy, Inc.
7800 Shoal Creek BLVD., Suite 171-E
Austin, Texas 78757
1-800-252-9108 (voice and TDD)**

Utilization Manager and/or UM Physician

Date

NAME OF LMHA
Expedited Appeal Resolution – Second Review

Request Date _____

Decision Date _____

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

Decision	
Clinical Basis for the Decision	
Specialization of Consulted Providers	

Please be informed that the second review of the decision to deny authorization has been upheld-there is no further mechanism for appeal. If there is any part of this notice that you do not understand, or if you need further assistance, please contact

LMHA Name
Utilization Management Department
Name and Title of Utilization Management Staff
LMHA Address
LMHA fax and phone number

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

LMHA Client Rights Coordinator
 (insert phone number and address)

Texas Department of State Health Services (DSHS)
Office of Client Services and Rights Protection
P.O. Box 12668
Austin, Texas, 78711-2668
1-800-252-8154

Advocacy, Inc.
7800 Shoal Creek BLVD., Suite 171-E
Austin, Texas 78757
1-800-252-9108 (voice and TDD)

Utilization Manager and/or UM Physician _____

Date _____

Modification or Reversal of Appeal Resolution

Request Date _____

Decision Date _____

Name of Person Requesting or Receiving Services		Record #
Name of Person Requesting Appeal		
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. (Insert appropriate name) will contact you within _____ business days to discuss the plan to initiate or re-engage the requested services.

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

LMHA Name
Name and Title of Utilization Management Staff
LMHA Address
LMHA fax and phone number

If you would like to make a complaint, you may contact one or more of the following:
LMHA Client Rights Coordinator
 (insert phone number and address)

Texas Department of State Health Services (DSHS)
Office of Client Services and Rights Protection
 P.O. Box 12668
 Austin, Texas, 78711-2668
 1-800-252-8154

Advocacy, Inc.
 7800 Shoal Creek BLVD., Suite 171-E
 Austin, Texas 78757
 1-800-252-9108 (voice and TDD)

Utilization Manager and/or UM Physician

Date

SECTION 10. UTILIZATION MANAGEMENT GLOSSARY

ADVERSE DETERMINATION – Any decision by the LMHA or its review agent to:

- Deny eligibility for services.
- Deny a request for a specific service, procedure, support or extension of stay to an individual whose eligibility has been approved.
- Terminate or reduce an individual's services, procedures or extension of stay.

APPEAL – A formal process used by a provider of service and/or an individual to request review of a plan decision or utilization determination with which they disagree. This includes determinations in which individuals:

- Are found ineligible for services during the eligibility determination process;
- Have been terminated from services and/or supports;
- Have had an involuntary reduction in their level of service and/or support; or
- Have been denied access to a service and/or support they believe they need to receive.

APPEAL REPRESENTATIVE – Any person, including a provider, actively involved adult relative, friend or advocate who represents the individual with an appeal or complaint resolution process at the individual's request and with their consent.

APPELLANT – An individual or appeal representative who is requesting an appeal of an adverse determination.

ASO (ADMINISTRATIVE SERVICES ORGANIZATION) - an entity, public or private, capable of meeting SA performance standards and [efficiency](#) measures.

AUTOMATIC AUTHORIZATION - A process that allows an authorization to be given without UM staff review. Automatic Authorization is a formal process that is based on a written agreement between the LMHA and its providers, that allows automatic authorization only when the recommended LOC is the same as the LOC to be authorized and the providers have been determined through oversight to document [competence](#) in assessment using the UA-TRAG.

CHOICE – The opportunity for an individual to select providers based upon the availability of multiple providers qualified to provide the needed services and sufficient information to make an informed decision.

CLIENT – See **INDIVIDUAL**

COMPETENCY – The provider's ability to perform services in accordance with stated requirements and professional standards of care and practice.

COMPLAINT – Any dissatisfaction expressed orally or in writing to the LMHA regarding any aspect of the LMHA's operation, including but not limited to, dissatisfaction with benefit administration, unsatisfactory behavior/treatment by a provider, unsatisfactory behavior/treatment by representatives of the LMHA, the environmental conditions of treatment/service sites and concerns about the [quality](#) of services provided. The term does not include:

- a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the individual, or

- a provider's or individual's oral or written expression of dissatisfaction or disagreement with an adverse determination.

CONCURRENT REVIEW – See Utilization Review.

CONFIDENTIALITY – Restricting access to data and information only to those individuals who have need, a reason, and permission for access. A patient has the right, within the law, to personal and informational privacy, including his/her medical record.

CONTINUED STAY REVIEW – A review conducted by an external or internal auditor to determine if the current place of service remains the most appropriate to provide the level of care (LOC) required by the individual.

CREDENTIALS – documented evidence of licensure, education, training, experience, or other qualifications.

CRISIS – The sudden onset or exacerbation of a mental illness or condition in a person, manifested by acute symptoms of sufficient severity such that the absence of immediate medical or clinical attention could reasonably be expected to result in seriously jeopardizing or endangering the mental health or physical well-being of the person or seriously jeopardizing or endangering the mental health or physical well-being of a third party. Crisis services include both Emergent services and Urgent services.

DELEGATION – A formal process by which an organization gives a contractor the authority to perform certain functions on its behalf, such as credentialing, Utilization Management, and quality improvement. Although an organization may delegate the authority to perform a function, it cannot delegate the responsibility for assuring that the function is performed appropriately. That responsibility remains with the organization.

DISCHARGE PLANNING – The process of developing a care regimen for an individual leaving clinical care, including appropriate timing and follow-up examinations and treatment.

DISEASE MANAGEMENT – See Resiliency and Disease Management.

EFFECTIVENESS – The degree to which the desired or projected outcome is achieved for the individual.

EFFICIENCY – The relationship between outcomes (results of care) and the resources used to deliver care.

ELIGIBILITY – The determination that an individual meets the requirements to receive health care benefits as defined by the payer.

EXCEPTION – The authorization of additional amounts of services based on [medical necessity](#) when the individual has reached the maximum service units of their currently authorized level of care (LOC).

EXPEDITED APPEAL – An appeal of an adverse determination (denial) for inpatient services or continued stay for hospitalization. Because of the immediacy of the condition, the time frames for appeal and resolution are shorter than the standard appeal process.

EXTENDED REVIEW – The Extended Review is an extension of the time frame of reassessment of the TRAG from 90 to 180 days. The Extended Review Period Requested field on the UA/TRAG form may be completed if the individual:

- is receiving an Update assessment
- is highly stable and in ongoing services
- is not scheduled to see a prescribing professional during the first 90 days but still within 180 days
- whose last TRAG (for adults) scored LOC-R 1 = LOC-A 1 and has a current LOC-R 1 = LOC-A 1, or
- whose last TRAG (for children or adolescents) scored LOC-R 4 = LOC-A 4.

FAIR HEARING – See [Medicaid Fair Hearing](#)

INDICATOR – A defined, measurable variable used to monitor the quality or appropriateness of an important aspect of patient care or service. Indicators can be activities, events, occurrences, or outcomes for which data can be collected to allow comparison with a threshold, a benchmark or prior performance. A measure used to determine, over time, an organization’s performance of functions, processes, and outcomes.

INDIVIDUAL – A person who has direct personal experience with mental health services as a person receiving those services. The term individual is not meant to be limited to those who have participated in the Texas Department of State Health Services system of services.

INTER-RATER RELIABILITY – The level of agreement between conclusions, observations, assessments, etc., drawn by different persons on the same data or information.

LOC (LEVEL OF CARE) – A designation given to DSHS’s standardized packages of mental health services, based on the Uniform Assessment and the Utilization Management Guidelines, which specify the type, amount, and duration of mental health community services to be provided to an individual.

LOCAL MENTAL HEALTH AUTHORITY (LMHA) – A publicly accountable entity to which the Texas Department of State Health Services delegates its authority and responsibility for planning, policy development, coordination, resource development, and allocation of and oversight of mental health services within a specified local service area. The primary activity of the LMHA is the creation and management of a coordinated service system for people needing mental health services. This system, assembled using public input, must provide the LMHA, as purchaser of services for the [priority population](#), with the best value for the public dollar.

MBOW – (MR and Behavioral Health Outpatient Warehouse): – Formerly known as Data Warehouse-Business Objects:

<http://www2.hhsc.state.tx.us/applications/datawarehouse/>

MEDICAID ELIGIBLE – In Texas, this term is used to reference persons who, after going through a certification process, are found eligible to receive services and other assistance under the auspices of, and are officially enrolled in the Medicaid program. The term does not include persons who meet all eligibility criteria but are not enrolled in the program.

MEDICAID FAIR HEARING – A federally required process that ensures Medicaid-eligible individuals are not denied access to medically necessary services.

<http://www2.hhsc.state.tx.us/CentralOffice/BehavioralHealthServices/MedFairHear.html>

MEDICAL NECESSITY – a clinical determination by an LPHA that services are:

- reasonable and necessary for the treatment of a mental health or chemical dependency disorder or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
- in accordance with accepted standards of practice in behavioral health care;
- furnished in the most appropriate and least restrictive setting in which services can be safely provided;
- the most appropriate level or amount of service that can be safely provided; and
- could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.

This determination is required for Medicaid reimbursement.

OUTCOME – The result of actions on people, systems, and communities.

OUTLIER – An observation in a distribution that falls significantly outside the range of most of the data and skews statistics calculated upon the data in a particular direction.

OVERRIDE – An authorization that results in a higher or lower LOC than is recommended by the uniform assessment.

OVER-UTILIZATION – Provision of services that are not clearly indicated, or provision of services in excess of the amount or level usually considered sufficient.

PEER REVIEW – Evaluation of review of the performance of colleagues by professionals with similar types and degrees of expertise (e.g. the evaluation of one physician's practice by another physician).

PERSONS WITH SPECIAL CIRCUMSTANCES AND NEEDS – A person who in addition to their psychiatric needs:

- has a physical disability;
- has an acute health condition, life-threatening or terminal illness;
- has mental retardation or a developmental disability;
- is pregnant; and/or
- has other complicating factors.

PRIOR AUTHORIZATION – The process of obtaining coverage approval for a service or medication prior to that service or medication being rendered. Without such prior authorization, the service or medication is not covered or is reimbursed at a lower level.

PRIORITY POPULATION – Those groups of persons with mental illness and co-occurring substance disorders, identified in DSHS's current strategic plan, and operationally defined in the performance contract, as being most in need of Mental Health services.

PROSPECTIVE REVIEW – See Utilization Review.

PROVIDER – A practitioner, group practice, program or facility whose credentials, including, but not limited to, degree, licensure, certifications and specialists, have been reviewed and found acceptable by the LMHA to render services to persons with mental health issues residing in the LMHA's local service area.

PROVIDER NETWORK – A group of providers that will accept referrals from the LMHA for persons who need Mental Health services.

PROVIDER PROFILING – An essential mechanism by which LMHAs use aggregate data and information about providers in their networks. The collection of data associated with profiling allows the LMHA to assess performance of clinicians, programs and services. The intent of such a process is not to point out “bad” or “good” performers, but to identify areas for questioning or further study and to potentially facilitate processes by which the provider modifies their practice so that services are more efficient and effective. Profiling covers multiple areas of care delivery such as:

- [Competency](#) of providers to provide care.
- Accessibility to services.
- Safety of the environment in which services are provided.
- Continuity of care.
- Effectiveness and [efficiency](#) of treatment.
- Satisfaction of individuals and family members with services. Psychiatric clinical diagnostic interview performed by a qualified physician.

QUALIFIED MENTAL HEALTH PROFESSIONAL – Community Services (QMHP-CS) – A staff member who is credentialed to provide QMHP-CS services, who has demonstrated and documented [competency](#) in the work to be performed, and who
(a) has a bachelor’s degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the local Mental Health authority) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
(b) is a registered nurse.

QUALITY – A judgment related to the degree of excellence achieved through the provision of service. The most fundamental evaluation of quality is how well the individual achieves their desired outcomes from participating in the service.

QUALITY ASSESSMENT – Measurement and evaluation of the quality of care for individuals, groups or populations.

QUALITY IMPROVEMENT – A systematic approach to the continuous study and improvement of the processes within an organization providing health care services.

QUALITY MANAGEMENT (QM) – A program developed and implemented by the LMHA by which organizational performance and services are assessed and evaluated to ensure the existence of those structures and processes necessary for the achievement of client outcomes and continuous quality improvement.

RECIDIVISM – The frequency of the same individual returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.

RECOVERY – The ability to live well irrespective of an individual’s experience of a disorder. Development of new meaning and purpose as one grows beyond the catastrophic effects of mental illness.

REFERRAL – The sending of an individual:

- from one clinician to another clinician or specialist,
- from one setting or service to another setting or service; or

- by one physician (the referring physician) to another physician (or some other resource) either for consultation or care.

RESILIENCY AND DISEASE MANAGEMENT – Resiliency and Disease Management (RDM)

refers to the clinical principles underlying the redesign of the DSHS mental health services.

- Relating to child and adolescent services, *Resiliency* refers to the interaction between individual traits and environmental resources that allow children, adolescents and families to cope effectively with serious emotional disturbances and other complexities and to move forward with a sense of hope and competence. A resiliency - based mental health system is family - driven and community – based, and promotes strengths, skill-building, and competence.
- Relating to adult services, *Disease Management* employs evidence-based practices, self-empowerment strategies, and continuous evaluation of clinical, quality of life, and economic outcomes to prevent acute relapses and complications and improve overall health and functioning.

RETROSPECTIVE REVIEW – See Utilization Review.

SCREENING – Brief assessment to determine initial eligibility for and urgency of care/treatment to be provided. This can be by telephone or walk-in.

SERVICE PACKAGE (SP) – A standardized set of services that are available to an individual authorized to receive them. See LEVEL OF CARE.

TEXAS RECOMMENDED AUTHORIZATION GUIDELINES (TRAG) – A clinical assessment instrument designed to quantifiably assess dimensions of mental health needs and assist clinicians in making decisions about appropriate levels of care within the DSHS Resiliency and Disease Management service delivery model.

UNDER-UTILIZATION – Failure to provide appropriate and/or medically necessary services, or provision of a lower quantity or level of services than recommended or than is usually considered sufficient or needed.

UNIFORM ASSESSMENT (UA) – A required assessment that assists in determining the medical necessity of services and LOC. For adults, the UA includes the TRAG, TIMA scales, and Community Data. For children and adolescents, the UA includes the CA-TRAG and Community Data.

UTILIZATION – Extent to which individuals (or enrollees of a managed health care plan) use health care services. Utilization rates are established to help in comprehensive health planning, budget review, and cost containment. Utilization can be expressed in a variety of ways:

A. Patterns or rates of use of a single service or type of service, e.g. hospital care, physician visits, prescription drugs.

B. The extent to which individuals (or members of a covered group) use a program or obtain a particular service, or a category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for services.

UTILIZATION CARE MANAGEMENT – Activities whereby individuals with special circumstances are assisted to access needed services.

UTILIZATION MANAGEMENT – The planning, organizing, directing, and controlling of the healthcare product/service that balances cost-effectiveness, [efficiency](#), and quality to meet the overall goals of the LMHA. Use of systematic data-driven processes to influence client care and

decision making to ensure an optimal level of service is provided consistent with client diagnosis and level of functioning within the financial constraints of funding. Includes but is not limited to service authorization, prospective, concurrent and retrospective reviews, discharge planning, and Utilization Care Management.

UTILIZATION MANAGEMENT COMMITTEE – LMHA standing committee that consists of LMHA physicians, utilization and quality management staff, financial staff, and others as indicated. Meets at least quarterly to evaluate and monitor service utilization patterns and trends and clinical practices; provide information for agency resource planning and allocation decisions; and ensure ongoing improvement in the utilization management process. Committee functions also include ensuring that resources are channeled to the services that are needed by individuals and that a balance between crisis and routine services is achieved.

UTILIZATION MANAGEMENT GUIDELINES – Descriptions of evidence-based clinical practices that are configured into Service Packages which describe the type, amount and duration of services for each level of care and also provide admission, continued stay and discharge criteria for all services and levels of care for the mental health service system. They are functionally integrated into treatment processes.

<http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>

UTILIZATION MANAGEMENT PERSONNEL (LMHA) – Qualified staff member assigned by the LMHA to perform [authority](#) functions of utilization management, review, and oversight. Job descriptions define specific areas of responsibility, [competence](#), and supervision.

UTILIZATION MANAGEMENT PROGRAM PLAN – A written plan describing the LMHA's Utilization Management Program. The plan must include:

- A description of how the Utilization Management program's [effectiveness](#) in meeting goals will be evaluated;
- how improvements will be made on a regular basis; and
- the oversight and control mechanism to ensure that utilization management activities meet required standards when they are delegated to an administrative services organization or a DSHS-approved entity.

UTILIZATION REVIEW – A formal review of client utilization of health care services to assess [efficiency](#), and/or appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. Utilization review may be accomplished by a peer review group or a public agency. Utilization review (UR) is part of the utilization management process.

- **PROSPECTIVE REVIEW** – Pre-admission review for appropriateness of admission to service prior to receiving services.
- **CONCURRENT REVIEW** – A routine review by a utilization manager or utilization reviewer, during the course of a patient's treatment, to determine if continued treatment is medically necessary.
- **RETROSPECTIVE REVIEW** – 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.

WEBCARE – WebCARE is the front-end to the mainframe Client Assignment and Registration (CARE) system which registers and tracks individuals served by the Texas Health and Human Services System throughout the service delivery system.

OTHER USEFUL RDM/UTILIZATION MANAGEMENT LINKS:

RDM MISSION AND KEY COMPONENTS

<http://www.dshs.state.tx.us/mhprograms/RDM.shtm>

RDM PROGRAM MANUAL

http://www.hhsc.state.tx.us/CentralOffice/BehavioralHealthServices/RDM_Program_Manual_ver_1.pdf

CONTRACTS

(This page contains links to the most current versions of the DSHS MH Performance Contract, Attachments and Reports)

<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>

ASSESSMENTS (TRAG AND TIMA)

<http://www.dshs.state.tx.us/mhprograms/RDMAssess.shtm>

ADULT UA FORM.

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/adult%20ua-rdm.pdf>

RDM ADULT ASSESSMENT FORM COMPLETION AND SCHEDULE

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Adult%20Form%20Completion%20and%20Schedule.pdf>

CHILD & ADOLSCENT UA FORM

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Child%20CUA-RDM.pdf>

RDM CHILD & ADOLESCENT EVALUATION ASSESSMENT FORM COMPLETION AND SCHEDULE

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/forms/Child%20Form%20Completion%20and%20Schedule.pdf>

UM PROCESS/UM MANUAL

(This page provides the on-line link to this UM Manual.)

<http://www.dshs.state.tx.us/mhprograms/RDMUMProcess.shtm>

CLINICAL GUIDELINES/UTILIZATION MANAGEMENT GUIDELINES

(This page contains links to the most current versions of the Utilization Management Guidelines for Adults and for Children and Adolescents)

<http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>

WAITING LIST MANUAL

http://www.dshs.state.tx.us/mhcontracts/FY07Contract/Info_Item_R_%20RDM_Waiting_List_Maintenance_Manual.doc

MEDICAID FAIR HEARING PROCEDURES

http://www.dshs.state.tx.us/mhcontracts/FY07Contract/Info_Item_Q_Fair_Hearing_Procedures.doc

MEDICAID FAIR HEARING LETTERS AND FORMS

<http://www2.hhsc.state.tx.us/CentralOffice/BehavioralHealthServices/MedFairHear.html>

WEBCARE MANUAL

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/webcare/technicalmanual/WebCARE%20Manual.pdf>

BUSINESS RULES FOR WEBCARE

<http://www2.hhsc.state.tx.us/655/CIS/Training/files/webcare/technicalmanual/Appendix%201%20-%20Business%20Rules%20by%20Sections.xls>

TEXAS ADMINISTRATIVE CODE (TAC TITLE 25, PART 1)

[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=3&ti=25&pt=1](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=3&ti=25&pt=1)

TEXAS LAWS FOR MENTAL HEALTH

http://www.dshs.state.tx.us/mhrules/Texas_Laws.shtm