



ACCESS AND UTILIZATION
MANAGEMENT
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PBH UM/ACCESS Communication Bulletin

Communication Bulletin FY-1011 -UM-02

To: PBH Network Providers

From: David Jones, MA Director of Clinical Operations

Date: July 13th, 2010

RE: Submission of complete requests

To remain consistent with Division of Medical Assistance (DMA) guidelines the PBH Utilization Management (UM) Department is only able to make formal decisions (approval, denial, or extensions when appropriate) when a complete request is received. For a request to be considered “complete” it must contain the following elements:

- Recipient Name
- Medicaid ID
- Date of Birth
- Provider contact information and signatures
- Date of request
- Service(s) requested
- Service Order
- Completed Check boxes (Signature Page / Service Order Yes or No Check Boxes related to medical necessity, direct contact with the individual, and review of the individual’s Clinical Assessment)
- PCP/ISP (if applicable)

This is the criteria as outlined in NC DHHS Implementation Update # 66.

<http://www.dhhs.state.nc.us/mhddsas/servicedefinitions/servdefupdates/update66/dmadmh66memo.pdf>

Some of these elements will be contained in the corresponding Treatment Authorization Request (TAR). A TAR constitutes a service request and starts the timeline for review. A plan alone does not initiate a request for service, as it does not meet the criteria identified above since it does not indicate the service provider and requested services dates, as this information is submitted via the TAR. PBH still recommends specific provider names not are listed in plans, as this information would be identified on the TAR, in the event a transfer would ever need to occur.

If a TAR is received and requests a service or frequency that is different from the plan that the PBH UM department has this will be administratively denied as an incomplete request and provider notified.

If a TAR is received that requires a corresponding plan and none is submitted this will be administratively denied as an incomplete request and provider notified.

For Mental Health Child Residential consumers this will be a change in the current process. Plan updates can be submitted to request additional units of Community Support for securing residential treatment **with no specific**

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level of care identified. This allows the team flexibility to discuss and explore all potential treatment options and levels of care. In these cases Community Support can be requested for 30 days at a time, and frequency on the plan should be “per Month”. Children needing out of home treatment service are some of the most high risk consumers. By authorizing for 30 days at a time this allows UM to continue monitoring closely and providing technical assistance to providers and stakeholders to ensure the medically necessary treatment is secured as quickly as possible.

Once a child and family team has identified a specific residential level of treatment, a provider for this service, and a tentative start date a plan update and TAR should be submitted at that time. Providers should ensure that these plans contain all elements identified on the residential checklists in as much detail as possible to avoid return by UM for additional information.

As a reminder any request for MH Residential Level III services should be submitted with a comprehensive assessment completed within the last 30 days and a discharge plan on the state format. For any Psychiatric Residential Treatment Facility (PRTF) requests these should be submitted with a Psychological Evaluation **and all other corresponding documents (especially if team is requested prior approval / authorization for Out of State PRTF services).**

If a plan is received requesting additional community support units to secure placement and **does** list a specific level of care in the narrative, on the goals, etc. but a provider for the residential services has not been determined, a formal decision will be made only on the services requested on the accompanying TAR. The UM department may offer feedback or recommendations for the Child and Family Team’s consideration on the mentioned level of care but this does not imply that the service would be authorized. Formal decision on authorization will be made only when a complete request is received, reiterating that a “complete” request for service includes a PCP / Updated PCP + corresponding TAR submitted at same time.

Appeal rights would not be initiated until UM makes a formal decision on a complete service request after review of a TAR, plan/plan update, and any other corresponding documents.

Please contact PBH’s UM Department at 704-743-2100 for any questions or concerns.