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Broward Behavioral Health Coalition, Inc.	
Policy Title: Utilization Management of Clinical Services	
Policy Number: BBHC.0011	**Contract Section (s): JH343**
Effective Date: 5/16/13	**Revision Date**:07/14/23
Responsible Department: Operations/System of Care	
Approved by: Elida Segrera, Director of Operations Signature: DocuSigned by: Elida Segrera 172B164165AD41D...	Date: 07/14/2023
Approved by: Silvia Quintana, Chief Executive Officer Signature: DocuSigned by: Silvia Quintana 38C7D57E4C654C4...	Date: 07/14/2023

Policy: It is the policy of Broward Behavioral Health Coalition (BBHC) to develop and implement a Utilization Management (UM) Program for managing the delivery of the high-cost level care of care services.

Purpose: The purpose of the UM Program is to ensure that each consumer served by the BBHC system of care has equitable access to services, especially those levels of care and programs for which there may be a waiting list. The UM Program shall ensure that resources are utilized based on clinical need and medical necessity, in the least restrictive level of care that is clinically appropriate. It shall be a further goal that the UM Program shall serve to balance effective and efficient service delivery with cost effectiveness.

Procedure: The BBHC utilization management procedure includes the assessment of individuals for eligibility verification, referrals, and utilization management for Adult Mental Health (MH) and Substance Abuse (SA) Residential Services (Levels I, II, Forensic and Short-Term Residential (SRT), Care Coordination (CCT & CCT-CW), Florida Assertive Community Treatment (FACT), the Forensic Multi-Disciplinary Team(FMT), Community Action Team (CAT), Family Intensive Treatment team (FITT), Family Support Teams (FST), High Accuity Team (HAT) through a Services referral process.

I. Referral Process

A. Referral Source (case Manager or other) completes the appropriate Online Services Application which includes high level of care services for Levels I and II Residential Placement, Forensic RTF, SRT, Care Coordination (CCT & CCT-CW), FACT, FMT, FITT, HAT, FST and CAT programs; the LOCUS or CaLOCUS assessment, the Network Release of Protected Health Information, the Consent to Release and Exchange Information and Data Sharing Agreement form and other pertinent documents according to the program requirements (clinical evaluations, labs, medication lists, court orders, etc.).

B. Referrals are assessed and linked according to clinical need and level of care (LOC) criteria for the individual. Completed Packets are submitted to BBHC via Online Forms submission. BBHC has up to 72 hours (or 3 business days) to review documentation for medical and/or clinical necessity and to verify that level of care (LOC) criteria for services are met. Incomplete packets will not be reviewed and will be returned to the referral source for completion.

C. If it is determined that the person served meets LOC criteria for Adult or Youth Services, a screening approval is generated for an appropriate provider screening. This screening approval notice is emailed to the referral source and/or the Case Manager, and the screening provider contact person. Supervisor.

D. After the completion of the screening by the selected provider(s)the Online Screening Disposition Report will be submitted by the screening provider.

E. When a person served' s screening disposition is completed with a positive results, a bed or slot is immediately available and there is no person served listed on the BBHC Program Master Waiting List for the respective Level of Care Program and Population Type, the Case Manager, of the Referral Source will coordinate the admission, as applicable.

F. If the person served is authorized, but there is no bed or slot available for the Level of Care, and Program and Populations Type, the person served will be placed on the BBHC Master Waiting List until a bed/slot becomes available.

G. Case Managers are responsible for following up on the status of their person served at all times by monitoring the waiting list and should communicate with BBHC when concerned about their person served placement process.

H. Once a client is admitted to the program, a BBHC Program Admission Notice will be submitted within 24 hrs of admission. At this point and authorization will be provided to the admitting provider.

I. BBHC will schedule and participate in staffing's to discuss progress or lack of progress of the person served, to provide technical assistance as needed. Other treatment team members such as the program staff, court liaisons are encouraged to attend. Frequency of staffing's may vary according to

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the level of care type.

J. Programs Supervisors notify BBHC and the referral source and/or the Case Manager when person served are admitted or plan to discharge the program.

I. Case Managers are responsible for following up on the status of their person served at all times and should contact the SRT, Residential Program, FACT, FMT, CCT, CAT, FIT or the Forensic BBHC point person when they have not received timely response on their person served. Other responsibilities include:
   1. The preparation of comprehensive, timely and accurate reports for the court using the approved format,
   2. Coordinating transportation, screenings and admissions,
   3. Ensuring the provision of interim services when applicable,
   4. Maintaining communication with the person served and the program for admitted person served,
   5. Having a "Plan B"
   6. Ensuring long-term placement arrangements when applicable
   7. Obtaining Conditional Release Plans at the time that person served person served are screened and accepted on to wail list

II. Patient Rosters:

Patient rosters/census are submitted to BBHC based on the level of care placement. STR and Residential programs rosters are submitted daily. Care Coordination (CCT & CCT-CW), FACT, FMT, FIT and CAT are submitted on a weekly or monthly basis. Patient Rosters/census are used to confirm admissions and discharges, to verify accuracy of authorizations and to update the Daily Bed Census Report. Patient Rosters must include accurate information on funding sources and procedures. If Residential Programs do not submit the daily and updated Patient Roster, an email will be sent to the Program Director to address the issue.

III. Wait List Centralization

BBHC produces and maintains a Master Waiting List.

A. Provider Waiting Lists are submitted to BBHC based on the level of care placement. STR and Residential programs rosters are submitted daily. Care Coordination (CCT & CCT-CW), FACT, FMT, FIT. HAT, FST and CAT are submitted on a weekly or monthly basis.

B. BBHC will review all submission and maintain a Master Waiting List for each level of Care by provider and level of care.

C. When beds become available, person served on the Master Wait List have priority and are placed according to the date they were added to the List.

D. If by 3:00 PM each day, beds remain available, The Residential Programs are permitted to admit Homeless or walk-in person served who meet criteria for Residential Levels I and II. The service application must be received,

and if it meets LOC, admission will be retroactively authorized to admission date.

E. Person served who are clinically determined to require an expedited placement may be placed in a program ahead of person served on the Wait List.

1. For SA, this includes person served who are from a Department of Children and Families (DCF) Substance abuse and Mental Health (SAMH) Target Priority Population. These are:
   a. pregnant women
   b. IV Drug users
   c. Women with dependent children (including those involved in Child Welfare System)
   d. Other parents putting children at risk (including those involved in Child Welfare System)
   e. Consumers involved with the criminal justice system
   f. Dual diagnosed / Consumers with co-occurring disorders

2. For MH, Target Populations are individuals being served by the SAMH system who generally have a long-term involvement with that system, have multiple problems and needs, and require multiple services or resources to meet these needs.
   a. Persons at least 18 years old diagnosed with a severe and persistent mental illness, with or without co-occurring disorders, with one of the following characteristics are priority person served:
      i. Persons who are been discharged from a state treatment facility;
      ii. Persons who are forensic consumers (have an incompetent to proceed or a not guilty by reason of insanity court order);
      iii. Persons who are at risk of institutionalization or incarceration for mental health reasons;
      iv. Persons who have had three (3) or more admissions to a crisis stabilization unit (CSU), short-term residential facility (SRT), or inpatient psychiatric unit;
      v. Persons who are experiencing long-term or serious acute episodes of mental impairment that may put them at risk of requiring more intensive services.

IV. Eligibility and Utilization Review Process

A. Providers are responsible for checking eligibility and ensuring that DCF is the payer of last resort. Providers will be expected to invoice the appropriate payer as determine by the program guidelines.

B. Providers are provided prior authorization for the appropriate level of care. Authorizations have a start and an end date. Reimbursements will only be provided for service dates covered by the authorization.

C. Preliminary Treatment Plans must be completed at admission. An Individual Treatment Plan must be completed that includes objective and measurable treatment goals and discharge planning (Step down in level of care).

D. Both Treatment Plan reviews and recommendations for continued stay must show progress and clinical necessity. Clinical documentation must show clinical necessity for continued stay to be approved after the initial authorized period.

E. The primary goal of the provider/program will be to prepare the person served for a less intensive level of care by the end of the first authorization period.

F. Case staffings/reviews are scheduled based on the program. Case staffings/ reviews are scheduled based on the program. Providers should be prepared to discuss the primary clinical reasoning for requesting to extend the services at the same level of care, treatment and discharge plans and barriers, unmet goals and alternative treatment strategies to replace those that have not yielded sufficient results. Documentation required for reviews will include: The Individualized Treatment Plan, LOCUS/CA-LOCUS and the Discharge Planning form along with all revisions and updates. Provider may be required to submit additional medical record documentation as part of the concurrent review process.

G. Case Managers should participate in concurrent reviews.

H. If the person served continues to meet criteria for Adult or Youth Services high level of care, the authorization may be extended.

I. At any time, BBHC or the provider can request a Case staffings/ review or a peer to peer consultation.

J. The Provider must notify BBHC of all discharges and discharge plans will be reviewed during Case staffings/ reviews.

K. Discharge planning from any particular level of care is expected to begin at admission.

V. Authorizations and Invoicing

A. BBHC will send Providers will receive an Utilization Roster for each person served that includes dates of service, the corresponding authorization number and covered services no later than the 3rd day of each month.

B. Providers will have 48 hrs to review, make adjustments to this report and return to BBHC. If a report in not received by the allotted time, it will be assumed the report has not changes.

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C. This report with provider review and adjustments will be submitted to Carisk, no later than the 7th of every month

D. Provider payment basis will be this report. Any discrepancies related to days/units of services and/or covered services will need to be discussed with BBHC directly.

E. Carisk will process payment and may apply additional reduction base don data and/or invoice submitted, along with other items.

VI. UM Reports

UM Quarterly Reports – Based on Service Data Authorization
Data UM Reports – From Authorization Data
Wait List report (and per provider) –
Roster/Census
Weekly Forensic Status report - Weekly
Services billed versus monthly Authorizations

REFERENCES:

ATTACHMENTS:

DEFINITIONS:

REVISION/REVIEW LOG

REVISION/REVIEW	DATE
Revised	1/11/18
Revised-no changes	1/11/19
Revised -changes due to new UM management process implements (Carisk to BBHC)	7/1/20
Revised - minor changes regarding invoicing expectations	7/14/21
Revised-additional Multidisciplinary teams	7/14/23

The Director of Operations and Chief Executive Officer are responsible for all content in this policy.