

# Clinical Services

## Assessment and Triage

PBH provides 24-hour, seven-day-a-week telephonic assessment by experienced clinical services staff.

The objectives of the initial assessment are to:

- ◆ Identify symptoms
- ◆ Determine the severity of symptoms
- ◆ Determine appropriate level of care based on Medical Necessity
- ◆ Make timely referral to a PBH participating practitioner or facility

The PBH clinical assessment is designed to rapidly determine acuity. The assessment is modified as needed to meet the needs of specific populations, such as children and adolescents. Members are assessed by telephone, with additional information obtained from the Primary Care Physician (PCP), EAP, family and others as needed.

In most cases, a referral for treatment is given to the member during the initial telephone contact. Members presenting with extremely acute symptoms may receive further assessment by PBH's clinical services staff to determine whether referral for inpatient care should be considered.

## Eligibility Verification

PBH's fully automated clinical assessment system includes on-line verification of eligibility. This system includes the most up-to-date information available from the employer group at the time of referral. Provider questions about eligibility should be referred to the Provider Helpline at (800) 716-1166.

## How a Member Accesses the PBH Benefit

- 1) The member calls the toll-free 24-hour PacifiCare Behavioral Health number.
- 2) The PBH clinical services representative checks the member's eligibility, gathers basic demographic information and helps determine the type of services the member is seeking.
- 3) The PBH clinical services representative conducts an assessment. The member will be asked questions about:
  - ◆ The severity of the problem he/she is experiencing
  - ◆ How the problem may be affecting family/ home life, social activities, and work/school performance
  - ◆ Relevant prior history.
- 4) The PBH clinical services representative matches the member with an appropriate PBH contracted group practice or individual provider based on the member's needs. PBH makes every attempt to ensure that members are provided services in a culturally competent manner, including those members with limited English proficiency, diverse cultural backgrounds and physical and mental disabilities.
- 5) The member is then referred to the provider and instructed to call for an appointment. The provider is authorized for a specific number of visits over a specified period of time.

## The Referral Process

- 1) The PBH clinical services staff member calls the provider to inform him or her of the referral. The provider is given the following information about the member being referred:
  - 2) Name and authorization number
  - 3) The member's benefit structure
  - 4) Urgency of the referral or anything unique to the member's request for services
- 5) A written authorization is mailed to the provider

- 6) Under certain circumstances the nature of a problem may be such that the PBH clinical services staff requests that the member be seen on the same or next day. If not identified as an urgent or emergent case, the member must be seen within ten business days.
- 7) If the case is urgent or emergent, the provider is expected to call the PBH clinical staff person immediately following the first appointment with information about the proposed treatment strategy for the member.
- 8) If the member does not show up for the first urgent or emergent appointment, the provider should report this immediately to PBH staff. It is not necessary for the provider to return the authorization form to PBH for the patient in this situation.

On occasion, a PBH member may call a network provider directly prior to receiving an authorization for treatment. In such cases, the provider should instruct the patient to call our toll-free member number (available in the Quick Reference Guide in the Region Specific Information section of this manual) to request authorization and referral instructions directly from PBH.

On occasion, a PBH member may call a network provider immediately after their telephone assessment to schedule an appointment. In these situations the provider will not yet have received phone notification or written verification from PBH. The provider is encouraged to schedule the appointment and confirm the authorization by telephone by calling the Provider Helpline at (800) 716-1166.

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### ***Remember***

- ◆ *A member must call to initiate care*
  - ◆ *In the event a member is unable to complete the assessment due to emergency or grave disability, a facility representative, Primary Care Physician (PCP), Employee Assistance Program (EAP) counselor, family member or provider can call for a referral/authorization for that member.*
  - ◆ *All services except emergencies and urgently needed care must be pre-authorized. Services will not be reviewed retrospectively. Make sure the member has contacted PBH before you see them for an appointment.*
  - ◆ *The telephone assessment is intended to provide the member with quality care by making timely referrals to the appropriate provider and level of care.*
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## Emergency Services

PBH adheres to the following definitions related to emergency services:

- ◆ Emergency condition is a mental disorder or substance use disorder manifesting itself by acute symptoms of sufficient severity, including pain, such that the absence of immediate behavioral health services could reasonably be expected to result in any of the following:
  - Immediate harm to self or others
  - Serious and permanent dysfunction to the member
  - Serious impairment of the member's functioning
  - Placing the member's health in serious jeopardy
- ◆ Urgent and emergent services are also covered without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an urgent or emergency medical condition existed.
- ◆ Examples of an emergency include:
  - A PBH member who is in imminent danger of suicide, as evidenced by a clearly defined plan and history of suicide attempts requiring medical or psychiatric treatment
  - A PBH member who threatens to seriously injure a named or clearly designated person within a specified period of time
- ◆ Emergency treatment is the immediate and unscheduled behavioral health screening, examination and evaluation of a member by a physician to determine if an Emergency Condition exists and, if it does, the care and treatment necessary to relieve or eliminate the emergency condition.
- ◆ Emergency admission is medically necessary behavioral health services which are immediately required because the member is experiencing a severe level of symptoms according to a DSM-IV diagnosis and is impaired in his or her functioning to the extent that he or she presents an immediate danger of harm to self or others.

A member requiring emergency services usually comes to the attention of PBH in one of the following ways:

- ◆ The member contacts PBH, and in the course of the assessment the patient evidences need for emergency intensive services
- ◆ A facility contacts PBH and requests emergency services

- ◆ A PBH provider requests a step up to emergency services from a lower level of care (e.g. routine outpatient services)
- ◆ The member's PCP has identified symptoms or behaviors requiring an emergency assessment

## **Emergency Situations Requiring Hospitalization**

PBH should be notified of any admission or impending admission as soon as possible. PBH staff is available 24 hours a day at our member line to discuss authorization for inpatient admissions and to facilitate referral to a participating facility. (See Quick Reference Guide in the Region Specific Information section of this manual for the member access number). If it is impossible for a provider to obtain such authorization, an “emergency condition” must be reasonably suspected for PBH to consider reimbursement for that admission.

In some cases it may be impossible for the provider to contact PBH due to imminent concerns about the safety of the member. In such circumstances the provider should ensure the member's safety or admit the member into a hospital. However, PBH should be contacted as soon as possible or within 24 hours and provided with a clinical update as well as the facility's phone number and the name of the facility's representative. The provider should also be prepared to assist in arranging transportation for the member to a participating facility.

Emergency conditions, such as an overdose or lacerations that require emergency medical treatment or clearance, are the responsibility of the member's medical plan. A referral for medical care must be arranged. Once the member is medically stable, behavioral health problems can be addressed.

If it is determined that a member does not need the level of care provided by a hospital, or that an alternate facility would be more appropriate for his or her treatment, a PBH Care manager will recommend a referral to an alternate program or provider. The original admitting facility and attending professional will be reimbursed for the authorized emergency admission and medically necessary services rendered until such transfer of the member can be arranged.

If it is determined by PBH that the admission did not meet the definition of emergency as stated above, the facility and attending provider may not be reimbursed.

Claims for services provided to a PBH member that do not qualify as emergency services or urgently needed care and that have not been pre-authorized by PBH may be denied. Emergency services and urgently needed care for screening and stabilization, without Pre-Authorization, are covered for cases where a prudent

layperson, acting reasonably, would have believed that an urgent need or emergency existed.

## Concurrent Review

PBH conducts concurrent review by monitoring services during treatment to ensure that the member's needs are being met by the authorized visits and treatment plan.

Concurrent review may include the following:

- ◆ Review of the written Provider Assessment Report, and/or Life Status Questionnaire (see documentation requirements in the Provider Guidelines section of this manual)
- ◆ Speaking by phone to the provider and/or a utilization review nurse at a facility
- ◆ Review of the medical chart, treatment plan and/or discharge plan
- ◆ Speaking with the member's family or significant others
- ◆ Speaking with the member

The care manager will base treatment authorization decisions on clinical judgment and written evaluation criteria.

## Second Opinion

At any time during the course of treatment, the PBH care manager, the member or the provider may solicit a second opinion. Members or providers may request a second opinion by submitting either an oral or written request to PBH. The request will be reviewed and evaluated by a PBH licensed clinician based on Medical Necessity, the nature of the recommended treatment plan and the member's current symptoms.

All decisions regarding second medical opinions will be rendered within the following time limits:

- ◆ Urgent/Emergent treatment within 24 hours
- ◆ All other treatment within fourteen 14 calendar days

Second medical opinions may only be rendered by providers qualified to review and treat the medical condition in question. Request for referrals to non-

participating providers for second medical opinions will be considered only in the event that the services requested are not available within the contracted network of providers

Second medical opinions requested by the member and authorized by PBH will be deducted from the member's available benefit plan and the member will incur the applicable copayment amount. If a second medical opinion is requested by PBH or by the treating provider, the member will not be required to pay a copayment and their benefit will not be reduced.

## **EAP Services**

PBH provides a wide variety of Employee Assistance Program (EAP) services to eligible members. These services include 24 hour a day access to assessment and referral, brief counseling, community resource referrals, critical incident debriefing, wellness programs, supervisor and management consultation, and post-treatment workplace reintegration.

EAP is fundamentally a program designed to assist employees and managers in early identification and resolution of productivity problems associated with behavioral health disorders and other personal concerns. Services to family members of the employee are often included as well. PBH offers a 3-visit EAP model that provides assessment and counseling to the point of referral. In addition, 5-visit and 8-visit models have been designed to offer short-term counseling (see Employee Assistance Program section).