**DEPARTMENT OF HUMAN SERVICES**
**DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES**

**ADMINISTRATIVE BULLETIN 6:03**

**DATE ISSUED:** June 13, 2017 **EFFECTIVE DATE:** July 1, 2017

**SUBJECT: Interim Management Entity (IME) Treatment Reviews and Appeals**

## I. Purpose

To have a uniform procedure governing initial and continuing stay reviews (CSR) and appeals of denial of services or reduction of services. The use of these guidelines will determine services that are reimbursable according to Division of Mental Health and Addiction Services' (DMHAS) policy. These guidelines are not meant to determine individual client treatment plans.

## II. Scope

This policy is effective for the following State and Block Grant funded Fee-for-Service (FFS) Initiatives managed by the IME: Driving Under the Influence Initiative (DUII), Medication Assisted Treatment Initiative (MATI), and the South Jersey Initiative (SJI), New Jersey Statewide Initiative (NJSI) and Substance Abuse Prevention Treatment (SAPT). It will also apply to any future IME managed State initiatives.

All benefit package rules and Eligible Individual annual limits by Level of Care (LOC) for the above-mentioned initiatives must also adhere to current initial and extension lengths of stay published by DMHAS at Annex 1.

All appeals of Medicaid reimbursable services are governed by Medicaid requirements including the Fair Hearing process, and the Network Provider Agency and the Eligible Individual must follow the requirements of N.J.A.C. 10:49-9.14 and N.J.A.C.10:49-10.3. Annex 2 of this bulletin provides information for Medicaid fair hearings.

## III. Definitions

**(a) Continuing Stay Reviews** - (CSR) the process in which a Network Provider submits, through New Jersey Substance Abuse Monitoring System (NJSAMS), an extension request for continuing care through the Level of Care Index (LOCI).

**(b) Eligible Individual** - An adult who meets DHS State funding or federal block grant criteria or Medicaid criteria for addiction services.

**(c) Interim Management Entity (IME)** - is the contracted entity managing substance use services for eligible adult individuals on a non-risk basis. The IME supports and

manages screening, utilization management, care coordination, quality management information systems, complaints and grievances.

(d) **Initial Reviews** - The process by which a Prior Authorization (PA) is issued to the network provider at the start of a treatment episode. The request for a PA is submitted to the IME through the NJSAMS and includes the completion of a current DSM and ASAM LOCI for that client.

(e) **Level of Care** - the general term that encompasses the different options for treatment that vary according to the intensity of services offered/needed.

(f) **Medical Necessity** – means health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

(g) **Network Provider** - An agency licensed by DHS (Office of Licensing "("OOL") as a substance use treatment provider and under contract with DMHAS or enrolled as a Medicaid provider that provides addiction services managed by the IME.

(h) **Prior authorization** - Approval granted by DMHAS or the IME in advance of the Network Provider rendering a service. Prior-authorization by the IME is granted after appropriate review of the assessment of need and the approval of clinical criteria. Approval includes a specific level of care, a specific timeframe, and identifies the funding source.

(i) **Reconsideration Process** - When a request for prior authorization is denied at the LOC requested by the provider, the provider has the right to request reconsiderations of that denial through the IME. See Annex 3.

## IV. Initial Reviews

Prior authorization (PA) for placement in a level of care other than outpatient and Methadone outpatient are issued by the IME based on Medical Necessity. The IME will not issue a PA if the client information does not indicate medical necessity. The IME may deny any PA or may issue a PA for a less intensive level of care.

## V. Lengths of Stay

Treatment lengths of stay exceeding published timeframe in Annex I will not be authorized without an approved CSR.

In circumstances where a clinical determination is made that an Eligible Individual needs additional treatment and the length of stay will exceed the established timeframes, a CSR must be completed and approved by the IME to obtain a PA for treatment.

## VI. Initial Reviews

An initial PA will be required for a successful claim for payment for treatment services funded through a State initiative for the following levels of care: Intensive Outpatient, Short-Term Residential, Long-Term Residential, Halfway House and Withdrawal Management. PAs for services funded through Medicaid will apply to the following levels of care: Methadone Maintenance, Outpatient after a cap of $6,000, Intensive Outpatient Program, Short-Term Rehabilitation and Withdrawal Management. The timeframe of the initial PA will be issued based on medical necessity and the published lengths of stay. **Annex 1.** The IME may respond to any request for an initial PA by 1) denying a PA for that level of care; 2) requesting further information to confirm medical necessity; and/or, 3) issuing a PA for a LOC that differs from the level that was originally requested. Issuance of the initial PA will be based on the medical necessity communicated by the provider through the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 or subsequent amendments and the American Society of Addiction Medicine (ASAM) Level of Care Index (LOCI).

## VII. Continuing Stay Review

### A. Guidelines

The Eligible Individual must participate in the decision to submit a CSR. There must be documentation in the chart that the CSR was discussed with and approved by the Eligible Individual. Documentation must include that an Eligible Individual has been informed how the CSR will impact their overall benefit package. At admission each Eligible Individual will receive an explanation of the benefit package for the level of service and initiative to which they were admitted. The Eligible Individual will also receive a copy of their Summary of Benefits as indicated in NJSAMS. The explanation should also inform the Eligible Individual of the right to transfer to another level of care without a CSR, regardless of the agency's ability to provide that care. Each Eligible Individual will also receive an explanation of the CSR policies including the client specific appeal procedures.

Proof that the Eligible Individual has received this information must be added to the chart and available for DMHAS monitors.

When the Eligible Individual need exceeds the previous described level of care and the CSR LOC (CSRL) is completed in NJSAMS. CSRL's can be completed on the following timelines for State and Medicaid authorizations:

- Intensive Outpatient (IOP), Partial Care (PC), submitted for review up to ten (10) days prior to the end of the current authorization;
- Long-Term Residential (LTR) can be submitted for review up to 25 days prior to the end of the current authorization;

- Halfway House submitted for review up to 16 days prior to the end of the current authorization;

- Short-Term Residential (STR) submitted for review up to seven (7) days prior to the expiration of the current authorization;

- Detoxification submitted for review up to three (3) days prior to the expiration of the current authorization;

- Extension Request LOCI (ERL) for Medicaid Eligible Individuals for all levels of care is required to be submitted ten (10) days prior to end of the current authorization.

- If CSR is denied, the agency will not receive a prior authorization for extended treatment.

- Eligible Individuals' treatment should not be disrupted pending review of a CSR.

## VIII. Appeals and Fair Hearings

When the IME denies a request for PA for a treatment service, the Eligible Individual (or their authorized representative) or the provider may ask for further review of that decision.

If, after further review, a request for a PA is being denied or if a recommendation for a lower level of care is made, the provider and the Eligible Individual will be informed of their right to appeal the decision or request a Medicaid Fair Hearing.

### A. Appeal to DMHAS for State and Block Grant funded services

1. When the provider is dissatisfied with an IME decision and has completed the IME Reconsideration Process to deny PA at Annex 2, the provider or Eligible Individual may appeal to the DMHAS Office of the Medical Director within five (5) business days of completing the IME Reconsideration process.

2. The provider is to fully complete and submit in writing, the Appeal form at Annex 3 attached to this Administrative Bulletin along with all documents originally submitted to the IME, as well as IME recommendation and any new relevant materials.

3. The submitted material will be reviewed by the DMHAS Medical Director or his/her designee(s). The DMHAS Medical Director or his/her designee will convene a panel, of at minimum, two (2) members including Medical Director or designee and one (1) other licensed behavioral health professional, to review the material and provide a recommendation for his/her consideration.

Requests for DMHAS Appeal shall be mailed to:

DMHAS Office of the Medical Director
Division of Mental Health and Addiction Services
222 South Warren Street
P.O Box 700
Trenton, NJ 08625-0700
**Note: Time Sensitive Material**

or

dasextensionappeal@dhs.state.nj.us
**Subject Line to read: "Time Sensitive Material"**

***Confidential personally identifiable information or protected health information should only be sent to this email address via encrypted email.***

Time frames for submission of materials and responses:

The DMHAS Medical Director or his/her designee must receive the Appeal and other required materials within five (5) days of receipt of the IME final recommendation. If the Appeal is not received within the prescribed timeframe, the DMHAS Medical Director or his/her designee will not consider the Appeal.

Non-Discrimination Statement

DMHAS complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. DMHAS does not exclude people or treat them differently because of race, color, national origin, sex, age or disability. See Annex 4.

**B. Appeal to DMAHS for Medicaid-funded services**

When an Eligible Individual who is a Medicaid beneficiary is denied PA for initial treatment, continuing treatment, or is denied a particular level of care but authorized for a different level of care, the Eligible Individual must be provided with notice of the right to a Medicaid Fair Hearing consistent with 42 U.S.C. 431.200 et seq and N.J.A.C. 10:49-9.14 and N.J.A.C. 10:49-10.3. The IME will enter the denial, termination or reduction in LOC into the NJMMIS or current system at the time of the action. The Medicaid fiscal agent will send a letter to the Eligible Individual and the provider advising that the Eligible Individual or their authorized representative, or the provider requesting the PA can request a Fair Hearing. The Eligible Individual or the provider has 20 days from the date of the notice of action to send in the request for a Medicaid

Fair Hearing. The Eligible Individual has ten (10) days from the date of the notice to request continuation of services. If the Eligible Individual requests continuation of services and continued services is granted, and the continued services are later determined not to be medically necessary, the Eligible Individual may be required to pay for the cost of the services.

The Medicaid Fair Hearing must be requested **in writing** to the following address or fax:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712
Fax: 609-588-2435

The authorized representative form for providers and other Eligible Individual representatives can be found at:
http://www.state.nj.us/humanservices/dmahs/news/

## IX. Payment during DMHAS Appeal Process

During the DMHAS Appeal Process the following payment rules apply:

- if the denial is upheld, the provider will not be reimbursed for any client treatment costs that were the subject of the Appeal;
- If the Appeal overturns the denial, DMHAS will reimburse the agency for any client treatment costs during the Appeal process.

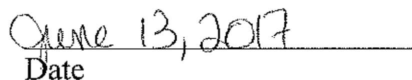
## X. Current Policy Supersedes Earlier Policies

This Administrative Bulletin is effective as of the date of signature and replaces any previous Initial and Continuing Care Review Policies issued by DMHAS.

## XI. Medicaid requirements

Medicaid eligibility and the Fair Hearing process for Medicaid beneficiaries and services are governed by Medicaid law, rules, State plan and related CMS and DMAHS guidance and requirements.

Valerie L. Mielke, MSW
Assistant Commissioner


Date

## Appeal

To the DMHAS Office of the Medical Director

Name of Provider Agency: ______________________________

Contact Person and Title: ______________________________

Contact Telephone # ______________________________

Date of Determination by IME: ______________________________

Describe why you disagree with IME: ______________________________

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Attach the following documentation:

- All documents originally submitted through NJSAMS
- The IME recommendation

______________________________ ______________________

Signature Date

## Annex 1

## Length of Stay

## PARAMETERS

| | IOP/PC | STR* | HWH | LTR | DETOX* | OP | METH |
|---|---|---|---|---|---|---|---|
| Length of Initial PA | 60 days-State<br><br>Up to 60 days - Medicaid | 14-days State<br><br>Up to 14 days - Medicaid | 90 days-State<br><br>N/A-Medicaid | 60 days-State<br><br>N/A - Medicaid | 5 days-State<br><br>5 days - Medicaid | No initial PA needed-Review needed at CAP for Medicaid only** | N/A-State<br><br>1 year - Medicaid |
| Length of each Extension (CCR) | 30 days-State<br><br>Up to 30 Days - Medicaid | 7 or 14 days-State<br><br>Up to 14 days - Medicaid | 7, 14 or 30 days-State<br><br>N/A - Medicaid | 7, 14 or 30 days-State<br><br>N/A - Medicaid | 5 days-State<br><br>Up to 5 days - Medicaid | N/A-State<br><br>TBD-State | N/A/ State<br><br>1 year - Medicaid |

# <u>Annex 2</u>

## IME RECONSIDERATION OF DENIAL OF A REQUEST FOR ADDICTION TREATMENT PRIOR AUTHORIZATION – *PROVIDER AND IME PROCEDURES*

(For Both Initial Prior-Authorization and Extension/Continuing Care Requests)

MEDICAID and NJ STATE MANAGED INITIATIVE FUNDED ADDICTION TREATMENT

After completing the utilization review (UR) of a provider's request for prior authorization for a specified treatment Level of Care (LOC), the IME may decide to *not approve* that request for authorization. The decision by the IME to *not approve* the provider's original LOC request is communicated to the provider by telephone and/or encrypted email. The provider is informed that, while the original request was not approved by the first IME reviewer, the provider has the right to request two additional reconsideration reviews (Initial and Advanced –see below) within the IME. When the provider requests a reconsideration review within the IME, the provider's authorization request is placed on "Reconsideration" status in NJSAMS while the provider and IME arrange, by telephone and encrypted email communication, a date and time for reconsideration review. The "Reconsideration" status remains in NJSAMS throughout the duration of the reconsideration review procedures.

The two (2) reconsideration reviews available within the IME are:

1. An **Initial** review is conducted by an IME Supervisor or their representative and the provider staff. Prior to the Initial reconsideration review the provider may submit to IME any additional clinical documents they believe will support their reconsideration. This review may result in one of three (3) outcomes: **A**. IME approves the original LOC requested; **B.** a LOC that differs from the LOC originally requested is approved and, **C**. the request remains non-approved. Should the Initial review result in outcome B or C, the provider may request an advanced reconsideration review.

2. An **Advanced** review is conducted by the IME Medical Director or their representative and the provider staff. The provider may submit to IME any additional clinical documents they believe will support their reconsideration. This review may result in one of three outcomes: **A**. IME approves the original LOC requested; **B**. IME approves a LOC that differs from the LOC originally requested; and, **C**. IME does not approve the requested LOC request. Should the Initial review result in outcome B or C the provider may elect to seek a Fair Hearing with Medicaid or an Appeal to DMHAS, depending on the funding source of the requested services. (See below).

For IME Denied Medicaid covered treatment, the client or treatment provider on behalf of the client has a right to request a Fair Hearing with the Office of Administrative Law *at any time during* the IME reconsideration process. However, it is recommended that the client/provider complete the IME internal reconsideration review procedures prior to requesting a Fair Hearing to allow for a timely utilization review decision.

**All transactions between provider and IME during the Reconsideration period are recorded in email communication.**

# Annex 3

## Appeal

To the DMHAS Office of the Medical Director

Name of Provider Agency: ______________________________

Contact Person and Title: ______________________________

Contact Telephone # ______________________________

Date of Determination by IME: ______________________________

Describe why you disagree with IME: ______________________________

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Attach the following documentation:

- All documents originally submitted through NJSAMS
- The IME recommendation

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
222 SOUTH WARREN STREET
PO BOX 700
TRENTON, NJ 08625-0700

CHRIS CHRISTIE
*Governor*

KIM GUADAGNO
*Lt. Governor*

ELIZABETH CONNOLLY
*Acting Commissioner*

VALERIE L. MIELKE, MSW
*Assistant Commissioner*

# Annex 4
# Non-Discrimination Statement

## Discrimination is Against the Law

The Department of Human Services (DHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. DHS does not exclude people or treat them differently because of race, color, national origin, sex, age or disability.

**DHS:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact 1-800-701-0710 (TTY: 1-800-701-0720).

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can file a grievance with the following: NJ Civil Rights Coordinator, NJ Department of Human Services, Office of Legal Affairs, P.O. Box 700, Trenton, NJ 08625-0700, 609-777-2026, DHS-CO.OLRA@dhs.state.nj.us. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also electronically file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
SW, Room 509F, HHH Building
200 Independence Avenue
Washington, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

U.S. Department of Health and Human Services complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).