Reality of Reviews in MH/SUD

It is essential that the proposed rule reexamines the criteria used to assess parity between authorizations and reviews for medical/surgical services versus MH/SUD services.

In MH/SUD, facilities often do not request the actual number of medically necessary days. Instead, they accept whatever is offered, which results in a management practice that does not appear as a denial. Providers are informed that they will never receive the full amount of medically necessary days and are encouraged to agree to shortened periods. Consequently, even within the same admission, individuals may undergo multiple “prior authorizations” and reviews, with each review being treated as a new admission. Due to the inability to request authorizations more than a day in advance, patients have no opportunity to appeal—even on an expedited basis—without paying out of pocket.

The primary indicator for a potential red flag should be the number of reviews per admission, particularly if the length of time authorized is inconsistent with the standard of care. Admissions should be identified as consecutive days in a specific facility, rather than by how the claim is labeled in the system.

From: UR_MARY <UR_MARY@cool.com>
Date: Wed, Aug 21, 2024 at 4:35 PM
Subject: Re: RD with info about residential insurance reviews
To: Domna A <domna.rocks@tired.como

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Could you chat at 12 PM CST next Thursday? I would be able to chat for about 30 min.

Let me know,
UR_Mary

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Some carriers would allow for earlier authorization to be submitted, however some required day of or even on site admission, and Yes, a client could find out that they did not meet criteria day of admission, however that would just mean an approval for the next lower level of care. I don't think I ever had someone not approved for IOP from the onset.

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They could be time consuming depending on the client and the insurance company. Live reviews on the phone, which would be scheduled with the case manager, could be anywhere from 5-30 minutes (in addition to any prep we would do beforehand). Fax in reviews would require pulling from EMR and sending over documentation, and voicemail reviews would take 10-20 min of prep (pulling information from the client's EMR) and then 5-10 min to leave the voicemail.

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Algorithm Suggestions

1. Admission Duration Consistency Check

Objective: Identify discrepancies in the authorization duration compared to the standard of care.

Algorithm:
1. Input Data: Claims data including admission dates, authorization duration, and diagnosis codes.
2. Step 1: Group claims by patient ID and admission start date.
3. Step 2: For each admission, calculate the total number of authorized days.
4. Step 3: Compare the authorized days to the standard duration for similar diagnoses and treatment types (can be based on clinical guidelines).
5. Output: Flag admissions where the authorized duration is significantly shorter than the standard of care.

2. Multiple Authorization Flagging

Objective: Detect cases where a single admission is split into multiple authorizations, which may prevent appeals or suggest undue burden on the patient.

Algorithm:
1. Input Data: Claims data including admission dates, authorization records, and associated reviews.
2. Step 1: Identify consecutive authorizations within the same facility for the same patient.
3. Step 2: Calculate the number of authorizations or reviews within each admission period.
4. Step 3: Set a threshold (e.g., more than 2 reviews within a single admission) to flag potential issues.
5. Output: Generate a report of cases where multiple authorizations or reviews are detected within a single admission.

3. Appeal Opportunity Detection

Objective: Determine if the timing of authorizations allows for a reasonable opportunity to appeal decisions.

Algorithm:
1. Input Data: Claims data including authorization request dates, approval dates, and admission dates.
2. Step 1: For each authorization, calculate the time gap between the request and the approval.
3. Step 2: Identify cases where the authorization was granted with less than 24 hours notice before the next review period.
4. Step 3: Cross-reference with appeal records to see if any appeals were made or if patients paid out-of-pocket.
5. Output: Flag cases where insufficient time was provided for appeal.

4. Admission Continuity Check

Objective: Ensure that an admission is treated as a continuous stay rather than multiple separate admissions.

Algorithm:
1. Input Data: Claims data including patient ID, admission dates, discharge dates, and facility codes.
2. Step 1: Sort claims by patient ID and admission dates.
3. Step 2: Identify admissions that occur consecutively (i.e., the discharge date of one admission is the day before the next admission start date).
4. Step 3: Merge these consecutive admissions and treat them as a single continuous stay.
5. Output: Generate a list of continuous admissions and flag any that are incorrectly labeled as separate admissions.

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