CONNECTICUT VALLEY HOSPITAL
UTILIZATION REVIEW OPERATIONAL GUIDELINES

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Continuum of Care
PROCEDURE 2.31:	**Utilization Review Operational Guidelines**
REVISED:	03/07; 11/09; 11/11; 04/13; 11/14; 06/15; 6/27/16; 02/18
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PURPOSE: To instruct the Utilization Review Nurses on procedures related to client entitlements.

SCOPE: Utilization Review Nurse Coordinator and Nurses

PROCEDURE:

I. Guarantor Identification

1. The Utilization Review (UR) Nurse identifies/verifies the guarantor of each patient at the time of admission utilizing available resources such as the National Government Services Fiscal Intermediary Standard Service (FISS), ABILITY, the Department of Administrative Services (DAS), Connecticut Medical Assistance Program (CT-MAP), the DSS Eligibility Management System, DAS Collection Services and the CVH entitlement designee.

2. The Utilization Review Nurse ensures required authorizations are signed by the patient or conservator of person and/or estate as follows:

   A. Medicare:

      1) *Medicare Claim Authorization Form* (CVH-211) for all patients.
      2) *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-514) for patients in the Addiction Services Division (ASD) **ONLY**.

   B. Medicaid and Private Insurance:

      1) *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-514) for patients in the ASD.
      2) *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-543) for patients in the General Psychiatry Division (GPD).

3. The Utilization Review Nurse ensures that all admissions related documents are signed by the patient or conservator of person and/or estate as follows:

   Notice of Liability (CVH-241)
   Treatment Permit (CVH-657)
   Receipt for Notice of Privacy Practices (CVH-682)
   Advance Directives (CVH-407a)
   Notice of Advocacy Services (CVH-606)

Anatomical Gift (CVH-407b)
The Admission RN may have the patient sign appropriate forms, but will refer the patient to the Utilization Review Nurse if the patient has any questions related to entitlements. The Utilization Review Nurse remains responsible for ensuring that the appropriate forms (as stated above) are in the chart.

4. The Utilization Review Nurse enters the guarantor information into WITS by the next business day. If the guarantor information has already been entered into WITS by another department, the Utilization Review Nurse verifies the accuracy of this information in WITS, also by the next business day.

   Note: The Admission Screening Unit in ASD enters all admissions on the Utilization Review Admission Log at the time of admission. Guarantor information, from the Administrative Service Organization (ASO), and prior authorization from the Connecticut Behavioral Health Partnership (CT BHP) and other guarantors such as Medicare and private insurers are also entered on this log and entered in WITS by the ASD screening office.

   The Utilization Review Nurse verifies the accuracy of information on the log and the presence of required authorizations, and investigates and resolves any issues and/or discrepancies. The Utilization Review Nurse ensures that accurate guarantor information has been entered into WITS.

5. The Utilization Review Nurse identifies the guarantor as "Self-Pay" in WITS when the patient is uninsured or when the Utilization Review Nurse is unable to verify the guarantor.

6. The Utilization Review Nurse in the ASD ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-514) prior to proceeding with coverage requirements listed below.

7. The Utilization Review Nurse in the GPD ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-543) prior to proceeding with coverage requirements listed below.

8. The Utilization Review Nurse identifies the guarantor as "Patient - No Signed Release" on the Medicare Determination form in WITS when the patient or conservator has not signed the required authorization(s) for Medicare, Medicaid or other insurance.

9. The Utilization Review Nurse monitors changes in legal status by monitoring the weekly probate court list and the Legal Status Log on the T: Drive and initialing the log when reviewed (HIM is responsible for maintaining this log and updating the legal status in WITS). The Utilization Review Nurse may also verify legal status through the WITS census or through contact with HIM staff. The Utilization Review Nurse does the following when the patient's legal status changes from non-billable to billable (situation of incurring liability):

   a. Re-verifies guarantors using available resources.
   b. Enters the updated guarantor information into WITS.
   c. Ensures that an updated Face Sheet is printed and placed in the patient's chart.

d. Begins the internal UR piece of the billing process, based on the new guarantor. This step includes issuing the Important Message from Medicare within the appropriate time frame, when indicated.

10. The Utilization Review Nurse in the GPD verifies/updates guarantor information on all bi-annually (January and July) and earlier for patients approaching the age of 65. The Utilization Review Nurse enters the updated guarantor information into WITS and ensures that the appropriate paperwork (such as the CVH-211, CVH-514 or CVH-543) is signed and in the chart.

    a. During the bi-annual review of entitlements, the Utilization Review Nurse in the GPD informs the hospital entitlement designee of all billing eligible admissions who will be turning 65 within the next year. The entitlement designee will follow-up as needed. For patients under the age of 21, if Medicaid is inactive or the patient is not on file in the DSS Medical Assistance Program, the Utilization Review Nurse will alert the entitlement designee.

    b. The hospital entitlement designee will notify the Utilization Review Nurse once a patient attains active Medicare/Medicaid status. The Utilization Review Nurse will enter new guarantor status into WITS and start the review process as required.

11. At any time when the Utilization Review Nurse becomes aware of a billing eligible patient who is approaching age 65, the Utilization Review Nurse will obtain a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-543) from that patient and will inform the hospital entitlement designee to initiate the Medicaid application process and application for Medicare Part B if coverage is not yet effective and the patient elects to do so.

12. The entitlement designee alerts the Utilization Review Nurse when a patient's Medicare or Medicaid Application has been successfully processed and Medicaid and/or Medicare Part B becomes effective.

    a. The Utilization Review Nurse enters this information into WITS and ensures that the appropriate paperwork (such as the CVH-211, CVH-514 or CVH-543) is signed and in the chart.

    b. The Utilization Review Nurse then prints an updated Face Sheet for the patient and faxes this face sheet to DAS Collection Services. The Utilization Review Nurse begins the internal UR piece of the billing process, based on the new guarantor.

II. Utilization Review Activities

1. Medicare

Medicare Secondary Payer (MSP):

A. At the time of admission, or when a client is later identified as having Medicare, the Utilization Review Nurse completes the Medicare Secondary Payer (MSP) Screening Form (CVH-692) with each patient who is identified as having Medicare. (Note: MSP requirements do not apply to Medicare Advantage Plans.) For any patient who responds

"Yes" to key items on the screening form, the Utilization Review Nurse will complete the full MSP Questionnaire (CVH-693).

B. The Utilization Review Nurse will maintain documentation reflecting reevaluation of the MSP status every 90 days with their entitlement search documents.

C. The Utilization Review Nurse will fax all MSP Screening forms and Questionnaires to DAS, place the original in the legal section of the client's chart and file a copy in the UR file along with the entitlement search documents. Copies will be retained for 10 years from date of service for audit purposes.

D. MSP documents will be faxed to DAS as follows:

- Part A: with the Medicare Determination Form
- Part B: Prior to releasing any encounters.

An Important Message from Medicare:

E. The Utilization Review Nurse reviews *An Important Message from Medicare About Your Rights* and the *Medicare Claim Authorization Form* (CVH-211) with the patient or conservator. The signed CVH-211 is filed in the Legal Section of the Medical Record. The patient or conservator is asked to sign and date *An Important Message from Medicare About Your Rights*, is given a copy of the signed document and the original is placed in the legal section of the medical record. This occurs no later than two calendar days following admission.

F. If the patient is not competent to sign *An Important Message from Medicare About Your Rights*, the Utilization Review Nurse meets with the conservator in person or speaks with him/her directly on the telephone. All attempts to contact the conservator, as well as discussion of the Important Message, should be recorded on the document. If communication is by phone, and/or the Utilization Review Nurse is unable to speak directly with the conservator within two days, the Utilization Review Nurse verifies the conservatorship and contact information and the form is sent for signature via certified mail. This information is to be documented with a note in the Medical Record.

G. If the patient or conservator refuses to sign *An Important Message from Medicare About Your Rights* the Utilization Review Nurse or Admission Nurse notes this on the document with his/her signature and date, gives a copy to the patient or conservator and files the original in the legal section of the medical record. The Utilization Review Nurse monitors to ensure these forms are completed correctly and that the patient and/or conservator have been given copies.

H. All patients who are dually eligible or have original Medicare, Medicare Advantage (MA) or other health plans under MA regulations or Medicare as secondary payer must be issued *An Important Message from Medicare About Your Rights* as stated above.

Medicare Days:

I. The Utilization Review Nurse verifies the availability of Inpatient Psychiatric Hospital Days through available resources including ABILITY, HIQA, and/or FISS and proceeds accordingly:

- If there are no Inpatient Psychiatric Hospital Days and no Lifetime Reserve (LTR) Days (or the patient/conservator elects not to use LTR Days on CVH-211) available to the patient, the Utilization Review Nurse in the General Psychiatry Division identifies Medicare as guarantor in WITS, indicates the admission is not certified for coverage and faxes an updated Face Sheet to DAS Collection Services. The Utilization Review Nurse indicates that benefits are exhausted on the Medicare Determination Form, and also faxes this form to DAS

- If there are Inpatient Psychiatric Hospital Days available to the patient, the Utilization Review Nurse ensures the appropriate subsequent steps are taken.

Medicare Certification:

J. The admitting physician or attending psychiatrist determines if the admission qualifies for coverage under the Medicare guidelines and proceeds accordingly.

1. Medicare Certification:

   a) If the admission qualifies for coverage, the physician completes the admission certification portion of the *Certification for Coverage Form* (CVH-212).

   b) The Utilization Review Nurse reviews the CVH-212 to ensure that it is completed correctly and provides any related feedback to the physician.

   c) The Utilization Review Nurse applies a Medicare sticker to the patient's medical record.

2. Medicare Non-Certification

   a) If the Physician believes that the admission does not qualify for coverage, and if the Utilization Review Nurse agrees, the physician documents this on the initial certification portion of the *Certification for Coverage Form* (CVH-212), the Utilization Review Nurse notifies the Director of Admissions and UM and an *Admission Hospital Issued Notice of Non-coverage* (AHINN) is issued to the patient or conservator. The AHINN is issued in lieu of *An Important Message from Medicare About Your Rights*. A copy of the signed AHINN is filed in the legal section of the medical record and a copy is given to the patient or conservator.

   b) If the Physician and the Utilization Review Nurse disagree about whether the hospital stay qualifies for coverage, they consult with the Service Medical Director for a final decision. If the decision is that the stay does not qualify, the Utilization Review Nurse will proceed as in a). If the decision is that the stay is qualified, the Physician will proceed with the Certification Process.

   c) If an AHINN is issued, the Utilization Review Nurse notifies DAS Collection Services and HIM of the issued notice and the date of patient liability via the *Medicare Determination Form*. (When the AHINN is issued to the patient no

later than 3:00 PM on the day of admission, the patient will be liable for charges effective the day of admission. If the AHINN is issued after 3:00 PM on the day of admission, the patient will begin to incur liability on the day following admission).

d) The Utilization Review Nurse notes this information on the Important Message Log on the T: Drive.
e) A copy of the AHINN is sent to Livanta within three business days of being issued.
f) A copy of the AHINN is given to the Director of Admissions and Utilization Management.

K. Utilization Nurse Review

The Utilization Review Nurse reviews the charts of all Medicare eligible patients upon admission, or date of eligibility, for determination of coverage. A reinstatement of coverage at any point throughout the hospitalization that would allow for Medicare billing, constitutes an admission for procedural purposes.

L. Concurrent Review

The Utilization Review Nurse coordinates with the attending psychiatrist to ensure ongoing concurrent review (documented on the CVH-212) and determination of coverage is performed on day 12, day 18, day 48, and every 30 days thereafter for the 90-day spell of illness coverage period, unless the patient exhausts his/her Inpatient Psychiatric Hospital Days, a determination is made that the patient no longer meets coverage criteria or the patient is discharged prior to the 90 days.

The Utilization Review Nurse coordinates with the attending psychiatrist to ensure continued concurrent review and determination of coverage is performed every 30 days, for up to an additional 60 days if <u>both</u> of the following conditions are met:

1. The patient meets coverage criteria at the end of the 90-day spell of illness.
2. The patient/conservator has elected to use Lifetime Reserve (LTR) Days as authorized on *Medicare Claim Authorization Form* (CVH-211).

The Utilization Review Nurse reviews documentation in the medical record at each concurrent review interval for justification of continued coverage under the Medicare Program, including evidence of ongoing active treatment prescribed on the patient's treatment plan and evidence that the patient has not yet reached optimal level of improvement.

The Utilization Review Nurse continues to monitor the CVH-212 for timeliness and accurate reflection of treatment, anticipated length of stay, discharge plan, etc.

In the ASD, the Utilization Review Nurse verifies that the physician is recording the procedure codes on the CVH-212 and that the procedure codes reflect the treatment provided to the patient and documented in the chart. If there are discrepancies, the Utilization Review Nurse will discuss these concerns with the physician.

The Utilization Review Nurse reviews the medical record throughout the course of hospitalization for all required documentation to meet federal, state and peer review requirements; any identified deficiencies are referred back to the responsible individual for correction. When corrections are not completed in a timely manner, the Utilization Review Nurse will bring these deficiencies to the attention of a physician member of the division-based Utilization Review Committee or to the Service Medical Director for review.

M. Continued Coverage Certification

If the attending psychiatrist determines that the patient continues to qualify for coverage under Medicare guidelines, the Utilization Review Nurse ensures that the attending psychiatrist certifies continued coverage on the *Certification for Coverage Form* (CVH-212).

If the Utilization Review Nurse disagrees with the determination to continue coverage, the case will be discussed with the attending psychiatrist to afford him/her the opportunity to review the record before a final determination is made.

N. Discontinued Coverage

If the attending psychiatrist agrees with the Utilization Review Nurse, coverage will be discontinued per physician documentation on the *Certification for Coverage Form* (CVH-212). *An Important Message From Medicare About Your Rights (Discontinued Coverage* will be delivered to the patient or conservator. The patient or conservator is asked to sign and date page 2 of the document that explains the steps to appeal. The patient or conservator is given a copy of the document and the original is attached to the document issued on admission and placed in the legal section of the medical record. The Utilization review Nurse records the status of the Important Message in the Important Message log on the T: Drive.

DAS Collection Services is notified of the discontinued coverage and the date of patient liability via the *Medicare Determination Form*. (The patient will be liable for customary charges for services furnished beginning the third day following the date of receipt of the hospital notice.)

For clients in the ASD, the UR Nurse will report procedure codes on the Medicare Determination Form. These codes will be assigned by the Attending Physician and will be recorded by the Physician on the Medicare Certification form during the client's length of stay.

A copy of *An Important Message From Medicare About Your Rights (Discontinued Coverage)* is sent to Livanta within three business days of being issued.

O. Resolution of Opposing Certification Recommendations

If the attending psychiatrist does not agree with the Utilization Review Nurse, the case is referred to a physician member of the division-based Utilization Review Committee or the Service Medical Director for review, and final determination is made in collaboration with the attending psychiatrist.

P. Patient Discharge Notification Process

The Utilization Review Nurse delivers *An Important Message From Medicare About Your Rights (Discharge)* no sooner than two calendar days before a planned discharge and no later than four hours prior to discharge. Day of discharge delivery should not be done routinely. The patient or conservator is asked to sign and date page 2 of the document which explains the steps to appeal. If the patient or conservator decides to appeal, the physician is notified and the process outlined on the *Important Message From Medicare* is implemented. The patient or conservator is given a copy and the original is attached to the Important Message document issued on admission and placed in the legal section of the medical record. The Utilization Review Nurse documents this activity on the Important Message Log on the T: Drive and with a note in the medical record.

Q. Patient Discharge Notification Exemptions

An Important Message From Medicare About Your Rights (Discharge) is not delivered to the patient or conservator in the following circumstances:

An *Admission Hospital Issued Notice of Non-coverage* (AHINN) was issued at admission.

The patient has exhausted Medicare Part A days.

A Continued Stay Hospital Issued Notice of Non-coverage was issued.

The patient leaves the facility Against Medical Advice (AMA) or Against Clinical Advice (ACA).

The patient is discharged to the same level of care.

R. DAS Notification of Discontinued Coverage

The Utilization Review Nurse forwards a completed *Medicare Determination Form* to DAS Collection Services for all Medicare patients, including Managed Medicare, when one of the following occurs:

- Inpatient Psychiatric Hospital Days, and Lifetime Reserve Days if elected, are exhausted, or
- Coverage criteria is no longer met and *An Important Message From Medicare About Your Rights (Discontinued Coverage)* is issued to the patient or conservator; or
- The patient is discharged from the facility.

The Utilization Review Nurse completes the Medicare Determination Form in WITS:

1. In the ASD, the Utilization Review Nurse ensures that procedure codes (as recorded by the physician on the CVH-212) are noted on the Medicare Determination Form.

2. For all divisions, the Utilization Review Nurse records episodes of MDAC, ECT or Oncology treatments on the Medicare Determination Form.

When the Medicare Determination Form is complete, the Utilization Review Nurse prints the form, signs and dates the form and faxes it to the CVH contact at the Department of Administrative Services (DAS). The UR Nurse maintains a copy of the fax verification and the Medicare Determination Form in the UR chart. The original Medicare Determination Form is filed in the legal section patient's medical record.

S. Coverage Denial Appeal

The patient or conservator may initiate an appeal with Livanta the designated Quality Improvement Organization (QIO) based on the issuance of an *Admission Hospital Issued Notice of Noncoverage* (AHINN*), An Important Message From Medicare About Your Rights (Discontinued Coverage)* or *An Important Message From Medicare About Your Rights (Discharge).* If an appeal of discharge is initiated by midnight beginning the day of discharge, the patient cannot be discharged until there is a determination rendered by Livanta.

The Director of HIM or Designee is the point of contact at the hospital for all appeals, and coordinates all Livanta requests for records.

Upon notification of an appeal, the Director of HIM or Designee contacts the Utilization Review Nurse or the Attending/on-call physician to issue the *Detailed Notice of Discharge* to the patient or conservator as directed by the QIO. The notice must be issued no later than noon of the day after the QIO notification. A copy of the *Detailed Notice of Dis*charge is given to the patient or conservator and the original is filed in the legal section of the medical record.

Note: For patients participating in Medicare Advantage Plans, it is the Managed Care Company's responsibility to deliver the *Detailed Notice of Discharge* to the patient.

T. HIM provides the requested documentation to Livanta (fax number 1-855-236-2423), no later than noon of the day after the request, pursuant to valid authorization(s). Requested documentation may include:

1. Physician Orders;
2. Assessments;
3. Progress Notes;
4. Labs;
5. Special Procedure Sheets;
6. Discharge Summary
7. *Medicare Claim Authorization Form* (CVH-211);
   An Important Message From Medicare About Your Rights
8. Detailed Notice of Discharge

The Director of HIM or Designee, as the hospital contact for decisions rendered by Livanta, immediately notifies the assigned Utilization Review Nurse of the appeal decision and ensures that the appeal outcome letter is filed in the legal section of the medical record.

The Utilization Review Nurse ensures appropriate liability is reflected on the *Medicare Determination Form* in the case of a timely discharge appeal as follows:

1. If Livanta upholds the appeal, there is no patient liability for continued care.

2. If Livanta denies the appeal, patient liability will begin noon of the day after Livanta notifies the patient or conservator of the decision.

U. Denial of Coverage Appeal Window

A patient or conservator who has been issued *An Important Message From Medicare About Your Rights (Discontinued Coverage)* may appeal at any time through the course of hospitalization. The QIO will assist the hospital in determining the date of patient liability in these cases, as applicable.

Discharged patients have up to 30 calendar days of the discharge date to appeal. The QIO will assist the hospital in determining the date of patient liability in these cases, as applicable.

2. Medicaid

A. The Utilization Review Nurse identifies patients with Medicaid using one of the DSS eligibility identification programs and verifies the date of birth for these patients.

B. In the ASD, the Utilization Review Nurse reviews the Admission Psychiatric Evaluation to determine whether or not the patient has a primary psychiatric diagnosis of substance dependence. If not, the Utilization Review Nurse will discuss level of care with the physician.

C. The Utilization Review Nurse in the ASD ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-514) prior to proceeding with coverage requirements listed below.

D. The Utilization Review Nurse in the GPD ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-543) prior to proceeding with coverage requirements listed below.

E. Admissions of clients ages 18-21 with Husky (A-D) benefits, must be precertified through Beacon Health Options, Inc.

F. If a patient is between the ages of 18 and 21 and is Medicaid Husky eligible, the sending facility must obtain preauthorization from Beacon Health Options, Inc. for admission to CVH. After admission, the Utilization Review Nurse conducts concurrent reviews as required with the Beacon Health Options, Inc. Intensive Care Manager. Note that the admission will not be denied or delayed based on the sending facility's inability to obtain a preauthorization in a timely manner. Once the patient is admitted at CVH, the Utilization Review Nurse will complete any follow-up related to preauthorization.

G. Medicaid does not cover room and board for patients at CVH between the ages of 22 and 64. Active Medicaid is only billed as a supplement to Medicare for coverage of deductible and/or coinsurance for these patients.

H. The Utilization Review Nurse monitors the status of annual reapplication for Medicaid through collaboration with the hospital entitlement designee. Any change in Medicaid status is reported DAS Collection Services and entered into WITS.

K. The Utilization Review Nurse communicates coverage decisions with DAS Collection Services via fax.

Medicaid Husky A

Detox:

1. The screening office obtains a Release of Information (ROI) from the client and calls Beacon Health Options, Inc. to register the client and obtain the initial authorization.

2. Authorizations for Detox services and continued stay reviews for clients with Medicaid Husky A who are under 21 or over 65 years of age will be obtained from the Connecticut Behavioral Health Partnership/Beacon Health Options, Inc. Website: www.ctbhp.com

3. Any additional hospitalization beyond the initial authorization requires a concurrent review to be conducted by the UR Nurse. Reviews can be done via the online process or by phone. The UR Nurse will verify that a ROI is on file before communicating with Beacon Health Options, Inc.

4. The Utilization Review Nurse will notify Beacon Health Options, Inc. when the client is discharged from Detox (including transfer to Rehab). This can be done via phone, fax or online. Beacon Health Options, Inc. will need the client name, Medicaid ID number, date of discharge and a description of the D/C follow up plan.

5. Beacon Health Options, Inc. and ABH are notified by fax daily of any clients who have any type of Medicaid, are diagnosed with Opioid Use Disorder and have signed a RIO.

Rehabilitation:

1. Registration: On the next business day following admission, the UR Nurse Registers the admission of any client who has Husky D, inactive Husky D or no entitlements with ABH. This includes any transfers from Detox (the transfer date is considered the admission date for the purpose of the registration). The registration is done by fax using ABH form "Electronic Registration System II Form". ABH typically authorizes 10 days.

2. Concurrent Reviews: Additional reviews are done by the UR Nurse to cover any period beyond the initial authorization. The reviews are conducted via fax using ABH form "Electronic Treatment Review Form". If a client is placed on and MDAC status, ABH is notified and the client is re registered upon return to CVH. ABH is notified via their website www.abhct.com/ whenever a client is discharged (including MDAC).

3. When the discharge plan is identified, the Utilization Review Nurse may be asked to obtain a precertification for the next level of care from ABH. If a precertification is

needed, the information is gathered from the Treatment Team or the Case Coordinator and phoned in to ABH.

Clients Under the Age of 21 (all divisions):

A. Certificate of Need (CON):

1. A Certificate of Need (CON) must be completed and filed in the chart for any patient under age 21.

2. When a client under 21 has Medicaid Husky A, the registration process with Beacon Health Options, Inc. (done by the screening office in ASD and the referring facility in GPD) will trigger a CON. Beacon Health Options, Inc. will prepare the CON and send it via secure email to the Director of Admissions and UM. The CON will then be saved to the UR Folder on the T: Drive and the UR Nurse will be notified by email. The Utilization Review Nurse will print the CON from the T: Drive folder and place a copy in the client's chart and in the UR file.

3. In the ASD, Beacon Health Options, Inc. will only complete CON forms for Medicaid Husky A clients admitted for Detox.

4. For patients with entitlements that are not managed by Beacon Health Options, Inc., (including Medicaid patients admitted to Rehab) the Utilization Review Nurse will have the treatment team complete the CON, and will have the Physician sign the form. The Utilization Review Nurse will place the completed form in the patient's chart.

Note: The CON is a document requested by DSS to meet Federal requirements. It is not related to the authorization process.

Clients 65 and Older:

When a client age 65 or older is admitted, or when the Utilization Review Nurse becomes aware of a client nearing the age of 65, the Utilization Review Nurse will notify the CVH Entitlement Specialist. The Entitlement Specialist will ensure the application for Medicaid is completed and sent to the onsite DSS workers for approval and activation of benefits. Upon verification of eligibility, the Utilization Review Nurse will enter the changes into WITS, and notify DAS. In ASD each client is seen by the DSS workers during their length of stay and the application is completed at that time.

3. Other Insurance

The Utilization Review Nurse in the Addiction Services Division ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form*

(CVH-514) from the patient or conservator prior to verifying benefits, certifying the admission or conducting concurrent reviews.

The Utilization Review Nurse in the General Psychiatry Division ensures there is a signed *Authorization for the Release of Protected Health Information for Reimbursement Form* (CVH-543) from the patient or conservator prior to verifying benefits, certifying the admission or conducting concurrent reviews.

The Utilization Review Nurse conducts admission and concurrent reviews as required by the Managed Care Organization (MCO) of the insurance company. All contacts are documented in the Progress Note Section of the Medical Record in a timely manner as part of the continuous record.

All correspondence received from the MCO is placed in the Correspondence Section of the Medical Record.

The Utilization Review Nurse faxes copies of authorization and denial letters to DAS Collection Services upon receipt.

If the admission, or any part thereof, is denied coverage by the MCO the Utilization Review Nurse consults with the division Medical Director, or designee (a psychiatrist representative of the Utilization Review Subcommittee), to determine whether or not to initiate the appeal process. This consultation is documented with a note in the Medical Record.

If it is agreed that the client requires inpatient hospitalization, the Utilization Review Nurse will work with the physician to implement and follow through with the appeal process.

The Utilization Review Nurse coordinates MCO requests for records (such as in the case of an appeal) in conjunction with HIM. HIM provides the documentation requested pursuant to a valid authorization.

The Utilization Review Nurse informs patients and/or conservators about denial and appeal activity when appropriate.

III. General UR processes:

By the end of the second business day following admission, the UR Nurse will introduce her/himself to newly admitted clients who have entitlements and determine whether the client has any questions about their entitlements or liability. Questions about liability may be referred to the CVH representative at DAS Collection Services.

4. Other Duties

A. Auditing and Processing Encounters:
The Utilization Review Nurse will audit a sample of encounters in WITS as instructed. Audits will consist of a chart review to determine whether the Evaluation and Management (E&M) code entered for the encounter is supported by documentation in the chart. If the documentation supports the encounter, the UR Nurse will release the encounter. Encounters that are not supported by the documentation will be processed as follows:

- If the documentation is good, but coded incorrectly (the physician used an invalid code, the encounter does not have enough elements for the code assigned, etc.), the Utilization Review Nurse will reject the encounter and enter a note advising the physician why the encounter was rejected. The Utilization Review Nurse will provide their initials and phone extension on this note.

- If the documentation is not adequate, (no evidence of a face-to-face with the client, date of service does not match date signed, there is no note for the encounter date, etc.) the Utilization Review Nurse will process the note as "not billable" and speak with the physician to let him/her know why the note is not billable

The Utilization Review Nurse is responsible for processing encounters entered by the physicians. The Utilization Review Nurse will batch and release billable encounters so that these encounters move forward to DMHAS Healthcare Finance for final processing. The Utilization Review Nurse will work directly with physicians to educate and advise them regarding the quality of their documentation and how they are coding their encounters. If the audit reveals ongoing concerns about the quality of a physician's encounters and/or corresponding documentation, the Utilization Review Nurse will bring this to the attention of the Utilization Review Nurse Coordinator who will consult with the Director of Admissions and UM to determine how best to work with the physician.

Encounter Audit selections will be adjusted based on ongoing assessment of the quality of each physician's documentation and encounter coding.

B. Monitoring reports, entering data and maintaining records

The Utilization Review Nurse monitors the "Change in Legal Status Log" on the T: Drive to ensure that appropriate actions are taken when a change in legal status affects a client's billing status.

The Utilization Review Nurse enters all data into the compliance reports on the T: Drive in a timely manner.

The Utilization Review Nurse completes audits of the Notice of Liability and Notice of Privacy Practices as requested by the CVH Compliance Committee (at least annually).

The Utilization Review Nurse will maintain a file of entitlement related documents. The current time frame for retaining these documents is 10 years from the date of service.