LEVEL OF CARE GUIDELINES: INTRODUCTION

Guideline Number: BH72723INTRO_032017 **Effective Date**: March, 2017

Table of Contents **Page**

INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members'[1] recovery, resiliency, and wellbeing[2] for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California ("Optum-CA")).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, profesisonal specialty societies, consumers, and regulators.

GUIDING PRINCIPLES

We enable the system of care to become more engaging, effective, and affordable by way of three core competencies or "pillars": Care Advocacy, Service System Solutions, and Information Management & Technology.

Engagement, evidence-based practices, as well as recovery, resiliency, and wellbeing are integral to each of the pillars.

Pillar One: Care Advocacy
Care Advocacy is a means for intervening on behalf of members living with a behavioral health issue. We improve the experience of members living in the communities we serve, using our managed care tools and techniques to support wellbeing.

[1] The term "member" is used throughout the *Level of Care Guidelines*. The term is synonymous with "consumer" and "enrollee". It is assumed that in circumstances such as when the member is not an emancipated minor or is incapacitated, that the member's representative will participate in decision making and treatment to the extent that is clinically and legally indicated.

[2] The terms "recovery" and resiliency" are used throughout the Level of Care Guidelines. SAMHSA defines "recovery" as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines "resilience" as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines "recovery" as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

We use Utilization Management and the *Level of Care Guidelines* in a focused and time-limited manner to accomplish specific sustained and measured improvement in provider practice. When that purpose is accomplished, we stop. We consider the member's presenting symptoms, clinical history, biopsychosocial factors, as well as the member's benefit plan and availability of services. We authorize services the provider can offer to meet the member's immediate needs and preferences, and support the member's broader recovery, resiliency, and wellbeing goals.

Using Utilization Management and the *Level of Care Guidelines* reduces undesirable variation from evidence-based practice. This is key to improving quality and affordability.

Pillar Two: Service System Solutions
The purpose of service system management is to improve the structure of, access to, and the practice within systems of care.

We develop and sustain systems of care including services to manage crises and to facilitate recovery, resiliency, and wellbeing. The *Level of Care Guidelines* are used to promote access to the most appropriate and available and least restrictive level of care, enable safe and timely transitions between levels of care, facilitate coordination among providers, and promote use of services that support recovery, resiliency, and wellbeing. When the most appropriate level of care is not available in the service system, we either facilitate access to services that augment a lower level of care thus allowing for safe and effective treatment, or we facilitate access to a higher level of care.

A the system level, the information and decisions derived from using the *Level of Care Guidelines* provides us with a source of information that is used to align incentives, partner with providers, and improve quality and affordability.

Pillar Three: Information Management and Technology
The purpose of Information Management and Technology is to empower staff, providers, and members living with a behavioral health issue to create a more engaging, effective, and affordable healthcare experience and to empower members in their recovery, resiliency, and pursuit of wellbeing.

At the member level, the Level of Care Guidelines provide a consistent structure for collecting case information which allows us to confirm that services offered by the provider can meet a member's immediate needs, identify alternatives that exist in the service system to meet those needs, and foster the development of a person-centered plan.

At the system level, the information and decisions derived from using the *Level of Care Guidelines* provides us with aggregate information which allows us to better understand our members' needs and experiences with the system of care. This information is used to evaluate and improve the adequacy of the service system.

DEVELOPMENT AND APPROVAL, DISSIMINATION, AND USE

The *Level of Care Guidelines* are supported by written policies that govern their development, dissemination, and use.

Development and Approval

Optum uses a three-stage process to develop the *Level of Care Guidelines*:

1. **Draft Development:** The *Level of Care Guidelines* are updated annually to reflect changes to the network, advances in evidence-based practice, regulatory requirements, and other opportunities to improve the quality of the *Level of Care Guidelines*.
2. **Stakeholder Input:** The *Level of Care Guidelines* are further shaped by input solicited from clinical personnel, providers, professional specialty societies, members, and regulators.
3. **Committee Approval:** The final draft is presented to the Utilization Management Committee for approval.

OptumHealth Behavioral Solutions of California ("OHBS-CA"; "Optum-CA") works with Optum to update the *Level of Care Guidelines* to reflect changes to the network, advances in evidence-based practice, regulatory requirements, and other opportunities to improve the quality of the *Level of Care Guidelines*. OHBS-CA works with Optum to solicit input from OHBS-CA's Medical Director and other clinical personnel, providers, members, and regulators. The final draft of the Level of Care Guidelines is presented to the OHBS-CA Quality Improvement Committee for approval, and the approved draft is presented to the OHBS-CA Board of Directors for final approval.

Dissemination

The *Level of Care Guidelines* are available to personnel, providers, and members on Optum's websites. Printed copies are provided upon request.

Use and Limitations

Services are medically necessary[3] when they are provided for the purpose of preventing, evaluating, diagnosing, or treating a mental illness or substance use disorder, or its symptoms that are all of the following as determined by us or our designee, within our sole discretion:

1. In accordance with *Generally Accepted Standards of Medical Practice*.
2. Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the mental illness, substance use disorder, or its symptoms.
3. Not mainly for the member's convenience or that of the member's doctor or other health care provider.
4. Not more costly than an alternative drug, service, or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's mental illness, substance use disorder, or its symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relavent medical community, relaying primarily on controlled clinical trials or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion shall be within our sole discretion.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revsied from time to time) are available to Covered Persons on Optum's member web site or by calling the telephone number on the Covered Person's ID care. They are available to physicians and other health care professionals on Optum's provider website or by calling the telephone number on the Covered Person's ID care.

Care Advocates use the *Level of Care Guidelines* when making medical necessity determinations and as guidance when providing referral assistance. Determinations of medical necessity are determinations whether the benefit plan will pay for any portion of the cost of a health care service, and so are decisions that are for payment purposes only. The member and the member's provider make decisions about the actual treatment the member will receive, and so we do not dictate treatment. When making determinations about medical necessity, we use the information provided to us to ascertain whether services are in accordance with standards of practice, are clinically appropriate, are not mainly for convenience, and whether the services are cost-effective and provided in the least restrictive environment.

Peer Reviewers use the *Level of Care Guidelines* when staffing a case, conducting a peer review, and as a basis for adverse medical necessity determinations. Personnel use the information and decisions derived from using the *Level of Care Guidelines* to identify opportunities to improve the adequacy of the service system.

Staff must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the *Level of Care Guidelines*, and the plan benefit coverage prior to use of these guidelines. Other clinical guidelines may apply.

The *Level of Care Guidelines* are used flexibly, and are intended to augment – but not replace – sound clinical judgment. Use is informed by the unique aspects of the case, the member's benefit plan, services the provider can offer to meet the member's immediate needs and preferences, alternatives that exist in the service system to meet those needs, and the member's broader recovery, resiliency, and wellbeing goals.

Exceptions may be made to the *Level of Care Guidelines*, such as when there is a superseding contractual requirement or regulation, or when a Medical Director authorizes a case-specific exception from using evidence-based treatment when the member's condition has not responded to treatment as anticipated.

It is expected that exceptions be carefully thought out, documented, and approved by the responsible level of management. It is also expected that an effort will be made to work with the provider to identify an appropriate level of care and forms of treatment that are most likely to be effective.

While the *Level of Care Guidelines* do reflect Optum's understanding of current best practices in care, they do not constitute medical advice.

Optum reserves the right, in its sole discretion, to modify the *Level of Care Guidelines* as necessary.

---

[3] The definition of medical necessity may vary by health plan or payor however, most definitions of medical necessity center around care that is essential and appropriate.

HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2017	• Version 1 (Approved by UMC)