



**Office of  
Mental Health**

**New York State Office of Mental Health Best Practices  
Manual for Utilization Review for Adult and Child Mental  
Health Services**

## Table of Contents

<b>1</b>	<b><i>Background and Legal Basis</i></b> .....	<b>3</b>
<b>2</b>	<b><i>Applicability</i></b> .....	<b>3</b>
<b>3</b>	<b><i>Use and Disclosure of OMH-approved Level of Care Tools or other Clinical Review Criteria</i></b> <b>4</b>	<b>4</b>
<b>4</b>	<b><i>Communication Between Insurers and Providers</i></b> .....	<b>4</b>
4.1	<b>Notification of Admission</b> .....	<b>4</b>
4.2	<b>Clinical Consultation</b> .....	<b>5</b>
4.3	<b>Prior Authorization Request</b> .....	<b>5</b>
4.4	<b>Concurrent Review Request</b> .....	<b>5</b>
4.5	<b>Retrospective Review</b> .....	<b>5</b>
<b>5</b>	<b><i>When to Conduct Utilization Review</i></b> .....	<b>5</b>
5.1	<b>Recommended Patient-related Triggers for Utilization Review of Acute Services</b> .....	<b>6</b>
5.2	<b>Provider Quality-Related Triggers for Utilization Review of Acute Services</b> .....	<b>6</b>
5.3	<b>Utilization Review for Ambulatory, Residential, and Specialty Services</b> .....	<b>7</b>
<b>6</b>	<b><i>LOCUS and CALOCUS/CASII Levels of Care Mapped onto NYS Adult and Children Mental Health Continuum of Care</i></b> .....	<b>7</b>
<b>7</b>	<b><i>Admission Workflow</i></b> .....	<b>7</b>
7.1	<b>Authorizing Higher Levels of Care</b> .....	<b>8</b>
7.2	<b>Authorizing Services that are Not Available</b> .....	<b>8</b>
7.3	<b>Lack of Clarity of Level of Care Determination</b> .....	<b>8</b>
<b>8</b>	<b><i>Provider Responsibilities</i></b> .....	<b>8</b>
<b>9</b>	<b><i>Discharge from Acute Services</i></b> .....	<b>8</b>
<b>10</b>	<b><i>Training</i></b> .....	<b>9</b>
	<b>Appendix A</b> .....	<b>10</b>

## 1 Background and Legal Basis

Chapter 57 of the Laws of 2019 added a new provision to the utilization review program standards in Insurance Law § 4902 and Public Health Law § 4902. The new provision requires that, when conducting utilization review for purposes of determining health care coverage for a mental health (MH) condition, insurers<sup>1</sup> utilize evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and which have been deemed appropriate and approved for use in determining health care coverage for the treatment of MH conditions by the Commissioner of the NYS Office of Mental Health (OMH), in consultation with the Commissioner of Health and the Superintendent of Financial Services. These provisions were effective January 1, 2020 and apply to health insurance policies issued or renewed on and after that date. Other provisions in the Insurance and Public Health laws proscribe that utilization review shall not be conducted more frequently than is reasonably required to assess whether the health care services under review are medically necessary.

Lastly, Chapter 57 of the Laws of 2019 also expanded and codified in New York State law the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended. Such provisions reinforce that insurers issuing comprehensive coverage that provides for utilization review are required to conduct utilization review for services for the treatment of MH or substance use disorder conditions in a manner that is comparable to and no more stringent than utilization review for medical/surgical benefits.

On November 25, 2019, OMH issued a guidance memo entitled, [\*Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services\*](#) (“Guiding Principles”), outlining the State’s expectations regarding appropriate utilization review activities for mental health services. Insurers were subsequently instructed to submit their clinical review criteria for mental health services and associated utilization review policies and procedures to the State for review. In the Guiding Principles document, OMH noted that the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) for adults over 18 years and the Child and Adolescent Level of Care Utilization System (CALOCUS) for children 6-18 years, both published by the American Association for Community Psychiatry (AAP), are clinical review criteria that best adhere to the Guiding Principles. The CALOCUS is also distributed as the Child and Adolescent Service Intensity Instrument (CASII) published by the American Academy of Child and Adolescent Psychiatry (AACAP) and has an accompanying clinical review criteria for services for children age 5 and under called the Early Childhood Service Intensity Instrument (ECSII). Detailed information about the LOCUS & CALOCUS and CASII and ECSII is available online. OMH will approve other clinical review criteria which adhere to the Guiding Principles.

This manual outlines the best practice approaches to utilization review in a manner that is aligned with the Guiding Principles as well as state and federal laws related to utilization review and behavioral health parity.

## 2 Applicability

Unless otherwise noted, this manual pertains to acute mental health services, which are defined as inpatient psychiatric hospital and partial hospitalization services. Additionally, this manual applies to utilization review for acute mental health services provided by both in-network and out-of-network providers.

---

<sup>1</sup> As used in this manual, the term “insurer” includes utilization review agents who perform utilization review on behalf of insurers pursuant to Article 49 of the New York State Insurance and Public Health Law.

### 3 Use and Disclosure of OMH-approved Level of Care Tools or other Clinical Review Criteria

Insurers who have adopted the LOCUS/CALOCUS/CASII/ECSII level of care tools or any other OMH-approved clinical review criteria for making level of care authorization decisions for covered benefits will collect clinical information from providers and use previously obtained historical information about patients to determine the appropriate level of care for a patient. Insurers should not require providers complete and submit clinical worksheets or scoresheets associated with the level of care tool or other clinical review criteria. However, insurers may share completed worksheets or scoresheets with providers during peer to peer reviews.

Insurers are required to make available the clinical review criteria they use for medical necessity determinations to any insured, prospective insured, or in-network provider upon request. Insurers and the State will work to educate providers about these OMH-approved clinical review criteria to facilitate a common language for level of care determinations.

### 4 Communication Between Insurers and Providers

The State recognizes the importance of effective communication between insurers and providers about appropriate care to improve health outcomes and reduce wasteful spending in health care. Below are best practices for the types of interactions which may occur between insurers and providers regarding clinical care which may be appropriate to promote those objectives. It is important to note that these types of communications, which may include specific documentation requests for the purpose of utilization review, are subject to New York State and Federal parity requirements. As such, insurers should assess their communication strategies and policies for communicating with and requesting information from providers, which may exist both in writing or as carried out in practice by insurer staff or their agents, to ensure that such strategies and policies are comparable to and applied no more stringently to services for the treatment of mental health conditions than those that apply to medical or surgical treatment.

#### 4.1 Notification of Admission

Providers should notify insurers of all in-network and out-of-network admissions to inpatient and partial hospital programs, even if specific triggers are not met (see [Section 5](#)). In the case of in-network providers, the method for such notifications may be established in provider agreements. If an insurer conducts utilization review and requests additional information accompany, or be submitted in response to the notification of admission, such request should be reasonable in light of the reasons for the request and should not be more than what is routinely requested from providers who provide notices of admission for medical or surgical treatment. Insurers may use an OMH-developed form (See [Appendix A](#)) to guide providers in collecting necessary information.

NOTE: Utilization review is prohibited for the first 14 days of admission to an in-network, in-state hospital licensed by the Office of Mental Health for inpatient psychiatric hospital services for members under 18 years of age. Providers treating children under age 18 in inpatient settings must provide such notification and the initial treatment plan within two business days of the admission.<sup>2</sup> The guidance memo can be found [here](#) and an example of a notification and treatment plan form can be found [here](#). Such services may be reviewed by the insurer retrospectively once the episode of care is complete.

---

<sup>2</sup> See Ins. Law §§ 3216(i)(35)(G), 3221(l)(5)(G), and 4303(g)(8).

## 4.2 Clinical Consultation

Insurers may initiate a clinical consultation conversation with the member's attending provider or treatment team to review the member's clinical progress and provide information deemed critical to support the treatment plan. This can occur for in-network, in-state inpatient psychiatric hospital treatment for children even when prior authorization and concurrent review is prohibited. OMH also encourages providers to initiate clinical consultation with insurers to foster a collaborative approach to discharge planning.

## 4.3 Prior Authorization Request

A member or a provider on behalf of the member may need to make a request for prior authorization of a new service according to the requirements of an insurance policy. Insurers make a coverage determination based on clinical information submitted by the treating provider or by other providers, and the member's prior treatment history. Other information may be relevant, especially in the case of requests for out-of-network coverage, where available pursuant to the terms of a health insurance policy.

NOTE: NYS Insurance Law § 4902(a)(8) and Public Health Law § 4902(1)(h) prohibit the establishment of a requirement for prior authorization for emergency services, including inpatient psychiatric treatment, that are medically necessary to stabilize and treat an emergency condition.

## 4.4 Concurrent Review Request

A member or a provider on behalf of the member may need to make a request for continued or additional services beyond what has already been authorized by the insurer according to the requirements of an insurance policy. Concurrent reviews are also initiated by insurers to review services for which prior authorization is prohibited for medical necessity. Insurers make a coverage determination based on clinical information submitted by the treating provider or other providers, and the member's prior treatment history.

## 4.5 Retrospective Review

Retrospective reviews are initiated by the insurer to review an episode of care that is complete and for which no authorization was previously obtained. Insurers make a coverage determination based on review of closed records submitted by the provider, or other providers, or any other relevant information, including the member's prior treatment history.

## 5 When to Conduct Utilization Review

As outlined in the Guiding Principles, where insurers conduct utilization for all services within a benefit classification, the State is concerned about the possible more stringent application of utilization review standards to mental health services, which may manifest in more aggressive concurrent review timeframes or provider documentation requests.

For these reasons, as a best practice, the State recommends insurers conduct utilization review for acute mental health services when suggested predefined clinical and/or quality improvement-based triggers as described in this section are present. This approach ensures that utilization review is conducted in a clinically-appropriate and parity-compliant manner and no more frequently than is reasonably required to assess whether services are medically necessary. Insurers who choose to implement utilization review practices that differ from those described in this best practices manual will be required to submit relevant policies and

procedures that govern their utilization review practices for both behavioral health and medical/surgical care and the insurer's most recent comparative analysis of their utilization review practices for further evaluation, prior to receiving OMH approval of an insurer's clinical review criteria for mental health services.

## 5.1 Recommended Patient-related Triggers for Utilization Review of Acute Services

To ensure clinically-appropriate and parity-compliant coverage, the State recommends insurers only conduct utilization review for acute services (inpatient or partial hospital programs) for patients who meet the following clinical criteria:

- a. Individuals subject to a current Assisted Outpatient Treatment (AOT) court order;
- b. Individuals who had an AOT court order that expired within the past five years;
- c. Individuals with high utilization of inpatient or emergency department (ED) services in the past year as evidence by:
  - 1) Three (3) or more psychiatric inpatient hospitalizations in the prior 12 months; OR
  - 2) Four (4) or more psychiatric ED visits in the prior 12 months; OR
  - 3) Three (3) or more medical inpatient hospitalizations in prior 12-months;
- d. Individuals who are readmitted to any mental health inpatient unit within thirty days of discharge from a prior mental health inpatient admission; or
- e. Individuals not meeting any of the above triggers whose length of stay exceeds 30 days. In these cases, the insurer should apply concurrent review from Day 31 onwards but should not apply medical necessity criteria or issue denials for any of the first 30 days.

NOTE: Utilization review for members under 18 years of age during the first 14 days of admission to an in-network, in-state inpatient hospital setting is prohibited as per section 4.1 above, even if the child or adolescent meets any of the clinical triggers listed above.

Upon admission to acute services, the admitting provider may convey in the notification whether one or more triggers are met, however, the insurer has the authority to independently determine if the case meets a trigger for utilization review based on its review of all available information. As a best practice for acute services, insurers should inform providers that a trigger is met within two business days of the admission notification.

## 5.2 Provider Quality-Related Triggers for Utilization Review of Acute Services

In addition to situations where patient-related triggers are met, insurers may also choose to increase the frequency of utilization review and/or conduct utilization review for all members receiving specific services (except where prohibited by State Law) when concerns arise regarding provider quality of care. Insurers who implement provider quality-related triggers for utilization review must submit their policies and procedures that define triggers and govern their implementation for both behavioral health and medical/surgical care as a condition of approval of the insurer's clinical review criteria, to ensure the insurer's utilization review practices are comparable and no more stringently applied to behavioral health care.

Insurers also remain obligated to implement a plan for the detection, investigation and prevention of insurance fraud. Government sponsored plans must also comply with federal and state Medicaid program integrity regulations and obligations established in the Medicaid Model Contract.

### 5.3 Utilization Review for Ambulatory, Residential, and Specialty Services

For Ambulatory and Residential mental health services, OMH recommends insurers apply a similar, clinical and/or quality-based trigger approach to utilization review.

NYS Medicaid Managed Care Plans must adhere to all [State-issued guidance](#) for specialty mental health services including, but not limited to, Assertive Community Treatment (ACT), Personalized Recovery Oriented Services (PROS), Adult Behavioral Health Home and Community Based Services (HCBS), Children and Family Treatment and Support Services (CFTSS), and Children’s HCBS. OMH expects that insurers authorized to write any type of policy in New York State, which covers these services will also follow the utilization review guidelines applicable to Medicaid Managed Care policies.

### 6 LOCUS and CALOCUS/CASII Levels of Care Mapped onto NYS Adult and Children Mental Health Continuum of Care

The table below shows NYS adult and children mental health services mapped onto the LOCUS and CALOCUS/CASII levels of care.

Level of Care	NYS Service
1 – Recovery Maintenance/Health Management	Office-based Outpatient Treatment
2 – Low Intensity Community Based Services	Clinic Treatment Programs Office-based Outpatient Treatment Personalized Recovery Oriented Services (PROS)
3 – High Intensity Community Based Services	Intensive Outpatient Services (IOP) Personalized Recovery Oriented Services (PROS)
4 – Medically-Monitored Non-Residential Services	Assertive Community Treatment (ACT) Partial Hospital Program (PHP)
5 – Medically-Monitored Residential Services	Residential Treatment Program Residential Crisis Support Intensive Crisis Residence
6 – Medically-Managed Residential Services	Inpatient Psychiatric Unit

### 7 Admission Workflow

Upon a patient’s admission to an inpatient or partial hospitalization program, the provider should notify the insurer within two business days of the admission (see [Section 4](#)).

The State recommends that if any of the member-related or provider-related triggers are met, utilization review may be initiated. Utilization review shall not be conducted more frequently than is reasonably required to assess whether the mental health services under review are medically necessary.

As a best practice, in the event that the insurer does not agree with the level of care requested by the provider based on the clinical information supplied by the treating or other providers, a clinician employed by the insurer or the contracted behavioral health organization should contact the clinical team to walk through the instrument findings and determine if any clinical information was missing or misinterpreted. Ideally, this will be a clinically-oriented conversation between the insurer and the clinical treatment team with the goal of reaching a

consensus regarding the most appropriate level of care. If an agreement is not reached and the instrument's recommended level of care is available, the insurer should issue an initial adverse determination and the member and/or the provider may initiate an internal appeal.

## 7.1 Authorizing Higher Levels of Care

In all instances, when the insurer receives a service authorization request for coverage of a service, utilization review staff can authorize a higher level of care than what is recommended by the clinical review criteria, but not a lower level. Once identified, a provider capable of providing care at the optimal level should be substituted onto the prior authorization request.

## 7.2 Authorizing Services that are Not Available

While admitted to a psychiatric inpatient hospital, if the member improves and no longer meets clinical review criteria for inpatient care, the insurer should continue to authorize inpatient level of care if the next most appropriate level of care is not available in the member's geographic area or otherwise not available to the member.

## 7.3 Lack of Clarity of Level of Care Determination

When a member's clinical presentation straddles two different levels of care, and if placement remains ambiguous even after thoughtful clinical review and discussion with the clinical treatment team, the State recommends the insurer utilization review staff authorize the higher level of care.

# 8 Provider Responsibilities

When an insurer adopts the recommendations of this guidance, it is essential that providers cooperate, communicate, and engage in close care coordination with insurers. Providers have the following responsibilities to ensure effective communication with insurers:

- a. Providers should notify the insurer of all admissions to inpatient and partial hospital programs within two business days. For individuals under age 18 who are admitted to in-network inpatient hospital facilities, such notification must include the initial treatment plan as well;
- b. Providers should make a good faith effort to identify the member and the member's insurance coverage for notification purposes. In cases where a member's identification or coverage are identified after two business days, providers should notify insurer as soon as possible;
- c. Providers should participate in utilization review discussions for cases that meet a utilization review trigger;
- d. Providers should respond in a timely manner when the insurer requests clinical consultation regarding any member, regardless of whether the member has triggered formal utilization review; and
- e. Providers should notify the insurer two days prior to the patient's planned discharge date so insurers can work collaboratively with the provider to establish the discharge plan, suggest additional or alternative resources, and ensure the member follows up with care.

# 9 Discharge from Acute Services

Discharge planning must be coordinated with the current provider, the member's outpatient providers and insurer care managers. The insurer is responsible for ensuring that the member has a safe and appropriate link to another level of care and must remain engaged until that linkage is complete. In general, and unless



otherwise clinically indicated, the State recommends that the insurer authorize the next highest level of care when the recommended level of care is not available (see Section 7.2).

## 10 Training

Insurers must provide training for all their utilization review staff on the OMH-approved critical review criteria. New staff must be trained before they conduct utilization review independently. While providers will not be required to complete the instruments, it is strongly encouraged that providers receive training as well.

Inter-rater reliability (IRR) testing for the use of the OMH-approved medical necessity determination instrument is required annually and that the minimum IRR must be 85%. Insurers should provide for the remediation of poor IRR results and IRR testing for all new staff before they can conduct utilization review without supervision.



**ADMISSION NOTIFICATION FORM**

For use by inpatient and partial hospitalization to notify insurers within two business days of covered patient admission.

Patient Name:		Date of Birth:
Legal Guardian (and phone number) if under 18:	Insurance Plan Name and ID:	
Admitting Program Name:		Date of Admission:
Service Location/Billing Address		NPI and/or TIN:

**Diagnoses**

Psychiatric:	Co-occurring SUD:	Medical:
		<input type="checkbox"/> NO <input type="checkbox"/> YES (list):
	<input type="checkbox"/> Tobacco (or other nicotine) Use Disorder	

Reason for Admission:

Recommended Trigger(s) for utilization management (check one or more, if any):

- Current AOT order or AOT order expired in last 5 years
- Three or more inpatient psychiatric admissions in last year
- Four or more psychiatric emergency department or CPEP visits in last year
- Three or more medical or surgical hospital inpatient admissions in last year
- Psychiatric inpatient readmission within 30 days of psychiatric inpatient discharge
- Other \_\_\_\_\_

Clinician Contact Information:	Administrative Contact Information:
--------------------------------	-------------------------------------

Clinician Signature	Print Name and Title	Date
---------------------	----------------------	------