UTILIZATION MANAGEMENT PLAN FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER (SUD) SERVICES FISCAL YEARS 2025-2026

The primary purpose of the Utilization Management (UM) Program is to ensure that person-centered, high-quality, and trauma-informed services are provided to eligible individuals, in the most cost effective and efficient manner, that supports each individual's personal recovery plan. Integral to this cause is the concept of continuous quality improvement with a focus on progressively improving administrative and clinical efficiencies as well as outcomes of care. Since performance of important organizational functions significantly affects service outcomes of care and customer satisfaction, the UM, and Quality Management (QM) Programs primary focus is to achieve these goals by monitoring, analyzing, evaluating, reporting, and recommending improvements in the organizational functions of LifePath Systems and its contracted providers for mental health and substance use disorder services.

The Utilization Management workforce and the Utilization Management Committee identify and monitor patterns of over-utilization, under-utilization and other utilization problems that compromise care from inappropriately utilized resources. This may include weekly, monthly, and quarterly monitoring of the performance measures outlined in the most current performance contract notebook for mental health and substance use disorder services, billing issues, clinical outcomes, and barriers to access. Based on the findings, UM workforce and the UM Committee recommend and participate in interventions to make utilization of services more efficient and consistent with contractual requirements and the local planning processes. The interventions and recommendations by the UM committee to providers are monitored for outcome improvement on a regular basis.

This plan is based on compliance with the Texas Resilience & Recovery (TRR) Utilization Management Program Manual, the Local Mental Health Authority and Substance Use Disorder (SUD) Contracts, and the Texas Administrative Code (TAC).

Required Utilization Management Personnel

UM Physician: Board eligible psychiatrist who possesses a license to practice medicine in Texas.

Job Functions Include: Oversight of the UM process and approving of all policy and procedures related to UM; clinically supervises the Utilization Manager; is responsible for providing consultation on all adverse determinations upon request of UM, and for reviewing all first level appeals of adverse determinations; resolves conflicts that may arise regarding the authorization of services that are not resolved through usual procedures; is a member of the UM Committee; provides physician-to-physician review as indicated.

UM Manager: Registered Nurse (RN), Advance Practice Nurse (RN-APN), Physician's Assistant (PA), PhD psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT) licensed in the State of Texas who has at least 5 years of experience in direct care of persons with a serious mental illness and/or children and adolescents with serious emotional disturbance, which may include experience in an acute care or crisis setting; at least 5 years of experience participating as a member of a treatment team that develops and monitors recovery plans for individuals with chronic and serious mental illness; has demonstrated understanding of psychopharmacology and medical/psychiatric comorbidity through training and/or experience within the past 3 years; has one year experience in program oversight of mental health care services; and has demonstrated competence in performing UM and review activities.

Job Functions Include: Conducting utilization review and granting and denying authorizations for all Levels of Care (LOC) and services as part of the HHSC UM Guidelines; conducts prospective, concurrent, and retrospective reviews for authorization of LOCs/services for individuals; conducts reviews using clinical information submitted by providers, direct contact with providers, review of medical necessity records, and contact with the individual and family members when needed and appropriate; makes initial adverse determinations and all clinical overrides and exceptions to the UM

Guidelines, in consultation with the LBHA UM physician when indicated; monitors service delivery and outcomes to ensure services are not over-utilized or under- utilized; reviews data to detect outliers and unusual patterns of utilization and recommends interventions to the UM Committee; informs individuals and providers relative to appropriate treatment alternatives and community resources; performs Utilization Care Management for those individuals with special circumstances needing special authorization by an LBHA representative; participates in provider training on the UM process, monitors provider adherence to UM Guidelines, and provides consultation when needed.

Utilization Management Committee

The primary function of the UM Committee is to monitor utilization of clinical and fiscal resources to ensure that clinical resources are being expended effectively and efficiently. The UM Committee assists the promotion, maintenance, and availability of high-quality care through the evaluation of clinical practices, services, and supports delivered by the covered providers using clinical, encounter and administrative data, and performance measures. Based on review of utilization data, the Committee makes recommendations for improvements in provider practices and agency processes. The UM Committee meets at least quarterly and may meet more frequently as needed. All activities of the UM Committee are under the supervision of the UM Physician. Minutes are kept for each meeting. In addition to any other current issues the Committee reviews the following:

- Appropriateness of Eligibility Determinations;
- Use of Exceptions and Overrides to service authorization ensuring rationale is clinically appropriate and documented administratively and clinically;
- Over and Under Utilization;
- Appeals and Denials;
- Fairness and Equity;
- Cost Effectiveness of all services provided; and,
- Outcomes in relationship to services provided.

The Composition of the Utilization Management Committee includes at a minimum:

- Medical Director/Utilization Management Physician;
- Utilization Management Representative;
- Quality Management Representative; and,
- Financial Services Representative.

Training Members of the Utilization Management Committee:

LifePath Systems ensures that all UM Committee members receive appropriate training to fulfill the responsibilities of the Committee. Training is conducted at least annually, when needed, or when a new member is added. LifePath Systems provides to each member of the UM Committee a copy of the "UM Program Plan," the current HHSC UM Guidelines and other information necessary to perform their function. The UM Physician, or designee, discusses with each new member of the Committee:

- the role of the UM Committee;
- types of cases;
- data and information reviewed by the Committee; and,
- clarification of the UM program and processes.

All participants in the Utilization Management process are subject to strict confidentiality practices, as defined by federal, State, and other applicable rules.

Review of UM Committee Activities:

The Utilization Committee is responsible for the continuous review of procedures and protocols related to utilization management. Using reports available via CMBHS, MBOW, CARE, and internal reports, the Committee monitors the appropriateness and effectiveness of the UM processes at LifePath Systems. The UM Committee evaluates this data and recommends improvements to the UM process to the Behavioral Health Management Team. The Committee also conducts an evaluation of UM activities annually. This annual review appraises the past year's effectiveness of UM in its

role of ensuring that the center meets the performance measures established in the contract for services delivered and for UM effectiveness as per UM Performance Measures outlined in section 7 of the HHSC UM Program Manual. As per the Local Mental Health Authority contract, the UM plan is reviewed and updated in conjunction with the quality management plan on a biennial basis.

Provider Profiling

Provider profiles, to include review of data and relevant methodology, are used for the purpose of evaluating a provider's performance in relation to the use of resources and compliance with utilization review guidelines.

LifePath Systems assesses utilization through the use of provider utilization profiles. Profiling may be defined as gathering data and using relevant methodology for the purpose of describing and evaluating a provider's mental health practice performance in relation to the use of resources. Profiles are used to identify areas in need of improvement in the effectiveness and efficiency of the delivery of care and services rendered by providers. The primary objective of profiling is to encourage high-quality service delivery, which includes appropriate utilization of resources and results in improved satisfaction of those served and positive outcomes. Profiles are employed for informational purposes for LifePath Systems and providers including information concerning factors that influence utilization rates and outcomes.

Providers who advocate for necessary and appropriate mental health care and services will not experience retaliation by Lifepath Systems. LifePath Systems will not terminate, demote, or refuse to compensate a provider because the provider advocates in good faith for an individual, seeks reconsideration of a decision denying a service, or reports a violation of law to an appropriate authority.

The development of provider profiles includes but is not limited to the following data:

- length of stay (LOS);
- readmission or recidivism rates to identified services;
- number of requests for special or support services;
- prescription charges;
- number of inpatient bed days;
- number of outpatient service days;
- use of crisis services & emergency room visits;
- lab tests;
- individual achievement of clinical outcomes;
- number of adverse determinations; and,
- number of appeals

UM Responsibilities

Utilization Reviews and Authorization of Services

Services are authorized for all levels of care as per the Performance Contract, current utilization management guidelines, payer standards, uniform assessment, diagnosis, additional clinical information submitted, and clinical judgment.

Authorization is required prior to delivery of services, with the exception of crisis services. Behavioral Health routine authorization requests must be received the same day the face-to-face uniform assessment (UA) is completed but no later than 3 business days from the date of assessment. SUD service authorization requests must be submitted within 3 business days of the begin service date. Requests submitted outside of the 3 business days of completion must be accompanied with written justification for the delay of the submission and are considered by the UM Department and authorized accordingly.

Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested is reviewed by either the Utilization Manager or board certified or board eligible psychiatrists of the same or similar specialty as the services being denied.

Utilization Review (UR):

Under the direction of the UM Physician, the Utilization Manager monitors the Utilization Review process. Utilization Review entails the protocols and procedures involved in the determination of eligibility and delivery of services. The Utilization Manager ensures that business practices guiding the UR process are in compliance with the current Mental Health and Substance Use Disorder contracts and the various manuals, guidelines and administrative codes that provide protocols, policies, and procedures of the delivery of behavioral healthcare. For substance use disorder services, the following Texas Department of Insurance (TDI) criteria is utilized for care management and utilization review determinations; TAC Title 28, Part 1, Chapter 3, Subchapter HH, Rule 3.8001 and Insurance Code 1368.007.

1. Prospective Review:
   - This is a pre-admission review for appropriateness of admission into services prior to receiving services.
   - Preauthorization for outpatient services is required to document medical necessity and determine appropriate level of care. Preauthorization can be made only by the UM physician and UM workforce not involved in the providing of services. Prospective review is determined no later than two business days, based on information gained via the ANSA/CANS, Clinical Management for Behavioral Health Services (CMBHS) SUD Assessment and the initial eligibility interview. Crisis services do not require preauthorization; however, the authorization must be completed within two business days after the provision of the crisis intervention service.

2. Concurrent Review:
   - This is a routine review by a Utilization Manager or a utilization reviewer, during the course of an individual's treatment to determine if continued treatment is medically necessary.
   - A concurrent review process is used to identify, evaluate, and coordinate appropriate clinical and cost-effective treatment. The UM workforce is responsible for the authorization of services. Determination of concurrent reviews is made within one business day after receipt of request. Notification is available to the provider through SmartCare and/or CMBHS within two business days of making the determination.

3. Retrospective Review:
   - A review following service provision to assess the appropriateness, necessity, quality, and reasonableness of health care services provided, usually conducted on a case-by-case or aggregate basis.
   - The Utilization Manager monitors the individual clinic's activities within the utilization review process to ensure consistency in the UR process throughout LifePath Systems and its provider network. Retrospective review takes place within 30 days of determination of the need for a retrospective review. Specifically, UM monitors:
     - Determination, authorization, and documentation of medical necessity for services;
     - Level of Care Assignment;
     - Inpatient admissions and discharge planning;
     - Effectiveness of services;
     - Provider productivity;
     - Service capacity;
     - Clinical overrides; and,
     - Outlier data

Authorization of Services:

As the LBHA, LifePath Systems completes service authorizations per each provider for TRR Non-Managed Care Organization (MCO) individuals and substance use disorder individuals. UM monitors the authorization process for MCO individuals as follows:

1. **Authorization Procedure for TRR Non-MCO Individuals:**
   - Assessing workforce complete the Uniform Assessment (UA).
   - The Utilization Manager reviews the assessments within two business days for prospective reviews and one business day for concurrent reviews and makes a determination to authorize, deny, or modify requested service. The Utilization Managers are Licensed Practitioners of the Healing Arts (LPHA) that do not function as

service providers.

- Services are authorized for the length of time specified by the current UM Guidelines for each level of care.
- In the event that the requested service is at capacity, a lesser level of care may be offered, or the individual may be placed on a waiting list, unless the individual is a Medicaid recipient. Individuals with Medicaid may not be placed on a waiting list for a Medicaid service.
- With appropriate clinical justification, the Utilization Manager may override the recommended level of care and approve an alternate level of care. Documentation of authorization is signed by the Utilization Manager and placed in the clinical record.
- In the event that an individual is not authorized for a requested level of care, the Utilization Manager notifies the responsible workforce member.
- Authorization of crisis services takes place within two business days of service delivery.

2. **Authorization Monitoring Procedure for TRR MCO Individuals:**
   - Assessing workforce completes the Uniform Assessment (UA).
   - The designated LPHA reviews the uniform assessment for medical necessity within two business days for prospective reviews and one business day for concurrent reviews and submits to the MCO to authorize a requested level of care according to current UM Guidelines.
   - With appropriate clinical justification, the LPHA may request that the MCO override the recommended level of care into an alternate level of care.
   - Final service authorizations are made by MCO UM in accordance with UM Guidelines for each level of care.
   - In the event that an individual is not authorized for a requested level of care by the MCO, the MCO notifies the provider in accordance with UM guidelines.
   - Utilization Managers serve as the primary points of contact for the MCO UM.

3. **Authorization of Substance Use Disorder General Revenue Individuals:**
   - Assessing workforce enter diagnostic, clinical assessment, and request for authorization into CMBHS and the local EHR.
   - Prospective and concurrent reviews for detoxification and residential services are completed by the Utilization Manager within one business day of receiving all necessary clinical information and makes a determination to authorize, deny, or modify requested service.
   - For outpatient services prospective reviews are completed by the utilization manager within two business days and concurrent reviews are completed within one business day.
   - Services are authorized for the length of time in accordance with current American Society of Addiction Medicine (ASAM), Texas Department of Insurance (TDI) criteria, Texas Administrative Code (TAC) criteria, clinical presentation, and contractual specifications relevant to each episode of care.
   - In the event that the requested service is at capacity, and it is clinically appropriate, a lesser level of care may be offered, or the individual may be placed on a waiting list.

4. **Automatic Authorization**
   - Automatic Authorization is an alternative method of authorizing Levels of Care (LOC) in which authorization is “automatically” granted to qualified providers for specified populations. The requests are authorized and processed electronically and are not individually reviewed by Utilization Management (UM) workforce members.
   - Automatic Authorization may be used for Initial Adult LOC-Recommended (LOCR) 1M and Update Adult LOCR 1S or LOC 2. Both the UM department in conjunction with the Management of Information Systems (MIS) division will exercise their discretion in determining which packages will be automatically authorized according to HHSC UM Manual guidelines.
   - Overrides cannot be automatically authorized. Continued stay in Adult LOC3 & 4 cannot be automatically authorized since these are considered high-risk populations. Automatic Authorizations are limited to two consecutive automatic authorizations. The third request for authorization must be reviewed by UM workforce members. An Automatic Authorization cannot be used in conjunction with the Extended Review option.

Making Adverse Determinations:
The UM Department makes adverse determinations and denials in an objective manner. Unless otherwise indicated, the following processes and guidelines apply to mental health and substance use disorder services. An adverse determination (i.e., a decision to deny, reduce or terminate a service) applies to those individuals requesting services that are denied and those individuals who are receiving services who no longer meet UM criteria for that service(s) and for whom the provider and individual request additional authorization. The initial recommendation to deny authorization for continued stay is made by the Utilization Manager. Upon appeal, the UM Manager and, as appropriate, the UM Physician conducts a review of all necessary information.

- Denial of services based on an administrative determination, such as failure to comply with contractual authorization procedures, may be made by the Utilization Manager or the UM physician. At the time of the decision to deny further authorizations, UM workforce assigned to the case verbally notifies the appellant and the individual or their Legally Authorized Representative (LAR) requesting or receiving services (if different), and his/her provider. Within four business days of the decision, a Denial of Authorization letter is mailed to the appellant and individual requesting or receiving services (if different) and his/her provider. The appeal process does not go further for an administrative denial.

- Referral of an individual to their third-party coverage in accordance with Texas Administrative Code (TAC), Title 25, Chapter 412, Subchapter C (relating to Charges for Community Services) may only be made by the Utilization Manager, if available, or the UM physician. At the time of the decision, UM workforce assigned to the case verbally notifies the individual or the LAR receiving services and the provider of the proposed action. Within four business days of the decision, a notification letter is mailed to the individual receiving services and the provider.

- Denial of services based on a clinical determination may only be made by the Utilization Manager or UM Physician, and a final denial of services based on failure to meet clinical criteria may only be made by a physician. At the time of the decision to deny further authorizations, UM workforce assigned to the case verbally notifies the appellant and individual or their LAR requesting or receiving services, if different, and them provider. Within 3 business days of the decision, a Denial of Authorization letter is mailed to the appellant and individual or their LAR requesting or receiving services, if different, and their provider.

- A proposal to reduce or terminate services based on a clinical determination that non-payment is not related to the individual's mental illness and the proposed action would not cause the individual's mental or physical health to be at imminent risk of serious deterioration may only be made by the Utilization Manager or UM Physician. This proposal is not applicable for individuals for whom the LBHA is identified as responsible for providing court-ordered outpatient services. At the time of the decision to reduce or terminate services in accordance with Title 25, TAC Chapter 412, Subchapter C (relating to Charges for Community Services) UM workforce assigned to the case verbally notifies the individual or them LAR receiving services and them provider of the proposed action. Within 3 business days of the decision, a notification letter is mailed to the individual receiving services or them LAR and the individual's provider. LifePath Systems does not take the proposed action while an appeal of the proposed action is pending.

Maintaining an Appeals Process:
LifePath Systems UM Department maintains an appeals process that assures notification of adverse determinations to the person receiving or requesting services and their provider and includes information on how to file an appeal. Lifepath Systems ensures individuals' have access to an objective appeals process when services are denied, reduced, or terminated. Individuals funded by Medicaid are also afforded access to the Medicaid Fair Hearing Process. LifePath Systems ensures that all providers and individuals are provided information about the right to appeal and the process to do so.

Appeals:

The appeals process provides a mechanism for individuals requesting or receiving services, their LAR, individuals advocating on the individual's behalf, and providers to challenge utilization management (UM)/resource allocation decisions with which they disagree. The individual requesting or receiving services, them LAR, the provider or someone else acting on the individual's behalf has 30 calendar days after receipt of written notification of an adverse determination to initiate a request for appeal. Individuals requesting or receiving services may notify the UM Department of their decision to appeal an adverse determination either in writing or verbally. An individual's LAR, appeals representative, or the individual's provider then submits the request for appeal of an adverse determination in writing. The appealing party has the opportunity to submit, in writing, good cause for having a particular type of specialty provider review the case. In such circumstances, the appeal includes a review by a provider in the same or similar specialty as typically manages the specialty condition, procedure, or treatment under review. All requests to appeal an adverse determination is sent to the UM Department.

This process is separate and distinct from the process that allows a person with Medicaid coverage the right to request a Medicaid fair hearing. In accordance with Uniform Fair Hearing Rules outlined in Title 1, TAC Chapter 357, Subchapter A, LifePath Systems affords persons an opportunity to a fair hearing in any Medicaid case for an individual whose claim for services is denied or not acted upon promptly or LifePath Systems takes action to suspend, terminate or reduce services, including a denial of prior authorization request for Medicaid-covered services. Although the Medicaid fair hearing process is distinct from the appeal processes, similar activities may be synchronized.

Routine Appeal Process:

- The individual has **30 calendar days** after receipt of written notification of an adverse determination to initiate a request for an appeal. The LBHA Program Administrator, or their designee, when requested, assists the appellant, LAR and/or provider, as needed to meet required time frames in the appeal process, assists in collecting additional information from UM workforce, the individual requesting services or receiving services, the LAR and /or provider to obtain any additional information as needed to submit the appeal.

- As soon as all necessary information is received, UM has **2 business days** to make a determination. The UM representative submits the individual's records and other data necessary to review the adverse determination decision to a designated individual who was not involved in the original authorization decision. The individual reviewing the appeal may obtain additional information including but not limited to interviews with the individual requesting or receiving services, the individual's LAR, and/or anyone the individual designates to advocate for them and the individual's provider.

- Review of the appeal shall be completed within **20 business days** of receipt of notification to appeal unless the chief executive officer of the LifePath Systems grants an extension of the timeframe. The final denial of services based on failure to meet clinical criteria may only be made by a physician.

- Following the appeal decision, UM workforce assigned to the case verbally, in person or by telephone, notifies the appellant and individual requesting or receiving services, if different, and their provider of the decision.

- Within **3 business days** of the decision, UM workforce assigned to the case mails written notification of the decision (an Appeal Resolution letter) to the appellant and individual requesting or receiving services, if different, and their provider. The letter includes information about making a complaint to the Health and Human Services Commission (HHSC) Individual Services and Rights Protection Division (1-800-252-8154) if they are not satisfied with the appeal decision.

Expedited Initial Appeal Process:

- Denial of admission or continued stay for mental health inpatient services or substance use disorder detoxification (detox) or residential treatment requires an expedited appeal process. Within **1 hour** of making the adverse decision, for admission or continued stay for inpatient services, designated LifePath Systems UM workforce notifies the

individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for them, or the individual's provider of the adverse decision.

- Once notified of a denial of detox, residential treatment, inpatient services, or continued stays for hospitalization, the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for them, or the individual's provider has **1 business day** to request an appeal through the UM Department. However, if notification of the denial is made at 5:00 PM or later, they have until 8:30 AM the next business day to make the request.

- A LifePath Systems physician who was not involved in the original authorization decision reviews the appeal. The expedited appeal is completed based on the immediacy of the condition and no later than **1 calendar day** from the date that all information necessary to complete the review is received by the UM Department.

- Within **1 calendar day** of the decision, UM workforce assigned to the case verbally, in person or by telephone, as well as certified mail (Appeal Resolution letter), notifies the appellant and individual requesting or receiving services, if different, and their provider of the decision.

At any time, the appellant and individual requesting or receiving services, or their LAR, may contact the HHSC Office of Individual Services and Rights Protection (1-800-252-8154) for further review of their concern about the appeal decision and any proposed action.

Waitlist

TRR Services:
The Utilization Management team in compliance with Texas Resilience and Recovery Waiting List Maintenance requirements and State performance contracts determines capacity levels for each level of care and maintains waitlists for services, as necessary. UM triages and prioritizes the service needs of the individuals determined eligible for services, but for which LifePath Systems has reached or exceeded capacity to provide services. If a wait list is implemented, designated authority workforce utilize MBOW and CMBHS on a regular basis to monitor both individuals waiting for all services and underserved due to resource limitations to ensure any person who becomes eligible for Medicaid, after being placed on a wait list, is promptly identified, and placed into the appropriate LOCR. Designated workforce will document contact attempts, which are made no later than 14 days from when the individual's Medicaid status is reflected in MBOW.

In accordance with performance contract Info Item R guidelines for TRR, to ensure individuals on the wait list are not deteriorating, still have a desire and need for services and can be located, type and frequency of monitoring occurs as follows:

- For LOC-A 8 with an LOC-R of adult LOC 3 or 4 and all children on the wait list are monitored every **30 days**.
- For LOC-A 8 with an LOC-R of adult LOC 1S or LOC 2 are monitored every **90 days**.
- For both of the above timeframes, workforce utilize a brief clinical screening (see Attachment A) to assess for current urgency of need. If it is determined the individual is in need of crisis services, these are provided. Otherwise, the individual remains on the wait list until capacity is available.
- The workforce member attempts to contact and document at least 2 different efforts either via phone, letter, or home visits to reach the individual within the above noted timeframes. If an individual cannot be reached after these efforts the individual is removed from the wait list but no sooner than **30 days** prior to the preceding contact.
- Individuals on the waiting list are reassessed at least every 180 days using the CANS or ANSA

For individuals placed on the wait list with limited financial resources a screening for benefits assistance is provided.

Inpatient Care Waitlist:
Pursuant to TAC Title 26, Part 1, Chapter 301 Subchapter G pertaining to Access to Mental Health Community Services and Standards of Care, LifePath Systems shall utilize the Inpatient Care Waitlist (ICW) through CMBHS within **1 business day** of the LMHA determination that an individual requires inpatient services, and there are no resources available in the local service area, (i.e., no Private Psychiatric Beds available locally or at Terrell State hospital).

Substance Use Disorder Services:
The Utilization Management team, in compliance with State performance contracts, monitors capacity for each level of care and maintains waitlists for services, as necessary. Priority for admission follows priority population guidelines admitting pregnant injecting individuals within 48 hours, injecting users within 14 days, DFPS referrals within 72 hours, individuals who are experiencing housing instability or homelessness within 72 hours, and then all others. In the event that LifePath Systems reaches capacity HHSC is notified. As per contractual guidelines interim services are provided to the priority population by the regional Outreach, Screening and Referral (OSAR) provider. If an individual cannot be admitted who is at risk for dangerous withdrawal the contractor shall ensure that an emergency medical care provider is notified. In accordance with contractual guidelines, daily capacity is reported as follows:

- Residential detoxification, intensive residential and supportive residential treatment providers will submit, via encrypted email by 9:30 am, each business day their daily census to LifePath Systems UM.

- Ambulatory detoxification and outpatient treatment providers may report the previous day's census when submitting their daily census report to LifePath Systems UM. For example: Monday's daily attendance may be reported on Tuesday and Friday's attendance may be reported on the following Monday. Reports will be sent each business day via encrypted email by 9:30am.

- If a pregnant woman or an injecting substance user is on the waiting list, this shall be confirmed in the Daily Capacity Management Report.

For individuals who are not on the wait list for capacity reasons the following removal procedure shall apply; the individual is removed from the waitlist upon admission to treatment; upon notification from the individual that they are no longer interested in services, the individual no longer meets the criteria for a certain level of care or if the individual has not had face to face contact with the OSAR and cannot be contacted for a period of 30 days, with a minimum of 3 unsuccessful documented attempts via phone and/or mail.

YES Waiver
The Youth Empowerment Services (YES) Waiver provides comprehensive home and community-based mental health services to youth at risk of institutionalization and/or out-of-home placement due to a serious emotional disturbance (SED). Services are available until the month before a youth's 19th birthday. The program provides flexibility in the funding of intensive community-based services and supports for youth and their families.

YES Authority Requirements:
The UM Department monitors compliance with LifePath Systems' YES Waiver Work Plan. As per the YES Waiver Policy Manual January 2022, an individual is required to obtain and maintain Medicaid in order to receive YES Waiver services. To facilitate management of timely and appropriate YES service utilization, LifePath Systems coordinates the flow of information between the YES single point of entry and the UM program.

- Access to UM workforce is consistent throughout each business day.

- UM workforce is available throughout the business day to review clinical information needed to make authorization decisions.

- The Center provides twenty-four hours a day seven days a week telephone answering system and FAX machine

through which authorization request messages may be received.

- Upon receipt of all required information, requests for authorization of services are reviewed by UM in accordance with the YES Waiver standards.

- Information about the right of persons requesting or receiving services to express concerns, dissatisfaction, or appeal an adverse determination decision is posted at all service sites. The information includes an easily understood explanation of the appeal process.

- Process for clinical eligibility determination (CED):
  - Within seven 7 business days of the initial demographic eligibility determination, and if LifePath Systems has enrollment capacity, an LPHA must complete the Clinical Eligibility Determination-assessment (completion of a TRR UA).

  - If it is determined the youth meets clinical eligibility as per the YES Waiver Policy Manual the UM Department then authorizes the individual into an LOC-YES.
    NOTE: Authorization for TRR services through LOC–YES occurs independently from enrollment into the YES Waiver. An LOC-YES authorization is 90 days.

  - Following CED by HHSC then LifePath Systems completes the enrollment process for Waiver services or, if denied, completes the process to get the individual into the appropriate TRR LOC other than LOC-YES as applicable. A CED authorized by HHSC is valid for 365 days from the CED date in CMBHS.

- Process for service authorization:
  - All service authorization requests (initial, review and annual renewals) must be entered into CMBHS and placed in "Ready for Review" status within 5 business days of the completion of the Individual Plan of Care (IPC) for HHSC's review.

  - HHSC makes an authorization determination within 5 business days of the IPC being submitted to CMBHS. Clarification or questions regarding the service authorization request from the HHSC authorizer are placed in the 'Note' section and the request is placed into 'Draft' status (not authorized).

  - Changes to the request must be communicated to HHSC prior to authorization or denial of the request. Any changes made by the Facilitator must be placed back in 'Ready for Review' status within five business days of the request being placed into 'Draft' status by HHSC.

  - Transition Planning and service coordination begins at least six (6) months prior to the Waiver participant's 19th birthday.

ATTACHMENT A
LIFEPATH SYSTEMS WAIT LIST

1. **Brief Clinical Screening Assessment**
   i. Do you understand that you are on the waiting list for all services at this time?

2. **Since the last contact:**
   i. Are the mental health problems you were seeking services for still present?
   ii. Has the individual found anyone in the community to provide services to address these needs?
   iii. Have those problems gotten better, worse, stayed the same, or caused a crisis?
   iv. Has the individual expressed any suicidal/homicidal ideation? M(Noticed any increased risk of harm to self or others?)
   v. Have there been any psychiatric hospitalizations?
   vi. Did the individual report any alcohol or drug use? If yes describe.
   vii. Would you like or have you already been given any counseling referrals?
   viii. Do you have a family doctor that can be seen if needed?
   ix. Have there been any recent arrests?
   x. Has the individual's phone number, address or living situation changed since the last contact?
   xi. Have you gained Medicaid since last contact?

3. **Conclusion:** Waiting list status following assessment (indicate all that apply):
   i. Remove from waitlist by person's choice.
   ii. Remove from waitlist; services were acquired elsewhere.
   iii. Referred for emergency services.
   iv. Remain on waitlist.

ATTACHMENT B
Denial of Authorization Based on Administrative Determination

Request Date: _____ **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Services		

Reason for Authorization Denial	

Please be informed that you have the right to make a complaint regarding this decision. In order to make a complaint you may contact one or more of the following:

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive,
McKinney, TX 75069
(972) 562-0190

Texas Health and Human Services Commission (HHSC) Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

Disability Rights, Texas 2222 West Braker Lane
Austin, TX 78758
(800) 252-9108
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)
(866) 362-2851 (Video Phone)

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

Utilization Management (UM) Department
1515 Heritage Drive,
McKinney, TX 75069
Phone: (972) 422-5939 or Toll Free: 844-544-5939

Staff Issuing Denial: _____ Signature: _____

ATTACHMENT C
Denial of Authorization Based on Clinical Determination

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		
Reason for Authorization Denial		

Please be informed that you have the right to appeal this decision. In order to appeal the authorization decision, you must contact the Utilization Management Department at LifePath Systems by telephone, in person, or by mail within 30 days of receipt of this notice. Afterwards, you will receive a letter from LifePath Systems Utilization Management staff acknowledging your request to appeal. You may request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal. Prior to a decision, you have the right to meet with the individual(s) who will be deciding the appeal. Within 20 business days of your request to appeal, LifePath Systems Utilization Management staff notify you in person or by telephone of the decision.

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

LifePath Systems
Utilization Management (UM) Department
1515 Heritage Drive
McKinney, TX 75069
Phone: (972) 422-5939 / Fax: (972) 665-0076

The appeal for authorization may be requested by:

- You
- Your legally authorized representative (LAR)
- Your Provider
- Your actively involved adult relative, friend, or advocate (with your written consent)

Staff Issuing Denial: _____ Signature: _____

ATTACHMENT D
Texas Health and Human Services Commission (HHSC)
Appeal Procedure for Indigent Community Mental Health or Substance Use Disorder Services

Your Right to Appeal
If one of these decisions is made about your services, and you do not agree with the decision, you have the right to appeal it:

- A decision that you are not eligible for services based on a determination made during the intake process.
- A decision to reduce your services and supports based on a clinical determination.
- A decision to deny your request for a service or support that is not clinically indicated.
- A decision to terminate your services and supports based on a clinical determination.

How to Begin

- Call the Utilization Management (UM) Department (972) 422-5939 and say that you want to appeal a decision and they will assist you. Or you may tell your provider that you want to appeal, and your provider will assist you.
- You must start your appeal no later than thirty (30) days from the time you are notified of the decision.

The Appeal Process

1. Once LifePath Systems receives notice of your appeal, an Appeal Acknowledgement letter will be mailed to you. You should receive the letter within one week of your notice to appeal.
2. You may be asked to provide additional information.
3. Within twenty (20) business days after the date that all necessary information is received by LifePath Systems, a decision shall be made.
4. Within one (1) business day of the decision, the Utilization Management workforce assigned to your case shall notify you in person or by telephone of the decision.
5. Within three (3) business days, the UM workforce assigned to your case shall mail an Appeal Resolution letter to you to inform you of the decision and offer additional information. The Appeal Resolution letter will include notice that the decision is final.
6. If you disagree with the decision, you will have ten (10) calendar das to request a review of your concerns by contacting the HHSC Office of Individual Services and Rights Protection at (800) 252-8154.

If you have Medicaid, this appeal process does not preclude you from requesting a Medicaid Fair Hearing. If you have questions, need help, or have problems or complaints related to the appeal process, you may call the Rights Protection Officer or HHSC.

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive, McKinney, TX 75069
(972) 562-0190

HHSC Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

ATTACHMENT E
Request to Appeal Denial of Authorization

Date of Denial: _____ **Request Date: _____** **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		
Reason for Authorization Denial		
Reason for Appeal		

I am aware that I have the right to appeal the above-mentioned decision. I am submitting this appeal to the Utilization Management (UM) Department within thirty (30) days of receipt of denial. I am aware I will receive a letter from the Utilization Manager acknowledging my request to appeal. I may also request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal. Prior to a decision, I have the right to meet with the individual(s) who will be deciding the appeal. Within twenty (20) business days of my request to appeal, the Utilization Management Department will notify me in person or telephone of the decision.

Appellant's Signature: _____ Date: _____

Submit this completed form to the following contact:

LifePath Systems
Utilization Management (UM) Department
1515 Heritage Drive
McKinney, TX 75069

ATTACHMENT F
Appeal Acknowledgement

Date of Denial: _____ **Request Date: _____** **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s) for which authorization was denied		
Reason for Appeal		

Your request to appeal a decision to deny authorization for service(s) is acknowledged. Please be informed of the following:

- You have the right to meet with the individual(s) who will be deciding the appeal.
- You may also provide additional information (in writing, in person, by telephone, or through your representative) for the individual(s) who will be deciding the appeal as long as it is received by LifePath Systems within 10 business days of the date of this notification.
- Within twenty (20) business days of your request to appeal, LifePath Systems will notify you in person or telephone of the decision.
- The denied service(s) will not be initiated or re-instituted until the appeal process is complete and only if the decision is in your favor.

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

LifePath Systems
Utilization Management (UM) Department
1515 Heritage Drive
McKinney, TX 75069
Phone: (972) 422-5939 or Toll Free: (844) 544-5939

_____ _____ _____
Utilization Manager or UM Physician Name Signature Date

ATTACHMENT G
Appeal Resolution

Request Date: _____ **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Service(s) Requested/Denied		
Decision		
Clinial Basis for the Decision		
Specialization of Consulted Providers		

Please be informed that if you disagree with the decision, you will have ten (10) calendar days to request a review of your concerns by HHSC Office of Individual Services and Rights Protection at (800) 252-8154.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

Utilization Management (UM) Department
1515 Heritage Drive,
McKinney, TX 75069
Phone: (972) 422-5939 or Toll Free: 844-544-5939

If you would like to make a complaint, you may contact one or more of the following:

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive,
McKinney, TX 75069
(972) 562-0190

Texas Health and Human Services Commission (HHSC) Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

Disability Rights, Texas
2222 West Braker Lane
Austin, TX 78758
(800) 252-9108
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)
(866) 362-2851 (Video Phone)

_____ _____ _____
Utilization Manager or UM Physician Name Signature Date

ATTACHMENT H
Modification or Reversal of Appeal Resolution

Request Date: _____ **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Service(s) Requested/Denied		
Decision		
Clinical Basis for the Decision		
Reviewer(s) Name & Specialization		
Plan to Initiate or Re-Engage Services		

Please be informed that the decision to deny authorization for service(s) has been modified or reversed. The UM Director or their designee will contact you within twenty (20) business days for a routine appeal or two (2) calendar days for expedited appeal to discuss the plan to initiate or re-engage in the requested services.
If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

Utilization Management (UM) Department
1515 Heritage Drive,
McKinney, TX 75069
Phone: (972) 422-5939 or Toll Free: 844-544-5939

If you would like to make a complaint, you may contact one or more of the following:

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive, McKinney, TX 75069
(972) 562-0190

Texas Health and Human Services Commission
(HHSC) Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

Disability Rights, Texas
2222 West Braker Lane
Austin, TX 78758
(800) 252-9108
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)
(866) 362-2851 (Video Phone)

_____ _____ _____
Utilization Manager or UM Physician Name Signature Date

ATTACHMENT I

Denial of Authorization Based on Clinical Determination for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential Treatment

Request Date: _____ **Decision Date:** _____

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s)		
Reason for Authorization Denial		

Please be informed that you have the right to appeal this decision. In order to appeal the authorization decision, you must contact the Utilization Management (UM) Department by telephone at 972-422-5939 or encrypted email at BHUM@lifepathsystems.org and BHCOC@lifepathsystems.org **within 1 business day** of receipt of this notice. If notification of the denial is made at 5:00 pm or later, you will have until 8:30 am the next business day to make the request. Afterwards, you will receive notice either by phone, fax or encrypted email from the UM Department acknowledging your request to appeal. You may request, in writing, that the appeal review be conducted by a provider in the same or similar specialty as typically manages the condition, procedure or treatment under review. In all cases, no one who participated in the review of the initial decision will be allowed to participate in the review of the appeal.

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

LifePath Systems
Utilization Management (UM) Department
1515 Heritage Drive
McKinney, TX 75069
Phone: (972) 422-5939 / Fax: (214) 871-3328
BHUM@lifepathsystems.org and BHOC@lifepathsystems.org

The appeal for authorization may be requested by:

- You
- Your legally authorized representative (LAR)
- Your Provider
- Your actively involved adult relative, friend, or advocate (with your written consent)

Signature of UM Physician: _____ Date: _____

ATTACHMENT J

Expedited Appeal Procedure for Denial of authorization for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential Treatment

Request Date: _____ **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Requested Service(s) for which Authorization Denied		
Decision		
Reason for Appeal		
Name of Individual Requesting the Appeal		

Within **1 hour** of making the adverse decision, for admission or continued stay for inpatient services, detoxification or residential treatment, the designated LifePath Systems UM Workforce will notify the individual requesting or receiving services, the individual's LAR, anyone the individual designates to advocate for them, or the individual's provider of the adverse decision. If an appeal is requested by the individual, please submit this completed form to LifePath Systems Utilization Management (UM) Department via fax or encrypted email to contact information noted below, within **1 business day** of notification of denial of authorization. If notification of the denial is made at 5:00 pm or later, you will have until 8:30 am the next business day to make the request.

If there is any part of this notice that you do not understand or if you need further assistance, please contact:

LifePath Systems
Utilization Management (UM) Department
1515 Heritage Drive
McKinney, TX 75069
Phone: (972) 422-5939 / Fax: (214) 871-3328
BHUM@lifepathsystems.org

If you would like to make a complaint, you may contact one or more of the following:

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive, McKinney, TX 75069
(972) 562-0190

Texas Health and Human Services Commission
(HHSC) Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

Disability Rights, Texas
2222 West Braker Lane
Austin, TX 78758
(800) 252-9108
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)
(866) 362-2851 (Video Phone)

ATTACHMENT K
Initial Appeal Resolution Notice for Psychiatric Inpatient, Substance Use Disorder Detoxification or Residential

Request Date: _____ **Decision Date: _____**

Name and Address of Individual Requesting/Receiving Services		**Record #**
Provider Name		
Service(s) Requested/Denied		
Decision		
Clinical Basis for the Decision to Uphold, Reverse, or Modify Denial & Additional Days Authorized (if any).		
Specialization of Consulted Providers		

Please be informed that if you disagree with the decision, you will have ten (10) calendar days to request a review of your concerns by HHSC Office of Individual Services and Rights Protection at 1-800-252-8154.

If there is any part of this notice that you do not understand, or if you need further assistance, please contact:

Utilization Management (UM) Department
1515 Heritage Drive,
McKinney, TX 75069
Phone: (972) 422-5939 or Toll Free: 844-544-5939

_____ _____ _____
Utilization Manager or UM Physician Name Signature Date

If you would like to make a complaint, you may contact one or more of the following:

LBHA Rights Protection Officer
Jordan Planchon
1515 Heritage Drive, McKinney, TX 75069
(972) 562-0190

Texas Health and Human Services Commission
(HHSC) Office of Consumer Services/Rights Protection
P.O. Box 149347
Austin, TX 78714-9347
MC: 2019
(800) 252-8154

Disability Rights, Texas
2222 West Braker Lane
Austin, TX 78758
(800) 252-9108
(512) 454-4816 (Voice)
(512) 323-0902 (Fax)
(866) 362-2851 (Video Phone)

ATTACHMENT L
YES Waiver Denial of Eligibility & Fair Hearing Request (HHSC Form)

[Date]

[Legally Authorized Representative's (LAR's) First Name] [LAR's Last Name]
[LAR's mailing address]
[City, State and ZIP Code]

Re: [Child or Youth Full Name]
Date of Birth: [DOB], Age: [Age]; Medicaid Number: [Number]

Dear [Name of LAR]:

[Name of organization that reviewed eligibility] reviewed your child or youth's eligibility for the Youth Empowerment Services (YES) Waiver Program. The purpose of YES benefits is to prevent or reduce the institutionalization of children and adolescents who have severe emotional disturbance (see 26 TAC §307.1).

As a result of the review, [Name of organization that reviewed eligibility] has determined that [choose option] through the YES Waiver program [choose option] for your child or youth as of [date of the denial, suspension, reduction, or termination].

The YES Waiver services are [choose option] because [choose option].

Specifically, the [choose option] is based on [specific reasons and pertinent policies that support the decision. Include applicable language from the TAC, Waiver, and Provider Manual.]

[Insert denial reason in plain language.]

If you have questions about any of information in this letter, please contact:

LMHA Contact Name: _____ LMHA Contact Name: _____

LMHA Contact Title: _____ LMHA Contact Title: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

If you disagree with the decision to [deny, suspend, reduce, terminate] YES Waiver services, you have the right to request a fair hearing to appeal this decision. To request a fair hearing, you must submit a written request to the Texas Health and Human Services Commission (HHSC) no more than 90 days from the date of the letter. You may lose the right to appeal if the request is not received by this date.

Form 2800, Notice of Denial – Eligibility

At a fir hearing, you may: 1.) represent your child or youth; or 2.) choose, at your expense, an authorized representative, such as a relative, friend, lawyer, or other spokesperson, to represent your child or youth.

If your child or youth is currently receiving YES Waiver services, they may be eligible to continue to receive those services while the hearing is pending. To qualify, you must ask for a fair hearing before the service is stopped or reduced.

To request a fair hearing:

Complete Form 2801, Fair Hearing Request, and mail to:	**Or** *Call:*
Texas Health and Human Services Commission (HHSC) Office of the Ombudsman Attn: Behavioral Health Ombudsman P.O. Box 13247, Mail Code: H700 Austin, TX 78711-3247	(800) 252-8154 (Toll Free Number, available Monday – Friday 8am to 5pm)

Sincerely,

_____
[Signer's Name]
Youth Empowerment Services (YES) Waiver

Enclosure