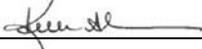


## 15. INFORMATION MANAGEMENT

### 1.0 POLICY TITLE: Information System Management

1.1 Officially Adopted: March 1, 2018

1.2 Effective Date: April 1, 2018

1.3 Signed:   
Kelli Nomura, Behavioral Health Organization Administrator

2.0 PURPOSE: To define the requirements for collecting, maintaining, and reporting client and service data to support the administrative operation, management decisions, clinical operations, utilization analysis, and system performance of the King County Behavioral Health and Recovery Division (BHRD) and King County Behavioral Health Organization (KCBHO).

### 3.0 POLICIES/PROCEDURES/RESPONSIBILITIES:

#### 3.1 Policy

##### 3.1.1 Configuration of the Behavioral Health Information System

- A. “Information System” refers to the management of an integrated network of databases, structures, and applications to support operations and management.
- B. The Behavioral Health Information System (BHIS) refers to the total electronic information system and network used by the state, KCBHO, and contract providers to collect, store, and disseminate information concerning client participation in behavioral health services.
- C. The BHIS consists of the following information systems (see Section 19 Definitions for descriptions of each):
  1. DSHS ProviderOne;
  2. BHRD Information System (BHRD IS); and
  3. King County provider information systems located at each provider site, which contain client, staff, and service information.
- D. The following networks support the BHIS:
  1. BHRD Local Area Network (LAN), maintained by the King County Information Technology (KCIT) Department at the King County Chinook Building office and remote business offices. These LANs are connected to the County Wide Area Network (WAN) behind a firewall that limits traffic into the BHRD system;
  2. The WAN provides email services and links to the Internet and the Government Trusted Network (GTN) through a County firewall;

3. GTN provides secure linkage between state and local governments in Washington including BHRD access to the state Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) intranet site; and
4. Remote SSL VPN access to the County WAN allows providers to access the BHRD IS.

### 3.1.2 Data Provider

- A. Data providers include all providers responsible for directly providing, or responsible for overseeing the provision of, services to clients authorized to receive inpatient, outpatient, or residential levels of care or other specialty program services. This includes providers providing screening, assessment, authorization, and care management services.
- B. Types of data providers covered under these policies include community behavioral health centers, inpatient facilities, evaluation and treatment facilities, King County Crisis and Commitment Services (CCS), and other contracted providers that provide direct or administrative services.
- C. The provider holding the authorization for a level of care or other program is responsible for meeting all data requirements.
- D. When two or more data providers are providing outpatient services, the provider holding a case-rate authorization, a Long-Term Rehabilitation (LTR) authorization, or a Homeless Outreach, Stabilization, and Transition (HOST) case management authorization is responsible maintaining client data accuracy.

### 3.1.3 Data Provider Requirements

- A. All data providers must have at least the following basic management capabilities:
  1. Collect, document, report, and maintain data on clients and services provided;
  2. Collect, document, report, and maintain staff data;
  3. Establish and maintain the capability for technical interface with the BHRD IS and provide regular daily transmissions of data in the format specified in KCBHO IS policies and procedures;
  4. Maintain current, complete, and accurate information in the BHRD IS through regular review, audit, and correction;
  5. Respond to reports and data processes as required and necessary. See the “Provider Technical Reference” (available online to authorized users);

6. Maintain data quality; and
7. Maintain data security.

#### 3.1.4 Data Security

Providers must develop and implement policies and procedures to ensure the security of information systems data and the confidentiality of client records. See Section 16, Privacy and Security of Information Systems Data and Client Records.

#### 3.1.5 Data Certification

- A. Providers must certify the data quality and integrity of Medicaid-funded client and services data that are submitted to the BHRD IS.
- B. Client and services data must be certified by one of the following:
  1. Chief Executive Officer;
  2. Chief Financial Officer; or
  3. An individual who has delegated authority to sign for, and reports directly to the Chief Executive Officer or Chief Financial Officer.
- C. Content of the certification must include a statement that attests, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the client and services data.
- D. Data certification must be submitted on the last business day of each month.

#### 3.1.6 Data Collection

- A. Providers must collect, maintain, and report all client and services data according to the requirements in this section.
- B. Registration is completed with the reporting of the required demographic and service data elements to the BHRD IS.
- C. KCBHO programs are grouped in levels of care for the purpose of data collection. Data elements required for collection for each level of care are listed in “Data Dictionary Summary of Attributes” (Attachment A) and detailed in “Data Dictionary Provider Transactions” (Attachment B) to this section.
- D. There are two types of required data sets that must be collected by KCBHO providers:
  1. Reported Data Set – those data elements that describe clients, services, facilities, and staff that providers are required to collect and electronically report to the BHRD IS as described in “Data Dictionary

Summary of Attributes” (Attachment A) and in “Data Dictionary Provider Transactions” (Attachment B) in this section; and

2. Extended Data Set –data that providers are required to collect and maintain in provider records as described in Attachment B.
  - a. Reporting requirements for the extended data set vary according to the elements. Some elements must be regularly reported to the KCBHO in aggregate form.
  - b. In order to support file reviews, all elements must be documented and maintained in provider records as described in this section and in “Data Dictionary Provider Transactions” (Attachment B).
- E. Specific source documentation requirements for each attribute are described in “Data Dictionary Provider Transactions” (Attachment B). If a source document is not specified, the provider must record the document(s) or other means used to verify client or services information as reported.

#### 3.1.7 Data Reporting

- A. Authorization data is expected to be reported within 72 hours of enrollment.
- B. A data element is considered reported to the BHRD IS only when recorded in the master tables of the BHRD IS and time recorded in the post-date field.
- C. A person is determined to be enrolled in KCBHO services when data are reported within the specified timelines and the requirements for reporting assessment data are met. See “Data Dictionary Summary of Attributes” (Attachment A).
- D. Providers must report data elements by means of electronic transmission of batches or through direct online data entry of those elements, in accordance with the format and manner described in this section, to ensure that the data is successfully posted to the BHRD IS. See also the “Provider Technical Reference” which is available in the ISAC Notebook.
- E. Providers must ensure all transactions have valid form and content before submission to the BHRD IS. Transactions rejected by the system for invalid form or content are not posted to the database and are not considered reported. The valid form and content for transactions are described in “Data Dictionary Provider Transactions” (Attachment B).
- F. BHRD IS does not change or delete data reported by data providers except:
  1. At the specific written request of the data provider; or

2. Where the data reported poses a danger to the integrity of data reported by other providers.
  - a. All changes or deletions to provider reported data must be reported to the affected provider(s) within two business days.
  - b. All data elements entered must be identified as reported to the BHRD IS by the data provider. The data provider and/or staff identifier and date and time of posting are recorded as part of the data submission.

### 3.1.8 Data Timeliness

- A. Each attribute must be collected and reported to the BHRD IS according to the specific timeframes described in the “Frequency” section of the transaction that contains the attribute. (See Attachments A and B)
- B. Providers must ensure that required data has been successfully posted to the BHRD IS by midnight on the required date. Posting by the BHRD IS may take up to 24 hours from the time of data submission by the provider.
  1. The payment data set must be reported to the BHRD IS by the last day of the calendar month following the month of assessment.
  2. The clinical data set must be reported to the BHRD IS by the last day of the calendar month following the month of assessment.
  3. The outcome data set must be reported to the BHRD IS by the last day of the second calendar month following the month of assessment.
- C. Case-rate Validation – The data elements necessary to validate a case-rate benefit request are detailed in Attachment A. Providers must ensure the posting of all elements to the BHRD IS in accordance with the timelines outlined in “Data Dictionary Summary of Attributes” (Attachment A).
- D. Non Case-rate Programs – The complete set of data elements for all persons being served in other specialty programs must be posted within two business days of the completion of intake and initial evaluation. Attributes under investigation can be coded as “Unknown”.
- E. All service data detail must be posted no later than 30 calendar days after the date of service. Service data received after 30th calendar day will be subject to data timeliness actions.
- F. Data elements about clients must be posted no later than 15 calendar days after the assessment, change, review or discharge date to which they apply. Data Elements with a frequency of On Hire and On Departure are posted within 30 days of the date of hire or departure.
  1. On Hire – Report on most recent date of hire for staff.

2. On Departure – Report date the staff person leaves employment.
- G. Discharge – Providers must report all required data elements at discharge according to “Data Dictionary Provider Transactions” (Attachment B).
1. For case-rate benefits, discharge is the point at which a clients authorization expires or is terminated. For non-case-rate programs, it is the date a provider determines no further services will be provided.
  2. For a client exited from services prior to the expiration of an authorized benefit, providers must report complete discharge data at the time of exit.
  3. For other specialty programs, providers must report complete discharge data at the time of termination.
- H. Data requirements that apply to both the expiration of a current authorized benefit and the authorization of a new case-rate benefit may be met with a single set of data with an appropriate date for each required transaction.
- I. Inpatient authorizations, extensions, and discharges – The complete set of required data elements for all persons authorized to an inpatient facility must be posted within two calendar days of the authorization or extension. Discharge data must be posted within two calendar days of receiving it from the inpatient facility.
- J. Investigations, detentions, and legal data under the Involuntary Treatment Act (ITA) – The complete set of required data elements under the ITA must be posted within two calendar days of the event.

#### 3.1.9 Data Completeness

- A. Providers must report all required elements on all clients as described in “Data Dictionary Summary of Attributes” (Attachment A).
- B. No more than one percent of case-rate benefits other specialty programs may be missing any required attributes from any provider data stored in the BHRD IS.
- C. Attributes coded as unknown are not considered to meet the requirements for data completeness unless otherwise indicated in “Data Dictionary Summary of Attributes” (Attachment A).
- D. When an attribute is coded as unknown, providers must document the justification for the unknown code and update attributes as soon as information becomes available.
1. When a provider has reported the unknown code for more than five percent of any single required attribute in any case-rate benefit or other specialty program, the provider may be required to identify the causes

of this coding pattern and, where appropriate, develop a plan to obtain the required data.

2. The five percent limitation does not apply to HOST outreach or case management clients except that as data subsequently becomes known, the provider must update the attributes.

#### 3.1.10 Data Accuracy

- A. The data provider is responsible for ensuring the accuracy of the data submitted and stored in the BHRD IS and for resolving any contradictions between the data recorded on the BHRD IS and the data recorded in provider records. Providers must report any necessary corrections.
- B. At a minimum, 95 percent of the provider's submission of data for each element stored on the BHRD IS must be consistent with provider records.
- C. Providers must maintain written data collection procedures that identify the documents, persons, and specific protocols used to ensure the accurate and timely collection and reporting of data. Providers must construct these procedures so that a review team may reasonably use them to determine the accuracy of any data elements.
- D. Providers must review and certify the accuracy of reports generated by the BHRD IS. Where the provider cannot certify the accuracy of the report, the provider must immediately submit corrected data to the BHRD IS so that it does accurately describe the provider's clients, staff, and services.

#### 3.1.11 Unduplication of Client Records

- A. BHRD IS and providers must ensure that recipients of behavioral health services are uniquely identified for purposes of tracking and maintaining service and demographic information attached to that individual.
- B. BHRD IS assigns a unique identifier to each person in the behavioral health system. Providers must ensure client-related data is always entered under the correct King County Person ID code.
- C. Providers must query the BHRD IS to establish whether a client is known to the behavioral health system. Providers must identify and resolve any client duplication issues.

When a provider finds a record on King County that appears to refer to a person who has requested services:

1. The provider must confirm or eliminate the possible duplication by comparing the identifying elements in the BHRD IS master records to the provider collected data; and

2. If the client has been assigned a King County ID and one or more identifying elements stored in the BHRD IS person record differ from those collected by the provider, the provider must investigate and determine the correct value(s) prior to reporting any data.

#### 3.1.12 Online Information

- A. Providers must access the King County online Extended Client Lookup System (ECLS) to query client clinical information, behavioral health care provider information, and client status prior to providing services to any new client.

The provider must use the online systems to:

1. Identify all components of the public behavioral health system involved in the client's care for persons entering service; and
  2. Establish whether a client is already known to the BHRD IS in order to unduplicate records.
- B. Access to and handling of online confidential client information is explained in Section 16, Privacy and Security of Information Systems Data and Client Records.
  - C. Online access also allows data providers to access clinical, financial, contractual, and data quality reports posted by BHRD staff and KCIT staff assigned to BHRD.
  - D. Provider technical reference, assistance, and detailed information on data reporting requirements, specific transaction formats and steps, valid codes, specific programs and algorithms, and other technical information are also available online in the ISAC Notebook.

#### 3.1.13 Information System Revisions

When a revision is made to the data dictionary (Attachment B) that includes new or modified attributes, providers are required to update the BHRD IS with the changes at the time of intake or the regularly scheduled review.

#### 3.1.14 Data Products

- A. KCIT staff assigned to BHRD, BHRD administrators, and other authorized users may create data products derived from the data stored on the BHRD IS. All products identified as derived in whole or in part from the BHRD IS must comply with the data policies described in this manual.
- B. Any person or agency who wishes to use BHRD IS data for any product or purpose must receive permission from the BHRD Evaluation and Research Committee (see Section 16: Privacy and Security of Information Systems Data and Client Records).

- C. The KCBHO prohibits the release of information that identifies a client to unauthorized persons (see Section 16: Privacy and Security of Information Systems Data and Client Records).

### 3.2 Procedure: Information Systems Business Rules

#### 3.2.1 Data Tests

All outpatient authorizations requests have a data status. The data status is coded as follows:

ID	Insufficient Data for Payment
PY	Payment Data Set Complete
VL	Validation of Clinical Data Set Complete
OC	Outcome Data Set Complete

- A. Data tests are required for all outpatient authorizations and are based on the last case-rate and benefit codes assigned and posted in master event tables.
- B. All non-canceled outpatient authorizations are tested for data status and updated each day.
- C. All required data elements must be present in the BHRD IS tables.
1. Required data elements are listed in Data Dictionary Summary of Attributes” (Attachment A).
  2. Required valid codes are listed in the “Data Dictionary Provider Transactions” (Attachment B).
- D. BHRD IS is responsible for ensuring that data are posted to the master event tables no later than 7 p.m. on the day following the day of the provider data submission.
- E. Authorizations must have a PY, VL, or OC data status to be paid.
- F. The date of posting in the master event table is the date used to determine data status compliance. Data status compliance is met when the record reported by the providers has a posting date no more than 30 days prior to the start date of the benefit and is no later than the last day of the second calendar month of the benefit.
1. Validation of Clinical Data Test: On the first of each month, authorizations that have an ID or PY data status and have a clinical data cutoff date prior to the first of the month are canceled.

2. Outcomes Data Test: For each month past the outcome data cutoff date, a stop payment status is set for that month where outcomes data is not complete.

G. The provider is notified each time the data status changes.

### 3.2.2 Case-rate Validation

Case-rate validation evaluates the data submitted for the specific outpatient benefit case rate requested against the case-rate criteria for that benefit and determines if the request meets the criteria.

- A. Case-rate validation is based on data in the BHRD IS tables and occurs on a daily basis for all outpatient authorizations.
- B. All outpatient authorizations have a Medical Necessity (MN) validation status.
- C. Any change in the BHRD IS clinical data or requested case rate requires a new MN validation until the clinical data cut-off date.
- D. Every change in the MN validation is reported to providers.
- E. On the first of each month, requests with a MN validation of null or less than the requested case rate with a clinical data cut-off date prior to the first of the month will be canceled.
- F. A client receiving a specific outpatient benefit must meet all of the criteria for that benefit.
- G. A client meeting the requirements of a requested outpatient benefit must be validated to the requested benefit.
- H. A monthly report is generated for all MN-validated clients who, after the second calendar month, show a data update that no longer meets MN criteria for their authorized benefit.
- I. Residential and other specialty programs are not MN-validated.

### 3.2.3 Authorization Status Codes

At any one time, an authorization will have one of the following status codes:

UA	Unauthorized <ul style="list-style-type: none"> <li>• Authorization has been received, but coverage not yet evaluated.</li> </ul>
AA	Approved <ul style="list-style-type: none"> <li>• Authorization is approved.</li> <li>• It may still be subject to review by KCBHO.</li> </ul>

CX	<p>Canceled</p> <ul style="list-style-type: none"> <li>• Authorization is canceled.</li> </ul>
PN	<p>Pending Manual Review</p> <ul style="list-style-type: none"> <li>• Authorization is pending.</li> <li>• Pended authorizations are not paid until they are approved.</li> <li>• When they are approved, payment is retroactive.</li> </ul>
TM	<p>Terminated</p> <ul style="list-style-type: none"> <li>• Authorization has been terminated.</li> </ul>
WL	<p>Waitlisted</p> <ul style="list-style-type: none"> <li>• Authorization Waitlisted (for non-Medicaid only)</li> </ul>

### 3.2.4 Non-Medicaid Resource Test

Every submitted outpatient authorization request is tested against the non-Medicaid criteria and all non-Medicaid benefits shall be tested against the provider's available non-Medicaid quarterly allocation.

- A. All outpatient authorization requests are initially assigned a status of Unauthorized (UA).
- B. Until the payment data status has been met (PY), all outpatient authorization requests shall remain at status UA and are not tested for coverage.
- C. An outpatient authorization request that does not meet non-Medicaid criteria requirements is assigned a KCBHO coverage code (see "Determining Coverage" 3.2.8 in this document) and is not eligible for an authorization.
- D. All non-Medicaid outpatient authorization requests that meet the non-Medicaid criteria are placed on the waitlist. Requests put on the waitlist have a condition code which indicates the condition under the non-Medicaid criteria for which the client qualified.
- E. Condition status is calculated based on the data with the earliest event date following the reported assessment date. Condition status code is updated on a daily basis, based on changes to the data in the BHRD IS.
- F. Where there are sufficient dollars left in the provider's allocation to cover the projected cost of the outpatient authorization request, the request is taken off the waitlist and given the status of Authorization Approved (AA), and the standard authorization process for the benefit is followed.
- G. When there are insufficient dollars left in the provider's quarterly allocation, no more non-Medicaid outpatient requests will be authorized from the waitlist.

3.2.5 Cancellation of Waitlist Outpatient Authorization Requests

- A. Where a waitlisted outpatient authorization request does not meet data or MN status at the close of the second calendar month, the authorization request shall be canceled.
- B. Where a WL status outpatient authorization request is canceled as noted above, the assessment date for a new authorization request must fall after the termination date of the WL status request.

3.2.6 Non-Medicaid Waitlist Update

- A. Non-Medicaid benefit requests that meet the non-Medicaid criteria shall be put on the waitlist in the order in which they were received. Requests put on the waitlist shall have an authorization status code WL.
- B. Based on the provider's available quarterly non-Medicaid dollars allotment, a number of benefit requests on the waitlist will be authorized and the authorization status changes from WL to PN, if a manual review is required, or AA if a review is not necessary. Benefits shall be authorized in the order of waitlist postdate.
- C. On a daily basis, condition code is recalculated for all authorizations on the waitlist, based on information in the BHRD IS. Authorizations that no longer meet the non-Medicaid condition to be on the waitlist are removed.

3.2.7 Determination of Residency

- A. The County Code as reported by the provider determines King County residency.
- B. When a client becomes a non-King County resident, the benefit shall be terminated effective the event date of the change as reported by the provider.

3.2.8 Determining Coverage

- A. When a provider has submitted an outpatient authorization request for a client meeting the payment data status test, the system tests the request for coverage (see table below) based on the data submitted by the provider. The provider submitted coverage data will be compared with coverage data obtained from the Health Care Authority (HCA) ProviderOne system. When a discrepancy is detected the outpatient authorization request remains in an unauthorized (UA) state until the discrepancy is cleared.
- B. Medicaid coverage is always effective for a complete month, irrespective of the event date reported by the provider.

Where a client loses Medicaid coverage within a month, the new coverage status is calculated and applied to the month following the Medicaid covered month.

C. Eligibility for KCBHO services by BHRD IS coverage type is detailed in the following table:

Summary of Coverage Type and Eligibility for Benefits

Coverage Type		Eligibility for Benefits if Criteria are Met
F19	King County resident with KCBHO-eligible Medicaid	Eligible for KCBHO outpatient benefits
PHP	King County resident without eligible Medicaid program/match combination: <ul style="list-style-type: none"> <li>• “Non-Medicaid”, and</li> <li>• &lt;220% poverty adult or older adult; or</li> <li>• &lt;300% poverty child</li> </ul>	Eligible for KCBHO outpatient benefits, when funding is available
OCM	Out-of-County—Medicaid	Not eligible for KCBHO benefits
OCU	Out-of-County—Non-Medicaid	Not eligible for KCBHO benefits
RSN	King County resident without eligible Medicaid program/match combination: <ul style="list-style-type: none"> <li>• “Non-Medicaid” and</li> <li>• &gt;=220% poverty adult or older adult; or</li> <li>• &gt;=300% poverty child</li> </ul>	Eligible for some specialty programs

- D. Non-Medicaid and Medicaid covered clients are eligible for identical outpatient benefits.
- E. The system shall recalculate coverage when a provider submits changes to any data elements that determine coverage (Medicaid record, income record, county code).
- F. Coverage changes reported by a provider shall be applied retroactively to terminate a benefit on the last day of valid coverage except that where a provider fails to report a series of coverage changes within reporting timelines, adjustments shall be based on the date of the last coverage change.
- G. Automated review of coverage for purposes of benefit termination shall not be processed until the validation data status timeline is past.

### 3.2.9 Provider Outpatient Authorization Requests

The BHRD IS business rules for each of the provider initiated outpatient authorization requests are detailed as follows:

#### A. For all outpatient authorization requests:

1. All authorization requests from providers are processed within 24 hours of posting unless they require KCBHO approval;
2. Authorization requests that fail to meet the rules as noted are rejected;
3. The assessment date must never be later than the posting date;
4. A request for interim case-rate change, catastrophic case-rate change, provider change, or a next benefit refers to a valid authorization that has not been canceled or terminated;
5. If the authorization is pending a manual review, the request is rejected;
6. If the client has an outstanding outpatient authorization or provider change request pending, the request is rejected;
7. Providers shall receive daily reports on all actions taken; and
8. When an authorization request cannot be processed the provider is notified via daily error reports.

#### B. Initial Authorization Requests – For a new client:

1. The posting date must be on or before the assessment cut-off date. The assessment cutoff date is the end of the 2nd calendar month from the authorization's assessment date;
2. If the authorization request requires a manual review, the new authorization is created with a pending (PN) status; and
3. If a manual review is not required, the authorization is created with an AA status.

#### C. Interim Case-Rate Change Request – For requests to change the case rate for an existing outpatient authorization:

1. Any interim case-rate change request can be made only once a day;
2. The posting date must be on or before the authorization change cutoff date. The authorization change cut-off date is the end of the second calendar month from the authorization start date;
3. The assessment date is not used to set the start date for this type of request;

4. The authorization number is not changed by this action;
  5. A change to a case-rate request has no effect on the data attached to the outpatient authorization request;
  6. The case rate requested by the provider is assigned in the BHRD IS without regard to case-rate criteria: validation will occur later when the authorization is retested for data timelines and case-rate criteria;
  7. The case-rate re-determination is retroactive to the start date of the authorization and an adjustment are made to any payments; and
- D. If KCBHO has already approved the authorization (a manual review was approved), the request is rejected.
- E. Catastrophic Case-Rate Change Request – For requests to change the case rate due to a catastrophic and permanent change in the client:
1. The assessment date of the request must be after the authorization cut-off date and on or before the expiration date of the existing authorization;
  2. The posting date of the request for a case-rate change will be on or before the assessment cut-off date of the catastrophic case-rate change request;
  3. All catastrophic case-rate change requests require a manual review;
  4. Upon approval by KCBHO, the existing outpatient authorization is terminated as of the day before the assessment date of the request; and
  5. A new pending outpatient authorization is created with a start date equal to the assessment date of the new request and with the new case rate.
- F. Provider Change Request – For provider change initiated by clients:
1. The assessment date of the request must be after the start date of the existing outpatient authorization and on or before the expiration date of the existing authorization;
  2. The posting date of the provider change request must be on or before the assessment cut-off date of the provider change request;
  3. The existing authorization is terminated as of the day before the assessment date of the request;
  4. A new outpatient authorization is created with a start date equal to the assessment date of the request; the case rate is set to the case rate in the request.

- G. Continued Stay Request – For provider request to renew an existing authorization benefit:
  - 1. The assessment date of the request must be within the last 30 days of the current authorization;
  - 2. The posting date of the continuation request must be on or before the assessment cut-off date of the next authorization request;
  - 3. The start date of the new authorization will be set to the day following the expiration date of the current authorization;
  - 4. The provider may request a case rate different from the case-rate of the existing authorization; and
  - 5. The authorization may require a manual review. If so, the status of the authorization shall be set to PN.
  
- H. Provider Request for Cancellation – For provider requests to cancel an existing authorization request due to a submission error:
  - 1. The posting date shall be on or before the authorization change cut-off date;
  - 2. The existing authorization request shall not already have a cancellation status; and
  - 3. Long Term Residential authorizations can only be canceled by KCBHO.
  
- I. Provider Request for Termination
  - 1. The posting date must be no more than 60 days after the expiration date of the existing authorization.
  - 2. The existing authorization is not already be canceled or terminated.
  - 3. The authorization does not have a pending manual review.

#### 3.2.10 KCBHO Outpatient Authorization Functions

- A. KCBHO reviews flagged cases.
  - 1. KCBHO may approve the requested authorization, change the case rate, pend the review, or cancel the authorization request.
  - 2. KCBHO may approve an outpatient authorization request at any time up to the review cut-off date. The review cut-off date is 14 days past the end of the second calendar month from the authorization start date. A review cannot be started after the review cut-off date.

3. Outpatient authorization requests requiring KCBHO review that are not approved by the review cut-off date are automatically canceled.
  4. KCBHO only approves outpatient authorization requests that have met clinical data validation. KCBHO will not authorize an outpatient authorization request that is not supported by MN.
  5. KCBHO may cancel an outpatient authorization request as a result of failure of the provider to meet benefit response timelines (i.e., the provider fails to submit a complete request within the timelines required).
  6. The result of a KCBHO review is reported to the provider.
- B. A retroactive authorization allows authorized users to create an authorization record without an existing authorization request, provided that the start date of the authorization is within 365 days from the authorization request. (See Section 12, Financial Management under “Exceptions to Policy.”)
1. A retroactive authorization is not based on a provider-submitted authorization request.
  2. The start date cannot be in the future.
  3. The expiration date is equal to or greater than the start date and cannot be more than 364 days after the start date.
  4. The case-rate code is based on demographic data in the system. It cannot be overridden.

#### 3.2.11 Authorization Response Record

- A. Providers shall receive notification of every action taken on each authorization request submitted. (See the Authorization Response Transaction in the “Provider Technical Reference,” available online, for format.)
- B. An authorization response record is created upon:
1. Changes made to the submitted clinical or demographic data, authorization duration, case rate, provider and/or status; and
  2. System validation of data or MN.

### 3.3 Information System Business Rules:

#### 3.3.1 Service Periods

The service period is the duration of the benefit, from start date to expiration date.

- A. A client is expected to be receiving services under a case-rate benefit, other specialty program or inpatient services during the calendar dates on or following the start date through to the expiration date recorded in the BHRD IS.
- B. The expiration date for a benefit is 364 days from the start date (a 365-day benefit).
- C. The expiration date may be null, indicating the benefit is open.
  - 1. A specialty program or inpatient services authorization shall have a null expiration date until the provider submits a notice of exit.
  - 2. A residential benefit and a case-rate benefit never have a null expiration date.
- D. The default expiration date may be overridden by authorized KCBHO staff when creating a retroactive authorization.
- E. A supervised living benefit has an associated case-rate benefit; the supervised living expiration date defaults to the expiration date of the associated case-rate benefit.

#### 3.3.2 Case-Rate Benefit Case-Rate Code Calculation

A case-rate code is assigned to every authorized benefit to determine the benefit payment amount. The actual case-rate amount paid depends on the case-rate code, the benefit, and the payment month. (See Section 12, Financial Management, "Case Rates," Attachment A.)

- A. Case-rate code is based on data stored in the information system.
- B. The case-rate code may change from month to month and the change is applicable for the entire month in which the change appears.
- C. The case-rate code is determined by four factors: 1) provider, 2) cultural differential status, 3) the age of the client on the assessment date, and 4) language differential status.
  - 1. "Provider" is the contractor holding the benefit authorization.

2. The case rate includes a “Cultural differential” if one or more of the following apply: the client is deaf or hard-of-hearing; the client is medically compromised and homebound; the client is an ethnic minority; the client is a sexual minority.
    - a. For deaf or hard-of-hearing clients, the impairment codes that qualify for cultural differential status are Deaf (32) or Hard-of-hearing (33).
    - b. For non-facility-based medically compromised homebound clients, the impairment kind code that qualifies for cultural differential status is Medically Compromised (43), and the residential arrangement codes that qualify are Permanent Housing-unassisted (01), Permanent Housing-assisted (02), Temporary Housing-unassisted (03), Temporary Housing-assisted (04), Temporary Housing-dependent (05), Transitional Housing (06), Adult Family Home (22), Foster Care for children (26), and Homeless (82).
  3. “Age” of the client is calculated from the provider-reported birth date of the client.
  4. If the client is a child, “language differential status” is calculated if an interpreter is needed. If the client is an adult or older adult, the “language differential status” requires both that an interpreter is needed and that the client’s language is not English.
- D. Where elements used to calculate case-rate code are coded as unknown, the case-rate code defaults to the non-special population adult case-rate code, with no language differential.
- E. Submission of new demographic information by the provider can trigger a recalculation of case-rate code at any time up to the authorization change cut-off date.
- F. The cultural differential case rate is available for clients in one of the following categories: Ethnic Minority, Sexual Minority, Homebound, and/or Deaf or Hard-of-hearing. This Client Demographics transaction data must be processed successfully on or prior to the second month cutoff date in order to update the Case Rate Reason Code resulting in the Cultural Differential additional payment to apply.

### 3.3.3 Management of Non-Medicaid Dollars

- A. The quarterly allotment of non-Medicaid dollars shall be updated on the 15th of the month prior to the calendar quarter (see Section 05 Outpatient Services Level of Care).
- B. The allotment takes into account the expenditures for non-Medicaid benefits year to date, to account for any benefits authorized through the exception procedure or due to spend down status.

- C. For benefits where the client has lost Medicaid coverage, the client funding status will be checked to see if any individuals who were authorized as non-Medicaid have been converted to Medicaid during the past calendar month. If so, the amount of the remaining future payments for their authorized benefit will be reduced from the non-Medicaid encumbrance.
- D. The system allotment is structured to provide as consistent a level of new benefits authorization throughout the year as is practicable.
- E. As each non-Medicaid benefit is authorized, the amount of the remaining quarterly allotment will be reduced and future payments will be encumbered. When the quarterly allotment is fully converted into non-Medicaid benefit authorizations, no more benefits will be authorized during the calendar quarter, except for those authorized through the exception process.

If there are funds left in the quarterly allotment, and the dollar amount is not sufficient to authorize a whole new benefit, the dollars are rolled forward into the amount available for the remaining quarters of the year.

### 3.4 Responsibilities

#### 3.4.1 King County Behavioral Health and Recovery Division (BHRD)

- A. BHRD is responsible for the design, management, and operation of the BHRD IS.
- B. BHRD is responsible for ensuring and overseeing the security of the BHRD IS.
- C. BHRD shall provide reasonable technical assistance and support to KCBHP providers to enable providers to establish and maintain technical interface with the BHRD IS.
- D. BHRD shall produce data reports and tables to support the clinical and administrative functions of the KCBHO.

#### 3.4.2 Providers

KCBHO providers and specialized services agencies required to input or access information on the BHRD IS must develop, implement, and maintain information systems structures and personnel to support the policies, procedures, and requirements detailed in this publication.

### 4.0 LIST OF ATTACHMENTS:

- 4.1 Attachment A: Data Dictionary Summary of Attributes
- 4.2 Attachment B: Data Dictionary Provider Transactions

4.3 Attachment C: HIPAA Trading Partner Agreement

4.4 Attachment D: Trading Partner Agreement 837P

5.0 REFERENCES:

Federal Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- 42 Code of Federal Regulations (CFR) Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records
- 42 CFR Part 438 Managed Care
- 42 CFR Parts 400, 430, 431, 434, 435, 440
- 45 CFR Part 142 Security and Electronic Signature Standards
- 45 CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information
- 45 CFR Part 162 Health Insurance Reform: Modifications to Standards for Electronic Transactions and Code Sets

Washington State Law, Regulations, and Policy including any successor, amended, or replacement laws, regulations, or policies

- Chapters 388-865, 388-877, 388-877A WAC – DSHS – Mental Health – Community Mental Health and Involuntary Treatment Programs
- Chapter 10.77 Revised Code of Washington (RCW) – Criminal Procedure – Criminally Insane
- Chapter 13.50 RCW – Juvenile Courts and Juvenile Offenders – Keeping and Release of Records by Juvenile Justice or Care
- Chapter 70.02 RCW – Public Health and Safety – Medical Records – Health Care Information Access and Disclosure
- Chapter 71.05 RCW – Mental Illness – Mental Illness
- Chapter 71.24 RCW – Mental Illness – Community Mental Health Services Act
- Chapter 71.34 RCW – Mental Illness – Mental Health Services for Minors