State of Montana Department of Public Health and Human Services
Addictive and Mental Disorders Division (AMDD)

Adult Crisis Stabilization Provider Manual, Including Clinical Management Guidelines

Developed in collaboration with Magellan Medicaid Administration

Version 2.4

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Magellan Rx MANAGEMENT℠

Revision History

Document Version	Date	Name	Comments
1.0	2008/2009	Tim Kober	Original Word document unable to be located; used PDF version to convert to Word and use as basis for the 2008/09 annual review (V1.0)
2.0	06/01/2010	Tim Kober	Determinations updated to reflect State of MT Policy Change for Adverse Determinations
2.1	02/02/2012	Tim Kober/QI Team	No changes
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2.3	04/03/2015	Julie Prigmore	Annual review; No revisions
2.4	04/19/2016	Staci Lindsay; Comm & Doc Management	Annual review; Initial Prior Authorization Review Procedure and Continued Stay/Treatment Review Procedure revised; Rebranded and formatted

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1.0 Definitions

1.1 Crisis Stabilization

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) define Adult Crisis Stabilization services as "services that are available 24 hours per day, 7 days a week, by a licensed mental health center with an endorsement to provide crisis stabilization services. A multi-disciplinary team of licensed and appropriately credentialed professionals and professionally supervised paraprofessionals provides services throughout the 24-hour day in an environment in which there is a high degree of assurance of safety. Staff must include, but not be limited to, Board-eligible or certified psychiatrists, registered nurses, other licensed mental health professionals, and other ancillary staff."

1.2 Prior Authorization Reviews

Adult crisis stabilization services require prior authorization and must meet medical necessity as defined in the *Clinical Management Guidelines* specific to adult crisis stabilization. Please refer to *Section 6.0 – Adult Crisis Stabilization Clinical Management Guidelines*. The length of services initially authorized will depend solely on the recipient's level of functioning and clinical presentation.

1.3 Continued Stay/Treatment Reviews

All adult crisis stabilization services that extend beyond the initial authorization date must be authorized through a continued stay/treatment review. Discussion of the continued stay/treatment review process begins in *Section 2.2 – Continued Stay/Treatment Review Procedure*.

1.4 Retrospective Reviews

Adult crisis stabilization services are not subject to retrospective review by Magellan Medicaid Administration unless otherwise requested by the Department of Public Health and Human Services.

1.5 Discharge Procedure

AMDD no longer requires the discharge notification form to be completed following patient discharge from services for this level of care.

2.0 Prior Authorization Review Procedure

Since adult crisis stabilization admissions often occur during non-business hours, all are urgent/emergent in nature. The following review procedure will be followed for authorization of crisis stabilization services.

2.1 Initial Prior Authorization Review Procedure

- The provider must verify the recipient's Medicaid eligibility.
- Effective January 1, 2016, prior authorization is no longer required for crisis stabilization services. A provider is required to submit a continued stay request to Magellan Medicaid Administration for crisis stabilization services beyond 7 days.

2.2 Continued Stay/Treatment Review Procedure

2.2.1 Definition

A continued stay treatment review is a review of currently delivered treatment and patient status to determine current medical necessity for a continued level of care.

Reviews of requests for continued treatment authorization are based on updated treatment plans, progress notes and recommendations of the individual's treatment team based on the patient's ongoing need for this level of services. Continued treatment requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines* specific to adult crisis stabilization in *Section 6.0 – Adult Crisis Stabilization Clinical Management Guidelines*. The length of continued treatment services authorized will depend solely on the recipient's level of functioning and clinical presentation.

1. The facility is responsible for contacting Magellan Medicaid Administration by fax or web 24 hours/1 business day prior to the end of the initial 7-days of treatment.
2. The facility must submit the following information to complete a continued treatment review:
    - For the initial continued stay request, use the Adult Crisis Stabilization Request for First Continued Stay form (see Providers → Adult → Forms https://montana.fhsc.com) that includes demographic and clinical information. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include
    - Demographic Information
        – Recipient's Medicaid ID (MID) number

  - Recipient's Social Security Number (SSN)
  - Recipient's name, date of birth, sex
  - Recipient's address, county of eligibility, and telephone number
  - Responsible party name, address, phone number
  - Provider name, provider number, and date of admission
- Clinical Information
  - Prior inpatient treatment
  - Prior outpatient treatment/alternative treatment
  - Initial treatment plan
  - DSM-V diagnosis
  - Medication history
  - Current symptoms requiring crisis stabilization
  - Chronic behavior/symptoms
  - Appropriate medical, social, and family histories
  - Proposed aftercare treatment

3. The authorization review will be completed within two business days from receipt of the review request and clinical information providing the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.

   If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five days of the request for additional information; and

   - The authorization review will be completed within two business days from receipt of additional information.

If medical necessity is met, the Magellan Medicaid Administration's reviewer will authorize the adult crisis stabilization admission. If medical necessity is not met, then the case is deferred to a board-certified psychiatrist in the Magellan Medicaid Administration National Clinical Review Center for review and determination.

- For subsequent continued stay requests, use the Adult Crisis Stabilization Continued Stay Request form (see Providers → Adult → Forms https://montana.fhsc.com);
- Changes to current DSM-V diagnosis;
- Justification for continued services at this level of care;
- Assessment of treatment progress related to admitting symptoms and identified treatment goals;

Current list of medications or rationale for medication changes, if applicable; and

- Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of the plan.

4. Upon receipt of the above documentation, Magellan Medicaid Administration's clinical reviewer will complete the review process as demonstrated in the *Continued Stay Review Flow Chart*.
5. The continued treatment review will be completed within two business days from receipt of the review request when the clinical information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.
    - If medical necessity is met, the Magellan Medicaid Administration reviewer will authorize the continued treatment and generate notification to all appropriate parties.
    - If medical necessity is not met, then the case is deferred to a board-certified psychiatrist in the Magellan Medicaid Administration National Clinical Review Center for review and determination.
6. If the Magellan Medicaid Administration clinical reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five days of the request for additional information. The authorization review will be completed within two business days from receipt of additional information.
    - If medical necessity is met, the Magellan Medicaid Administration reviewer will authorize the continued treatment and generate notification to all appropriate parties.
    - If medical necessity is not met, then the case is deferred to a board-certified psychiatrist in the Magellan Medicaid Administration National Clinical Review Center for review and determination.

3.0 Determinations

Upon completion of the review, one of the following determinations will be applied and notification will be made as outlined in *Section 4.0 – Notification Process* of this section:

3.1 Authorization

An authorization determination indicates that utilization review resulted in approval of all provider requested services and/or service units and a prior authorization number is issued.

3.2 Information Pending

Indicates that a Magellan Medicaid Administration reviewer or Magellan Medicaid Administration psychiatrist has requested additional information from the provider. The provider will have five days to provide any additional information needed to make a payment determination.

3.3 Denied with Less than Requested Days (Prior Authorization for Initial Request)

Denied with less than requested days is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested for an initial authorization request. Only a Magellan Medicaid Administration psychiatrist may issue a denial with less than requested days. Denials are subject to the Magellan Medicaid Administration Appeal process. **If the appellate physician upholds the denial, and a new episode of clinical significance arises that would meet the medical necessity criteria, a new initial request must be made.**

3.4 Denied with Additional Days to Complete Discharge Plan (Prior Authorization for Continued Stay Request)

Denied with additional days to complete discharge plan is considered an adverse payment determination indicating that the request does not meet the appropriate Medicaid criteria to justify Medicaid payments for the level or complete duration of services requested for a continued stay authorization request. Only a Magellan Medicaid Administration psychiatrist may issue a denial with additional days to allow the provider to complete the discharge plan. Denials are subject to the Magellan Medicaid Administration Appeal process. If the appellate physician upholds the denial, and a new episode of clinical significance arises that would meet the medical necessity criteria, a new initial request must be made.

3.5 Denial

The request for authorization of payment does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payment for the services requested. Authorization for payment is denied. Only a Magellan Medicaid Administration psychiatrist may issue a denial. Denials are subject to the Magellan Medicaid Administration Appeal process. If the appellate physician upholds the denial, and a new episode of clinical significance arises that would meet the medical necessity criteria, a new initial request must be made.

3.6 Technical Denial (Administrative Denial)

A prior authorization review was not administered on medical necessity criteria as a result of provider Medicaid protocol noncompliance. Noncompliance indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the Mental Health Services Bureau within 30 days of date of notification.

> Note: The ARM specifically states, "An authorization by the department of its utilization review under this rule is not final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time."

4.0 Notification Process

Magellan Medicaid Administration recognizes the importance of prompt notification to all relevant parties with regard to authorizations and denials. "Relevant parties" is defined as beneficiaries, families or guardians of beneficiaries, requesting providers, and the Department. When appropriate, Magellan Medicaid Administration will notify the regional care coordinator to assist in the transition to other levels of care.

Magellan Medicaid Administration will implement a two-step notification process, providing both informal and formal notification.

4.1 Informal Notification

Informal notification will be completed via facsimile on a daily basis and will include

- Outcome report to the department of all denials and technical denials, regardless of region or provider
- Outcome report of all determinations will be given to each provider (provider-specific information only)
- Outcome report of all determinations will be provided to the regional care coordinator (region-specific only)

The above outcome reports are generated and transmitted via facsimile by 9:00 a.m. Mountain Time on the next business day.

4.2 Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination sent by U.S. Mail.

- Authorization determinations will be mailed by regular U.S. Mail.
- Denial determinations (technical denial or denial for medically unnecessary) will be mailed by regular U.S. Mail.
- Notifications for technical denials will include:
  - Dates of service denied a payment recommendation because of non-compliance with administrative rules;
  - References applicable to federal and/or state regulations;
  - An explanation of the right of the parties to request an appeal;
  - Name and address of person to contact to request an appeal; and
  - A brief statement of the Magellan Medicaid Administration contractual responsibility to the State of Montana for utilization reviews.

- Notifications for denial determinations for medically unnecessarily treatment/services will include:
  - Dates of service that are denied a payment recommendation because the services in question are considered medically unnecessary according to Medicaid criteria or protocols;
  - Case-specific denial rationale based on the medical necessity criteria upon which the determination was made;
  - Reference federal and/or state regulations governing the review process;
  - Date of notice of Magellan Medicaid Administration's decision, which is the date of printing and mailing; and/or the date of the confirmed facsimile transmission;
  - An explanation of the right of the recipient (or legal guardian), the psychiatrist/physician, and/or the provider to request an appeal;
  - Name and address of person of office to contract to request an appeal; and
  - A brief statement of Magellan Medicaid Administration's contractual responsibility to the State of Montana for utilization reviews.

5.0 Appeal Process

5.1 Definition

An Appeal is a consumer, provider, or agent's challenge of a denial. An appeal may be indicated through the use of any one of the following terms: Appeal, Administrative Review, Reconsideration, or Fair Hearing.

5.2 Process

All adverse determinations are made by board-certified psychiatrists. The Magellan Medicaid Administration review process is designed to take advantage of the Montana-specific knowledge of treatment availability, access, and program strengths that the Montana physician panel brings to the determination process. Therefore, Magellan Medicaid Administration will defer appeals to a Montana-based physician for final determination whenever possible. Magellan Medicaid Administration's panel includes a sufficient number of psychiatrists certified by the American Board of Psychiatry and Neurology so that all appeal determinations will be completed by a psychiatrist not involved in the original adverse determination. This process allows for a choice of a peer-to-peer or a desk-based review using the following process:

- Upon receipt of an adverse determination, the recipient or recipient's guardian or the provider/facility may request an appeal of the adverse determination.
- The request for appeal must be received at the Magellan Medicaid Administration's Helena office within 30 days of the date of the determination notice.
- The request for appeal must specify the option of peer discussion/review or desk review.
- Any additional information to be considered must be included with the request.

5.2.1 Peer-to-Peer Discussion/Review

Scheduling of peer reviews must be requested and coordinated through the Magellan Medicaid Administration Helena office. To permit completion of the appeal process within 5 business days of receipt of the request, the peer-to-peer discussion will be requested and must be completed within 72 hours/3 business days of receipt of the request.

5.2.2 Desk Review

A desk review will be performed in the following circumstances:

The request for appeal does not specify peer discussion or desk review; or

- The appellate physician was not able to realize contact with the requestor to complete the peer-to-peer discussion.

5.2.3 General Information

Magellan Medicaid Administration completes the appeal review within five business days of the receipt of the request. A board-certified psychiatrist who has no prior knowledge of the case, no professional relationship or ties to the provider completes the reconsideration review. Whenever possible, Montana licensed and based board-certified psychiatrists will complete these reviews.

All final determinations include rationale for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final Magellan Medicaid Administration decision.

If the appeal review upholds the original adverse determination, the rights of the provider and/or beneficiary to an administrative review or reconsideration with the Montana Department of Public Health and Human Services will be included in the formal notification. Magellan Medicaid Administration's board-certified psychiatrists may provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

5.2.4 Notification Process: Appeal Determinations

In accordance with state and federal policy, Magellan Medicaid Administration will provide written notification of the appeal determination to the recipient or recipient's legal guardian and to the provider/facility of their right to the next level of appeal. Notification will include those elements as discussed in *Section 4.0 – Notification Process*.

5.2.5 Fair Hearing Process

Magellan Medicaid Administration will be available to participate in the Medicaid Fair Hearing process to provide testimony related to the determination under appeal and will provide copies of all documentation and correspondence related to the determination under appeal.

Please refer to the notification letter for detailed instructions regarding Appeals/ Reconsiderations/Administrative Review/Fair Hearing processes.

6.0 Adult Crisis Stabilization Clinical Management Guidelines

Magellan Medicaid Administration will employ the use of the *Montana Medicaid Clinical Management Guidelines* strictly as **guidelines.** This practical application, coupled with our professional judgment based on clinical expertise and national best practices, will enhance the rendering of authorization decisions. The *Clinical Management Guidelines* for Adult Crisis Stabilization, including admission, continued stay, and discharge criteria are as follows.

6.1 Admission Criteria

A covered DSM-V diagnosis as the principle diagnosis and at least one of the following:

1. Dangerousness to self as a result of the DSM-V diagnosis as evidenced by behaviors that may include, but not be limited to any of the following:
    a. Self-injurious behavior or threats of same with continued risk without 24-hour supervision
    b. Current suicidal ideation with expressed intentions and/or past history of carrying out such behavior with some expressed inability or aversion to doing so, or with ability to contract for safety
    c. Self-destructive behavior or ideation that cannot be adequately managed and/or treated at a lower level of care without risk to the patient's safety or clinical well-being
    d. History of serious self-destructive or impulsive, parasuicidal behavior with **current** verbalizing of intent to engage in such behavior, with the risk, as judged by a clinician, being significantly above the patient's baseline level of functioning
2. Dangerous to others as a result of a DSM-V diagnosis, as evidenced by behaviors that may include, but are not limited to expressed intent to harm others, current threats to harm others with expressed intentions of carrying out such behavior with some expressed inability or aversion to doing so.

3. Grave disability as exhibited by ideas or behaviors resulting from the DSM-V diagnosis, as evidenced by behaviors that may include, but are not limited to any of the following:
    a. Mental status deterioration sufficient to render the patient unable to reasonably provide for his/her own safety and well being
    b. An acute exacerbation of symptoms sufficient to render the patient unable to reasonably provide for his/her own safety and well being
    c. Deterioration in the patient's function in the community sufficient to render the patient unable to reasonably provide for his/her own safety and well being
    d. An inability of the patient to cooperate with treatment combined with symptoms or behaviors sufficient to render the patient unable to reasonably provide for his/her own safety and well being
    e. A clinician's inability to adequately assess and diagnose a patient, as a result of the unusually complicated nature of a patient's clinical presentation, with behaviors or symptoms sufficient to render the patient unable to reasonably provide for his/her own safety and well being, but not sufficient to require the intensity of inpatient treatment

6.2 Continued Treatment Criteria

Must meet 1 and 2 and 3, and either 4 or 5 or 6:

1. A covered DSM-V diagnosis as the principal diagnosis; and
2. Active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria and that still exist; and
3. A lower level of care is inadequate to meet the patient's need with regard to either treatment or safety together with;
4. There is reasonable likelihood of a clinically significant benefit as a result of medical intervention requiring the inpatient setting ; or
5. A high likelihood of either risk to the patient's safety or clinical well-being or of further significant acute deterioration in the patient's condition without continued care, with lower levels of care inadequate to meet these needs; or
6. Appearance of new impairments meeting admission guidelines.

6.3 Discharge Criteria

Must meet 1 or 2:

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care; or
2. The patient voluntarily withdraws from treatment and does not meet criteria for involuntary treatment.