MAGELLAN MEDICAID ADMINISTRATION

State of Montana Department of Public Health and Human Services Addictive and Mental Disorders Division (AMDD) Montana Adult Intensive Outpatient Services (AIOS) Provider Manual, Including Clinical Management Guidelines

Developed in collaboration with Magellan Medicaid Administration

Version 2.0

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	07/16/07		Initial creation of document
1.1	07/28/09	Tim Kober	Updated Admission Criteria and Continued Stay Criteria
2.0	06/01/10	Tim Kober, Documentation Management Team	Determinations updated to reflect State of MT Policy Change for Adverse Determinations

Table of Contents

1.0 Introduction

1.1 Adult Intensive Outpatient Services

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) for adult intensive outpatient services define these services as community-based treatment, with the following services and procedure codes:

- HIPAA H0046, Modifier HB (Individual or Family Therapy)
- HIPAA H2014 (1:1 Telephone or face-to-face DBT Coaching & Case Management)
- HIPAA H2014, Modifier HQ (DBT Skills Group)

Intensive outpatient therapy services must be provided by individuals or agencies licensed by the State of Montana.

1.2 Prior Authorization Reviews

All adult intensive outpatient services require prior authorization and must meet medical necessity guidelines as defined in the *Clinical Management Guidelines*. Refer to *Section 7.0 – Adult Intensive Outpatient Therapy Services Clinical Management Guidelines* for the complete *Clinical Management Guidelines* specific to adult intensive outpatient. Discussion of the prior authorization review process begins in *Section 2.0 – Prior Authorization Procedure*.

1.3 Continued Stay Review

All adult intensive outpatient services that extend beyond the initial authorization date must be prior authorized through a continued stay review. Discussion of the continued stay review process begins in *Section 3.0 – Continued Stay Review Procedure*.

1.4 Retrospective Review

Adult intensive outpatient services are not subject to retrospective review by Magellan Medicaid Administration except as requested by the Department of Public Health and Human Services, an individual, or individual's guardian or provider.

1.5 Discharge Procedure

Addictive and Mental Disorders Division (AMDD) no longer requires a discharge notification form to be completed following patient discharge from services for this level of care.

2.0 Prior Authorization Procedure

These services must be medically necessary and advantageous to the client. They are considered as elective treatment. Therefore, prior authorization is required for all adult intensive outpatient services.

2.1 Procedure

1. The provider must verify the recipient's Medicaid eligibility.
2. The provider should notify Magellan Medicaid Administration as soon as the need for services is determined, but **must** notify Magellan Medicaid Administration at least 48 hours/2 business days prior to initiation of services. This allows for timely completion of the prior authorization review process. This is a fax or Web-based notification process for submission of the request for prior authorization and pertinent information.
3. The provider must submit a prior authorization request form by fax or Web 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 number (MID) number
     - Recipient's Social Security Number (SSN)
     - Recipient's name, date of birth, sex
     - Recipient's address, county of eligibility, telephone number
     - Responsible party name, address, phone number
     - Provider name, provider number, planned date of placement
   - **Clinical Information**
     - Prior inpatient treatment
     - Prior outpatient treatment/alternative treatment
     - Anticipated date of service initiation
     - Treatment plan
     - DSM-IV diagnosis on Axis I through V
     - Medication history
     - Current symptoms/circumstances requiring intensive outpatient services
     - Chronic behavior/symptoms
     - Appropriate medical, social, and family histories

- Proposed aftercare treatment

4. Upon receipt of the above documentation, Magellan Medicaid Administration's clinical reviewer will complete the review process.
   - ❖ 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.
   - ❖ The authorization review will be completed within two business days from receipt of additional information.
5. If medical necessity is met, the Magellan Medicaid Administration reviewer will authorize placement and generate notification to all appropriate parties.
6. 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.

Note: For information regarding Determination, Notification, and Appeal Procedures, please refer to *Section 4.0 – Determinations, Section 5.0 – Notification Process,* or *Section 6.0 – Appeal Process* in this manual.

3.0 Continued Stay Review Procedure

A continued stay review is a review of currently delivered treatment to determine ongoing medical necessity for a continued level of care.

Reviews of requests for continued stay authorization are based on updated treatment plans, progress notes, and recommendations of the individual's treatment team. Continued stay requests require prior authorization and must meet the medical necessity criteria as defined in the *Clinical Management Guidelines* for intensive outpatient, continued stay criteria.

3.1 Length of Authorization

Magellan Medicaid Administration will conduct continued stay reviews for all medically necessary stays in intensive outpatient services that extend beyond the number of days initially authorized. Each continued stay review may permit authorization of additional treatment when medical necessity is determined. Subsequent continued stay reviews will occur until the recipient is discharged from the service or medical necessity is no longer met.

3.2 Procedure

1. The provider is responsible for contacting Magellan Medicaid Administration by fax or Web no more than five business days prior to the termination of the initial certification.
2. The provider must submit the following information to complete a continued stay review:
    - ❖ Changes to current DSM-IV diagnosis on Axis I through V
    - ❖ Justification for continued services at this level of care
    - ❖ Behavioral Management interventions/Critical Incidents
    - ❖ Assessment of treatment progress related to admitting symptoms and identified treatment goals
    - ❖ Current list of medications or rationale for medication changes, if applicable
    - ❖ Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan
3. Upon receipt of the above documentation, Magellan Medicaid Administration's clinical reviewer will complete the review process:
    - ❖ The continued stay 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.
- The continued stay review will be completed within two business days from receipt of additional information.

4. If medical necessity is met, the Magellan Medicaid Administration reviewer will authorize the continued stay and generate notification to all appropriate parties
5. 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.

4.0 Determinations

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

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.
2. **Pending Authorization:** 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.

4.1 Denied with Less Than Requested Days (Prior Authorization for Initial Request)

Denied with less than requested units 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.

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

Denied with additional units 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.

4.3 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.

4.4 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."

5.0 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.

5.1 Informal Notification

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

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

5.2 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 that are denied a payment recommendation because of non-compliance with administrative rule
- Reference 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

- A brief statement of the Magellan Medicaid Administration's 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
- A brief statement of Magellan Medicaid Administration's contractual responsibility to the State of Montana for utilization reviews.

6.0 Appeal Process

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.

6.1 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:

1. Upon receipt of an adverse determination, the recipient or recipient's guardian, or the provider/facility, may request an appeal of the adverse determination.
2. The request for appeal must be received at the Magellan Medicaid Administration Helena office within 30 days of the date of the determination notice.
3. 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.

6.1.1 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.

6.1.2 Desk Review

A desk review will be performed whenever a peer-to-peer review has not been requested, when the request for appeal does not specify peer discussion or desk review, or when the appellate physician was not able to realize contact with the requestor to complete the peer-to-peer discussion.

1. 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 or professional relationship or ties with the provider completes the reconsideration review. Whenever possible, Montana licensed and based board-certified psychiatrists will complete these reviews.
2. All final determinations include rational for the determination based upon the applicable federal and state regulations, and include instructions as to the rights of further appeal.
3. The determination rendered by the appellate physician performing the review will, in all cases, stand as the final Magellan Medicaid Administration decision.
4. If the appeal review upholds by the 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 board-certified psychiatrists may provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

6.1.3 Notification Process: Appeal Determinations

In accordance with state and federal policy, Magellan Medicaid Administration will provide a written notification of the appeal determination to the recipient or recipient's legal guardian and the provider/facility of their right to the next level of appeal. Notification will include those elements as discussed in *Section 5.0 – Notification Process*.

6.1.4 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.

Note: Please refer to the notification letter for full instructions regarding the appeal process; i.e., appeals, reconsiderations, administrative reviews, fair hearings.

7.0 Adult Intensive Outpatient Therapy Services 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 professional judgment based on clinical expertise and national best practices, will enhance the authorization decisions.

Intensive outpatient therapy services represent community-based treatment, with the following services and procedure codes:

- HIPAA H0046, Modifier HB (Individual or Family Therapy)
- HIPAA H2014 (1:1 Telephone or face-to-face DBT Coaching & Case Management)
- HIPAA H2014, Modifier HQ (DBT Skills Group)

Intensive outpatient therapy services must be provided by individuals or agencies licensed by the State of Montana.

This level of treatment intervention includes a consideration of the person's safety and security needs, including the ability and likelihood of the person to benefit from intensive outpatient treatment.

7.1 Admission Criteria

Must meet **each** of the following:

1. The person meets the requirements of (a) **or** (b). The person must also meet the requirements of (c):
    a. Has a DSM-IV diagnosis of mood disorder (296.22, 296.23, 296.24, 296.32, 296.33, 296.34, 296.40, 296.42, 296.43, ,296.44, 296.52, 296.53, 296.54, 296.62, 296.63, 296.64, 296.7, 296.80, 296.89, 296.90, 293.83, 295.70)
    b. Has a DSM-IV diagnosis of 301.83 Borderline Personality Disorder, or 301.9 Personality Disorder NOS, with prominent features of 301.83 with a severity specifier of moderate or severe
    c. Has ongoing difficulties in functioning because of the mental illness for a period of at least 6 months (or for an obviously predictable period over the next 6 months), as indicated by
        i. Dysregulation of emotion, cognition, behavior, and interpersonal relationships

ii. Resulting in recurrent suicidal, parasuicidal, other serious self-damaging behaviors or ideation, or serious danger to others

iii. A history of high utilization of crisis, emergency room, or hospital services (including medical services for co-occurring behavioral health disorders or arrest and incarceration as a result of behavior associated with the mental illness)

iv. Evidence that lower levels of care are inadequate to meet the needs of the client

v. Difficulties in functioning that are not a result of active psychosis

7.2 Continued Stay Criteria

Must meet **each** of the following:

1. The person meets the requirements of (a) **or** (b). The person must also meet the requirements of (c) **or** (d):
    a. Has a DSM-IV diagnosis of mood disorder (296.22, 296.23, 296.24, 296.32, 296.33, 296.34, 296.40, 296.42, 296.43, ,296.44, 296.52, 296.53, 296.54, 296.62, 296.63, 296.64, 296.7, 296.80, 296.89, 296.90, 293.83, 295.70)
    b. Has a DSM-IV diagnosis of 301.83 Borderline Personality Disorder, or 301.9 Personality Disorder NOS, with prominent features of 301.83
    c. Has ongoing difficulties in functioning because of the mental illness as indicated by
        i. Dysregulation of emotion, cognition, behavior and interpersonal relationships
        ii. Resulting in recurrent suicidal, parasuicidal, other serious self-damaging behaviors or ideation, or serious danger to others
        iii. A history of high utilization of crisis, emergency room, or hospital services (including medical services for co-occurring behavioral health disorders or arrest and incarceration as a result of behavior associated with the mental illness)
        iv. Evidence that lower levels of care are inadequate to meet the needs of the client

v. Difficulties in functioning are not a result of active psychosis

d. Initially met criteria (c), either in treatment with this therapist or with another therapist, but now evidences a reduction of symptoms described in (c) as above.

7.3 Discharge Criteria

Must meet 1 or 2 or 3:

1. The Individual Treatment Plan goals have been sufficiently met such that the recipient no longer requires this level of care.
2. The recipient voluntarily leaves treatment or the beneficiary's legal guardian removes them from the program.
3. Recipient no longer meets Medicaid eligibility.