MAGELLAN MEDICAID ADMINISTRATION

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

Developed in collaboration with Magellan Medicaid Administration

Version 2.0

June 1, 2010

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
2.0	06/01/10	Timothy Kober, Documentation Management Team	Determinations updated to reflect State of MT Policy Change for Adverse Determinations

Table of Contents

1.0 Partial Hospital Care

1.1 Definition

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines*) define partial hospital care as "a level of care that is distinguished from 24-hour inpatient or intermediate/residential care only in that the person does not remain in the hospital 24-hours per day. Support and supervision must be sufficient to maintain the person's safety outside the hospital. Services of a high level of intensity are provided on-site."

Services are available a minimum of four hours per day and five days per week in an appropriately licensed facility. Treatment is intensive and is provided in a supervised environment by a multi-disciplinary team of qualified professionals including, but not limited to board-eligible or certified psychiatrists, clinicians, registered nurses, licensed mental health professionals, and other ancillary staff. Treatment is focused on the following:

- Reducing the risk of behaviors destructive to self or to others, including impulsive behaviors such as mutilation
- Reducing clinically significant disability
- Reducing the probability of impulsive behaviors that can be predicated to have a clinically significant risk based on the patient's history and current clinical presentation
- Reducing the probability of behaviors likely to lead to the need for a higher level of care
- Reducing medical factors that are associated with a mental disorder and place the patient at significant risk

1.2 Prior Authorization Reviews

All admissions of Medicaid recipients to partial hospital care require prior authorization and must meet medical necessity as defined in the *Clinical Management Guidelines*. Refer to *Section 7.0 – Partial Hospital Care Clinical Management Guidelines* for the clinical management guidelines specific to partial hospital care.

1.3 Continued Stay Reviews

All partial hospital care serves that extend beyond the initial authorization date must be prior authorized through a continued stay review. Discussion of the continued stay review process beings in *Section 3.0 – Continued Stay Review*.

1.4 Retrospective Reviews

Partial hospital care 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

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

2.0 Prior Authorization Review

2.1 Definition

A partial hospital care admission is a scheduled admission that is subject to the choice or discretion of the recipient or the physician advisor regarding medical services and/or procedures that are medically necessary and advantageous to the client, but not necessary to prevent death or disability. Prior authorization is required for all admissions to a partial hospital care program.

2.2 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 admission is determined, but must notify Magellan Medicaid Administration no later than 48 hours/2 business days prior to admission. This allows for timely completion of the pre-admission 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)
        - – Recipient's Social Security Number (SSN)
        - – Recipient's name, date of birth, and sex
        - – Recipient's address, county of eligibility, telephone number
        - – Responsible party name, address, phone number
        - – Hospital name, provider number, and planned date of admission
    - ❖ Clinical Information
        - – Prior inpatient treatment
        - – Prior outpatient treatment/alternative treatment
        - – Anticipated date of admission
        - – Initial treatment plan
        - – DSM-IV diagnosis on Axis I through V
        - – Medication history
        - – Current symptoms requiring partial hospital care

- Chronic behavior/symptoms
- Appropriate medical, social, and family histories
- Proposed discharge plan

4. The recipient's treatment must be documented to meet all of the following criteria:
    a. The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning.
    b. The recipient cannot be safely and appropriately treated or contained in a less restrictive level of care.
    c. Proper treatment of the beneficiary's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician.
    d. The recipient can be safely and effectively managed in a partial hospitalization setting without significant risk of harm to self or others.
    e. The services can reasonably be expected to improve the recipient's condition or prevent further regression.
    f. The recipient has exhausted or cannot be safely and effectively treated by less restrictive alternative services, including day treatment services or a combination of day treatment and other services.

3.0 Continued Stay Review

3.1 Definition

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

Reviews of request for continued stay authorization are based on updated treatment plans, progress notes, and recommendation 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*. Refer to *Section 7.0 – Partial Hospital Care Clinical Management Guidelines*.

3.2 Procedure

1. The provider is responsible for contacting Magellan Medicaid Administration by fax or Web five days prior to the termination of the initial certification.
2. The provider must submit a continued stay review request form by fax or Web that provides sufficient information for the clinical reviewer to make a determination regarding medical necessity and must include
    - ❖ Changes to current DSM-IV diagnosis on Axis I through V
    - ❖ 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
    - ❖ 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 authorization review will be completed within two business days from receipt of the original 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.

4. If medical necessity is met, the Magellan Medicaid Administration reviewer will authorize the admission 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 *Section 5.0 – Notification Process*:

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 a 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 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.

4.2 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.

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 non-compliance. Non-compliance 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” are 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 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.

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

6.1 Definition

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

6.2 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 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.

6.2.1 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.

6.2.2 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.

- 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.
- 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 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's board-certified psychiatrists may provide input regarding the determination rationale, application of federal and state regulations, and other relevant information.

6.2.3 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*.

6.2.4 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.

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

7.0 Partial Hospital Care 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 rendering of authorization decisions. The *Clinical Management Guidelines* for partial hospital care, including service components, admission, continued stay, and discharge criteria are as follows.

7.1 Services Components

Must meet all of the following:

1. Minimum of four hours of active mental disorder treatment per day within a structured therapeutic milieu (exclusive of formal education and support groups administered by non-licensed/certified personnel) that includes individual and/or group therapy
2. Person must be seen and evaluated by a physician who will participate with the multi-disciplinary team in preparation of an individualized, documented treatment plan directed toward the alleviation of the impairment(s) that caused the admission
3. Involvement of family and all active pre-admission caregivers in evaluation, treatment planning activities, and in treatment as appropriate
4. Active discharge planning must be initiated at time of admission to program and culminates in comprehensive discharge plan
5. Active treatment is focused upon stabilizing or reversing symptoms necessitating admission
6. Treatment plan is regularly updated to reflect person's progress and/or new information that has become available
7. Regular assessment and active interventions are completed by nurses, therapists, and physicians based upon the comprehensive treatment plan

7.2 Admission Criteria

Must meet all of the following:

1. A covered DSM-IV diagnosis as the principal diagnosis
2. The recipient is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairment in educational, social, vocational, and/or interpersonal functioning

3. The recipient cannot be safely and appropriately treated or contained in a less restrictive level of care
4. Proper treatment of the recipient's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician
5. The recipient can be safely and effectively managed in a partial hospital setting without significant risk of harm to self/others
6. The services can reasonably be expected to improve the recipient's condition or prevent further regression
7. Discharge planning will be initiated at the time of admission

7.3 Continued Treatment Criteria

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

1. A covered DSM-IV diagnosis as the principal diagnosis
2. Active treatment is occurring that is focused on stabilizing or reversing symptoms that meet the admission criteria and that still exist
3. A lower level of care is inadequate to meet the patient's needs with regard to either treatment or safety
4. There is a reasonable likelihood or clinically significant benefit, including stabilization, and reduced probability of future need for a higher level of care, as a result of medical intervention requiring the partial hospital setting
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 in the partial hospital setting, with lower levels of care inadequate to meet these needs
6. The appearance of new impairments meeting the admission guidelines

7.4 Discharge Criteria

Must meet 1 and 2, or 3:

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care
2. A comprehensive discharge plan has been developed and is ready to be implemented
3. The patient voluntarily withdraws from treatment or the person's parent or legal guardian removed him/her from the program