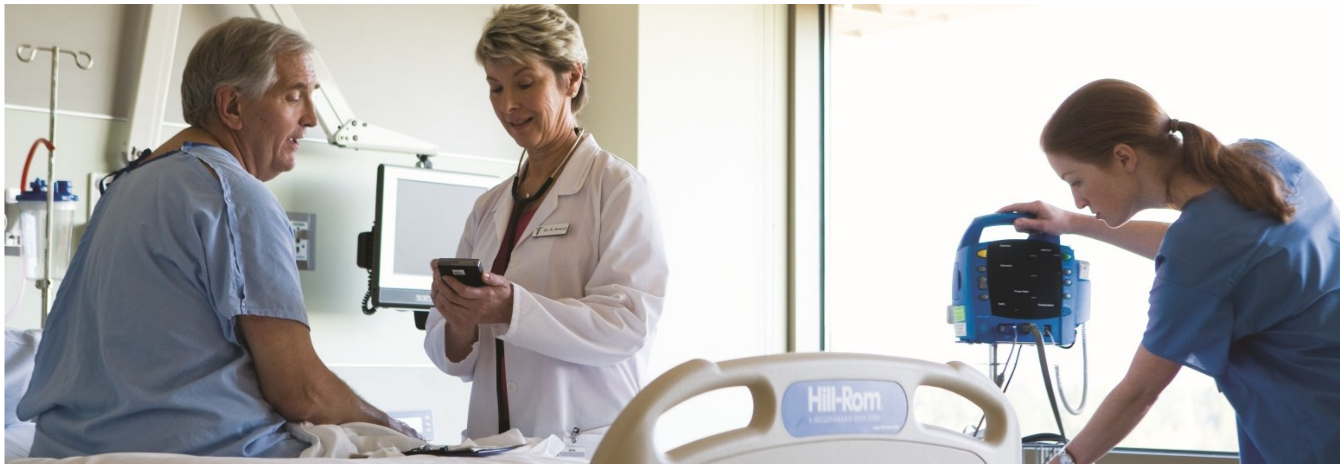
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201250 NOVEMBER 29, 2012



The OMPP updates PA criteria for PRTF admissions, continued stays, and re-admissions

The Office of Medicaid Policy and Planning (OMPP) announces changes to the established prior authorization (PA) criteria for admissions and continued stays in a psychiatric residential treatment facility (PRTF) (*405 IAC 5*-3). The OMPP is also implementing new criteria for discharges from and re-admissions to a PRTF. PA criteria updates are effective for dates of service on or after January 1, 2013.

The *PRTF Prior Authorization Quick Reference Guide* attached to this publication should be used as a reference to help providers complete the required PA documentation. Please see the *Indiana Health Coverage Programs Provider Manual* for other information about PRTF services and billing.

Coverage provisions

Medicaid reimbursement is available for medically necessary services provided to members 20 years of age and younger (before their 21st birth date) in a PRTF. For members who begin receiving PRTF services immediately before their 21st birth date, reimbursement is available up to 22 years of age (before their 22nd birth date). For members five years of age and younger (before sixth birth date), a waiver must be authorized by the Indiana Department of Child Services (DCS).

"All services require prior authorization (PA). Requests must be submitted to the appropriate PA vendor by mail, fax, or telephone before admission. PRTF PA requests may not be submitted via Web interChange."

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Medicaid reimbursement for an eligible individual is available for services in a PRTF only when the recipient's need for admission has been certified in accordance with *42 CFR 441.152(a)* (not including secondary *Code of Federal Regulations* citations therein) and *42 CFR 441.153* (not including tertiary *Code of Federal Regulations* citations resulting therefrom).

PA requirements and documentation for new admissions

PA documentation requirements for new admission requests submitted by mail or fax

- *Indiana Health Coverage Programs Prior Authorization Request Form* – A completed form is required. This form is available on the Forms page on indianamedicaid.com.
- *Certification – Plan of Care for Inpatient Psychiatric Hospital Services/Determination of Medicaid Eligibility (OMPP 1261A) (#44697)* – A completed form, signed by the certifying physician, is required. This form can be found on the Form.in.gov web page (search for form #44697).
- *Child and Adolescent Needs and Strengths (CANS) Assessment* – A recent CANS assessment, printed from the designated state system, indicating PRTF level of need. The assessment can be no more than 30 days old.
- *Physician history and physical (H&P)* – A completed physician history and physical (H&P) examination. The H&P can be no more than 90 days old.
- *Initial Master Multidisciplinary Treatment Plan* – The master multidisciplinary treatment plan must be completed no later than 10 days after admission and sent to the appropriate PA vendor. The treatment plan must be in accordance with the appropriate federal guidelines including, but not limited to, the following: *§441.155, §456.180*, and *§441.156*. Additionally, the master treatment plan should:
  - Be based on a diagnostic evaluation and outline the diagnosis along with problems related to the member's psychiatric condition
  - Include measurable goals and objectives relevant to the problems that include needs and strengths identified on the CANS, and include input from the member's family or legal guardian
  - Identify the team of professionals, as specified in *§441.156*, who will be involved in the member's care and treatment
  - Include interventions and timeframes for reaching the goals and objectives
  - Include expected discharge date of the member
- Documentation indicating the severity of the member's mental disorder – The member must have one or more Axis I diagnoses from the approved list. Axis II diagnoses may not be used to qualify a youth for admission to a PRTF. Mental health disorders are outlined in the *Diagnostic and Statistical Manual, Fourth Edition* (DSM=IV), or subsequent releases.
- Documentation indicating that intermediate or long-term care in a secure facility is needed for the member – The mem-

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ber must show need for intermediate or long-term residential, psychiatric treatment modalities, such as group counseling, individual counseling, recreational therapy, expressive therapies, or behavior modification treatment. Special programs that are strictly educational do not qualify as behavior therapy.

- Additional treatment information – Additional information from the member's current or previous treatment may be requested to ensure appropriate review and determination.
- *Freedom of Choice Form* – Acknowledgement by the member's parent or legal guardian that he or she has been informed of the services available to the family through the different child-serving systems and has chosen PRTF admission. This documentation must be included in the member's clinical record but is not required to be submitted.

PA documentation requirements for new admissions requests via telephone

Effective January 1, 2013, clinical providers will have the option to request PA for a member's admission to a PRTF via telephone. The clinician or provider must maintain the same documentation in the chart that would be required if submitting the request via mail or fax. Once PA is created in Indiana*AIM*, the request will remain in a "pending" status until the required documentation has been submitted via mail or fax. Submission is required within 14 business days of admission.

PA requests by telephone must be made by providers on or before the date of admission. The following information is required for telephone admissions:

- National Provider Identifier (NPI) or Legacy Provider Identifier (LPI)
- Member's Medicaid identification number (RID)
- Member's primary diagnosis
- Date of admission
- Overview of the member's current status and history of member's presenting issues

"If the provider fails to call within 48 hours of an urgent admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement will be denied for the period from admission to the actual date of notification."

Documentation requirements for requests for urgent admissions

Urgent admission is defined as an admission of a member when the placement was not preplanned by the facility, its physician, or the parent, guardian, or caregiver. An urgent admission should follow the same guidelines as a telephone admission, except that the provider must call within 48 hours of admission. If the provider fails to call within 48 hours of an urgent admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement will be denied for the period from admission to the actual date of notification.

Emergency admissions are not permitted

Members with emergency situations should be placed in an acute psychiatric facility and follow any criteria deemed necessary for that placement. For further details regarding appropriate placement, see the *Mental Health/Behavioral Health – Inpatient Services* fact sheet in *Chapter 6* of the *IHCP Provider Manual* on indianamedicaid.com.

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Emergency admission is referenced in *405 IAC 5-20-6*: "Medicaid reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.

(2) Danger to others.

(3) Death of the individual."

PA requirements and documentation for continued stay review

PA requirements and documentation for continued stay requests submitted by fax or mail (to be submitted every 30 days of the member's stay)

- *Indiana Health Coverage Programs Prior Authorization Request Form* – A completed form is required. This PA form is available on the Forms page on indianamedicaid.com.
- *Child and Adolescent Needs and Strengths (CANS) Assessment* – The most recent CANS assessment recommendations, printed from the designated state system. To monitor progress for youth and caregivers in specific areas of need and strengths, the CANS should be completed as part of the initial assessment and re-administered every 90 days or after significant clinical events to update information regarding initial level of need. The overall level of need score is considered in the context of circumstances identified in the intervention plan and progress report, and the availability of appropriate local transitional services.

- *Master Multidisciplinary Treatment Plan* (most current) – The master multidisciplinary treatment plan must be reviewed and updated every 30 days. The provider must submit an updated treatment plan via fax or mail 14 days after the date of admission and every 30 days thereafter. Failure to do so will result in a denial of additional days. The treatment plan must be in accordance with the appropriate federal guidelines including, but not limited to, *§441.155, §456.180*, and *§441.156*. Additionally, the master treatment plan should include the following information:
  - A diagnostic evaluation that justifies the diagnosis, along with an explanation of the problems related to the member's psychiatric condition
  - Measurable goals and objectives relevant to the problems that include needs and strengths identified on the CANS and include input from the member's family
  - Interventions to assist the member and his or her family in reaching the goals and objectives
  - Identity of the team of professionals, as specified in *§441.156*, involved in the member's care and treatment
  - Anticipated discharge date of the member
  - Additional information, such as physician and nursing notes from the member's current treatment team

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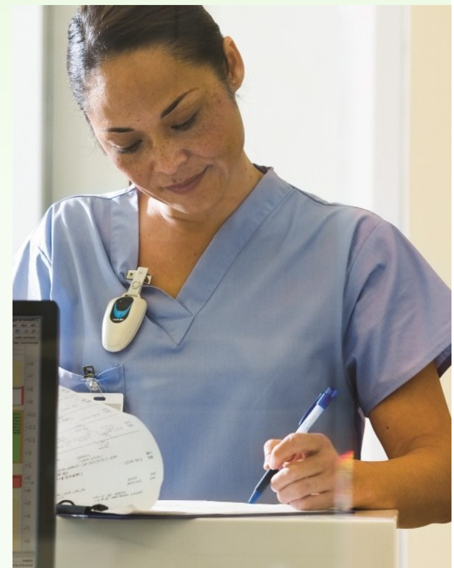
- Additional clinical documentation – The clinical documentation must support:
  - The likelihood of continued progress pertaining to specific measurable goals with specific completion deadlines
  - Explanation for the lack of progress, if no progress has been made
  - Changes to the master treatment plan to facilitate goal completion
  - The level of progress made on treatment goals must reflect the original anticipated completion date of the PRTF treatment goals. If the anticipated date of completion for the goals has changed, a detailed explanation of why the date change occurred, what changes have been made to the goals, and the new anticipated date of completion must be included.
- Plan for discharge and aftercare placement and treatment – The treatment facility must provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan should include discrete, behavioral discharge criteria, including a timeline for the transition to a less-intense level of care. The clinical documentation must include specific discharge dates, especially when discharge to the member's home may not be an option. Therapeutic leave may be an appropriate component of the member's discharge plan.

PA documentation requirements for continued stay requests via telephone (required every 30 days of the member's stay)

Effective January 1, 2013, clinical providers will have the option to phone in requests for PA for a member's continued stay in a PRTF. The clinician or provider must maintain the same documentation in the chart that would be required if submitting the request via mail or fax. Once PA is created in Indiana*AIM*, the request remains in a "pending" status until the required documentation has been submitted via mail or fax. Submission is required within 14 business days of the continued stay request.



For continued stay requests, providers must call before the current PA expires. The following information is required for a continued stay telephone request:

- National Provider Identifier (NPI) or Legacy Provider Identifier (LPI)
- Member's Medicaid identification number (RID)
- Member's primary diagnosis
- Date of continued admission
- Overview of the member's current status and history of member's presenting issues

PA requirements and documentation for re-admissions

Members may be re-admitted to a PRTF from the community if they have been discharged for at least 30 days or at any time if discharged from an inpatient hospital, and if they meet all criteria outlined for new admissions. The following is required for PA of a re-admission:

- All documentation outlined for a new admission

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- Clinical documentation that explains:
  - Failure of previous discharge plan to use a less-restrictive setting, including services or interventions that were attempted either successfully or unsuccessfully
  - Any significant changes in the member or the family situation that could have led to decrease in stability or increase in psychiatric symptoms
  - An estimated length of stay and recommendations for treatment goals and interventions during this stay
  - The significant changes that must occur during this stay in order for the member to successfully transition to a less restrictive setting.

Supplemental information

- **Retroactive eligibility admissions –** If a member is approved retroactively for Medicaid coverage, PA admission documentation may be submitted via mail or fax only.
- **Risk-based managed care –** PRTF services are carved out from the risk-based managed care entities' (MCEs') financial responsibility. The MCE retains responsibility for services outside the PRTF, including transportation and other related healthcare services. These services are subject to the PA and reimbursement policies of the member's managed care plan. Providers should verify the member's eligibility at initial admission and on the first and 15th of each month to determine the member's current managed care eligibility.

The treatment facility must notify the member's primary medical provider (PMP) and managed care entity (MCE) before the member is discharged or when the member is awaiting placement. The PMP and MCE will help the member transition back to the community and should be included as discharge plans are developed.

QUESTIONS?

If you have questions about this information, contact the appropriate PA vendor or HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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TO PRINT

A printer-friendly version of this publication, in black and white and without graphics, is available for your convenience.

PRTF Prior Authorization Quick Reference Guide

Documentation type	New admission	Continued stay[2]
If initiated by **telephone**[1], the following must be provided **immediately**.	**Required**	
NPI or LPI	x	x
Member's name and RID	x	x
Member's primary diagnosis	x	x
Date of new or continued admission	x	x
Overview of member's current status and history	x	x
For **all** requests, the following must be provided within **14 days** of admission:	**Required**	
Indiana Health Coverage Programs Prior Authorization Request Form	x	x
Certification - Plan of Care for Inpatient Psychiatric Hospital Services/Determination of Medicaid Eligibility (OMPP 1261A)	x	
Child and Adolescent Needs and Strengths (CANS) Assessment	x	x
Physician history and physical (H&P)	x	
Master (current) Multidisciplinary Treatment Plan	x	x
Documentation indicating the severity of the member's mental disorder	x	
Documentation indicating that secure facility intermediate or long-term care is needed for the member	x	
Additional treatment information	x	
Freedom of Choice Form (on file only)	x	
Additional clinical documentation		x
Plan for discharge and aftercare placement and treatment		x

[1]For telephone PA requests, providers must maintain the same documentation in the chart that would be required if submitting the request via mail or fax. For new requests not considered urgent admissions, providers must call on or before the date of admission. Once PA is created in Indiana*AIM*, the request will remain in a "pending" status until the previous required documentation has been submitted via mail or fax within 14 business days of admission.

[2]For continued stay requests, providers must call or submit the required documentation every 30 days of the member's stay and before the current PA expires. Once PA is created in Indiana*AIM*, the request will remain in the "pending" status until the previous required documentation has been submitted via mail or fax within 14 business days of the continued stay request.