IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201314 MAY 14, 2013

New forms to be submitted with PA requests for PRTF admissions, readmissions, and continued stays

In BT201250, dated November 29, 2012, the Office of Medicaid Policy and Planning (OMPP) announced changes to the prior authorization (PA) criteria for admissions, readmissions, and continued stays in a psychiatric residential treatment facility (PRTF) (*405 IAC 5-3*). PA criteria updates were effective for dates of service (DOS) on or after January 1, 2013, and are unchanged by this bulletin. This bulletin establishes the required submission of two additional forms to relay elements of the required documentation with all PA requests submitted by mail or fax.

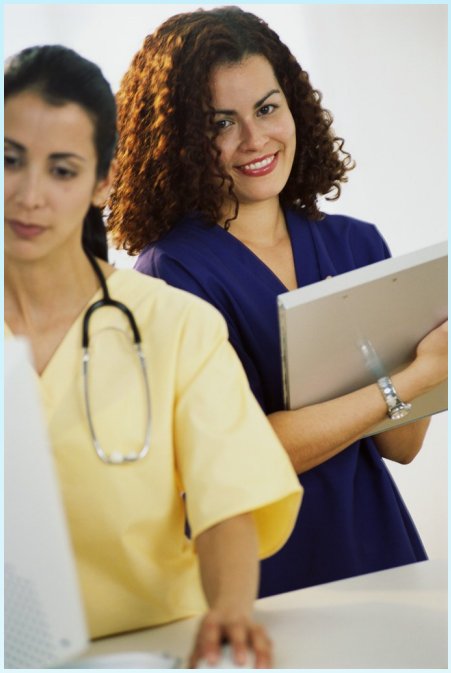
Effective July 1, 2013, providers are required to use the *PRTF Admissions Assessment* to document information supporting PA requests for PRTF admissions and readmissions and to use the *PRTF Extension Request Tool* to document information supporting PA requests for PRTF continued stays. These two forms are attached to this bulletin for reference and are accessible for use from the Forms page at indianamedicaid.com.

PA documentation requirements for new admissions

Effective with DOS on or after July 1, 2013, the PA documentation requirements for new admission requests submitted by mail or fax are as follows:

- *Indiana Health Coverage Programs Prior Authorization Request Form* – A completed form is required. This form is available on the Forms page at indianamedicaid.com.

- *PRTF Admission Assessment 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 Forms.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, is required. The assessment can be no more than 30 days old.
- *Physician history and physical (H&P)* – A completed physician H&P examination is required. 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, *42 CFR §441.155, §456.18*0, 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, which include needs and strengths identified on the CANS and input from the member's family or legal guardian.
  - Identify the team of professionals, as specified in *42 CFR §441.156*, who will be involved in the member's care and treatment.
  - Include interventions and time frames 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* (DSM). (*Note: DSM-5 is scheduled to be released May 2013.*)
- Documentation indicating that intermediate or long-term care in a secure facility is needed for the member – The member 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 is required from 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 readmissions

Effective with DOS on or after July 1, 2013, the PA documentation requirements for readmission requests submitted by mail or fax are as follows:

- All documentation outlined for a new admission
- Clinical documentation that explains:
  - Failure of previous discharge plan to use a less-restrictive setting, including services or interventions that were attempted 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 for the member to successfully transition to a less-restrictive setting

PA documentation requirements for continued stay

Effective with DOS on or after July 1, 2013, the PA documentation requirements for continued stay requests (required every 30 days of member's stay) submitted by mail or fax are as follows:

- *Indiana Health Coverage Programs Prior Authorization Request Form* – A completed form is required. This PA form is available on the Forms page at indianamedicaid.com.
- *PRTF Extension Request Tool* – A completed form is required. This PA form is available on the Forms page at indianamedicaid.com.
- *Child and Adolescent Needs and Strengths (CANS) Assessment* – The most recent CANS assessment recommendations, printed from the designated state system, is required. 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, *42 CFR §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, which include needs and strengths identified on the CANS and 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 *42 CFR §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
- 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, reflecting 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 time line 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.

A *PRTF Prior Authorization Quick Reference Guide* is attached to this bulletin as a reference tool to help providers complete the required documentation. Please see the *Indiana Health Coverage Programs Provider Manual* for other information about PRTF services and billing.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from indianamedicaid.com. To receive email notices of future IHCP publications, subscribe to IHCP Email Notifications.

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/ Readmission	Continued Stay[1]
If initiated by **telephone,** the following must be provided **immediately**:[2]	**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 by mail or fax within **14 days** of admission:	**Required**	
Indiana Health Coverage Programs Prior Authorization Request Form	X	X
PRTF Admission Assessment Form	X	
Certification – Plan of Care for Inpatient Psychiatric Hospital Services/ Determination of Medicaid Eligibility (OMPP 1261A)	X	
PRTF Extension Request Tool		X
Child and Adolescent Needs and Strengths (CANS) Assessment	X	X
Physician History & 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
Clinical documentation of previous discharge plan failure with recommendations for readmission treatment goals and interventions as well as changes planned for successful transition (readmissions only)	X	

[1] 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.

[2] 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 "pending" status until the previous required documentation has been submitted via mail or fax within 14 business days of admission.

PRTF Admission Assessment* **PA#:** _____ **Name:** _____ **RID#:** _____ **DOB:** _____

Please answer or list the following information:

1.	Current DSM Diagnoses on Axes I & II within the SED criteria as specified by DMHA/Medicaid a. b. c.		
2.	Identify which of the following risk behaviors is/are present:		
a.	☐Yes ☐No	History of severe physical, sexual or emotional maltreatment	
b.	☐Yes ☐No	History of disruptive adoption or multiple foster placements	
c.	☐Yes ☐No	Physical assault against a parent or adult caregiver	
d.	☐Yes ☐No	History of sexual assault by the individual	
e.	☐Yes ☐No	History of fire setting resulting in damage to a residence	
f.	☐Yes ☐No	Runaways from 2 or more community placements by a child <14 y/o	
g.	☐Yes ☐No	Other impairment of family functioning or social relatedness of similar severity	
h.	Other:	a)	
		b)	
3.	Identify which of the following interventions have been utilized: NA = not available		
a.	☐Yes ☐No ☐NA	Family or relative placement with outpatient therapy	
b.	☐Yes ☐No ☐NA	Day or after school treatment	
c.	☐Yes ☐No ☐NA	Foster care with outpatient therapy	
d.	☐Yes ☐No ☐NA	Therapeutic foster care	
e.	☐Yes ☐No ☐NA	Group child care supported by outpatient therapy	
f.	☐Yes ☐No ☐NA	Partial hospitalization	
g.	☐Yes ☐No ☐NA	Intensive Outpatient Counseling (IOC)	
h.	Other:	a)	
i.		b)	
4.	Are any of the following present which cause a threat to self or others?		
a.	☐Yes ☐No	Self care deficit severe and longstanding including refusal to comply with treatment	
b.	☐Yes ☐No	Self care deficit places child in life threatening physiological imbalance	
c.	☐Yes ☐No	Sleep deprivation or significant weight loss	
d.	☐Yes ☐No	Threats accompanied by depression, loss, suicide A/G/T, substance abuse, aggression	
e.	☐Yes ☐No	Verbalization escalating in intensity accompanied by gesture or plan	
f.	☐Yes ☐No	Impaired thought processes with disruption of safety to self or others	
g.	☐Yes ☐No	Nonresponsive to outpatient trial of medication or supportive care	
h.	☐Yes ☐No	Severe dysfunction patterns of behavior that prohibit lower level of care	
5.	Please indicate level of family engagement: ☐high ☐medium ☐low ☐unknown		
6.	Date of last CANS:	LON as last determined: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	
7.	Date and findings of Neuropsychological testing: ☐Not done ☐Not available		
	a.		
	b.		
	c.		
8.	Please indicate level of academic or school problems: ☐high ☐medium ☐low ☐none		
9.	Please attach documentation regarding the following:		
	a. A list of current medications, including drug, indication and dosage		
	b. Any additional information in support of PRTF including past pertinent events and interventions		
10.	Do any of the following apply regarding the admission?		
☐Yes ☐No	Non-DMHA/Medicaid approved DSM diagnoses e.g. anti-social personality disorder		
☐Yes ☐No	Recurrent criminal behavior or conviction		
☐Yes ☐No	Admission for respite care for parents who are not participating in the treatment process		
☐Yes ☐No	Admission to avoid prosecution, incarceration or other legal consequences		
☐Yes ☐No	Provided for the convenience of the parent(s) or provider or for custodial purposes only		
☐Yes ☐No	Persistent developmental delay is documented		
☐Yes ☐No	Family was informed of potential community-based options prior to placement and/or upon discharge from PRTF.		
Submitted by:	Signature:	Date:	
☐ HSPP ☐MD ☐DO Other			

*This form is required for prior authorization requests for admission to Psychiatric Residential Treatment Facilities .

Final 05-10-2013

PRTF Extension Request Tool*

The recipient is expected to meet the following for continued stay in PRTF:

- Behaviors continue to require intervention
- Continued progress is being made with interventions
- Consumer remains motivated for further treatment
- CANS completed within the past 90 days

Name: _____
RID#: _____
DOB: _____
DSM Dxs: _____
PA #: _____

Date of last CANS: LON: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
Reviews should contain the following: (N=new, C=continuing) **Select:** indicates drop down information

Fill in	Fill in		Fill in		Select (Drop Down)	Fill in
Date Onset	**Targeted and Measurable Goals for Risk Behaviors**	**N/C**	**Interventions or Medication Change**	**N/C**	**Progress Since Last Assessment**	**Barrier to Progress**
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	
		--		--	--	

1.	Estimated date of discharge is:	Is this a change from past report? ☐Yes☐ No If yes, state why:
2.	Initial contact for transition planning made for: ☐home ☐school/IEP ☐ BH provider ☐ PMP☐ Community Resources ☐ Other	
3.	Has a MFP-PRTF application been completed? ☐ Yes ☐ No ☐ Not available ☐ After needs assessed	
4.	If discharge is anticipated within the next 30 days has the MCO been informed? ☐Yes ☐ No	
5.	Has the consumer received any passes this past period? ☐Yes ☐No If yes, provide date/s:	
6.	Is the family (including nontraditional), guardian, or advocate participating in treatment? ☐Yes ☐No	
7.	Is there a change in family participants? ☐Yes ☐No If so, why?	
8.	Are the consumer's current educational and health needs being addressed? ☐Yes ☐No If no, please explain:	
9.	Tobacco use assessment ☐ Yes ☐ No Tobacco treatment ☐ Yes ☐ No ☐ NA ☐ Refused	
10	Additional comments to support continued stay such as barriers to success:	
	Submitted by: ☐HSPP ☐MD ☐DO Other Signature_____ Date_ _____	

Unsafe Behavior or Event/s	Events Last Month	Events This Month	Mild	Mod.	Severe
Run Away/ Attempts			☐	☐	☐
Child/Child Aggression			☐	☐	☐
Child/Adult (staff or parent) Aggression			☐	☐	☐
Sexual Behavior			☐	☐	☐
Sexual Offensive			☐	☐	☐
Suicide T/G/A			☐	☐	☐
Self-injurious			☐	☐	☐
Property Destruction			☐	☐	☐
Stealing			☐	☐	☐
Other			☐	☐	☐

*This form is required for prior authorization requests for continued stay at a Psychiatric Residential Treatment Facility.

Final 05-10-2013