Magellan HEALTHCARE

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

Montana State Hospital Acute Inpatient Provider Manual, Including Clinical Management Guidelines

Developed in collaboration with Magellan Medicaid Administration

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Magellan HEALTHCARE

Revision History

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1.0 Definitions

The *Montana Medicaid Mental Health Clinical Management Guidelines* (referred to hereafter as the *Clinical Management Guidelines)* define Montana State Hospital (MSH) acute inpatient as services that "are provided 24 hours per day, 7 days a week, by a multidisciplinary team of licensed and appropriately credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for the most restrictive levels of care necessary for the well-being and safety of the patient or others."

These services are provided in the Montana State psychiatric hospital to treat symptoms of such severity that the absence of immediate psychiatric intervention might lead to increased serious dysfunction, death, or harm to self or others.

1.1 Prior Authorization Reviews

All admissions of individuals under 21 years of age, and 65 years of age and over, to the MSH acute inpatient facility require prior authorization. Refer to Section 7.0 for the *Clinical Management Guidelines* specific to acute inpatient services.

1.2 Continued Stay Reviews

Lengths of stay for initial admissions to MSH will be for 60-day spans. If a continued stay is required beyond the initial 60 days, a continued stay review will be required.

1.3 Retrospective Reviews

MSH acute inpatient services are subject to retrospective review by Magellan Medicaid Administration, a Magellan Rx Management company, as requested by the Department of Public Health and Human Services.

1.4 Discharge Procedure

Upon recipient's discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a discharge notification form (see Providers → Adult → Forms https://montana.fhsc.com). This form must be submitted to Magellan Medicaid Administration within five business days after discharge.

2.0 Prior Authorization Review Procedure

2.1 Admissions

Admission for acute inpatient services to Montana State Hospital is an emergency admission as defined below. The federal guidelines applied to the prior authorization procedure for acute inpatient services are specific to emergency admissions.

2.2 Definition

An emergency admission is 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 serious dysfunction of any bodily organ/part, death of the recipient, or harm to another person by the individual.

2.3 Medicaid Recipient Ages Under 21, and 65 and Over

Since Montana State Hospital inpatient psychiatric admissions often occur during non-business hours, it may not be possible to obtain authorization for these services prior to them being rendered. Therefore, the following procedure will be followed for Montana State Hospital inpatient admission reviews:

1. The provider must verify the recipient's Medicaid eligibility.
2. For all admissions, the provider is responsible for notifying Magellan Medicaid Administration by fax or web within 14 days of the admission. Delay in contacting Magellan Medicaid Administration beyond 14 days will result in a technical denial of admission approval.
3. The provider must submit a prior authorization request form by fax or web that includes demographic and clinical information at the time of initial notification to Magellan Medicaid Administration. This information must be sufficient for the clinical reviewer to make a determination regarding medical necessity and must include the following:
   - Demographic Information
     - Recipient's Medicaid ID number (MID)
     - 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, date of admission

- Clinical Information
  - Prior inpatient treatment
  - Prior outpatient treatment/alternative treatment
  - Initial treatment plan
  - DSM-V diagnosis
  - Medication history
  - Current symptoms requiring inpatient care
  - Chronic behavior/symptoms
  - Appropriate medical, social, and family histories

4. The recipient's treatment must be documented to meet all three of the following criteria:
   - Ambulatory resources in the community do not meet the treatment needs of the recipient (42CFR 441.152 [a][1]).
   - Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician advisor (42CFR 441.152 [a][2]).
   - The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42CFR 441.152 [a][3]).
5. Upon fax or web receipt of the above documentation, Magellan Medicaid Administration's clinical reviewer will complete the review process as demonstrated in the Prior Authorization Flow Chart. 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.
6. 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.

3.0 Continued Stay Review Procedure

3.1 Definition

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

Review of requests for continued stay authorization is 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.* Refer to Section 8.0 for the Montana State Hospital Acute Inpatient *Clinical Management Guidelines.*

3.2 Length of Stay

Magellan Medicaid Administration will conduct continued stay reviews for all medically necessary stays for MSH acute inpatient services that extend beyond the 60 days initially authorized. Each continued stay review may permit authorization of up to an additional 60 days of treatment when medical necessity is determined. Subsequent continued stay reviews will occur until the recipient is discharged from the facility or medical necessity is no longer met.

3.3 Continued Stay Review Procedure

1. The provider is responsible for contacting Magellan Medicaid Administration by fax or web no later than 24 hours/1 business day prior to the termination of the initial certification. Failure to meet this deadline will result in a technical denial from the last day of the previous authorization to the date that the required continued stay review information is received.
2. The provider must submit the following information to complete a continued stay review:
   - Continued stay authorization 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
   - 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 fax or web 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.
   - 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.

3.4 Discharge Procedure

Upon recipient's discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a discharge notification form. This form must be submitted to Magellan Medicaid Administration within five business days after discharge.

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* of this manual.

4.1 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.

4.2 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.

4.3 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.**

4.4 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.**

4.5 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.

4.6 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 contractual responsibility to the State of Montana for utilization reviews

Notifications for denial determinations for medically unnecessarily treatment/services will include the following:

- 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, provider, or 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 of 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 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 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 for both the 65 and over and under 21 years of age populations.

The *Clinical Management Guidelines* for Montana State Hospital (MSH) acute inpatient, including admission, continued stay, and discharge criteria are as follows:

Inpatient services are provided 24 hours per day, 7 days a week, in an appropriately licensed facility by a multi-disciplinary team of licensed and appropriately credentialed professionals and professionally supervised paraprofessionals. Treatment is provided in a secure environment allowing for the most restrictive levels of care necessary for the well-being and safety of the patient or others. Staff must include, but not be limited to board eligible or certified psychiatrists, registered nurses, other licensed mental health professionals and other ancillary staff.

7.1 Admission Criteria

A DSM-V diagnosis that is covered under the provisions of Montana Medicaid as the principal diagnosis, and at least one of the following:

1. Dangerous to self as exhibited by ideas or behaviors resulting from the DSM-V diagnosis, as evidenced by behaviors that may include, but not be limited to
    a. An attempt or threat to harm self with continued acuity of risk, which cannot be safely or appropriately treated or contained in a less restrictive level of care
    b. An inability for the patient to contract for safety
    c. A specific plan for harming self and some acute risk of carrying out this plan
    d. Self-destructive impulses accompanied by rejection of, or lack of, available social/therapeutic support
    e. Actions, or threats of actions that could predictably result in harm to self, with the patient lacking either the insight or impulse control to refrain from such behaviors
    f. A past history of actions harmful to self and clear clinical evidence that high risk exists presently for a recurrence of such behavior
2. Dangerousness to others, as exhibited by ideas or behaviors resulting from the DSM-V diagnosis, as evidenced by behaviors that may include, but not be limited to

a. Actions, or threats of actions, intended to harm others

b. Actions, or threats of actions that could predictably result in harm to others, with the patient lacking either the insight or impulse control to refrain from such behaviors

c. A specific plan to harm others with the intention of carrying out this plan

d. Current threats to harm others without the ability to contract for the other person's safety

e. A past history of actions harmful to others and clear clinical evidence that high risk exists presently for a recurrence of such behavior

3. Grave disability, as exhibited by ideas or behaviors resulting from the DSM-V diagnosis, as evidenced by behaviors that may include, but not be limited to

   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 or refusal 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 patient's non-compliance or 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.

7.2 Continued Treatment Criteria

1. DSM-V diagnosis that is covered under the provisions of Montana Medicaid 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 needs with regard to either treatment or safety; **AND**
4. There is reasonable likelihood of 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 in the inpatient setting, with lower levels of care inadequate to meet these needs; **OR**

6. Appearance of new impairments meeting admission guidelines.

7.3 Discharge Criteria

1. The symptoms/behaviors that required services at this level of care have improved sufficiently to permit treatment at a lower level of care; **AND**

2. A comprehensive discharge plan has been developed and is ready to be implemented, **OR**

3. The patient voluntarily withdraws from treatment and does not meet criteria for involuntary treatment.