

# *Residential and Inpatient Services*

Refresher Training for Providers

March 2016



# **Primary Objectives of this training:**

## **For: Community-Based Residential Services [Level A and Level B Group Homes]**

### **Objectives:**

Service Definitions

Diagnosis requirements

Medical Necessity Criteria

Service Request Authorization – documentation requirements, question topics, reminders, etc.

Regulation changes in 2015

## **For: Residential Treatment Facility [Level C] programs**

### **Objectives:**

Service Definition

Diagnosis Requirements

Medical Necessity Criteria

Service Request Authorization - documentation requirements, question topics, reminders, etc.

## **For: Acute Inpatient Programs**

### **Objectives:**

Service Definition

Coverage Limitation

Medical Necessity Criteria

ECO and TDO

Inpatient Review – submission expectations, question topics, etc.

# *Community-Based Residential Services for Children and Adolescents under 21 (Level A & Level B Group Homes)*

## **Level A Group Homes**

CMHRS Manual Chapter IV [pages 36 to 43]

### **Service Definition**

Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This residential service provides structure for daily activities, psycho-education, and therapeutic supervision and behavioral health treatment to ensure the attainment of therapeutic mental health goals as identified in the individual service plan. The member must also receive at least weekly individual psychotherapy services (provided by an LMHP or LMHP Resident/Supervisee) in addition to the therapeutic residential services.

## **Level B Group Homes**

CMHRS Manual Chapter IV [pages 43 to 51]

### **Service Definition**

Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and treatment, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the ISP. The member must also receive individual and group psychotherapy services, at least weekly, in addition to the therapeutic residential services.

## Level A & B Group Homes (cont.)

Prior to admission to Community-Based Services for Children and Adolescents under 21 (Level A and Level B) member must have **a valid psychiatric diagnosis** and **must meet specified requirements for severity of need and intensity and quality of service** must be met to satisfy the criteria for admission.

- The diagnosis must be current; as documented within the previous year.
- If a current diagnosis is not available, the member will require a mental health evaluation by either a psychiatrist or licensed clinical social worker or licensed professional counselor or a licensed psychologist prior to admission.

## *Level A & B Group Homes (cont.)*

As of December 1, 2015 the eligibility criteria was changed to Magellan Medical Necessity Criteria.

For more information on the **Magellan Medical Necessity Criteria**, please review the recorded training and PowerPoint presentation, and other related resources, posted on the Magellan of Virginia website:

<http://www.magellanofvirginia.com/for-providers-va/training.aspx>

<http://www.magellanofvirginia.com/library/magellan-medical-necessity-criteria.aspx>

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for a member. Medical necessity decisions about each individual case are based on the clinical features of the member relative to the member's socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the member.

# Level A & B Group Homes (cont.)

## REQUIRED Supplemental Supporting Documentation for Service Request Authorizations [SRA]

### Initial Requests for CSA cases REQUIRE:

- 3 Digit Locality [FIPS] Code
- Reimbursement Rate Certification Sheet
- Certificate of Need (CON) with signatures from 3 FAPT members and a physician
- Updated Child and Adolescent Needs and Strengths (CANS) Assessment
- Initial Plan of Care (IPOC) must be completed by a QMHP, LMHP –type, or LMHP AND signed by a Program Director

### Initial Requests for non-CSA cases REQUIRE:

- Independent Team Certification. This can be either the Uniform Pre-Admission Screening Form and Report (DBHDS 0224eMH, <http://www.dbhds.virginia.gov/formsReports.asp>) OR a Certificate of Need [CON]. Must be signed by a LMHP AND a physician
- Initial Plan of Care (IPOC) must be completed by a QMHP, LMHP –type, or LMHP, AND signed by a Program Director

### Continued Stay Request for both CSA and non-CSA cases:

- Comprehensive Individual Plan Of Care (CIPOC) completed by a QMHP for Level A services or a LMHP for Level B services
- Updated Child and Adolescent Needs and Strengths (CANS) Assessment for CSA cases only

## *Level A & B Group Homes (cont.)*

### **Service Request Authorization [SRA] questions include:**

- Confirmation that the Service Specific Provider Intake assessment is completed by an LMHP
- Alternative placements tried or explored in the past year
- Family Involvement and expected Level of Participation
- Symptoms and behaviors in the past 7 days that support the need for this level of care
- Discharge plans

# Level A & B Group Homes (cont.)

## SRA Reminders:

Service Authorizations are always required for these two Levels of Care.

Place of Service code: 56 [Psychiatric RF]

Submission Timeframe: 30 days before the start OR reauthorization of services; may request within 3 business days after admission

Authorization frequency/subsequent reviews: 90-120 days

Authorization decision maximum timeframe: 3 business days

1 unit = 1 day

Reimbursement rate includes payment for therapeutic services not Room & Board.  
Other limits found in CMHRS Manual

The fiscal years will be run from July 1 through June 30.



# *Level A & B Group Homes (cont.)*

## **Reminders about Regulation changes in 2015:**

- Service Specific Provider Intake completed by a LMHP required for all cases prior to admission or at the onset of services
  
- The service provider must notify or document the attempts to notify the primary care provider or pediatrician of the member's receipt of this community mental health rehabilitative service.
  
- Care coordination is the same as Provider Service Coordination which, as defined in the DMAS manual, means collaboration and sharing of information among health care providers, who are involved with member's health care, to improve the care, is now a part of Group Home Level A services.
  
- Should the member receiving Group Home Level A or B services be enrolled in Case Management Services, it is required that the Level A or B service provider have a minimum of the following contact with the Community Services Board or Behavioral Health Authority case manager:
  - 1. Notify the CSB/BHA case manager that the member is enrolled services.
  - 2. Send monthly updates of the member's status to the CSB Case Manager.
  - 3. Send a discharge summary to the case manager within 30 days of the service discontinuation date.

# *Psychiatric Residential Treatment Facility (Level C)*

## **Psychiatric Services Provider Manual**

Chapter IV Covered Services and Limitations revision date 12/2/15

### **Service Definition**

“Residential inpatient care” means a 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders. All services must be provided at the facility as part of the therapeutic milieu.

## Level C RTC (cont.)

Prior to admission to Psychiatric Residential Treatment services (Level C), member must have **a valid psychiatric diagnosis** and **must meet specified requirements for severity of need and intensity and quality of service** must be met to satisfy the criteria for admission.

- The diagnosis must be current; as documented within the previous year.
- If a current diagnosis is not available, the member will require a mental health evaluation by either a psychiatrist or licensed clinical social worker or licensed professional counselor or a licensed psychologist prior to admission.

## *Level C RTC (cont.)*

As of December 1, 2015 the eligibility criteria was changed to Magellan Medical Necessity Criteria.

For more information on the **Magellan Medical Necessity Criteria**, please review the recorded training and PowerPoint presentation, and other related resources, posted on the Magellan of Virginia website:

<http://www.magellanofvirginia.com/for-providers-va/training.aspx>

<http://www.magellanofvirginia.com/library/magellan-medical-necessity-criteria.aspx>

The Magellan Medical Necessity Criteria Guidelines direct both providers and Magellan Care Managers to choose the most appropriate level of care for member. Medical necessity decisions about each individual case are based on the clinical features of the member relative to the member's socio-cultural environment, the medical necessity criteria, and the validated service resources that are available to the member.

## *Level C RTC (cont.)*

### **REQUIRED Supplemental Supporting Documentation for Service Request Authorizations [SRA]**

#### **Initial Requests for CSA cases REQUIRE:**

- 3 Digit Locality [FIPS] Code
- Reimbursement Rate Certification Sheet
- Certificate of Need (CON) with 3 FAPT member signatures and a physician
- Updated Child and Adolescent Needs and Strengths (CANS) Assessment
- Initial Plan of Care (IPOC) signed by a physician

#### **Initial Requests for non-CSA cases REQUIRE:**

- Independent Team Certification. This can be either the Uniform Pre-Admission Screening Form and Report (DBHDS 0224eMH, <http://www.dbhds.virginia.gov/formsReports.asp>) or the CON. Must be signed by a LMHP AND a physician
- Initial Plan of Care (IPOC) signed by a physician

#### **Continued Stay Requests REQUIRE:**

- Comprehensive Individual Plan Of Care (CIPOC)
- Updated Child and Adolescent Needs and Strengths (CANS) Assessment for CSA cases
- Reimbursement Rate Certification Sheet for CSA cases

## *Level C RTC (cont.)*

### **Service Request Authorization [SRA] questions include:**

- Confirmation that the Service Specific Provider Intake assessment is completed by an LMHP
- Alternative placements tried or explored in the past year
- Family Involvement and expected Level of Participation
- Symptoms and behaviors in the past 7 days that support the need for this level of care
- Discharge plans

## *Level C RTC (cont.)*

### **SRA Reminders:**

Service Authorization always required for this level of care

Place of Service code: 21 [Inpatient Hospital] , 51 [Inpatient Psychiatric Facility]

Submission Timeframe: 30 days before the start OR reauthorization of services; may request next business day after admission

Authorization frequency/subsequent reviews: 90-120 days

Authorization decision maximum timeframe: 3 business days

1 unit = 1 day

Details regarding therapeutic passes, non-reimbursable services and service limitations are found in the DMAS Psychiatric Services Manual [Chap. IV Pages 14-18]

## *Level C RTC (cont.)*

In 2015 DMAS began a project to Promulgate Emergency Regulations that govern the Level A, B, and C Residential Treatment services and address the individualized service needs of the EPSDT program. The mission of the project is to transition 3 of the most complex programs into models with evidence based treatment approaches, standardized medical necessity criteria, and rigorous program requirements.

DMAS and Magellan of Virginia will communicate any regulation changes or updates to providers as they occur.



# INPATIENT PSYCHIATRIC SERVICES

## Psychiatric Services Provider Manual

Chapter IV Covered Services and Limitations revision date 12/2/15

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section100/>

An **emergency acute care admission** is defined as a psychiatric hospitalization that is required, because the member is a danger to himself/herself or others or when the member is incapable of developmentally appropriate self-care due to a mental health problem. The admission follows a marked reduction in the member's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress.

## *INPATIENT PSYCHIATRIC SERVICES (cont.)*

Psychiatric acute inpatient services are available to members of all ages in psychiatric units of general acute care hospitals. For members 21 years of age and older, coverage is provided for days that are medically necessary and is limited to a maximum of 21 days within a 60 day period. This 21-day limit applies to the first eligible 21 days of hospitalization for the same diagnosis within a 60-day period. The 60-day period begins with the first approved day of a hospital admission. Only 21 total days will be covered for the same or similar diagnoses, whether incurred in one or more hospital stays or in the same or multiple hospitals, during the 60-day period. For members receiving treatment who are under the age of 21, inpatient psychiatric services are covered beyond the 21-day limit as long as criteria are met. Exceptions: Member's enrolled/eligible through Medicaid Works, no 21 day limit applies.

Inpatient Acute Psychiatric Services in both acute hospitals and freestanding hospitals require service authorization. To request service authorization for psychiatric services, contact the BHSA . Planned/scheduled admissions must be service authorized within 24 hours of admission, or on the next business day after admission. Unplanned/urgent or emergency admissions must be service authorized within 24 hours of admission, or on the next business day after admission.

# *INPATIENT PSYCHIATRIC SERVICES (cont.)*

As of December 1, 2015 the eligibility criteria was changed to Magellan Medical Necessity Criteria.

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# INPATIENT PSYCHIATRIC SERVICES (cont.)

## ECO and TDO

**Emergency Custody Order [ECO]** - Virginia Code § 37.2-808 (adult) and Virginia Code § 16.1-340 (minor) – order issued by a magistrate that requires any person in the magistrate’s judicial district who is incapable of volunteering or unwilling to volunteer for treatment to be taken into custody and transported for an evaluation in order to assess the need for hospitalization or treatment. An ECO shall be valid for 8 hours. “If the individual is detained at a state facility the ECO may be extended for an additional 4 hours in an attempt to identify an alternative facility that is able and willing to provide temporary detention and appropriate care for the individual.” (see codes listed above)

Magellan does NOT register or process ECO’s

**Temporary Detention Order [TDO]** - Virginia Code § 37.2-809 (adult) and Virginia Code § 16.1-340.1 (minor) – an order issued by a magistrate that authorizes law enforcement to take a person into custody and transport to a facility designated on the order

Adult- the duration of a TDO shall not exceed 72 hours. If the 72-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the adult may be detained as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday.

Minor - the duration of a TDO shall not exceed 96 hours. If the 96-hour period herein specified terminates on a Saturday, Sunday, or legal holiday, the minor may be detained as herein provided, until the close of business on the next day that is not a Saturday, Sunday, or legal holiday.

Magellan only registers the TDO when the member has Medicaid Fee For Service.

# *INPATIENT PSYCHIATRIC SERVICES (cont.)*

## **Magellan reviews the Inpatient Psychiatric Services requests when:**

- The member has Medicaid Fee For Service
- Members between the ages of 21-65 with Medicaid FFS do not have a benefit at a freestanding psychiatric. Magellan would review if the member is at a general hospital
- The member has an MCO and is admitted to a State Facility. The TDO would be covered by the MCO
- The member has Medicare but has utilized all of his or her inpatient days
- GAP members do not have inpatient benefits.

# INPATIENT PSYCHIATRIC SERVICES (cont.)

## Submission process

To request authorization, a provider can:

- Go to <https://www.magellanprovider.com/MagellanProvider/do/LoadHome> and sign in to ask for level of care you are requesting and follow the prompts
- Call Magellan at 1-800-424-4046 and go through CaseLogix with a Customer Service Associate
- Present clinical information to a Magellan Care Manager over the phone by calling 1-800-424-4046

**Continued stay inpatient requests are reviewed by a Magellan Care Manager over the phone**

## Review expectations

- The provider has checked and can confirm eligibility
- The provider requests authorization within 1 business days of the start date
- The provider has gathered as much clinical information that will assist the care manager in determining if MNC is met (i.e. What are the presenting problems/behaviors? Why now?)
- The provider has some information related to member's baseline level of functioning
- The provider is able to provide an appropriate mental health diagnosis
- The provider is able to provide current medications and information related to medication levels
- The provider can describe member's involvement in treatment and outcome of family sessions

## Discharge planning:

- At the initial review the provider has a preliminary discharge plan.
- The provider communicates updates or changes to the discharge plan.
- At discharge the provider gives the care manager the final discharge plans and include name and contact information of outpatient providers
- The provider also provides a list of upcoming appointments.

# *INPATIENT PSYCHIATRIC SERVICES (cont.)*

## **During a Review the Provider will be asked the following questions:**

**CALLER DEMOGRAPHICS:** [NAME, TITLE, PHONE NUMBER, MEMBER ELIGIBILITY, LEGAL GUARDIAN info]

**PRESENTING PROBLEM:** [SI/HI, PSYCHOSIS A/V, MOOD/AFFECT, BEH/AGGRES/REL'PS/WORK]

**WHY NOW?** [PERCIPITATING EVENT, COURT ORDER, ARRIVAL, FAMILY CONFLICT]

**HISTORY OF SUICIDAL/HOMICIDAL IDEATION OR ACTIONS:**

**HISTORY OF PREVIOUS HOSPITALIZATION:**

**DIAGNOSIS AND CURRENT PYSCHIATRIC MEDS:** [COMPLIANCE/ACCESS]

**CO-OCCURING MEDICAL CONDITION AND OTHER MEDICATIONS:**

**SUBSTANCE USE/ABUSE:**

**D/C PLAN SUPPORTS/CRISIS PLAN:**

**HARM? WHO WILL REMOVE/SAFEGUARD WEAPONS/MEDICATIONS?**

# *Discharge Planning*

**Residential and Inpatient are higher intensity levels of care and discharge planning is especially important to prevent readmission.**

**Magellan of Virginia requires providers to supply the following information regarding discharge:**

- At the initial review the provider should have a preliminary discharge plan.
- While the member is in the facility, the provider should identify any outpatient providers that were working with the member and engage in care coordination.
- The provider should communicate updates or changes to the discharge plan to the Magellan Care Manager.
- The final discharge plans should include the name and contact number for outpatient providers, a number to reach the member/guardian, and a list of upcoming appointments.
- At time of discharge, the provider should notify Magellan of the member's discharge either by completing the online discharge form OR calling 1-800-424-4046 and speaking with Magellan Care Manager.



# Resources

Covered Services Children

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section130>

Covered Service Adult

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section226>

UR criteria and MNC criteria in general:

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section5>

UR and MNC children's

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section61>

UR and MNC Adult

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter60/section143>

Marketing:

<http://law.lis.virginia.gov/admincode/title12/agency30/chapter130/section2000>

Go to <http://magellanofvirginia.com/for-providers-va.aspx> to obtain forms, access trainings, and view recent communications regarding all of these levels of care .

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*Thank You*

