

State of Montana
Department of Public Health and Human Services

CHILDREN'S MENTAL HEALTH BUREAU
PROVIDER MANUAL AND CLINICAL GUIDELINES
FOR UTILIZATION MANAGEMENT

Effective August 1st, 2011

Children's Mental Health Bureau

Provider Manual and Clinical Guidelines for Utilization Management

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Children's Mental Health Bureau (CMHB)

Provider Manual and Clinical Guidelines for Utilization Management

The utilization management information in this manual pertains to mental health services provided to youth covered by Healthy Montana Kids Plus (Montana Medicaid)

1.0 OVERVIEW

1.1 Purpose of Utilization Management

The federal government, through the Centers for Medicare and Medicaid Services (CMS), requires all agencies serving a Medicaid population and receiving Medicaid funds to have a utilization management program in place to monitor a beneficiary's need for a service before payment for the intended service is authorized. The purpose of utilization management is to ensure that requested services are appropriate to each individual's symptoms according to established clinical guidelines. The requirement for this type of review became statutory in 1972 for Medicaid and Medicare programs.

Montana also intends that only those services which are medically necessary, as determined by the Department or by the designated review organization, shall receive payment (ARM 37.85.410). CMHB's mission is to promote the most effective and least intrusive therapeutic interventions that meet the youth's critical needs. The CMHB has a contract with a Utilization Management Contractor (UMC) who assists the Department with reviews of covered services and recommends determinations about whether payment should be authorized, based on meeting medical necessity criteria.

1.2 Purpose of this Manual

The purpose of the *CMHB Provider Manual and Clinical Guidelines for Utilization Management* is to give providers enrolled in Montana Medicaid detailed instructions for initiating the review and appeals process for covered services. The manual only discusses services requiring reviews performed by the UMC, and therefore, is not a comprehensive list of all covered mental health services for youth. Covered services are listed on the Department's fee schedule found on the CMHB website, with exception of some codes for individual practitioners.

To use this manual effectively, providers are encouraged to read Section 2, which has general descriptions of review types, along with procedures the provider is required to follow for each review type. Section 5 clarifies the program-specific information about each type of review per service and provides the *Clinical Guidelines* used to determine medical necessity for each service. Providers are expected to know and understand the unique requirements for each service for which they submit claims. The CMHB website provides information about services needing prior authorization from the Department if they are provided on the same day as another service (See *Services Excluded from Simultaneous Reimbursement* matrix).

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The role of the UMC is to perform specific authorization reviews using the procedures and medical necessity criteria established by Montana Medicaid and presented in this manual, and then to render a *recommendation* regarding authorization or denial of payment to the Department.

A recommendation for approval does not guarantee payment. The Medicaid youth must also be determined eligible for the benefit. The review processes do not determine this eligibility. Payment is subject to the youth's eligibility and applicable benefit provisions at the time the service was rendered. Actual benefit determinations are made when a billing claim is submitted to the State's fiscal agent. For information about how to submit claims, please refer to:

<http://medicaidprovider.hhs.mt.gov/providerpages/claiminstructions.shtml> or

Provider Relations at **(800) 624-3958** or **(406) 442-1837** Helena only

1.3 Magellan Medicaid Administration, Inc.

Since 2000, Montana's UMC for mental health services has been First Health Services of Montana, now a subsidiary of Magellan. On July 1, 2010, First Health Services of Montana's name will change to Magellan Medicaid Administration.

Magellan Medicaid Administration's headquarters for Montana is Helena. The Montana office maintains the authority to administer the contractual services to the Department. In addition, Magellan Medicaid Administration uses the professional resources of its National Review Center in Richmond, VA, where it employs staff nurses, social workers, psychologists, and Board-certified or Board-eligible psychiatrists.

Magellan Medicaid Administration's standard hours of operation are Monday through Friday, **8 AM to 5 PM** Mountain Standard Time.

1.3.1 Contact Information for the UMC

Helena Office: Magellan Medicaid Administration
314 N. Last Chance Gulch STE 200W
Helena, MT 59601
Telephone: 1-866-545-9428
Fax: 1-406-449-6253

OR

Virginia Office: Magellan Medicaid Administration
Health Care Management Division
4300 Cox Road
Glen Allen, VA 23060
Telephone: 1-800-770-3084
Fax: 1-800-639-8982

For web based submissions, the website address is: <https://montana.fhsc.com/>

1.4 Regional Care Coordination

The Department's contract with the current UMC includes the services of five Regional Care Coordinators (RCCs) who work as part of the UM team along with the clinical reviewers. The primary role of the RCC is to support comprehensive interagency treatment planning through communication and coordination with providers and other stakeholders. The findings and recommendations of the RCCs are routinely communicated to the UMC clinical review staff. While their roles are differentiated, RCCs and clinical reviewers work seamlessly as a team, sharing a common database. All clinical information, authorization requests, and determinations are captured in an electronic record, regularly updated, and accessible by either staff member. The clinical reviewers rely upon the RCCs to provide them with additional information about the availability of services in a particular community because the RCCs have first-hand knowledge of community resources. They also have additional clinical information about specific youth. This communication allows the clinical reviewers to make better clinical decisions about whether the medical necessity criteria are met for a particular youth.

RCC responsibilities include:

1. Liaison with Providers

- a. Encourage family and youth driven treatment decisions;
- b. Assist providers in understanding the prior authorization, continued stay, and appeals processes and provide training as necessary;
- c. Encourage the use of least restrictive services, as appropriate, among providers and agencies;
- d. Encourage providers and agencies to engage in timely and adequate discharge planning along with active work towards implementing the discharge plan;
- e. Attend treatment team meetings (by phone) for all youth in PRTFs ;
- f. Gain a working knowledge of provider services and specialties, along with capacity and bed availability;
- g. Provide accurate information about changes in utilization management and answer provider questions and concerns about client-specific or system issues.

2. Liaison between UMC clinical reviewers and physicians

- a. Provide additional information to UMC psychiatrists when a request for authorization has been deferred to the UMC psychiatrist; Provide information to UMC clinical reviewers about availability of services and barriers to discharge;
- b. Encourage providers to communicate accurate, thorough clinical information to the UMC clinical reviewers;
- c. Identify training needs of providers through feedback from the UMC clinical reviewers.

3. Resource to the Department

- a. Provide accurate, thorough information to the Department about the delivery of services in each region;
- b. Provide accurate, thorough information to the Department about specific youth;
- c. Provide training as needed to providers;

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- d. Provide aggregate information about service utilization per region as well as child specific information about youth in PRTF level of care;
- e. Perform Retrospective Reviews and Quality Assurance Reviews (QARs) at the request of the Department.

1.5 Confidentiality

It is the policy of the Department of Public Health and Human Services to comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA). As a business associate, the state's UMC has access to specific personally identifiable youth information obtained through the UM process and used solely for the purpose of utilization and quality management. It is the policy of the UMC to treat this information as privileged and confidential information that is only exchanged for purposes of executing contractually-mandated duties. The information is exchanged in accordance with all applicable federal and state laws and regulations, as well as with the ethical and professional standards of the professions involved in conducting utilization management activities. These confidentiality policies govern all forms of information about beneficiaries, including written records, electronic records, facsimile mail, and electronic mail. The above-described policy is applied to all aspects of the UM process.

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2.0 REVIEW TYPES

2.1 Review Basics

Except for emergency admissions, all requests for Prior Authorization reviews must be submitted at least two (2) business days before the planned admission. Emergency admissions require the provider to notify the UMC within one (1) business day of the admission. Requests for Continued Stay reviews may be submitted no more than ten (10) and no less than five (5) business days before the end date of the initial authorization. Both of these reviews processes use clinical guidelines to determine if the treatment is medically necessary. Therefore, specific sections of this manual are devoted to outlining the clinical guidelines as well as the service specific exceptions and variations to the basic review procedures described in this section.

Requesting a review is a fax or web based process. Review requests are received by clinical reviewers who apply the clinical guidelines in this manual based on the clinical information provided with the request. All review staff are either licensed clinical social workers (LCSW) or registered nurses (RN) with specialized psychiatric training. The UMC requires each reviewer to have five or more years of psychiatric experience as a licensed mental health professional. The clinical review staff can authorize care, but only board-certified psychiatrists have the authority to issue adverse determinations (denials). The UMC maintains a Montana based panel of board-certified psychiatrists to review adverse determinations if they are appealed. These psychiatrists have the authority to reverse the denial based on their review, which is either a desk review of the clinical documentation provided or a peer to peer review, consisting of a telephone call with the provider’s clinician plus a review of the clinical documentation.

2.1.1 Table: Review Types required for the following mental health services for youth

	Prior Authorization	Continued Stay Review	Retrospective Review	CON Required
Acute Hospital Inpatient (psychiatric admission)	X		X	X
Psychiatric Residential Treatment Facility (PRTF)	X	X	X	X
PRTF HCBS Wavier	X Level of care determination	X Level of care re-determination	X	X
Partial Hospitalization	X	X	X	X
Therapeutic Group Home	X	X	X	X

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Therapeutic Family Care and Therapeutic Foster Care	X	X	X	X
Therapeutic Home Visits	X	Limit of 14 days per SFY	X	
Outpatient Services (in Excess of 24 Sessions in state fiscal year)	X See manual	X See manual	X	
Case Management	See manual	See manual	X	
Community Based Psychiatric Rehabilitation Services (CBPRS)	X (When concurrent) See manual	X (When concurrent); See manual	X	

Information about the specific procedures required for each type of submission is covered in the sections of the manual that follow.

2.2 Certificate of Need (CON)

A Certificate of Need (CON) is based on the federal requirement for documentation of the need for inpatient hospitalization for Medicaid beneficiaries under age 21 (42 CFR 441.152 and 441.153). Montana expanded on this federal requirement for inpatient hospitalization and requires a CON for other levels of care as well (ARM 37.88.1116). Targeted case management and outpatient therapy services do not require a CON.

2.2.1 CON Procedure

A CON is based on the determination by a team of mental health care professionals that has competence in diagnosis and treatment of mental illness, and that has knowledge of the youth's situation, including the youth's psychiatric condition. The interdisciplinary team must include a physician and a licensed mental health professional. The assessment must be made no more than thirty (30) days before the admission to the requested level of care for the youth.

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Summary of Required Signatures

A minimum of two (2) signatures from the team members, as described above, are required on the CON.

One of the signatures must be that of:

A physician who has competence in diagnosis and treatment of mental illness, preferably child psychiatry, OR a board-certified/board-eligible psychiatrist;

One additional signature must be that of:

A licensed mental health professional as defined in ARM 37.87.102.

The individual who completes the information required on the CON must also provide a name and contact information IF the form is not completed by one of the required signers.

All required CONs must actually and personally be signed. If a signature stamp is used, the team member must actually and personally initial the document over the signature stamp.

The provider maintains the original signed CON and sends a copy to the UMC.

If the youth is already Medicaid eligible at the time of admission, the above required members of the treatment team who develops the youth's plan of care must also complete, sign, and date the CON. Except for emergency admissions (inpatient hospital admissions), this is a community based team and the CON must accompany the Prior Authorization request. For inpatient hospital admissions, the CON must be sent to the UMC within fourteen (14) days of the admission.

If the youth is determined eligible for Medicaid after the admission to OR discharge from the facility, the guidelines in 42 CFR 441.153 Subpart D apply. The CON must be signed by team members responsible for the youth's plan of care and must cover the period before application to Medicaid for which the claims were made. When a youth is determined Medicaid eligible after admission to or discharge from the facility, the CON must be completed and sent:

1. Within fourteen (14) days after the eligibility determination if it is made while the person is still in the facility;
- OR
2. Ninety (90) days after the eligibility determination, if it is made after the person is discharged from the facility.

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The CON certifies that:

1. The ambulatory care resources available in the community do not meet the treatment needs of the youth and;
2. Proper treatment of the youth's psychiatric condition requires the requested service and;
3. The service can reasonably be expected to improve the youth's condition so that the services will no longer be needed.

Except for inpatient hospital care, the CON must be signed before the youth receives treatment. The CON is usually submitted with the initial Prior Authorization request.

2.3 Prior Authorization (initial) Reviews

Most Medicaid funded mental health services require prior authorization to verify that the service requested meets medical necessity criteria as defined by the *Clinical Guidelines* in this manual. Only the first or initial authorization is called a Prior Authorization. Subsequent prior authorizations are called Continued Stay Authorizations.

Each Prior Authorization and Continued Stay Authorization is for a specific number of days or units. A "Table of Authorization Spans" for each covered service is available on the CMHB website @ <http://www.dphhs.mt.gov/mentalhealth/children/tableofpriorauthorization.pdf>. When required, the CON must be submitted before the Prior Authorization review is completed. Case management and outpatient therapy services do not require a CON and may be initiated without a medical necessity review. The clinical guidelines for admission to these two services are located in Sections 5.8 and 5.9.

2.3.1 Prior Authorization Review Procedure

The provider must verify the youth's Medicaid eligibility. Medicaid eligibility can be verified @ <https://mtaccesstohealth.acs-shc.com>

The provider should notify the UMC as soon as the need for admission to a specific service is determined, but must notify the UMC no later than two (2) business days prior to admission. This allows for timely completion of the pre-admission review process. The *Prior Authorization Request form* is submitted with a fax/web-based notification process.

Refer to the Children's Mental Health Bureau website for the *most current version of required forms* at:

www.dphhs.mt.gov/mentalhealth/children/index.shtml

The lists of forms required for each service is found in Section 5. A complete list of all required forms is found at the end of Section 6.

The provider must submit a completed and valid CON at least two (2) business days prior to admission. *Reviews will not be completed until a valid CON is submitted.*

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The provider must submit a *Prior Authorization Request* form by fax or web along with adequate demographic and clinical information. The clinical information must be sufficient for the clinical reviewer to make a determination regarding medical necessity. Clinical information is not required for a prior authorization request for case management. The information requested may include:

1. Demographic information
2. Youth's Social Security Number (SSN)
3. Youth's name, date of birth, and gender
4. Youth's address, county of eligibility, and phone number
5. Responsible party name, address, and phone number
6. Provider name, provider NPI number, and planned date of admission
7. Clinical Information
8. Prior inpatient treatment
9. Prior outpatient treatment/alternative treatment
10. Anticipated date of admission
11. Initial treatment plan
12. DSM-IV diagnosis on Axis I through V
13. Medication history
14. Current symptoms requiring behavioral health care
15. Chronic behavior/symptoms
16. Appropriate medical, social, and family histories
17. Proposed aftercare placement/community-based treatment
18. Completed CON as required in ARM 37.87.1216 (3) and 42 CFR 441

Upon fax/web receipt of the above documentation, the UMC clinical reviewer will complete the following review process:

1. The authorization review will be completed within two (2) business days from receipt of the original review request and clinical information *if* the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.
2. If the reviewer determines that additional information is needed to complete the review, the review is pended and the provider must submit the requested information within five (5) business days of the request for additional information. If the requested information is not received within this time frame, the reviewer will issue a technical denial (see Section 2.5 for more information).
3. The authorization review will be completed within two (2) business days from receipt of additional information.
4. If medical necessity criteria are met and the CON, if required, has been completed at least two (2) business days prior to admission, the UMC reviewer will authorize the admission and generate notification to all relevant parties.

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5. If medical necessity criteria are not met, the case is deferred to a board-certified psychiatrist for review and determination.

2.4 Continued Stay Reviews

For payment from Medicaid to be available beyond the number of days or units authorized in the Prior Authorization review, a Continued Stay review must be requested by the provider with a *Continued Stay Authorization Request* form. Authorization of the continued stay is based on meeting medical necessity criteria as defined by the *Clinical Guidelines* in this manual. Targeted case management's continued stay review is called an *Unscheduled Revision*. Each continued stay authorization is for a specific number of days or units. A "Table of Authorization Spans" for each covered service is available on the CMHB website @ <http://www.dphhs.mt.gov/mentalhealth/children/tableofpriorauthorization.pdf>.

2.4.1 Continued Stay Review Procedure

The provider facility is responsible for contacting the UMC Services by fax/web no more than ten (10) business days before and no less than five (5) business days prior to the termination of the current certification. The following information must be submitted for a continued stay review:

1. Changes to current DSM-IV diagnosis on Axis I through V;
2. Justification for continued services at this level of care;
3. Description of behavioral management interventions and critical incidents;
4. Assessment of treatment progress related to admitting symptoms and identified treatment goals;
5. List of current medications and rationale for medication changes, if applicable;
6. Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan.

The *Continued Stay Request* form, when completed in its entirety, may serve as the CON recertification as required under 42 CFR 456.60 (b).

Upon fax/web receipt of the above information, the clinical reviewer will complete the continued stay review process:

1. The Continued Stay review will be completed within two (2) business days from receipt of the original review request provided the information submitted is sufficient for the clinical reviewer to make a determination regarding medical necessity.
2. If the reviewer determines that additional information is needed to complete the review, the provider must submit the requested information within five (5) business days of the request for additional information. A technical denial will be issued if the information requested is not received in this timeframe.
3. The Continued Stay review will be completed within two (2) business days from receipt of additional information.

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4. If medical necessity criteria are met, the reviewer will authorize the continued stay and generate notification to all appropriate parties.
5. If medical necessity criteria are not met, the case is deferred to a board-certified psychiatrist for review and determination.

Note: If continued stay authorization is not requested timely (prior to or after termination of the current certification), a technical denial will be issued by the UMC. The UMC cannot retroactively authorize days when the continued stay request is received late. The provider must request a new Prior Authorization with the "Start" date being the date the authorization request was made and the "End" date must be the last covered date, as if the continued stay request was made timely. The continued stay criteria, not the admission criteria, will be used in determining whether or not the youth's stay is medically necessary.

2.5 Determinations

Upon completion of either the Prior Authorization or the Continued Stay review, one of the following determinations will be applied, and notification will be made as outlined in Section 3.0 of this manual:

2.5.1 Authorization

An authorization determination indicates that the utilization review resulted in approval of all provider requested services and/or services units, and an authorization number is issued.

2.5.2 Pending Authorization

This determination indicates the clinical reviewer or psychiatrist has requested additional information from the provider. The provider will have five (5) business days to provide any additional information needed to make a payment determination. When the requested information has been received, the reviewer has an additional two (2) business days to complete the review and issue a determination. A technical denial will be issued if the requested information is not received in this timeframe.

2.5.3 Denial

Denial means that the request for authorization of payment does not meet the applicable medical necessity criteria to justify Medicaid payment for the service requested. A psychiatrist is the only party qualified to may issue a denial. Denials may be appealed according to the appeal process described in Section 4.0.

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After a denial, a new prior authorization may be requested, based on new clinical information. A *Continued Stay review is not available after a denial.*

Under some circumstances, a denial will be issued with additional days authorized for payment. Specifically, the psychiatrist may:

- a. Deny a Prior Authorization request with “*approval for less than requested days*” for specific clinical reasons;

OR

- b. Deny a Continued Stay Authorization request with “*approval for additional days to complete discharge planning*”.

NOTE: Both the provider and the guardian must make plans for discharge when a denial is issued, whether or not additional days for discharge planning are authorized. Providers and families should not delay planning for discharge pending the outcome of an administrative review if one is requested. The administrative review process can take up to 60 days from the date of the original denial.

2.5.4 Technical Denial

A technical denial is issued when the provider does not follow the authorization procedure. Technical denial indicates that the request and/or information was out of specified timeframes or was incomplete. Technical denials may be appealed to the CMHB through an administrative review request as described in Section 4.2

Note: If either the Prior Authorization or Continued Stay Authorization request is denied, the provider and the legal custodian have the right to appeal the decision. Only one reconsideration review will be conducted by the appellate physician per denial.

2.6 Retrospective Reviews

The UMC may perform retrospective clinical record reviews for two purposes:

1. As requested by the Department on a random sample basis;
2. As requested by the provider to establish the medical necessity for payment when the youth has become Medicaid eligible retroactively, or the provider has not enrolled in Montana Medicaid prior to the youth’s admission.

A retrospective clinical record review may be conducted either on-site or as a desk review. When a desk review is performed, the provider will be notified by letter of the review; of the purpose of the review; and of the specific time period within which the full medical record is due to the UMC. The provider will also be notified by letter of an on-site review. A list of the records to be reviewed will be included.

Retrospective reviews may be used to verify any of the following:

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1. There is sufficient evidence of medical necessity for payment;
2. The patient is engaged in active and appropriate treatment consistent with standards of practice for the diagnosis, age and circumstances of the individual;
3. The criteria for having a serious emotional disturbance (SED) have been met.

2.6.1 Retrospective Reviews requested by the Department

These retrospective reviews may be conducted on a random sample basis across various services to establish or verify that any of the above criteria have been met by the provider. The Department will develop criteria for each review requested, based on the purposes stated in Section 2.6.

2.6.2 Retrospective Reviews requested by the Provider

Retrospective review requested by the provider applies to those services and circumstances for which a CON has been waived or not completed prior to the admission of the youth. The provider requests a retrospective review of the CON and the Prior Authorization request, which includes all required clinical information, to determine the medical necessity of the admission to the program and the treatment provided. This may occur when the youth becomes Medicaid eligible after the admission to the facility or program, or when the provider has not enrolled in Montana Medicaid prior to the youth's admission.

In these circumstances, the provider requests a retrospective review of the CON and Prior Authorization request and completes either step one or step two below:

1. CON/PA request is received by the UMC within fourteen (14) days after the youth is determined Medicaid eligible following the admission, but before discharge.
2. CON/PA request is received by the UMC within ninety (90) days after the youth is determined eligible if the determination occurs after discharge.

2.7 Discharge Procedure

Upon the youth'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 the UMC within five (5) business days after discharge (see Section 5.3 and 5.4 for exceptions). A new prior authorization approval and prior authorization number cannot be issued until the UMC receives a *Discharge Notification* form from the previous provider, if applicable.

2.8 Corrections

When a provider needs to correct any information provided on the review request forms described in Section 2, the correction should be submitted on the *Corrections to Youth Information* form. When needed, this form can be faxed to the Montana office of the UMC.

3.0 NOTIFICATION TYPES

3.1 Notification Process

The UMC has a two part notification process. Informal notification goes to the provider and to the Regional Care Coordinator. Formal notification goes to the provider and to the legal custodian at the address listed on the authorization request forms. Therefore, *it is important the name and current address of the legal custodian is accurate on the authorization request forms.*

3.1.1 Informal Notification

Informal notification will be completed via FAX on a daily basis and will include an:

1. Outcome report of all determinations to each provider (provider specific information only);
2. Outcome report of all determinations to each Regional Care Coordinator (region specific only).

The Department receives a report of all determinations on a monthly basis.

3.1.2 Formal Notification

Formal notification will be made providing all relevant parties with a hardcopy determination letter sent by US mail.

1. Authorization determinations will be mailed by regular US mail.
2. Denial determinations (technical or clinical denials) will be mailed certified with a return receipt requested and tracked to ensure delivery.

Notification for technical denials will include:

1. Dates of service that are denied a payment recommendation because of non-compliance with protocol per ARM 37.87.903(4);
2. Reference to applicable regulations governing the review process;
3. An explanation of the right to request an administrative review/fair hearing;
4. Address and fax number of CMHB to request an administrative review;
5. Brief statement of the UMC contractual responsibility to the Department for utilization management.

Notification for clinical denials will include:

1. Dates of service that are denied a payment recommendation because the services requested do not meet the medical necessity criteria outline in the clinical guidelines;
2. Case specific clinical denial rationale based on the medical necessity criteria upon which the determination was made;
3. Reference to applicable regulation(s) governing the review process;
4. Date of notice of the UMC's decision, which is the mailing date or the date of the confirmed FAX transmission;
5. An explanation of the right to request an administrative review/fair hearing;

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6. Address and fax number of CMHB to request an administrative review;
7. Brief statement of the UMC contractual responsibility to the Department for utilization management.

Both the provider and the legal custodian have the right to appeal an adverse determination using the appeal processes outlined in Section 4.

4.0 APPEAL PROCESS

The appeal process has three parts:

1. A reconsideration review of the clinical decision conducted by a second psychiatrist;
2. An administrative review conducted by the CMHB staff of the denial for either a technical denial or a clinical denial (based on not meeting medical necessity criteria);
3. A fair hearing conducted by the Department.

Both the provider and the legal custodian have appeal rights. If the provider decides to appeal the determination, the provider must notify the legal custodian and invite the legal custodian to participate and provide additional information. If the provider decides not to appeal, the legal custodian retains the right to appeal and may initiate the appeal following the procedure outlined in this section.

4.1 Request for Reconsideration Review (Not available for technical denials)

The first step in the appeal of an adverse determination based on not meeting medical necessity criteria is a request for reconsideration. The UMC clinical reviewers can only approve an authorization request. If the reviewer has a question about whether the request meets the clinical guidelines, the request is deferred to a physician reviewer. All adverse determinations are made by a board-certified psychiatrist. The UMC uses its own psychiatrist(s) to make an initial adverse determination. A reconsideration review is not available for a technical denial.

A request for reconsideration must be submitted in writing by either the provider or the legal custodian. If the provider decides to request a reconsideration review, the provider must notify the legal custodian and invite the legal custodian to participate and/or to provide additional information. If the provider decides not to appeal, the legal custodian retains the right to appeal.

This review is conducted by a psychiatrist licensed to practice in Montana and not involved in the original determination. The purpose of the reconsideration review is to allow for a second clinical opinion. The reconsideration can include additional information that was not available during the first review.

4.1.1 Request for Reconsideration Review Procedure

1. Upon receipt of an adverse determination based on not meeting medical necessity criteria, the legal custodian or the provider may request a reconsideration review.

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2. The request for a reconsideration review must be received by the UMC within thirty (30) days of the date of the adverse determination.
3. The request must specify one of two options: a Desk Review or a Peer to Peer Review. *Any additional clinical information to be considered must be presented during or prior to the reconsideration review.*

4.1.2 Peer to Peer Discussion/Review

Scheduling of peer reviews must be directed to and coordinated through the UMC. To permit completion of the appeal process within five (5) business days of receipt of the request, the peer to peer discussion must be requested and completed within three (3) business days of receipt of the request.

The psychiatrist or clinician treating the youth must specify available three (3) times he/she can participate in the review during that period. Other members of the treatment team and/or the youth's legal custodian, if they have current and pertinent information relating to the medical necessity of the service, can provide relevant information to the treating clinician prior to the reconsideration review. The UMC's appellate physician will contact the participating party at one of the times offered and conduct the peer to peer discussion.

4.1.3 Desk Review

A desk review will be performed under any of the following circumstances:

- When a desk review is requested;
 - When the request for appeal does not specify which review is requested;
 - When the provider can't be reached to establish a time to schedule the peer review;
 - When the provider cannot be reached at the time scheduled for the peer review.
1. The UMC will complete either of the above reviews within five (5) business days of receipt of the request for reconsideration, based on the information submitted. Montana licensed psychiatrists act as the UMC's appellate physicians to complete both the peer review and the desk review.
 2. All determinations completed by the psychiatrist will include the specific rationale for the decision, including a reference to the applicable clinical guidelines.
 3. The determination of the appellate physician will, in all cases, stand as the final UMC decision.
 4. When the adverse determination is upheld by the appellate physician, the rights of the provider and/or legal custodian to an administrative review with the Department will be included in the formal notification.

4.2 Administrative Review

An administrative review is conducted with the purpose of identifying the issues around the adverse determination or technical denial. The administrative review may be conducted as an in person or phone meeting if requested. If a meeting is not requested, the review is conducted by the Department

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staff. Staff reviews the available documentation and consults with the involved parties to establish the facts of the situation. All relevant facts and issues must be identified during the administrative review. If there is new clinical information that was not available to the appellate physician that would support a new authorization request, a Prior Authorization request should be submitted instead of a request for administrative review.

An administrative review must be requested in writing, preferably on the *Administrative Review Request* form to ensure that the information provided is complete.

4.2.1 Technical Denial

A technical denial is not based on medical necessity criteria and may be appealed directly to the Children's Mental Health Bureau (CMHB) with a request for administrative review within thirty (30) days of notification date. Technical denials can be overturned by CMHB only if there was a clinical reason the request could not be made on time, or if there was a malfunction of the UMC's equipment that prevented transmittal of the request in the required timeframe per ARM 37.87.903(4).

If the technical denial was issued for submission of information outside the timeframes allotted, and the reason for overturning the denial is not covered in the above mentioned ARM, the provider may choose to submit a new Prior Authorization request to the UMC, rather than appeal the technical denial. However, a new Prior Authorization request must be supported by sufficient clinical information to meet medical necessity criteria.

If the new Prior Authorization request is approved, more covered days would be available if the technical denial is not overturned by CMHB. Requesting a new Prior Authorization after a technical denial does not waive the provider's right to request an administrative review from CMHB.

4.2.2 Clinical Denial

Before an administrative review is requested, the youth's legal custodian and/or the provider must request a reconsideration review from an appellate physician. A denial by the UMC's appellate physician does not prevent the Department from making a determination about medical necessity at any time. However, the Department considers an adverse determination by two board-certified psychiatrists as providing substantial weight to the Department's determination. Department determinations that override the board certified psychiatrists adverse determination are rare, are based on unique characteristics and circumstances of the particular case, and do not establish precedence for future determinations.

4.2.3 Claims Denial

Before an administrative review is requested for denied claims, all administrative remedies available must be exhausted. For denied claims, those remedies may include researching the denial codes, correcting errors and omissions, and resubmitting the claims. Assistance for providers with claims problems is available through the state's fiscal agent's provider relations program. If the fiscal agent is unable to assist the provider, the program officer in the Children's Mental Health Bureau responsible for

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the service affected may be contacted. Requests for administrative reviews should be submitted in writing, preferably on the *Administrative Review Request* form, with sufficient documentation to show all previous efforts to resolve the problem

4.2.4 Administrative Review Procedure

As provided for in ARM 37.5.310, an administrative review is the first phase of the fair hearing process and may be kept informal. Both the provider and the legal custodian have the right to request an administrative review after receiving notification of a technical denial or that an adverse determination has been upheld by the appellate psychiatrist. The Department will try to coordinate the administrative review if both parties request one. The request for administrative review must be received by the department within thirty (30) days of mailing of the department's written determination. The legal custodian has ninety (90) days from the date of the adverse determination to request a fair hearing, which is preceded by an administrative review. The request should be submitted on the *Administrative Review Request* form and sent to:

Children's Mental Health Bureau
111 Sanders, Rm 307
PO Box 4210
Helena, MT 59604-4210
FAX: 406-444-0230

The written request for administrative review must include the following information:

1. Detailed statement of the provider's or legal custodian's objections;
2. Any substantiating documents and information the provider wishes the Department to consider in the administrative review. It is not appropriate to introduce new clinical information that was not provided to the appellate psychiatrist at this time.

The Department has sixty (60) days from the date the administrative review request was received in which to respond in writing to the requestor with its determination. In some situations, the provider or legal custodian may request an expedited administrative review due to the clinical needs of the youth. When the Department can accommodate this request, it will conduct an expedited administrative review. An expedited administrative review must be explicitly requested, and the reason provided in writing to the Department at the time the request is submitted.

4.3 Fair Hearing

A fair hearing is the second phase of the formal appeal process. If the provider is not satisfied with Department's determination following the administrative review, the provider has thirty (30) days from its receipt to request a fair hearing. The legal custodian has ninety (90) days from the receipt of the adverse determination in which to request a fair hearing, and must request an administrative review within thirty (30) days of its receipt.

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The Department will follow the fair hearing procedures found in ARM 37.5.310 and 37.5.307. The UMC may participate in the fair hearing process to provide testimony, along with copies of documentation and correspondence related to the determination under appeal.

**5.0 PROGRAM SPECIFIC INFORMATION AND
CLINICAL GUIDELINES FOR UTILIZATION MANAGEMENT**
(Medical Necessity Criteria)

Program Specific Information

The general descriptions and procedures for reviews are found in Section 2. When the requirements and/or procedures for reviews for a specific service vary from the general descriptions, those will be noted in the program specific sections that follow.

Clinical Guidelines for Utilization Management

The UMC will employ the following *Clinical Guidelines* for each covered Medicaid mental health service strictly as guidelines. These guidelines are coupled with the professional judgment, based on clinical expertise, of the clinical reviewer and national best practice standards, to inform the reviewer's determination of whether medical necessity criteria are met.

Current forms required for Utilization Management are available on the CMHB website at www.dphhs.mt.gov/mentalhealth/children/index.shtml, and on the website of the UMC.

The CMHB website also has a "Table of Authorization Spans" for each service requiring a review.

5.1 Acute Inpatient Hospital Services

Service Definition

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

These services are provided to Medicaid youth in an acute care general hospital, a psychiatric hospital or a psychiatric unit of an acute care general 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.

Admission for acute inpatient services is an emergency admission manifesting itself by acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in the serious harm to self or others.

The youth must be seen and evaluated by a psychiatrist, who within 24 hours documents the results of the professional examination and assessment. The examination and assessment must include clinical history, be consistent with accreditation and licensure standards, be developed with involvement of the multi-disciplinary team, and include appropriate family members. The course of treatment and the

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youth's response to it must be thoroughly documented in the medical records with daily assessments reflecting progress towards discharge to a lower level of care. Records should reflect the initiation of discharge planning at the time of admission.

5.1.1 Program Specific Information

Certificate of Need

A CON is a state and federal requirement for this service and must be completed and submitted within fourteen (14) days of the admission to the facility.

Prior Authorization Reviews

All admissions to acute inpatient hospital facilities require prior authorization based on meeting medical necessity requirements, even if the youth has both Medicaid and another insurance. However, because it is an emergency admission, the facility has one (1) business day in which to submit the Prior Authorization request. Delay in contacting the UMC may result in either a technical denial or delay of admission approval.

If the provider notified the UMC of the admission with a *Prior Authorization Request* form within one (1) business day of the admission AND submitted the CON within fourteen (14) days and the beneficiary meets criteria for medical necessity and has been determined Medicaid eligible, the UMC will enter the "start date" for admission approval.

If the provider did not contact the UMC within one (1) business day of the admission, the UMC will issue a technical denial.

If the provider notified the UMC of the admission with a *Prior Authorization Request* form within one (1) business day and the CON is not submitted within fourteen (14) days with BOTH required signatures, the UMC will issue a technical denial.

If the medical necessity criteria are not met, UMC will defer to the UMC psychiatrist for review and determination.

Continued Stay Reviews

Acute inpatient services are reimbursed based on All Patient Refined Diagnostic Related Groups (APR-DRGs) and do not require continued stay reviews.

Retrospective Reviews

Acute inpatient services are be subject to retrospective review when requested by the Department.

Retrospective reviews for youth whose Medicaid eligibility is retroactive may be completed when documentation of retroactive Medicaid eligibility from the Office of Public Assistance is submitted with the prior authorization request.

Discharge Procedure

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The *Discharge Notification* form must be submitted to the UMC within five (5) business days of the discharge date.

The prior authorization number cannot be issued until the UMC receives a valid CON and a completed *Discharge Notification* form.

5.1.2 Clinical Guidelines

Admission Criteria

Admission to acute inpatient hospital services requires a DSM-IV diagnosis that is covered under the provisions of Montana Medicaid, as the primary diagnosis, and at least one of the following:

1. Dangerous to self as exhibited by ideas or behaviors resulting from the DSM-IV diagnosis, as evidenced by behaviors which 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 of the youth 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, which could predictably result in harm to self, with the youth 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-IV diagnosis, as evidenced by behaviors which may include, but not be limited to:
 - a. Actions, or threats of actions, intended to harm others;
 - b. Actions or threats of actions, which could predictably result in harm to others, with the youth 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 or functional impairment, as exhibited by ideas or behaviors resulting from the DSM-IV diagnosis, and as evidenced by behaviors which may include, but not be limited to:
 - a. Mental status deterioration sufficient to render the youth unable to reasonably provide for their own safety and well-being;
 - b. An acute exacerbation of symptoms sufficient to render the youth unable to reasonably provide for their own safety and well-being;

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- c. Deterioration in the youth's function in the community sufficient to render the person unable to reasonably provide for their 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 youth unable to reasonably provide for their own safety and well-being;
- e. A clinician's inability to adequately assess and diagnose a youth, as a result of the person's non-compliance or as a result of the unusually complicated nature of a clinical presentation, with behaviors or symptoms sufficient to render the youth unable to reasonably provide for their own safety and well-being.

Discharge Criteria

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

AND

A comprehensive discharge plan has been developed and is ready to be implemented;

OR

The parent/legal custodian or youth voluntarily withdraws from treatment and the youth does not meet criteria for involuntary treatment.

5.1.3 List of Required Forms

1. Certificate of Need (Acute Inpatient Hospital/PRTF/PRTF-AS)
2. Prior Authorization Request Form (Acute Inpatient Hospital)
3. Discharge Notification Form
4. Discharge Plan Review Form (Optional)

5.2 **Partial Hospital Program**

Service Definition

Partial Hospital Program (PHP) is provided by a licensed hospital by licensed and credentialed professionals. PHP is defined as “an active treatment program that offers therapeutically intense, coordinated, structured clinical services to youth with a serious emotional disturbance”. Partial hospital services are time limited and are provided at either an acute or sub-acute level of care. PHP uses an integrated, comprehensive, and complementary schedule of recognized treatment and therapeutic activities.

Acute level PHP is provided in a program co-located with a hospital for emergency purposes. Sub-acute level PHP is provided in a self-contained facility, but does not have to be co-located with a hospital. Both levels primarily serve youth being discharged from an inpatient psychiatric hospital or PRTF, or who would be admitted to inpatient services in the absence of partial hospital care.

In the acute level, individual, family, and group therapy are provided at a frequency designed to stabilize the youth and facilitate discharge from PHP at the earliest opportunity. From the acute level, discharge is generally within fifteen (15) days.

The sub-acute level provides, at a minimum, three group and five individual and/or family therapy sessions per month to stabilize youth. Discharge is generally within sixty (60) days.

Partial hospital services are available a minimum of four hours per day and five days per week in an appropriately licensed facility. A “half-day partial hospitalization program” means a partial hospitalization program providing services for at least four but less than six hours per day, at least four days per week. The intent of the half-day program is to provide needed support not available in the community while the youth is transitioning back to his/her community school.

PHP includes all of the following service components:

1. Minimum of four hours of active mental disorder treatment and therapy per day within a structured therapeutic milieu (exclusive of formal education and support groups administered by non-licensed/certified personnel), which includes individual, family, and group therapy;
2. Face-to-face evaluation by a physician who will participate with the multi-disciplinary team in preparation of an individualized, comprehensive, documented treatment plan directed toward the alleviation of the behavior/symptoms or functional 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 the time of admission to the program and culminate in comprehensive discharge plan;

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5. Active treatment is focused upon stabilizing or reversing behavior/symptoms necessitating admission;
6. Regularly updated comprehensive treatment plan to reflect youth's progress and/or new information as it becomes available;
7. Regular assessment and active treatment interventions are completed by nurses, therapists, behavior specialists, and physicians based upon the comprehensive treatment plan.

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:

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

5.2.1 Program Specific information

Certificate of Need

A PHP admission is a scheduled admission that is subject to the choice or discretion of the youth or the physician advisor regarding medical services and/or procedures that are medically necessary and advantageous to the youth, but not necessary to prevent death or disability. Therefore, a CON process is necessary and must be submitted with the *Prior Authorization Review Request* form.

Prior Authorization Reviews

All admissions to PHP require submission of a *Prior Authorization Request* form and completion of the prior authorization process. PHP admissions must meet medical necessity as defined in the *Clinical Guidelines*.

Acute Level

A completed review determination may authorize up to twenty one (21) calendar days for youth who are experiencing severe impairments in educational, social, vocational, and/or interpersonal functioning.

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If a youth requires sub-acute partial hospital services upon discharge from an acute partial hospital level of care, a new prior authorization review process for sub-acute partial hospital level of care is required.

Sub-acute Level

A completed review determination may authorize up to seventy-six (76) calendar days for youth who are experiencing moderately severe to severe impairments in educational, social, vocational, and/or interpersonal functioning.

Continued Stay Reviews

All PHP services that extend beyond the initial authorization date must be prior authorized through a continued stay review process using the *Continued Stay Authorization Request* form.

Retrospective Reviews

Partial hospital care services are subject to retrospective review by the UMC as requested by the Department and could be subject to retrospective review when the CON requirement is waived.

Discharge Notification Procedure

The *Discharge Notification* form must be submitted to the UMC within five (5) business days of the discharge date.

5.2.2 CLINICAL GUIDELINES

Admission Criteria

All of the following admission criteria must be met to qualify for the Partial Hospital Program:

1. A covered DSM-IV SED diagnosis as the primary diagnosis;
2. The youth is experiencing psychiatric symptoms of sufficient severity to create moderately severe to severe impairments in educational, social, vocational, and/or interpersonal functioning;
3. The youth has exhausted or cannot be safely treated in a less intensive level of care such as comprehensive school and community treatment, day treatment, outpatient therapy or a combination of these and other services;
4. Proper treatment of the youth's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician;
5. The youth 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 youth's condition or prevent further regression;

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7. Discharge planning will be initiated at the time of admission.

Continued Stay Criteria

For continued stay to be authorized, criteria 1 through 4 must all be met, plus at least one of criteria 5 through 7:

1. A covered DSM-IV SED diagnosis as the primary diagnosis;
AND
2. Active treatment is occurring, which is focused on stabilizing or reversing behavior/symptoms that meet the admission criteria and that still exists;
AND
3. A lower level of care is inadequate to meet the youth's needs with regard to either treatment or safety;
AND
4. Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date. Use of the *Discharge Plan Review Form* is optional;
5. 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;
OR
6. A high likelihood of either risk to the youth's safety or clinical well being or of further significant acute deterioration in the youth's condition without continued care in the partial hospital setting, with lower levels of care inadequate to meet these needs;
OR
7. The appearance of new functional impairments meeting the admission guidelines;

Discharge Criteria

Either criteria 1 and 2 or criteria 1 and 3 must be met for discharge:

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 youth's parent or legal custodian removed him/her from the program.

5.2.3 List of Required Forms

Certificate of Need (Partial Hospital Program)
Prior Authorization Request Form (Partial Hospital Program)
Continued Stay Request Form (Partial Hospital Program)
Discharge Plan Review Form (Optional)
Discharge Notification Form

5.3 Psychiatric Residential Treatment Facility (PRTF)

Service Definition

Psychiatric residential treatment is 24-hour non-acute secure facility setting for active interventions directed at addressing and reducing the specific impairments that led to the admission and at providing a degree of stabilization that permits safe return to the home environment and/or community-based services. Psychiatric Residential Treatment Facility (PRTF) services are provided by a licensed and credentialed professional, multi-disciplinary staff, based on a comprehensive treatment plan, in a licensed, accredited, and certified facility. Family therapy is an important component of the treatment in almost all cases. Medical and psychiatric services are readily available in the facility.

Psychiatric residential treatment is considered a structured inpatient program. As required in 42 CFR 440-160, the facility must be accredited as a psychiatric residential treatment facility by the Joint Commission on Accreditation of Health Care Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. This program must be provided under the direction of a board-eligible/certified child and adolescent psychiatrist or general psychiatrist with demonstrated experience in the treatment of children and adolescents. These services must be therapeutically appropriate and meet medical necessity criteria as established by the state and the federal government. Documentation requirements must meet both the requirements of the accrediting body and Medicaid guidelines.

5.3.1 Program Specific Information

Certificate of Need

A Certificate of Need (CON) process is necessary. The CON must be signed by an independent physician and mental health, acting as part of the community based treatment team, and must accompany the *Prior Authorization Review Request* form.

Prior Authorization Reviews

All admissions for PRTF services require prior authorization and must meet medical necessity criteria as defined in this section. An individual comprehensive treatment plan must be developed, implemented, and managed on a continuous basis.

It should be noted that youth who appropriately require this level of care may have demonstrated unlawful or criminal behaviors. Therefore, this level of care may be court ordered as an alternative to incarceration. The court order does not automatically guarantee reimbursement by Montana Medicaid. Requirements for prior authorization, including but not limited to determination of medical necessity, must be met.

Additionally, if a youth has been admitted to a facility that offers both acute inpatient psychiatric hospital services and PRTF services, and the youth is being transferred from inpatient psychiatric hospital services to PRTF services, the transfer must be prior authorized.

5.3.2 Prior Authorization Procedure for Out of State Facilities

Before a Montana youth receives prior authorization for admission to an out-of-state (OOS) PRTF, admission must first be requested from of all Montana PRTFs and applicable PRTF waiver site (effective July 1, 2011) and declined. In-state PRTF and PRTF waiver services will not be determined to be unavailable unless the youth has been screened for admission by all enrolled in-state facilities and waiver sites and denied admission because the facility or waiver site cannot meet the youth's clinical and/or treatment needs, or an opening is not available. The UMC will not begin a Prior Authorization review or issue an admission determination for an out-of-state PRTF until written verification of all in-state denials is completed.

Each Montana PRTF must complete the *In state PRTF Denial Letter* form and indicate the reason(s) the youth was not admitted. Those forms must accompany the *Prior Authorization Request* form from the OOS PRTF. For reporting purposes, a copy of these forms will be sent to the Department for each OOS admission approved by the UMC.

As a part of the admission process, families or legal custodians of all Montana Medicaid youth who are admitted to OOS PRTFs must complete an *Interstate Compact Agreement* before the youth leaves the state and as part of the prior authorization process. The form is located on the Department website at: <http://www.dphhs.mt.gov/forms/results.jsp?catchchoose=2&keywords>

Continued Stay Reviews

All PRTF services that extend beyond the initial authorization date must be authorized through a continued stay review process. Each *Continued Stay Request* form must be accompanied by a completed *Discharge Plan Review* form. The form must provide details about the discharge planning for the youth and must be provided to the youth's family or legal custodian. The *Discharge Plan Review Form* must be updated with each subsequent submission to reflect current planning and progress toward an adequate discharge.

42 CFR 456.60(b) requires recertification of the CON for inpatient care for each beneficiary by a physician at least every sixty (60) days. The CON recertification for PRTF services is integrated into the *Continued Stay Review* form which may serve to fulfill the CON recertification requirements when it is completed fully.

Retrospective Reviews

PRTF services are subject to retrospective review by the UMC when requested by the Department and could be subject to retrospective review when the CON requirement is waived.

Discharge Procedure

Upon the recipient's discharge from the PRTF, the provider must complete a *Discharge Notification* form. This form must be submitted to the UMC on the day of discharge or the first business day after discharge, if the youth discharges on a weekend or holiday. The Department may impose a \$100 fine

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against a PRTF for each instance where timely discharge notification is not received. Other Medicaid services are closed for youth while they are in a PRTF.

5.3.3 Clinical Guidelines

Treatment in a PRTF is provided 24 hours per day, seven days a week, creating a secure environment in a restrictive level of care necessary for the well being and safety of the youth and others. This is the highest level of care for youth, other than Acute Inpatient Psychiatric Hospital care. A youth should be referred to this level of care when:

1. Interventions at lower levels of care (e.g., therapeutic foster care, intensive outpatient, or partial hospitalization services) have failed to meet the youth's needs in the community setting;
- OR
2. The youth's medical condition is so complicated or the behavior is so dangerous or destructive that he/she requires 24-hour per day treatment under the direction of a physician.

PRTF services are expected to meet a youth's psychosocial needs, including educational goals. If a youth has an Individualized Educational Plan (IEP) upon admission to the facility, that facility must follow, as close as possible, the educational plan as outlined in the IEP until the IEP is revised or a new IEP is developed. If a youth is not a child with disabilities under the Individuals with Disabilities Education Act (IDEA), and therefore does not have an IEP upon admission, the facility must develop an educational plan appropriate to the student's needs. It is expected that a written referral to the home school district will be made prior to the youth's discharge from the facility in order to facilitate access to services upon return to the home community.

A PRTF level of care is considered a short-term medical treatment (approximately 120 days) with therapeutic interventions developed to stabilize the youth's emotional and behavioral disturbance. Generally, the youth is then stepped down to a less restrictive level of care after this period of time. This step down level of care should be clearly described in the *Discharge Plan Review* form.

Youth are seen and evaluated by a physician who documents, consistent with the standards of accrediting and/or licensing agencies, the youth's clinical history, results of the professional's examination, and the ongoing medical and therapeutic progress through discharge. The Individual Treatment Plan (ITP) must include individual and group psychotherapy, active involvement, when appropriate, by family members, and all active pre-admission caregivers. The course of treatment and the youth's response to the treatment efforts must be thoroughly documented in records consistent with the standards of accrediting and/or licensing agencies, with daily assessments reflecting progress toward discharge of the youth to a less restrictive level of care. *Records must reflect the initiation of discharge planning at the time of admission.*

Admission Criteria

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Admission criteria require a covered DSM-IV diagnosis as the primary diagnosis and a determination that the youth has a serious emotional disturbance. In addition, all of the following must be met:

1. Symptoms or functional impairments of the youth's emotional disturbance are of a severe and persistent nature and require 24-hour treatment under the direction of a physician;
2. Less restrictive services are documented to be insufficient to meet the youth's severe and persistent clinical and treatment needs. The prognosis for treatment at this PRTF level of care can reasonably be expected to improve the youth's condition or prevent further regression based upon the physician's evaluation;
3. The treatment plan includes the active participation of the parent(s) or legal custodian and all active pre-admission caregivers;
4. If the youth is a student with disabilities, an IEP is in place that provides programs and services consistent with requirements under IDEA and state special education requirements. If the youth is not a student with disabilities, educational services and programs are designed to meet the student's educational needs;
5. A comprehensive discharge plan and estimated length of stay will be developed upon admission identifying appropriate services to be provided necessary to meet the youth's needs at a less restrictive level of care.

Continued Treatment Criteria

All of the following requirements must be documented and present for continued stay:

1. The youth continues to meet all Admission Criteria;
2. The youth was seen and evaluated by a physician within 24 hours of admission;
3. The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress as indicated by objective behavioral measurements of improvement;
4. The youth and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the plan of care;
5. Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The Treatment team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date on the *Discharge Plan Review form*;

Discharge Criteria

Discharge criteria are met when one or more of the following is documented:

1. Treatment of the youth's emotional disturbance no longer requires 24-hour direction by a physician;
OR
2. The youth's clinical and treatment needs can be met in a less restrictive setting;
OR
3. The IEP goals have been sufficiently met such that the youth no longer requires this level of care;
OR

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4. The youth voluntarily leaves the program or the youth's parent or legal custodian removes them from the program.

5.3.4 List of Required Forms

(In-State)

- Certificate of Need (Acute Inpatient Hospital/PRTF/PRTF-AS)
- Prior Authorization Request Form (PRTF)
- Continued Stay Authorization Request Form (PRTF)
- Authorization Request Form (Therapeutic Home Visit)
- Discharge Plan Review Form (Required)
- Discharge Notification Form

(Out-of-State)

- In-state PRTF Denial Letter from all Montana PRTFs
- Interstate Compact Agreement
- Certificate of Need (Acute Inpatient Hospital/PRTF/PRTF-AS)
- Prior Authorization Request Form (PRTF)
- Continued Stay Authorization Request Form (PRTF)
- Discharge Plan Review Form (Required)
- Discharge Notification Form

Service Definition

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5.4 Psychiatric Residential Treatment Facility Assessment Service (PRTF-AS)

PRTF-AS is provided in a PRTF as described in the previous section. PRTF-AS is a short-term (14 days or less) intensive PRTF stay targeted at difficult to serve youth. "Difficult to serve" youth means a youth with multiple diagnoses and risk factors who present as "difficult to place." PRTF-AS is only available in in-state PRTFs. PRTF-AS may be used to:

1. Continue the stabilization of a youth discharging from the acute setting to permit a safe return to the home environment and/or community-based services;
2. Avert an admission to acute hospital care when symptoms that have led to hospital admissions in the past begin to emerge, if the pre-acute safety needs can be addressed in a PRTF level of care before they become acute.
3. Assess whether the youth has specialized treatment needs in PRTF level of care;

5.4.1 Program Specific Information

PRTF-AS stays are for youth who:

1. Have had multiple acute psychiatric hospital or PRTF admissions;
AND/OR
2. Are at-risk of being placed in an out-of-state PRTF with an unclear clinical presentation;
AND/OR
3. Are difficult to place due to an unclear or conflicting clinical picture AND meet criteria for a PRTF admission.

PRTF-AS include the following as clinically indicated: diagnostic and functional assessment, medication evaluation, psychological and IQ testing, chemical dependency assessment, and/or supported group or independent living needs assessment.

Certificate of Need

A Certificate of Need (CON) process is necessary and must be submitted along with the *Prior Authorization Review* form.

Prior Authorization Review

If a youth is authorized and admitted for PRTF-AS and additional days beyond fourteen (14) are needed, a regular PRTF prior authorization must be requested from the UMC no later than two (2) business days before the end of the PRTF-AS authorization.

Continue Stay Review

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Since this is a 14 day admission, a Continued Stay review is not applicable.

Retrospective Review

PRTF Assessment services are subject to retrospective review by the UMC as requested by the Department and could be subject to retrospective review when the CON requirement is waived.

Discharge Procedure

Upon the youth's discharge from the PRTF-AS service, the provider must complete a *Discharge Notification* form. This form must be submitted to the UMC on the day of discharge or the first business day after discharge, if the youth discharges on a weekend or holiday. The Department may impose a \$100 fine against a PRTF for each instance where timely discharge notification is not received. Other Medicaid services are closed for youth while they are in a PRTF.

5.4.2 Clinical Guidelines

Admission Criteria

Admission criteria require a covered DSM-IV diagnosis as the primary diagnosis, and a determination that the youth has a serious emotional disturbance. In addition, all of the following must be met:

1. Symptoms or functional impairments of the youth's emotional disturbance are of a severe and persistent nature, and require 24-hour treatment under the direction of a physician;
2. Less restrictive services are documented to be insufficient to meet the youth's severe and persistent clinical and treatment needs. The prognosis for treatment at this inpatient level of care can reasonably be expected to improve the youth's condition or prevent further regression based upon the physician's evaluation;
3. The assessment plan includes the active participation of the parent(s) or legal custodian and all active pre-admission caregivers;
4. If a youth has an IEP upon admission to the facility, that facility must follow, as closely as possible, the educational plan as outlined in the IEP until the IEP is revised or a new IEP is developed. If a youth is not a child with disabilities under the Individuals with Disabilities Act (IDEA), and therefore does not have an IEP upon admission, the facility must develop an educational plan appropriate to the student's needs. It is expected that a written referral to the home school district be made prior to the youth's discharge from the facility in order to facilitate access to services upon the youths return to the home community.
5. A comprehensive discharge plan will be developed upon admission identifying appropriate services to be provided necessary to meet the youth's needs at a less restrictive level of care;

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Discharge Criteria

Discharge criteria for PRTF –AS are met within 14 days or when at one or more of the following is documented:

1. Treatment of the youth's emotional disturbance no longer requires 24-hour direction by a physician and the youth's clinical and treatment needs can be met in a less restrictive setting.
2. The Individual Treatment Plan (ITP) goals have been sufficiently met such that the youth no longer requires this level of care.
3. The youth voluntarily leaves the program or the youth's parent or legal custodian removes him/her from the program.
4. The necessary assessments have been completed and services in a less restrictive setting are available.

5.4.3 List of Required Forms

Certificate of Need (Acute inpatient Hospital/PRTF/PRTF-AS)

Prior Authorization Request (PRTF/PRTF Assessment)

Discharge Notification

5.5 Psychiatric Residential Treatment Facility Home and Community Based Services (PRTF HCBS Waiver) Waiver Program

Service Definition

The Psychiatric Residential Treatment Facility (PRTF) Home and Community Based Services HCBS Waiver (PRTF HCBS) program is an alternative for youth who meet *Clinical Guidelines* for psychiatric residential treatment facility level of care. The program uses a community-based wraparound service delivery model to address the needs of the youth and family. It is structured to provide the supports necessary to maintain the youth safely in their home and community.

5.5.1 PRTF HCBS Waiver Services

1. **Consultative Clinical and Therapeutic Services:** Consultation specifically designed to provide the youth's treating physician or mid-level practitioner an opportunity to consult with a psychiatrist about diagnosis, treatment, behavioral, and medication management on an as needed basis.
2. **Customized Goods and Services:** Funds used to pay for supports designed to improve and maintain the youth's opportunities for membership in the community, socialization, and enrichment, as specified by the Individual Plan of Care.
3. **Education and Support Services:** Services designed to provide support for families parenting youth with severe emotional disturbance through information and skill-building in coping skills, dealing with schools, and advocacy.
4. **Home-based Therapist:** Home-based therapists are licensed mental health professionals who provide face-to face, individual and family therapy for youth/family in the family home at times convenient for the family and youth.
5. **Non-emergency Transportation:** Non-emergency Transportation enables participants to gain access to Waiver and other community services, supports, activities and resources specified by the individual service plan.
6. **Respite Care:** This service is designed to help meet the needs of the youth's caregiver and to reduce the stress generated by the provision of constant care to the individual receiving waiver services.
7. **Wraparound Facilitation:** Wraparound facilitation is a planning process that completes a series of tasks and is provided through a wraparound team. These tasks include: Engaging the youth and family in the wraparound process; assembling the wraparound team; facilitating plan of care meetings; working with the department in identifying providers of services and other community resources to meet family and youth needs; making necessary referrals for youth; documenting and

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maintaining all information about the plan of care and all revisions to plan of care; presenting plan of care to the plan manager for approval; providing copies of the plan of care to the youth and family; monitoring the implementation of the plan of care; consulting with family and other team members to ensure the services the youth and family are receiving continue to meet the youths needs; maintaining communication between all wraparound team members; educating new members to the wraparound process; and maintaining team cohesiveness.

8. **Family Support Specialist:** The family support specialist provides support and interventions to parents and youth in order to reinforce and enhance the youth's ability to function within the family and enhance the whole family's level of functioning. Family support specialists follow the plan of care developed by the wraparound team and works closely with the home-based therapist.
9. **Caregiver Peer-to-Peer Support:** Caregiver peer-to-peer support services offer and promote support to the parent/guardian of the youth with SED. Services are geared toward promoting self empowerment of the parent, enhancing community living skills, and developing natural supports.

5.5.2 Program Specific Information

Certificate of Need (CON)

For PRTF HCBS waiver program requests, the plan manager or provider must submit a completed CON at least two (2) business days prior to enrollment or up to ten (10) days prior to enrollment.

If the youth is transferred from acute inpatient or from a PRTF to the PRTF HCBS Waiver, the CON may be completed by the facility based team responsible for the plan of care prior to the youth's enrollment into the PRTF HCBS Waiver. The UMC will verify that the CON was received and completed before entry into the database.

Level of Care Determination (similar to the Prior Authorization Review)

The PRTF HCBS Waiver program requires a level of care determination instead of a prior authorization request, verifying the youth meets PRTF level of care and admission criteria as defined in the *Clinical Guidelines*. The Level of Care Determination is made by the UMC reviewer and is based on the information provided in the CON and on the *PRTF Wavier Referral* form.

Initial level of care certification spans are approved for twelve (12) months and continued stay spans are approved for an additional twelve (12) months. The Level of Care review is dependent upon not only meeting the criteria in the *Clinical Guidelines*, but also upon completion of the CON.

5.5.3 Level of Care Determination Procedure

Eligibility

To be eligible for PRTF HCBS Waiver program, a youth must:

1. Be Medicaid eligible;

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2. Be age six (6) through age seventeen (17) years of age;
3. Meet Serious Emotional Disturbance (SED) criteria;
4. Meet level of care and CON criteria for PRTF;
5. Reside in a geographic area of the state where the waiver program is available;
6. Voluntarily choose to be in the waiver program;
7. Be able to remain in the community through the availability of an appropriate package of services designed to meet multiple needs;
8. Have a viable and consistent living environment;
9. Have parent(s) or other responsible caregiver with physical custody committed to supporting and participating in the waiver program;
10. Receive waiver services and Medicaid state plan services that do not exceed the cost of services provided in a psychiatric residential treatment facility;
11. Not be receiving services through a Medicaid funded home and community-based services waiver program;
12. Not otherwise be receiving another Medicaid funded case management service.

The plan manager or provider must notify the UMC as soon as Medicaid eligibility is verified and the need for enrollment in the PRTF HBCS Waiver program is determined, no less than two (2) business days prior to enrollment. This allows for timely completion of the Level of Care review process.

The provider or plan manager must submit the CON and the PRTF referral form to the UMC. Information required on this form is similar to the information required for a Prior Authorization Review.

Level of Care Re-determination (similar to Continued Stay Review)

All PRTF HCBS Waiver enrollments that extend beyond the initial authorization date must complete a Level of Care Re-determination process initiated with a *Level of Care Re-determination Request* form. The plan manager is responsible for contacting the UMC no more than ten (10) and at least (5) business days prior to the termination of the initial level of care determination. The Re-determination request meets the CON requirement.

Retrospective Reviews

PRTF HCBS Waiver enrollees are subject to retrospective review by the UMC as requested by the Department. Provider requested retrospective reviews are not available.

Discharge Procedure

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Upon discharge of the youth from the PRTF HCBS Waiver program, the plan manager must complete a *Discharge Notification* form to be within five (5) business days after discharge. The youth must be discharged from the waiver program when admitted to a PRTF, even for a short stay.

Re-Enrollment in PRTF Waiver (PRTF Waiver to PRTF Facility to Re-Enrollment in PRTF Waiver)

When a youth has been enrolled in the PRTF HCBS Waiver and enters a PRTF facility, the youth must be discharged from the PRTF HCBS Waiver and the Plan Manager must notify the UMC of this discharge. If the youth is in the PRTF facility less than 60 days, and there is a recommendation from the PRTF facility for the youth to re-enroll in the PRTF HCBS program, the PRTF facility psychiatrist completes the CON form for the PRTF Waiver Program and sends it to the Plan Manager. The Plan Manager completes an abbreviated version of the *PRTF Waiver Program Referral* form and sends it along with the CON to the UMC. The UMC will complete the level of care determination process, including the notification process

5.5.4 Clinical Guidelines

Admission Criteria

Admission requires Criterion A, B, and C are all met.

Criterion A

Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42CFR 441.152a-7).

One of the following two (2) *accessibility criteria* must be documented and present to satisfy this requirement:

1. In lieu of the PRTF Waiver program, a less restrictive level of care within Montana will not meet the youth's treatment needs;

OR

2. Documented factors related to the youth's family or community prevents effective treatment at a less restrictive level of care within Montana (i.e. the youth's behaviors and/or symptoms persist despite appropriate treatment in a less restrictive level of care).

One of the following two (2) *treatment effectiveness criteria* must be documented and present to satisfy this requirement:

1. Therapeutic services provided in a less restrictive setting have been attempted and found ineffective, and in lieu of the PRTF Waiver program, the youth is at risk for treatment in an inpatient setting.

OR

2. Child/adolescent has a documented history of multiple admissions to a variety of therapeutic settings and has not progressed sufficiently or has regressed. (i.e. family or relative placement, community services, therapeutic family care, or therapeutic group home).

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The following *severity criteria* must be documented and present to satisfy this requirement:

- Assessments conducted by a physician or a qualified mental health professional demonstrate the need for active provision of multiple therapies in an inpatient setting, and the youth and family are provided the choice to receive services in either a PRTF or in the PRTF Waiver program.

Criterion B

In lieu of the PRTF Waiver program, the appropriate treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152-2).

Both of the following two conditions must be documented and present to satisfy Criterion B:

A covered DSM-IV diagnosis as the primary diagnosis and a determination that the youth has a serious emotional disturbance (SED);

AND

The youth is currently experiencing severe dysfunction related to the diagnosed psychiatric disorder as demonstrated in one (1) or more of the following areas:

1. Self Care Deficit --- Refusal to comply with treatment, refuses medication, persistent and severely depressed mood, self-care deficit may also place recipient in life threatening situations.
2. Impaired Safety --- History of chronic and severe loss of impulse control, repeated aggressive or destructive behavior toward self, others, or property, presence of suicidal ideation, gestures, or attempt or history of in family or peer group.
3. Severely impaired role functioning in the family, school, and/or community.

Criterion C

The services can reasonably be expected to improve the recipient's condition or prevent further regression so that residential treatment services will no longer be needed (CFR 441.155, 441.156). In lieu of receiving waiver services, the youth would regress and require institutionalization or inpatient hospitalization in the community.

All of the following requirements must be documented and present to satisfy Criterion C:

1. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for residential treatment care;
2. The individualized treatment plan (ITP) clearly identifies the goals and measurable objectives derived from the diagnostic evaluation;

AND

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All of the following criteria:

1. The ITP is developed by a team which includes professionals, the youth, and his/her parents/legal custodian in whose care he/she may be released after discharge;
2. The ITP clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently in their own environment;
3. The ITP clearly documents a comprehensive discharge plan that is based on treatment goals and measurable objectives. The ITP specifies approximate discharge date, post discharge service needs, identified post discharge service providers to insure continuity with the recipient's family, school, and community upon discharge, and any other provisions necessary for transition to a lesser restrictive environment.

Continued Stay Criteria

All of the following requirements must be documented and present for authorization of continued stay:

1. The youth continues to meet all admission criteria;
2. The treatment has stabilized the youth's behaviors and symptoms present at admission;
3. In lieu of waiver services, the youth would regress and require institutionalization or inpatient hospital services in the community;
4. The family or legal custodian and the plan manager are continuing to identify and document an appropriate less restrictive level of care for the youth for discharge;
5. The Treatment Team provides additional clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.

Discharge Criteria

Discharge criteria are met when one of the following is documented:

1. The ITP goals and objectives have been sufficiently met and the youth no longer requires this level of care;
- OR
2. The youth voluntarily leaves the program or the youth's family/legal custodian removes him/her from the program;
- OR
3. The youth no longer meets criteria for the program.

5.5.5 List of Required Forms

Certificate of Need (PRTF Waiver Program)
PRTF Waiver Referral Request Form
Level of Care Re-determination Request Form
Discharge Plan Review Form (Optional)
Discharge Notification Form

5.6 Therapeutic Group Home

Definition

Therapeutic Group Home (TGH), formerly referred to as one of the “Therapeutic Living Services”, is defined as an out-of-home, community-based treatment alternative appropriate for youth requiring specific treatment services and/or social supports and provided in a structured group home environment. TGH services for youth are provided by agencies licensed by the Department.

TGH services are appropriate for individuals requiring a higher intensity of specific therapeutic services and/or social supports than are available through traditional outpatient service, and which clearly exceed the capabilities of immediate family, relatives, friends, or other community systems.

The purpose of this service is to provide for the maximum reduction of the symptoms of the youth’s serious emotional disturbance, to restore the youth’s best possible functional level, to reverse or change maladaptive patterns of behavior and to encourage personality growth and development. A combination of supportive interactions, cognitive therapy, interactive psychotherapy and behavior modification techniques and therapeutic interventions which are used to induce therapeutic change for youth in therapeutic group homes. (Therapy and therapeutic interventions provided by the lead clinical staff or program manager are defined in ARM 37.87.1013)

The environment provided in the TGH is based on therapeutic treatment interventions that are provided in accordance with the youth’s individual treatment plan (ITP). Such interventions, guided by the treatment team, are provided by clinical staff or by specially trained staff under the supervision of clinical staff. The ITP is developed by the treatment team, including the youth and family, and specifies therapeutic goals and objectives, behavioral interventions, and supports that are designed and applied to result in the youth’s discharge to a lower level of service

This level of treatment intervention includes a consideration of the youth’s safety and security needs, the degree of self-care skills demonstrated by the youth, and the likelihood of the youth to benefit from a community integrated program. Room and board costs in a therapeutic group home are not covered by Montana Medicaid.

5.6.1 Program Specific Information

Certificate of Need (CON):

As required in administrative rule, the CON must certify that:

1. Symptoms of the youth’s emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service;

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2. The youth exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if TGH services are not provided, or the youth is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;
3. The prognosis for treatment of the youth's mental illness or emotional disturbance at a less restrictive level of care is poor because the youth demonstrates three (3) or more of the following due to the emotional disturbance or mental illness:
 - a. Significantly impaired interpersonal or social functioning;
 - b. Significantly impaired educational or occupational functioning;
 - c. Impairment of judgment;
 - d. Poor impulse control;
 - e. Lack of family or other community or social networks.
4. As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate manner;
5. As a result of the emotional disturbance or mental illness, the youth exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

Prior Authorization (PA) Review:

Prior authorization is required for TGH services. These services must meet medical necessity criteria as defined in the *Clinical Guidelines* and be advantageous to the youth.

Continued Stay Review:

All TGH services that extend beyond the initial authorization date must be authorized through a continued stay review process. Reviews of continued stay authorization requests are based on documented medical necessity for continued TGH level of care, with updated treatment plans, progress notes and recommendations from the youth's treatment team.

Retrospective Review:

TGH services are subject to retrospective review by the UMC as requested by the Department and could be subject to retrospective review when the CON requirement is waived.

Discharge Procedure:

Upon youth discharge from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a *Discharge Notification* form.

5.6.2 Clinical Guidelines

Admission Criteria

A request for authorization must include a recommendation by the youth's treatment team that TGH is the least restrictive setting appropriate for the youth's clinical needs. The criteria for placement include all of the following:

1. A covered DSM-IV diagnosis as the primary diagnosis and identification of the youth as having a serious emotional disturbance;
2. Outpatient interventions have been attempted and have been documented to be insufficient to meet the youth's needs and safety concerns;
3. The youth must meet all of the criteria listed in the CON section for TGH;
4. There is a comprehensive and viable discharge plan with an estimated date of discharge.

Continued Stay Review

The youth must continue to meet all of the admission criteria. In addition, all of the following criteria must be met:

1. Demonstrated progress toward identified treatment goals and the reasonable likelihood of continued progress;
2. The youth and family/legal custodian are engaged in treatment and making progress toward treatment goals;
3. The youth's symptoms do not require a more intensive level of care but have demonstrated they are severe enough that a less intensive level of care would be insufficient to meet treatment needs;
4. Demonstrated and documented progress is being made on the comprehensive discharge plan. The Treatment Team provides a clinical rationale for any recommended changes in the discharge plan or anticipated discharge date.

Discharge Criteria

Criteria 1 or 2 must be met:

1. The treatment plan goals have been sufficiently met such that the person no longer requires this level of care;

OR

2. The youth voluntarily leaves the program or the parent or legal custodian removes him/her from the program.

5.6.3 List of Required Forms

Certificate of Need (Therapeutic Group Home)

Prior Authorization Request Form (Therapeutic Group Home)

Continued Stay Authorization Request Form (Therapeutic Group Home)

Discharge Plan Review Form (Optional)

Discharge Notification Form

5.7 Therapeutic Family Care and Therapeutic Foster Care

Definition

Therapeutic Family Care (TFC) and Therapeutic Foster Care (TFOC) are home-based treatment alternatives for youth with a serious emotional disturbance (SED) requiring specific and frequent treatment interventions and/or social supports. TFC is provided in adoptive, regular foster care, kinship or biological homes. TFOC is provided in therapeutic foster homes. Placement into TFC or TFOC begins with the recommendation of the treatment team for the least restrictive setting possible to meet clinical need.

TFC and TFOC are appropriate for youth requiring a more intensive therapeutic intervention than are available through traditional outpatient services and which clearly exceed the capabilities of immediate family, relatives, friends, non-therapeutic foster care or other community systems. The supportive environments provided in TFC and TFOC are based on active treatment interventions provided in accordance with the youth's individual treatment plan (ITP). Such interventions, guided by the treatment team, are carried out by clinical staff or by specially trained individuals under the supervision of clinical staff.

The ITP is developed by the treatment team, including the youth and family, and specifies treatment, behavioral interventions, and supports designed and applied to result in the youth's discharge to a lower level of service. TFOC includes permanency or moderate levels, and is provided in a therapeutic foster home licensed by the Department. Permanency level is only available in TFOC. Montana Medicaid does not cover the cost of room and board in TFOC.

5.7.1 Program Specific Information

Certificate of Need, (CON)

As required in administrative rule, the CON must certify that:

1. Symptoms of the youth's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service;
2. The youth exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic family care is not provided, or the youth is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting;
3. The prognosis for treatment of the youth's mental illness or emotional disturbance at a less intensive level of care is very poor because the youth demonstrates three or more of the following due to the emotional disturbance or mental illness:
 - a. Significantly impaired interpersonal or social functioning;

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- b. Significantly impaired educational or occupational functioning;
 - c. Impairment of judgment;
 - d. Poor impulse control;
4. As a result of the serious emotional disturbance, the youth exhibits an inability to perform daily living activities in a developmentally appropriate manner;
 5. As a result of the emotional disturbance or mental illness, the youth exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

The provider must submit a completed and valid CON at least two (2) business days prior to placement. When a youth is determined Medicaid eligible as of the time of admission, reviews will not be completed until a valid CON is received. As established in ARM 37.87, the CON for youth determined Medicaid-eligible after admission to or discharge from TFC or TFOC is waived. A retrospective review to determine the medical necessity of the admission to the program and the treatment provided will be completed at the request of the provider.

Prior Authorization (PA) Reviews

Prior authorization is required for TFC and TFOC. Prior Authorization and a CON is required for moderate level TFOC when a youth in permanency level TFOC steps down to moderate level TFOC or when a youth in moderate level TFOC steps up to permanency level TFOC. These services must meet medical necessity criterion and be advantageous to the youth and family.

Continued Stay Review

All TFC and TFOC services that extend beyond the initial authorization date must be authorized through a continued stay review process. Continued stay authorization reviews are based on meeting medical necessity criteria for TFC or TFOC level of care as documented in updated treatment plans, progress notes and recommendations of the individual's treatment team. TFC and TFOC services are intended as a short term to assist the family in developing the skills and ability to meet the therapeutic and behavioral needs of the youth in the home setting.

Retrospective Review

TFC and TFOC services are subject to retrospective review by the UMC as requested by the Department and could be subject to retrospective review when the CON requirement is waived.

Discharge Procedure

Upon discharge of the youth from any service for which prior authorization or continued stay reviews have been performed, the provider must complete a *Discharge Notification* form within five (5) business days after discharge.

5.7.2 Clinical Guidelines

This level of treatment intervention includes consideration of the youth and family's safety and security needs, and the degree of self-care skills demonstrated by the youth. The ability and likelihood of the youth to benefit from a community integrated program is also considered.

TFC and TFOC for youth must be provided by an agency that is licensed by and contracted with the Department of Public Health and Human Services. Moderate therapeutic family care is provided in the youth's biological, adoptive, regular foster care, or kinship home. Permanency and moderate level therapeutic foster care is provided in therapeutic foster homes. Permanency level therapeutic foster care is an intensive therapeutic intervention for the foster family, intended to support the placement to become an adoptive home. Permanency level therapeutic foster care is not available in the youth's biological, regular foster care, kinship, or adoptive home.

Admission Criteria

A request for authorization for TFC or TFOC must include a recommendation by the youth's treatment team that TFC or TFOC is the least restrictive setting appropriate for the clinical need.

The admission criteria include:

1. A covered DSM-IV diagnosis as the primary diagnosis and identification of the youth as having a serious emotional disturbance;
2. Outpatient interventions have been attempted and have been documented to be insufficient to meet the youth's needs and safety concerns;
3. There is a comprehensive and viable discharge plan with an estimated length of stay.

Permanency Level Therapeutic Foster Care

The youth requires intensive care as a result of mental health symptoms and significant behavior problems. The youth must meet at least four (4) of the CON criteria. This level of care is provided in therapeutic foster homes.

Moderate Level Therapeutic Foster Care

The youth and family require assistance with behavior management skills, support, and treatment intervention, to maintain family functioning in the home. The youth must meet at least three (3) of the CON criteria. This level of care is provided in therapeutic foster homes.

Moderate level Therapeutic Family Care

The youth and family require assistance with behavior management skills, support, and treatment intervention, to maintain family functioning in the home. The youth must meet at least three (3) of the CON criteria. This level of care is provided in the youth's biological, adoptive, regular foster care, or kinship home.

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Continued Stay Criteria (for both permanency and moderate levels of TFOC and moderate level TFC)

The youth must continue to meet all of the admission criteria. In addition, all of the following criteria must be met:

1. The youth and family are engaged in treatment and making progress toward treatment goals;
2. The youth's symptoms do not require a more intensive level of care but have demonstrated they are severe enough that a less intensive level of care would be insufficient to meet treatment needs.
3. Demonstrated and documented progress is being made on the comprehensive discharge plan. If changes are made to the discharge plan or date, the provider must give the rationale for the change.

Discharge Criteria

Criteria 1 or 2 must be met:

1. The ITP goals have been sufficiently met such that the youth no longer requires this level of care;
OR
2. The youth voluntarily leaves the program or the youth's parent or legal custodian removes him/her from the program.

5.7.3 List of Required Forms

Certificate of Need (Therapeutic Family Care or Therapeutic Foster Care)

Prior Authorization Request Form (Therapeutic Family Care or Therapeutic Foster Care)

Continued Stay Authorization Request Form (Therapeutic Family Care or Therapeutic Foster Care)

Discharge Notification Form

5.8 Outpatient Therapy Services

Definition

Outpatient therapy services include individual, family, and group therapy in which psychotherapy and related services by a licensed mental health professional acting within the scope of the professional's license or a mental health center in-training mental health professional defined in ARM 37.87.702(3). Outpatient therapy services represent community-based treatment that incorporates Current Procedural Terminology (CPT) codes. Outpatient therapy services may only be provided by individuals licensed by the state of Montana or a mental health center in-training mental health professional. To be reimbursed for outpatient therapy services, the provider must be enrolled in Montana Medicaid.

The department uses both prior authorization and retrospective reviews to monitor outpatient therapy services. Comprehensive School Community Treatment (CSCT) is considered an all-inclusive mental health outpatient service intended to address needs of youth with SED. The department will not reimburse services that appear duplicative. When a youth is enrolled in the CSCT program, additional outpatient therapy services may be retrospectively reviewed for medical necessity. Guidelines and requirements for additional outpatient when a youth is enrolled in CSCT is described in section 5.8.3.

5.8.1 Program Specific Information

Certification of Need

A CON is not needed for outpatient therapy.

Prior Authorization Review

Prior authorization by the department or its designee is required for the following services:

1. Individual or family outpatient therapy services in excess of 24 sessions per state fiscal year. Outpatient therapy services that do not count towards the 24 session limit are:
 - a. Psychiatric Diagnostic or evaluative interview procedures
 - b. Group psychotherapy
 - c. Outpatient psychotherapy with medication evaluation and management services.
 - d. Pharmacological or medication management services.
 - e. Central nervous system assessments/tests or psychological testing performed by a physician or psychologists.
 - f. Outpatient therapy services provided as part of the CSCT service.

Continued Stay Review

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Prior authorization for outpatient therapy in excess of 24 sessions is limited to 90 days. If additional sessions are needed after the first 90 period authorized, a *Continued Stay Authorization Request Form* must be submitted.

Retrospective Review

Outpatient therapy is subject to retrospective review by the UMC or by the Department. It is not subject to retrospective review for lack of a CON since one is not required.

Discharge Procedure

A *Discharge Notification Form* is required, due to the fact that sometimes more than one therapist sees a youth and family concurrently. There may be the need to coordinate the use of the initial 24 visits or those subsequently authorized after 24 sessions. Use of the *Discharge Notification* form would help with coordination of services.

5.8.2 Clinical Guidelines

Individual or family outpatient therapy in excess of 24 sessions

Youth may receive up to twenty-four (24) outpatient sessions per state fiscal year (July 1 – June 30) without prior authorization. For the first 24 sessions, any covered DSM-IV TR diagnosis is sufficient to support payment for this service.

If additional sessions in excess of 24 would benefit the youth and family, the licensed mental health professional must submit a Prior Authorization request to the UMC prior to additional sessions. Section 2.3 of this manual lists the basic information needed for this request. In addition to the basic information, the licensed mental health professional must document the youth meets the clinical guidelines outlined below.

Admission Criteria for outpatient therapy in excess of 24 sessions (first 90 day period)

All five (5) of these criteria must be met:

1. The youth meets criteria for Serious Emotional Disturbance (SED) per (ARM 37.87.303) through a comprehensive mental health assessment that includes a multi-axial diagnosis on Axes I-V and identifies:
 - a. SED diagnosis and current Global Assessment Functioning (GAF);
 - b. Severity specifier of moderate or severe when applicable;
 - c. Specifies, for a period of at least six months, or for a predictable period over six months, the youth consistently and persistently demonstrates behavioral abnormality in two or more spheres (defined in ARM37.87.303), to a significant degree, well outside normative

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- developmental expectations, that cannot be attributed to intellectual, sensory, or health factors;
- d. If under the age of six, meet SED criteria outlined in (ARM 37.87.303);
 - e. Summary of youth's current psychological symptoms and behaviors supporting evidence of SED diagnosis;
 - f. How symptoms and behaviors are being addressed via out-patient therapy services;
 - g. Current Mental Status;
 - h. Current medication if applicable;
 - i. Past and current substance abuse if any;
 - j. Past and current legal involvement if any;
 - k. Other services the youth is receiving.
2. Current symptoms do not meet criteria for a more intensive level of treatment;
 3. A family driven Individualized Treatment Plan (ITP) has been formulated on admission that identifies strength based achievable goals and measurable objectives that are directed toward the alleviation of the symptoms and/or causes that led to the treatment. The youth's response to treatment has been regularly solicited and documented, and revisions in the ITP are consistent with the youth's clinical status;
 4. The youth and family have demonstrated investment in the therapeutic alliance and have agreed the goals/objectives of the ITP;
 5. A discharge plan has been formulated and regularly reviewed and revised. It identifies specific target dates for achieving specific goals, and defines criteria for conclusion of treatment.

Continued Stay Authorization for outpatient therapy in excess of 24 session (after the first 90 day period and for subsequent 90 days periods)

The youth continues to meet all of the Admission Criteria. In addition, all of the following criteria must be met:

1. Progress toward treatment goals has occurred as evidenced by measurable reduction of symptoms and/or behaviors that indicate continued responsiveness to treatment;
2. The youth's symptoms do not require a more intensive level of care;
3. Demonstrated and documented progress is being made on the comprehensive discharge plan and there is an anticipated discharge date;
4. The treatment provider provides clinical rationale for an additional 90 days of treatment to meet ITP and discharge planning goals.

Discharge Criteria

1. The treatment plan goals have been sufficiently met such that the recipient no longer require meets clinical guidelines for this level of care;
- OR
2. The youth voluntarily leaves treatment or parent or legal custodian removes them from the service.

5.8.3 Outpatient therapy services that are provided concurrently with Comprehensive School and Community Treatment (CSCT)

Medical Necessity Criteria for Providing Additional Outpatient Therapy Services When a Youth is Enrolled in CSCT

All criteria must be documented in youth's case records:

1. The youth meets criteria for Serious Emotional Disturbance (SED) per (ARM 37.87.303) through a comprehensive mental health assessment that includes a multi-axial diagnosis on Axes I-V.
2. A specific clinical need must be identified that cannot be addressed by the CSCT therapist. The youth must need a specific or specialized outpatient therapy service in addition to CSCT services (i.e. Trauma therapy; grief therapy etc);

Procedure to Initiate Outpatient Therapy Services When a Youth is Enrolled in CSCT

Providers should do the following:

1. Obtain a Release of Information (ROI) from the youth's legal guardian to the youth's current school.
2. Contact the youth's school to verify a youth's enrollment in CSCT.
3. Make reasonable efforts to coordinate services with the CSCT team.
4. Document at intake any other services being received as reported by the youth/family and request the legal guardian and caregivers notify the provider if the youth enrolls in CSCT services.

5.8.4 List of Required Forms

Prior Authorization/Continued Stay Request Form (Outpatient in Excess of 24 Sessions)
Discharge Notification Form

5.9 Targeted Case Management

Definition

Targeted Case Management (TCM) means services furnished to assist Medicaid eligible youth with Serious Emotional Disturbance (SED) in accessing needed medical, social, educational, and other services. TCM is provided by a licensed mental health center with an endorsement for case management services. TCM services do not require prior authorization. TCM rules and regulations are defined in Federal and state rule. Documented TCM services must comply with all applicable rules and regulations for reimbursement. All reimbursed services are subject to retrospective audits by the department.

TCM may include contacts with non Medicaid eligible individuals who know the youth's needs, are directly involved with the youth, and/or are providing services to the youth and family. Contacts with non-eligible individuals or collateral contacts are allowed for the purpose of helping the eligible youth access services, identifying supports needed to assist the eligible youth in obtaining services, providing useful feedback, and alerting the case manager to changes in the eligible youth's needs.

All case management activities billed must be identified and documented as one of four core functions. The core functions outlined in federal and state rule are 1) assessment/reassessment; 2) care planning; 3) referral/linkage; and 4) monitoring. All TCM activities must address the SED symptoms of the eligible youth. TCM activities may address the family's needs if the need impacts the youth's care.

A brief description of each core area follows:

5.9.1 Comprehensive Assessment and Periodic Reassessment

The TCM assesses the youth's need for medical, educational, social, or other related services, which is the basis for meeting medical necessity criteria for this service. The TCM is expected to assess the needs of the youth/family at admission and every 90 days thereafter to coincide with the service plan review. Assessment activities include the following (per ARM 37.86.3301):

1. Taking client history to include youth/family's strengths;
2. Identifying the needs of the youth/family, and gathering information from other sources such as extended family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

This assessment is not equivalent to a psychiatric, medical, or other specialized evaluation completed by other qualified professionals. This assessment identifies strengths and needs of the youth/families, along with resources and services necessary to implement a youth/family centered individualized care plan.

5.9.2 Development and Periodic Revision of a Specific Care Plan

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TCM aids the youth/family in the development of an individualized care plan based on the information collected through the assessment and ongoing monitoring. The measurable goals, objectives, and actions in the care plan should address medical, social, educational, substance abuse/dependency issues, and other services needed by the youth/family to promote a comprehensive and integrated care plan. The care plan is developed with participation by the youth/family to facilitate the recovery of the youth.

The care plan must:

1. Describe the youth's identified goals and care plan activities within the four core areas. The care plan must be updated every 90 days. Goals identified must aim to address a medical, social, educational, and other services needed by the youth;
2. Describe youth's progress towards identified achievable goals and measurable objectives.

Measureable goals should be: specific, measurable, agreed upon, realistic and time-based.

Include a crisis plan for the youth/family. The plan identifies potential problems that may lead to a mental health crisis, treatment team members and their roles and responsibilities, and documentation that the youth/family agreed to the crisis plan. To meet unscheduled revision criteria, the TCM must document specific examples of how the youth/family demonstrated progress on care plan goals and their likeliness of continued progress.

TCM Care plans for youth with SED must be updated at least every 90 days and must include:

- a. an objective to serve each youth in the least restrictive environment;
- b. identification of the strengths of the youth/family;
- c. a crisis response plan;
- d. a plan for each youth age 16 1/2 and older to transition to adult mental health services; and
- e. a discharge plan from targeted case management services.

5.9.3 Referral and Related Activities

Referral and related activities means making referrals and scheduling appointments and helping to identify individuals and agencies capable of providing needed services. Referral and related activities include:

1. Scheduling appointments to help the youth obtain needed services with medical, social, and educational providers;
2. Making referrals to services to address identified needs and achieve goals specified in the care plan;
3. Assisting the youth/family in identifying and accessing natural supports and community activities to develop a support network, improve self-reliance, and increase social and recreational skills.

5.9.4 Monitoring and Follow-Up Activities

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Monitoring and follow-up activities include activities and contacts needed to implement the care plan effectively. Monitoring may include communication with family members, service providers, or others who address the needs of the youth. Monitoring includes a determination of whether the following conditions are met:

1. Services are being furnished in accordance with the care plan;
2. Services in the care plan are adequate;
3. Changes in the needs or status of the youth/family are identified;
4. Necessary adjustments in the care plan and service arrangements with providers are made.

5.9.5 Non billable Case Management Activities

Federal rule and/or Montana Medicaid prohibit the following activities to be billed as case management:

1. The direct delivery of a medical, educational, social, or other service to which an eligible individual has been referred;
2. Transportation services;
3. Medicaid eligibility determination and redetermination activities which includes outreach, application, and referral activities.
4. Services provided by the case manager while the youth is in a psychiatric residential treatment facility, unless the PRTF contracts for care coordination in accordance with PRTF ARM.
5. Travel to and from youth/family activities.
6. The writing, recording, or entering case notes in a youth/family's file.
7. Coordination of the investigation of any suspected abuse, neglect and/or exploitation cases.
8. Any service less than 8 minutes duration if it is the only service provided that day and any services that does not incorporate the allowable TCM components.

5.9.9 Medical Necessity Criteria for TCM

TCM services must be medically necessary. All billed services are subject to Department review and payment recovery if the following required documentation does not meet state and federal regulations. The department defines medically necessary for TCM services as the following:

1. Youth has a covered DSM-IV TR diagnosis as the principal diagnosis which is identified and verified as meeting criteria for having a serious emotional disturbance;
2. An assessment of the youth's and family's needs has been completed at admission and identifies:
 - a. Youth's and family's strengths, abilities, potentials and skills;
 - b. Mental health treatment needs;
 - c. Substance abuse treatment needs;
 - d. Resources and services necessary to complete an individualized, strengths-based case management plan directed at achieving self-sufficiency for the youth/family;

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3. The TCM Care Plan has been developed within the four core areas with the youth and parent/legal custodian and is updated every 90 days to reflect progress towards identified achievable goals and measurable objectives;
4. The TCM Care Plan includes a crisis plan for youth/family, which is regularly updated and identifies:
 - a. Potential problems that may lead to a mental health crisis;
 - b. Treatment team members and their respective roles and responsibilities;
 - c. Documents that the youth/family have provided input and agree with the plan;
5. A comprehensive and viable discharge plan is developed and reviewed/revised every 90 days.
6. All documented TCM units reflect allowable federal and state activities.

Discharge Criteria

Discharge criteria must meet one of the following:

1. The care plan goals have been sufficiently met in that the youth/family no longer require these services;
2. The youth voluntarily leaves services or the parent/guardian terminates case management services;
3. Youth no longer meets clinical guidelines and medical necessity.

6.9 Therapeutic Home Visits

Definition

A therapeutic home visit is a planned temporary absence available to a Medicaid enrolled youth in a psychiatric residential treatment facility (PRTF), therapeutic group home (TGH) or moderate level therapeutic foster care (TFOC). The youth's plan of care must document the medical need for the therapeutic home visit as part of a therapeutic plan to transition the youth to a less restrictive level of care. The provider's records should also document both staff contact and the youth's achievements or regressions during and following the home visit.

5.10.1 Prior Authorization Review Procedure

All therapeutic home visit (THV) days require prior authorization when the youth is in a PRTF. Prior authorization for a THV in a TGH, or moderate level TFOC is only required when the visit is more than three (3) days. Authorization for THVs must be requested with a *Notification and Authorization Request* form (THV). A THV may not include other therapeutic services during the home visit days, (ie: CBPRS, ENA, OP, etc.), other than responsible staff support from the PRTF, TGH or TFOC provider already authorized to serve the youth. The PRTF THV authorization process is Different than the TGH and TFOC process.

For youth in a PRTF:

The *Notification and Authorization Request* form must be sent either by Fax or web to the UMC at least two (2) business days prior to the first day of the visit, unless the need to visit home is urgent, such as a funeral. In an urgent situation, the form must be sent within 24 hours of learning of the need for an urgent home visit. If the visit will be for more than three (3) days, the Department must approve the visit before it is authorized. For THV requests of over three days, the UMC will forward the *Notification and Authorization Request* form to the Department, and the CMHB will notify the UMC if it is approved. The UMC issues a prior authorization number for all approved THVs.

For youth in a TGH or moderate level TFOC:

Reimbursement will be made to the therapeutic group home or the TFOC provider while the youth is on a therapeutic home visit of three (3) days or less when the provider clearly documents the medical need for it as part of the therapeutic plan to transition to a lower level of care. For home visits of greater than three days, the *Notification and Authorization Request* form must be submitted to the CMHB at least two (2) business days prior to the first day of the visit. The CMHB will notify the provider if the visit is approved.

A youth is allowed a maximum of fourteen (14) days in each state fiscal year for therapeutic home visits.

5.10.2 List of Required Forms

Notification and Authorization Request Form (Therapeutic Home Visit)

6.10 Community Based Psychiatric Rehabilitation and Support Services (CBPRS)

This service is provided for a short period of time, generally 90 days or less, (unless the youth is in the PRTF waiver) to youth with SED who are at risk of out of home or residential placement or risk of removal for their current setting for youth under six years of age. CBPRS is provided face-to-face by qualified staff from a licensed mental health center as defined in ARMs 37.87.702 and 37.87.703, as part of a comprehensive treatment plan to assist the youth to improve functioning in one or more impaired areas identified in the SED definition. Both individual and group CBPRS is reimbursed in fifteen (15) minute units.

Group CBPRS may not exceed the following limits:

- a. up to a maximum of two hours per day, (unless the youth is in the PRTF waiver);
- b. up to a maximum of eight youth per group; and
- c. up to a staff ratio of four youth to one staff.

Other limitations include that CBPRS may only be provided when the youth is receiving other mental health services and that CBPRS:

- 1. must be prior authorized when it is provided during day treatment (Day Tx) hours for a youth in the PRTF waiver. (CBPRS is only allowed in Day Tx when prior authorized for youth in the PRTF waiver) ;
- 2. may not be provided during the program hours that Day Tx, PHP, or CSCT are provided;
- 3. may not be provided during program hours for Acute Psychiatric Hospital care, in a Psychiatric Residential Treatment Facility, Therapeutic Group Home, or with Permanency level Therapeutic Foster Care.

CBPRS (both individual and group), does not require prior authorization when provided on the same day as Day Tx, CSCT, or PHP services if CBPRS is provided before or after program hours, and the documentation supports the service was provided before or after these program hours. The youth's behaviors must meet the CBPRS requirements in ARM 37.87.702.

5.11.1 Prior Authorization Request Procedure

To request prior authorization of CBPRS services for a youth in the PRTF Waiver during Day Treatment program hours, the day treatment clinical staff must complete the department's Prior Authorization Request Form (CBPRS/ Day TX/PRTF waiver) and document the medical need for the service. The form may be obtained from the Children's Mental Health Bureau, P.O. Box 4210, Helena, MT 59604- 4210 or on the department's website: www.dphhs.mt.gov/mentalhealth/children/index.shtml.

The Prior Authorization Request Form (CBPRS/ Day TX/PRTF waiver) may be either faxed or mailed to the PRTF Waiver Plan Manager for the service area where the youth resides:

Yellowstone and surrounding Counties: Fax: (406)254-7305
PRTF Waiver Plan Manager, 1523 14th St. Suite 2, Billings, MT 59102

Missoula and Ravalli Counties: Fax: (406)[329-1332](tel:4063291332)

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PRTF Waiver Plan Manager, 2685 Palmer Suite E, Missoula, MT 59808

Lewis and Clark and surrounding Counties: Fax: (406)444-5940
PRTF Waiver Plan Manager, PO Box 4210, Helena, MT 59620

Cascade County: Fax: (406)454-6096
PRTF Waiver Plan Manager, 201 1st Street So. #3, Great Falls, MT 59405

The request form must include sufficient information to justify the need for CBPRS during Day Tx program hours for youth in the PRTF waiver. The Plan Manager will notify the provider in writing within three (3) business days whether the request has been approved and if so, will indicate the amount and duration of CBPRS approved and the prior authorization number to be used when billing

5.11.2 Clinical Guidelines

Admission Criteria for CBPRS provided during Day TX program hours for youth in the PRTF waiver.

A current behavioral assessment describing the functional behavior problems, which must be completed within the past 90 days by the program supervisor or program therapist, and a current treatment plan that includes the CBPRS rehabilitation goals for the youth must be submitted with the request. The behavioral assessment must include, but is not limited to:

1. A summary of current unmanageable behaviors, including a detailed description of the youth's unmanageable behaviors;
2. Justification of the need for additional staffing. Explain why the regularly scheduled staff cannot manage the youth's unmanageable behaviors;
3. Frequency of unmanageable behaviors to justify the number of CBPRS hours requested;
4. A detailed transition plan to decrease and/or terminate the CBPRS services.

Continued Stay Criteria for CBPRS during Day TX program hours for youth in the PTRF waiver.

1. Continues to meet admission criteria;
2. Demonstrates progress towards identified rehabilitation goals and the reasonable likelihood of continued progress;
3. Demonstrated and documented progress is being made to implement an adequate discharge and transition plan and a clinical rationale for any recommended changes in the transition plan or anticipated transition date.

511.3 List of Required Forms

Prior Authorization Request Form (CBPRS/ Day TX/PRTF waiver)

5.12 Extraordinary Needs Aide Services (ENA)

Definition

Extraordinary needs aide (ENA) services are prior authorized additional one-to-one, face-to-face, intensive short-term behavior management and stabilization services provided in therapeutic group homes (TGH) by TGH staff or in day treatment (Day Tx) by TGH staff for youth with serious emotional disturbance (SED). Short-term generally means 90 days or less. ENA services may only be provided by in state licensed therapeutic groups homes enrolled in Montana Medicaid.

5.12.1 Prior Authorization Request Procedure

To request prior authorization of ENA services, the Lead Clinical Staff must complete the department's ENA request form and document the medical need for the service. The form may be obtained from the Children's Mental Health Bureau, P.O. Box 4210, Helena, MT 59604- 4210 or on the department's website at www.dphhs.mt.gov/mentalhealth/children/index.shtml. Prior Authorization Form (Extraordinary Needs Aide) may be either faxed or mailed to the Children's Mental Health Bureau at:

111 Sanders Room 307
Helena, MT 59601
(FAX) 406-444-0230

Admission Criteria for ENA Services

ENA services are provided for youth in a TGH who exhibit extreme behaviors that cannot be managed by the TGH staffing required by licensure ARM 37.97 , and who do not require services in a higher level-of-care. These services may be requested if the youth has extreme behaviors that are current, moderately severe, and consist of documented incidents that are symptoms of the youth's SED. These behaviors are either frequent in occurrence, or at risk of becoming a serious occurrence, and include one or more of the following behaviors:

- (1) Harming self or others;
- (2) Destruction of property; or
- (3) A pattern of frequent extreme physical outbursts.

Continued Stay Criteria for ENA Services

1. Continues to meet admission criteria;
2. Demonstrates progress towards identified treatment goals and the reasonable likelihood of continued progress;
3. Demonstrated and documented progress is being made to implement an adequate transition plan and there is clinical rationale for any recommended changes in the transition plan or anticipated transition date.(Transition from ENA staffing to regular staffing.)

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If a continued stay authorization is requested, a new ENA request form must be completed prior to the end of the authorization period with an updated behavior assessment, plus a description of the behavior problems with new goals and objectives. ENA requests are reviewed on a case-by-case basis by the department or its designee to determine the medical need for the service and the number of units to be authorized. One unit of ENA service equals one hour. If the information on the ENA request form is incomplete, the request will not be reviewed.

ENA services must be provided according to measurable goals and objectives identified in the TGH treatment plan. ENA staff are supervised by the TGH lead clinical staff (LCS). The LCS is defined in licensure ARM 37. 97.

5.12.3 Required Form

Authorization Request form (Extraordinary Needs Aide)

6.0 ADDITIONAL INFORMATION

6.1 DEFINITION OF TERMS

ARM: Administrative Rules of Montana

Administrative Denial: See “Technical Denial”

Appellate physician: The physician, usually a board-certified psychiatrist, who performs the reconsideration review when that review is requested after a denial based on not meeting medical necessity criteria.

Authorization: Determination indicating the utilization review resulted in approval of all provider requested services and/or service units and a prior authorization (PA) number is issued.

Appeal: Legal custodian or provider challenge of a denial. An appeal includes the use of the following processes: Reconsideration Review; Administrative Review; or Fair Hearing.

CFR: Code of Federal Regulations

Certificate of Need (CON): A Certificate of Need (CON) is a state and/or federal requirement for medical necessity documentation. The CON process is not a guarantee of Medicaid eligibility. The provider must verify separately that the youth is eligible for Medicaid.

Clinical Guidelines: The written Montana protocols that define “medical necessity criteria” used to make clinical review determinations.

Concurrent Services: Services provided on the same day.

Continued Stay Authorization Review: A review of currently delivered treatment conducted to determine the medical necessity of continuing with the current level of care. Time frames for review vary across services.

Deferred to the physician: The clinical reviewer is unable to make a determination based on applying the clinical guidelines, so the authorization request is forwarded to the psychiatrist to review. Only a psychiatrist can make an adverse determination.

Denial: Request for authorization does not meet the appropriate Medicaid medical necessity criteria to justify Medicaid payments for the services requested. Authorization for payment is denied. Only a psychiatrist may issue a denial.

Denied with less than requested days (Prior Authorization Request only): Denied with less than requested days is considered an adverse payment determination indicating that the request does not meet the appropriate clinical guidelines to justify Medicaid payments for the level or complete duration of services requested. Only a psychiatrist may issue a denial with less than requested days. Denials are

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subject to the 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 initiated.

Denied with additional days to complete discharge plan (Continued Stay Authorization Request only):

Denied with additional days to complete discharge plan is considered an adverse payment determination indicating that the request does not meet the appropriate clinical guidelines to justify Medicaid payments for the level or complete duration of services requested. Only a psychiatrist may issue a denial with additional days to allow the provider to complete the discharge plan. Denials are subject to the 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.

Department, the: Montana Department of Public Health and Human Services

Desk Review: Process by which an appellate physician reviews both the clinical information provided in the record as well as additional information submitted by a provider. The appellate physician makes no other contact.

Elective Admission: Elective admission is a scheduled admission that is subject to the choice or discretion of the youth's legal custodian and is not considered necessary to prevent death or disability.

Emergency Admission: 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 youth, or harm to another person by the individual.

Fax or Web Based Review: An evaluation in which the clinical reviewer performs a requested review submitted via fax or electronically. There are three review types: Prior Authorization, Continued Stay, and Retrospective.

Guardian: The youth's parent, legal custodian, or guardian ad litem.

Peer-to-Peer Review: A telephonic or face-to-face discussion about a youth's medical necessity/clinical information. This may be requested by the provider instead of a desk review. The appellate physician still reviews clinical information provided in the record as well as any additional information submitted by the provider. This is scheduled to accommodate the provider when possible.

Pending Authorization: Indicates that a UMC reviewer or psychiatrist has requested additional information from the provider. The provider will have five (5) business days to provide any additional information requested to make a payment determination.

Prior Authorization Review: Reviews are performed by the UMC for selected services prior to authorizing recommendation for payment and generating a prior authorization (PA) number.

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Relevant Parties: These include the Medicaid youth, the youth's family or legal custodian, the requesting provider, and the Department.

SED: Severe emotional disturbance. See ARM 37.87.303 for definition of this term.

Technical Denial: (Also termed Administrative Denial) A prior authorization review was not administered on medical necessity criteria as a result of provider non-compliance with protocol. Non-compliance indicates that the request and/or information was out of specified timeframes or was incomplete.

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6.2 LIST OF FORMS :

(The most current version of each form is at: www.dphhs.mt.gov/mentalhealth/children)

1. Certificate of Need (Acute Inpatient Hospital/PRTF/PRTF-AS)
2. Certificate of Need (PRTF Waiver Program)Certificate of Need (Partial Hospital Program)
3. Certificate of Need (Therapeutic Group Home)
4. Certification of Need (Therapeutic Family Care and Therapeutic Foster Care)

5. Prior Authorization Request Form (Acute Inpatient Hospital)
6. Prior Authorization Request Form (Partial Hospital Program)
7. Prior Authorization Request Form (PRTF)
8. In-State PRTF Denial Letter
9. Interstate Compact Form – available at:
<http://www.dphhs.mt.gov/forms/results.jsp?catchoose=2&keywords>
10. PRTF Waiver Program Referral Form
11. Prior Authorization Request Form (Therapeutic Group Home)
12. Prior Authorization Request Form (Therapeutic Family Care/ Therapeutic Foster Care)
13. Prior Authorization/Continued Stay Request Form (Outpatient In Excess of 24 sessions)
14. Prior Authorization/Continued Stay Request Form (Outpatient Concurrent with CSCT)
15. Prior Authorization Request Form (CBPRS/ Day TX/PRTF waiver)
16. Prior Authorization Request Form (ENA services)
17. Prior Authorization Form (Targeted Youth Case Management)

18. Continued Stay Authorization Request Form (PRTF)
19. Level of Care Re-determination Request Form (PRTF Waiver Program)
20. Continued Stay Authorization Request Form (Partial Hospital)
21. Continued Stay Authorization Request Form (Therapeutic Group Home)
22. Continued Stay Authorization Request Form (Therapeutic Family / Therapeutic Foster Care)
23. Unscheduled Revision Request Form (Targeted Youth Case Management)

24. Authorization Request Form (Therapeutic Home Visit)
25. Discharge Plan Review Form
26. Discharge Notification Form
27. Correction to Youth Information Form
28. Administrative Review Request Form