Policy and Procedure

DEPARTMENT: Trillium Behavioral Health	**DOCUMENT NAME**: Acute and Long-Term Psychiatric Hospitalization
PAGE: 1 of 10	**REPLACES:** NA
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PRODUCT TYPE: Medicare, Medicaid and OHP	**REFERENCE NUMBER:** NA

A. Purpose

Trillium Behavioral Health (TBH) has written Utilization Management (UM) decision making clinical criteria to assist licensed UM staff make level of care (LOC) determinations for Acute Care and Long-Term Psychiatric Hospitalization services.

B. Policy

1. Clinical criteria for psychiatric acute care include:

- **1.1.** Behaviors, or behavioral threats posing imminent harm to self or others;
- **1.2.** Behaviors must be occurring at the time the request for psychiatric hospitalization is made.
- **1.3.** Acute care requests are initiated by:
  - **1.3.1.** Trillium member's current qualified mental health practitioner (QMHP),
  - **1.3.2.** Discharge plan from an emergency department, or
  - **1.3.3.** A licensed behavioral health practitioner (LBHP).
- **1.4.** A Diagnostic and Statistical Manual of Mental Disorder (DSM) and International Classification of Diseases (ICD) covered diagnosis supported by behavioral health assessment information to make:
  - **1.4.1.** Level of care (LOC) determination based on:
    - **1.4.1.1.** Treatment history,
    - **1.4.1.2.** Degree of impairment,
    - **1.4.1.3.** Current symptoms,
    - **1.4.1.4.** Community supports, and
    - **1.4.1.5.** Medical appropriateness to support DSM ICD covered diagnosis.

2. Appropriate available treatment environment characterized by:

- **2.1.** The most normative,
- **2.2.** Least restrictive,
- **2.3.** Least intrusive,
- **2.4.** Culturally and linguistically appropriate,
- **2.5.** Evidenced based and/or evidence informed, and
- **2.6.** Extent of family and community supports.

C. Procedure

1. Referrals:

- **1.1.** Referred member must be enrolled in Trillium Community Health Plan.
- **1.1.** If Trillium member is at immediate risk of acute medical care without intervention member is directed to medical services.

2. Prior authorization (PA) submission required by provider within two (2) business days of admission for coverage from the first date of service to include anticipated length of stay.

- **2.1.** All initial (certification) and concurrent (recertfication) Acute and Long-term Hospitalization PA requests are processed by TBH as urgent concurrent decisions within twenty-four hours.
- **2.2.** Retroactive authorization requests may be considered and will be reviewed to determine whether the reason for the request meet criteria as defined in Trillium's Retroactive Authorization process.

3. Acute hospital facility must submit:

- **3.1.** Current behavioral health assessment or addendum information completed by a licensed medical professional (LMP), including sufficient biopsychosocial information to support the presence of a Diagnostic and Statistical Manual of Mental Health (DSM) and International Classification of Diseases (ICD) diagnosis for medically appropriate services,
- **3.2.** Discharge planning information to include:
  - **3.2.1.** Voluntary discharge, or
  - **3.2.2.** Voluntary or civil commitment due to severe mental disorder , and
  - **3.2.3.** Need for specialized care and/or treatment available in an acute state or inpatient psychiatric hospital and not otherwise available to the patient in a community-based program, and failure to receive it would result in serious harm, and
  - **3.2.4.** One (1) of the following:
    - **3.2.4.1.** Member is determined to be imminently dangerous as evidenced by:
      - **3.2.4.1.1.** High risk for self destructive acts secondary to severe psychiatric symptoms, or
      - **3.2.4.1.2.** Significant life-threatening attempt to harm self or others within the past twenty-four (24) hours with continued imminent risk, or
      - **3.2.4.1.3.** Specific plan to harm self or others with clear intention, high lethality, and availability of means.

3.2.4.1.4. Member is unable to provide for basic needs and personal welfare due to their mental status;

3.2.4.1.5. Member's impairment of judgment, impulse control, and/or perception arising out of an acute mental disorder, indicates the need for hospital-level continuous monitoring and intervention to stabilize;

3.2.4.1.6. There is no less restrictive setting that is appropriate to address the member's clinical needs.

3.2.5. After care supports and needs information.

4. When initial (certification) request is approved:

4.1. Initial (certification) PAs authorized for appropriate length of stay as determined by InterQual Criteria review.

4.1.1. UM or CM staff may attend hospital based staff meetings and review records from the hospital as appropriate.

4.2. Certification (initial authorization) is necessary indicating that acute psychiatric services are required for:

4.2.1. Treatment that could reasonably be expected to improve the member's condition, or

4.2.2. For diagnostic study.

5. When concurrent (recertification) request is approved:

5.1. Concurrent (recertification) authorization for longer than initial approval date range, authorized for appropriate length of stay as determined by InterQual Criteria and, based on submitted updated clinical justification including:

5.1.1. Ongoing risk of imminent danger to self or others,

5.1.2. Length of stay is medically necessary, and

5.1.3. Measureable expected outcome.

5.2. Evidence of discharge planning since day two (2) of admission with clinical progress information and progress towards meeting discharge goals. Recertification (concurrent) documentation must indicate:

5.2.1. Acute care services since the previous certification or recertification continue to be required for:

5.2.1.1. Treatment that could reasonably be expected to improve the member's condition, or

5.2.1.2. For diagnostic study.

6. Long-Term Hospital

6.1. Screening occurs when:

6.1.1. Acute hospital staff refers Trillium member for screening to the Oregon State Hospital (OSH) or Secure Adolescent Inpatient (SAIP) or Secure Child Inpatient (SCIP) when acute care does not alleviate intensity of symptoms and/or functional impairment.

6.2. When Trillium member is approved for long-term hospitalization, Trillium Medicaid and/or OHP coverage terminates. Reimbursement and utilization review occurs through Oregon Health Authority (OHA) Health Systems Division (HSD).

6.3. When Medicare member is approved for long-term hospitalization:

6.3.1. Member maintains enrollment with Trillium Medicare, and

6.4. Long-term hospital facility requests authorization for Trillium Medicare members by submitting PA and clinical information to support medical necessity for the level of care. Clinical information must include,

6.4.1. Psychiatric evaluation within 60 hours of admission to include provisional or admitting diagnosis, medical history, record of mental status, noted onset of illness and circumstances leading to admission, member's legal status, description of attitudes and behavior, estimate of intellectual functioning and orientation, and social and treatment history. and

6.4.2. Evidence the services furnished are provided under an individualized treatment or diagnostic plan, can reasonably be expected to improve the member's condition or for the purposed of diagnosis, and are supervised and evaluated by physician.

6.4.2.1. An individual comprehensive treatment plan must,

6.4.2.1.1. Be based on an inventory of the member's strengths and disabilities, and

6.4.2.1.2. Include a substantiated diagnosis, short-term and long-range goals, the specific treatment modalities utilized, the responsibilities of each member of the treatment team, and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried.

6.4.2.1.3. Be designed both to reduce or control member's psychotic or neurotic symptoms that necessitated hospitalization and improve the member's level of functioning.

6.4.3. If approved, TBH UM staff authorizes initial certification requests for long-term hospitalization level of care for up to twelve (12) days.

6.5. Recertification Review:

6.5.1. Facility must submit updated clinical information to support medical necessity for this level of care to be approved.

6.5.2. TBH UM staff authorizes each recertification request based on additional clinical information, for up to twelve (12) days.

6.6. Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

6.6.1. Delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay.

7. TBH Licensed Utilization Management (UM) staff:

7.1. Review assessment information,

7.2. Ensure DSM and ICD supported diagnosis, and

7.3. Determine LOC.

7.4. Review applicable information,

7.5. Consider how services will fall within the definition of medical necessity per Oregon Administrative Rules (OARs),

7.6. Use InterQual Criteria or other applicable guidelines,

7.7. Coordinate admissions to and discharges from Acute Inpatient Hospital Psychiatric Care and Sub-Acute Care for Members 17 and under, including members in the care and custody of DHS Child Welfare or OYA.

7.7.1. For a member 17 and under, placed by DHS Child Welfare through a Voluntary Placement Agreement (CF 0499), UM staff shall also coordinate with member's parent or legal guardian.

7.8. Refer to TBH Care Coordination (CC), Care Management (CM), or Complex Care Management (CCM) staff, when necessary to:

7.8.1. Ensure members are transitioned out of hospital settings into the most appropriate, independent and integrated community settings, and

7.8.2. Ensure the provision of care coordination, treatment engagement, preventative services, community-based services, and follow-up services for all members' health conditions.

7.8.3. Monitors PreManage on a daily basis for all hospital admits.

8. Expected outcome and discharge planning to lower level of care considers the following factors:

8.1. Stabilization/improvement of symptoms,

8.2. Less restrictive LOC services are determined to be clinically appropriate, and

8.3. Prevention of higher LOC services.

9. Acute and Long-Term Hospital stays exceeding eight (8) calendar days will be reviewed by a Medical Director or board-certified consultant as evidenced by Clinical Note in TruCare summarizing case staffing.

10. Provider must notify TBH UM staff of discharge plan in writing within forty-eight (48) hours of discharge.

11. When request is denied:

11.1. If the initial (Certification) or concurrent (Recertification) review of the authorization request is determined not to meet criteria, practitioner is notified within determination timelines by TBH UM staff.

11.2. When the decision is to deny request, practitioner may request an expedited appeal if he/she disagrees with the determination.

12. When request is returned to sender:

12.1. Upon review, the authorization is determined to be incomplete due to missing one or more of the following required components:

12.1.1. Member identifying information,

12.1.2. Requesting and Servicing Provider information (i.e. Tax ID number, National Provider Identifier (NPI) number),

12.1.3. Start date and end date for services,

12.1.4. ICD diagnostic code(s),

12.1.5. Billing code(s),

12.1.6. Number of units/visits/days for each billing code.

12.2. Upon review, no authorization is required per the ARQ for participating providers.

12.3. Upon review, the member is ineligible for Trillium coverage for all dates of service requested.

12.4. Upon review, the request does not meet one of the following exceptions for acceptance of a retroactive request:

12.4.1. Catastrophic event that substantially interferes with normal business operations or a provider, or damage or destruction of the provider's business office or records by a natural disaster.

12.4.2. Mechanical or administrative delays or errors by the Contractor or State Office.

12.4.3. Provider was unaware that the member was eligible for services at the time that services were rendered and the following conditions are met:

12.4.3.1. The provider's records document that the member refused or was physically unable to provide the Recipient Identification Number.

12.4.3.2. The provider can substantiate that he/she continually pursued reimbursement from the patient until eligibility was discovered.

12.4.3.3. The provider submitted the request for authorization within 60 days of the date the eligibility was discovered (excluding retro-eligibility).

12.5. Upon review, the member has Third Party Liability or other primary insurance. Via return to sender, provider is notified Trillium coverage is payer of last resort and no authorization is required to submit claims for dates of service also covered by primary insurance. If primary insurance denies service, Trillium authorization can be initiated with inclusion of evidence of primary insurance denial.

12.6. Prior to returning the request, two attempts will be made to obtain the missing information for Trillium member requests and three attempts will be made to obtain the missing information for Medicare member requests**.**

D. Definitions

Word / Term	Definition
Acute	Abrupt onset, short in duration, rapidly progressive, and in need of urgent care.
ARQ	Authorization Required Qualifier.
Care Coordination (CC)	For members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Typically non-clinical activities with assistance from clinical staff if minor medical or behavioral health concerns arise. Services include outreach to member, appointment scheduling assistance, securing authorizations assistance and follow up to ensure compliance.
Care Coordination (CC) Staff	Non-licensed UM staff.
Care Management (CM)	For members needing a higher level of service with clinical needs. Members may have a complex condition or multiple co-morbidities generally well-managed, adequate family or other caregiver support, and in need of moderate to minimal assistance. Services include level of coordination along with identification of member agreed upon goals and progress toward meeting goals.
Care Management (CM) Staff	Licensed UM staff.
Centers for Medicare and Medicaid Services (CMS)	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Word / Term	Definition
Child	a person under the age of 18. An individual with Medicaid eligibility, who is in need of services specific to children, adolescents, or young adults in transition, must be considered a child until age 21 for purposes of these rules.
Clinical Criteria	Written decision rules, medical protocols, or guidelines used as an element in evaluation of medical necessity and appropriateness of requested medical and behavioral health care services.
Complex Care Management (CCM)	High-level of care management services for members with complex needs, including children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those non-adherent in less intensive programs; frail elderly, disabled, or end of life; experienced a critical event or have a complex diagnosis requiring oversight and coordination. Services include CM and CC for issues listed above, along with more frequent outreach to member to assess service plan compliance and progress toward goals. Key indicators of disease progress, e.g. HbaA1c levels and medication adherence will be monitored.
Complex Care Management (CCM) Staff	Licensed UM staff.
Contingent Prior Authorization	A blank ARQ alerting billing system an authorization could be required depends on whether member and category of service are covered by member's benefit plan.
Crisis	Either an actual or perceived urgent or emergent situation that occurs when an individual's stability or functioning is disrupted by mental health symptoms and there is an immediate need to resolve the situation to prevent a serious deterioration in the individual's mental health, ability to maintain safe behaviors, and/or to prevent a significantly higher level of care.
Diagnostic and Statistical Manual of Mental Disorders (DSM)	Standard classification of mental disorders used by mental health professionals in the United States, consisting of three major components: 1) Diagnostic classification; 2) Diagnostic criteria sets; 3) Descriptive text.
Health Systems Division	Formerly known as Division of Medical Assistance Programs (DMAP)
ICD	The International Classification of Diseases.
Level of Care (LOC)	The type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.
Level of Care Determination	The standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.
Licensed Behavioral Health Practitioner (LBHP)	Doctoral-level clinical psychologist or psychiatrist.
Licensed UM Staff	Licensed Behavioral Health UM staff are: • Behavioral Health Care Coordinators (QMHPs), Doctoral-level clinical psychologists, and psychiatrists.
Medical Necessity	Medical necessity decisions are: • Decisions about covered medical benefits, including hospitalization and emergency services listed in Evidence of Coverage and/or Summary of Benefits. • Decisions about care or services that could be considered either covered or non-covered, depending on circumstances, including decisions on requests for care that may be considered experimental. • Decisions about pharmacy-related requests regarding step-therapy or prior authorization cases.

Word / Term	Definition
Mental Health Assessment	A process in which the person's need for mental health services is determined through evaluation of the patient's strengths, goals, needs, and current level of functioning
Participating Provider	A physician, hospital or other licensed healthcare facility or licensed healthcare professional duly licensed in the State of Oregon, credentialed in accordance with Trillium's policies and procedures, who has entered into an agreement with Trillium to provide covered services to members.
Post Service Decision	Assessing appropriateness of behavioral health services on a case-by-case or aggregate basis after services were provided. Retro authorization and claims payment requests are post service decisions.
Pre-service Decision	Any care or service TBH must approve, in whole or in part, in advance of the member obtaining behavioral healthcare or services. Pre-authorization and pre-certification are pre-service decisions.
Prior Authorization (PA)	Prior assessment that proposed services are appropriate for a particular patient and will be covered by TBH. Payment for services depends on whether member and category of service are covered by member's benefit plan.
Psychiatric Emergency	An imminent threat to life or serious bodily injury to self or others resulting from a severe mental disorder
Qualified Mental Health Professional (QMHP)	An LMP or any other individual meeting the minimum qualifications as authorized by the Licensing Mental Health Authority or designee. Person demonstrating the ability to conduct an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, conducting a mental status examination, complete a DSM diagnosis; conducting best practice suicide risk assessments, lethal means counseling, and safety planning; writing and supervising the implementation of a Service Plan; and providing individual, family or group therapy within the scope of their training. (a) QMHPs shall meet the following minimum qualifications: (A) Bachelor's degree in nursing and licensed by the State or Oregon; (B) Bachelor's degree in occupational therapy and licensed by the State of Oregon; (C) Graduate degree in psychology; (D) Graduate degree in social work; (E) Graduate degree in recreational, art, or music therapy; or (F) Graduate degree in a behavioral science field; or (G) A qualified Mental Health Intern.
Respite Care	Planned and emergency supports designed to provide temporary relief from care giving to maintain a stable and safe living environment. Respite care can be provided in or out of the home. Respite care includes supervision and behavior support consistent with the strategies specified in the Service Plan.
Utilization Management (UM)	Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to patient, in cooperation with other parties, to ensure appropriate use of resources.
Utilization Management (UM) Staff	Licensed or Non-licensed UM staff.

E. Regulatory or Administrative Citations

Name	Citation Reference
CCO and OHP 2018 Contract	Provision of Covered Service
	B.2.2.c.(1-6)d.
	Authorization or Denial of Covered Services
	B.2.3.
	Covered Services
	B.2.4.a.3.
	B.2.4.b.2.(a-e)
	B.2.4.i.2.(a-g)
	B.2.4.j.1.
	Integration and Care Coordination
	B.4.1
	Delivery System and Provider Capacity
	B.4.3.a.3
	Mental Health Parity
	E.23.
Code of Federal Regulations	422.101(b)(1)-(5)
	422.566
Current NCQA Health Plan Standards and Guidelines	UM 2:C Clinical Criteria for UM Decisions
	UM 4: A, B, D, F, G Appropriate Professionals
	UM 5: C,D Timeliness of UM Decisions
	UM 6:B Relevant Information for Behavioral Health Decisions
	UM 7: D, E, F Denial Notices
Medicare Managed Care Manual	Chapter 2 (20, 30)
	Chapter 4 (20)
	Chapter 13 (40.1)
Oregon Administrative Rules	309.032.0850
	309.032.0870
	309.091.0015
	309.091.0025
	410.141.3160
	410.172.0630
	410.172.0650
Oregon Regulatory Statute	430.630
	430.644

F. Related Material

Name	Location
InterQual Criteria 2017	TruCare Database

G. Revisions Log

Type	Date
Merged Policy and Procedure into one document	11-16-17
Updated Definition List	12-1-17
Added discharge written planning notification timeline for 48 hrs of discharge.	12-1-17
Revised procedure to work in Medicare terminology throughout	12-14-17
Revised Section 2 of Procedure for PA process clarity	12-14-17
Revised Section 3 to include involuntary discharge language	12-14-17
Added Return to Sender language	2-5-18
Added CCO and OHA Contract Citations	2-5-18