

General Hospital Prior Authorization Manual For Inpatient Psychiatric & Substance Abuse Units

General Hospital Prior Authorization for Inpatient Psych./Sub. Abuse Units Process Overview

APS Healthcare will implement a system of prior authorization for all admissions to general hospital psychiatric and substance abuse units.

1. This system will be operational 7/1/09
2. All general hospitals with psychiatric and substance abuse units will be required to obtain a prior authorization from APS Healthcare in order to bill MaineCare for inpatient psychiatric and/or substance abuse services.
3. All admissions of MaineCare members, for whom claims will be submitted by the hospitals, are subject to Prior Authorization (PA) approval by APS Healthcare.
 - a. Involuntarily committed members will be approved for admission.
4. Hospital PA requests must be submitted by telephone
 - a. All non-scheduled hospital PA requests will be considered “emergency” by APS Healthcare. For telephonic reviews:
 - b. The hospital will present the PA request to the APS Healthcare clinician.
 - c. The APS Healthcare clinician will enter the clinical presentation for the PA into APS CareConnection®.
 - d. The APS Healthcare clinician will make a determination of whether to approve the request or refer it to an APS Healthcare Physician Advisor for review.
 - e. The Physician Advisor Emergency Review process and time frames described in the APS Healthcare contract will apply.
 - f. Approval will be verbally issued to the hospital at the time of the call (unless referred to the Physician Advisor).
 - g. Approval will also be transmitted to the hospital via the download notification the next calendar day.
5. Hospitals have up to 72 hours after admission to submit a PA request.
 - a. **If the PA request is submitted after the admission, the hospital will not be compensated for any part of the admission, or resulting hospital stay, if the request is denied.**
6. Hospital PA telephone requests that are made to APS Healthcare after business hours, on weekends, holidays or days that the office is closed due to inclement weather will be routed by auto-attendant to the APS Healthcare “after hours” national clinical network coverage for review by an APS Healthcare clinician.
7. APS Healthcare will submit a report to DHHS to be used in the hospital cost settlement process to ensure that all paid claims have been properly authorized prior to admission.

General Hospital Prior Authorization for Inpatient Psych./Sub. Abuse Units
Instructions for Clinical Submissions

To obtain Prior Authorization for Hospital Admissions:

1. The hospital will contact APS Healthcare at 1-866-521-0027 and choose the numeric prompt for Hospital Prior Authorization
2. All hospital PA requests will be considered “emergency” by APS Healthcare. The hospital will present the PA request to the APS Healthcare clinician. The APS Healthcare clinician will enter the clinical presentation for the PA into APS CareConnection® which will require the following information.

Administrative Information

- a. Member Information (please include at least two identifiers, MaineCare ID preferable)
- b. Guardianship information (if applicable)
- c. Name/Contact Information of requesting Staff and Facility
- d. Confirmation of Billing Provider MaineCare ID

Clinical Information

- e. Presenting problem (Why now?):
- f. Mental Status Exam: (Mood, Affect, Thought Process/Content, Perceptual Disturbances, Alertness/Orientation, Insight)
- g. Arrived at ER via: (Therapist, Crisis Worker, Police, etc)
- h. Attending Physician and contact information
- i. Diagnosis
 - a. Axis I:
 - b. Axis II:
 - c. Axis III:

d. Axis IV:

e. Axis V:

j. Barriers to Discharge:

k. Clinical Decision/Rationale

Brief Psychosocial History (If known)

l. Prior Psychiatric History: (Therapists, Inpatient/OP TX, Prior Suicide Attempts/Methods)

m. Agency Involvement if known: (DHHS Adult MH, DHHS Elder Services, DHHS Child Welfare, Corrections, etc.)

n. Medications:

o. Current Medical Issues:

p. Labs Relevant to Admission:

q. Current Legal Issues:

r. Current Psychosocial Issues:

s. Family History of MH or S/A Issues:

t. ELOS:

u. Discharge Plan:

3. The APS Healthcare clinician will make a determination of whether to approve the request or refer it to an APS Healthcare Physician Advisor for review based on Hospital Admission Criteria.

a. If the APS Healthcare clinician approves the request, a verbal authorization will be provided at the time of the call with an authorization/APS Case ID number. Authorizations will also be available in CareConnection® immediately and will also appear in the Download notification. Authorizations will be for 30 days and 1 unit.

b. If the APS Healthcare clinician determines that a second layer of review is needed, this notification will also be provided at the time of the call and will appear in the Download notification. The review will be placed into HOLD for MD status and will

be transferred for review by a Physician Advisor. The Physician Advisor Emergency Review process and time frames, as required by DHHS, will apply.

c. If the APS Healthcare Physician Advisor does not authorize admission, the hospital can request a reconsideration at the time of the call and a third layer of review will take place by a different APS Healthcare Physician. The Physician Advisor Emergency Review process and time frames, as required by DHHS, will apply.

4. Hospital PA telephone requests that are made to APS Healthcare after business hours, on weekends, holidays or days that the office is closed due to inclement weather will be routed by auto-attendant to the APS Healthcare “after hours” national clinical network coverage for review by an APS Healthcare clinician

5. If a member is at inpatient Level of Care beyond the authorized end date, please follow step one and an APS Healthcare clinician will extend the authorization for and additional 30 days and 1 unit. Additional clinical information is not necessary.

6. Hospitals are responsible for discharging members from APS CareConnection®. Please refer to APS CareConnection® Discharge Instructions.

- a. A discharge not captured in APS CareConnection® will affect both the Hospital Occupancy and Length of Stay Reports that are posted on Quality Care for Me.

How to Discharge an APS Case ID in CareConnection®

1. It is only necessary to discharge the most current case id per service. Go to Search Services and enter in your case ID. If you don't know your case ID, enter in the member's MaineCare number. BE SURE that you have chosen the correct case ID by verifying the member and service code. Once a discharge has been submitted it may not be undone. If there is any doubt, take the case ID to Search Responses where you will see more information about the case, such as dates of service. Once you have identified which case to discharge scroll over to the right side of the screen until you see “Actions.”
2. If the house icon has a red plus sign in it, the member has not been discharged. If the house icon is empty with a blue person, the member has been discharged. Click on the house icon to proceed to the discharge screen.
3. All red fields are required. Make sure to enter in the discharge date as mm/dd/yyyy, or use the calendar to choose the date.



4. Pick the reason for discharge that most represents your member's situation or choose "other" and enter in the reason.
5. Check off any anticipated step down services including dates of first appointments for these services. If none, leave blank.
6. Identify Treatment Progress.
7. Continue to answer the questions as applicable to the service you provide. For example, Section 17 services are required to fill out the Assessment Tool and Hospital Services are required to fill out the following questions:
 - a. Did the Hospital obtain the Member's ISP from their CI, ICI, ICM or ACT Provider?
 - b. Did the Hospital invite the Member's CI, ICI, ICM or ACT Provider to participate in treatment or discharge planning?
 - c. Did the Member's CI, ICI, ICM or ACT Provider participate in treatment or discharge planning?
8. Enter in the Plan for Transition Discharge in the box provided.
9. Click Submit. This completes the discharge.

Level of Care Criteria Inpatient Psychiatric Hospital Services

Admission and Continued Stay Criteria for Psychiatric Hospitals and Psychiatric Units at General Hospitals.

Admission Criteria: Items 1, 2, 3, and 4 must be met.

1. The member has a DSM-IV Axis I or Axis II Diagnosis , which may be determined after Admission to the Program AND
2. Treatment is medically necessary. Medical necessity includes ONE or more of the following:
 - a. The member is exhibiting an immediate or direct threat of serious harm to self or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour/day basis are required. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour/day basis.
 - b. The member is exhibiting an immediate or direct threat of serious harm to others or there is evidence for clear and reasonable inference of serious harm to others. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour/day basis.
 - c. The member is exhibiting an extreme disabling condition such that one cannot take care of self in a developmentally appropriate level or requires assistance beyond the home or residential setting. The member's symptoms must be of such severity that they require 24-hour/day intensive medical, psychiatric, and nursing services. Ambulatory treatment would be clearly unsafe or is unavailable. A lower level of care is not available or would not be adequate to successfully treat these symptoms.
 - d. The member requires psychiatric/medical treatment or monitoring that is not available or would be clearly unsafe in a lower level of care. This care must require individual plan of active treatment which includes 24-hour/day need for and access to full spectrum of psychiatric/ medical and nursing services.

3. Inpatient hospitalization is expected to significantly improve this condition so that acute 24-hour/day inpatient medical/psychiatric and nursing services will no longer be needed.

4. For Members under the age of 21 or adults with a legal guardian: The member's family / guardian(s), where applicable and clinically indicated, are willing to actively participate throughout the duration of treatment.

Continued Stay Criteria: Items 1, 2, 3 and 4 below must be met

1. There is daily documentation that Admission Criteria continue to be met.

2. There is daily documentation beginning on the day of admission of the provider's treatment plan and response to interventions. There is evidence of clinical symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered. Clinical documentation should reflect active discharge planning beginning with the day of admission and reflect evidence that lower levels of care are being pursued.

3. There is documented evidence that, if discharged, member's symptoms are of such severity that re-hospitalization would likely be necessary.

4. For Members under the age of 21 or adults with a legal guardian, there is documented evidence of significant family/guardian involvement at least three times weekly or documented evidence that such is medically contraindicated.