



HealthSystems
OF MISSISSIPPI

Day Treatment Services 5 Years of Age & Younger Provider Manual

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Introduction

Beneficiaries (5 years of age or younger) who are experiencing and/or recovering from a severe mental/behavioral health condition may access services provided by a Community Mental Health Center. Day treatment services are brief in nature but can last up to one year and may include psychotherapy and supportive/rehabilitative interventions. Due to the special nature of services provided to beneficiaries 5 years of age and younger, Mississippi Division of Medicaid has implemented a prior authorization requirement for this service.

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted to perform precertification for day treatment (5 years of age and younger) services rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (DOM) providing utilization and quality of care review since 1997. Review is performed for the following types of services.

- Inpatient Acute Hospitals.
- Free Standing Psychiatric Inpatient Hospitals.
- Psychiatric Residential Treatment Facilities.
- MYPAC – Mississippi Youth Programs Around the Clock.
- Hospital Outpatient Mental Health Services.
- Community Mental Health Post Payment Review.
- Day Treatment Services (5 Years of Age and Younger).
- Outpatient Physical, Occupational and Speech Therapy.
- School Health Related Outpatient Physical, Occupational and Speech Therapy.
- Home Health.
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies.
- Private Duty Nursing.
- Medical Necessity Review for Organ Transplant.

The purpose of this manual is to assist providers who provide day treatment services to children 5 years of age and younger in successfully navigating through HSM's review requirements and process.

II. Getting Started – Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222 or 601-206-3000. The above contact information is also used if you have a billing question.

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov>.

Verify that the revenue and HCPCS code that you plan to bill requires precertification by HSM. Currently, HSM will only review HCPCS code H2012.

In order to qualify for day treatment (5 years of age and younger) services, code H2012, the beneficiary must:

- Be Medicaid eligible.
- Be 5 years of age or younger.
- Be diagnosed with a Serious Emotional Disturbance (SED).
- Be clinically assessed by a qualified mental health professional and determined appropriate for services.

Day treatment services are not considered emergent in nature and must be precertified with HSM.

Requests for precertification are submitted to HSM following:

- Completion of a behavioral assessment performed at least 14 days prior to the proposed admission date. The assessment must be performed by a Mississippi licensed Master's level (or higher) mental health professional, **or**
- A pre-discharge recommendation is required if the beneficiary is in an acute care setting prior to the request for placement in a day treatment program. In addition, a clinical narrative that specifically describes the ongoing behaviors that require and can benefit from day treatment must be included, **and**
- Discussion between the assessing clinician and the youth's legal guardian, or representative/responsible party regarding available services, **and**
- Agreement between the day treatment provider and the youth's legal guardian, or representative/responsible party regarding the services, **and**
- Signed agreement between the day treatment provider and the beneficiary's legal guardian, or representative/responsible party regarding the services (HSM Caretaker/Guardian Agreement Form).

III. Information You Need to Know

Day treatment providers submit review requests and receive HSM certification responses via the Web. HSM's HIPAA secure Web-based system provides 24 hours a day, 7 days a week access to real-time electronic submission of:

- Review requests.
- Additional information for specific reviews when requested by HSM.
- Helpline inquiries.

If you do not have a HSM logon, contact HSM's Education Department at education@hsom.org or by phone at (601)-360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

In the event a day treatment provider cannot submit via the Web, HSM has dedicated fax numbers to assist with certification needs. When submitting review request by fax the required forms and instructions are included in this manual and can be downloaded from the HSM Web site at www.hsom.org.

The table below lists important phone numbers and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Day Treatment Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	<p>Web reviews: www.hsom.org. Click on "Submit Review Requests" link.</p> <p>Web: 24 hours, 7-days a week.</p> <p>The system will direct the end user to upload any required documents or provide instruction on generating a bar coded technology fax cover sheet with secure fax number to send required information.</p> <p><i>Reviews received after 5:00 p.m. or over the weekend or holidays are considered received the next working day.</i></p>
Helpline	Used by providers for questions regarding the precertification process and to obtain assistance.	<p>Web Helpline: www.hsom.org. Click on "Reports and Communications" link.</p> <p>Web: 24 hours, 7-days a week.</p> <p>Local: 601-360-4949 Toll Free: 1-866-740-2221</p> <p>Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)</p>
Hot Line	Number to use to report quality concerns and/or complaints.	<p>Toll Free: 1-888-204-0221</p> <p>Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)</p>

Electronic Helpline Inquiries

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. The reporting module is provider-specific and available 24 hours a day 7 days a week.

In addition to Internet access, minimum computer specifications are:

- PC 1GHz+ processor, 512 MB+ RAM, 500MB of free space.
- Super VGA (1024x768) or higher resolution video card and monitor.
- Broadband internet connection with a speed of at least 512Kbps.
- Internet Explorer Version 7.

IV. Day Treatment Review Exclusions

Medicaid policy exempts certain encounters from HSM review and the provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

Reason	Description
No Medicaid Eligibility	If the beneficiary is not eligible for Medicaid at the time of request, no HSM review is required.
Beneficiaries over 5 years of age	No HSM review is required for beneficiaries once they have attained 6 years of age.
Duplication of Services	No HSM review is allowed if a review determination has already been rendered for the requested services for a different provider.

V. Day Treatment HCPCS Codes Requiring Precertification

Day treatment providers must precertify services for beneficiaries 5 years of age and younger through HSM. Service codes and narrative descriptions are listed in the following table.

Helpful Tip: All requests must be medically necessary and follow approved clinical guidelines. The majority of requests should not exceed twelve (12) weeks in length. However, multiple requests or continued stay requests are allowed.

HCPCS Codes	Descriptions	Units	Notes
H2012	Day Treatment	1 hour = 1 unit	<ul style="list-style-type: none">• Minimum two (2) hours per day, two (2) days per week.• Maximum five (5) hours per day, five (5) days per week.

VI. Precertification Review Process

A. Requests for Precertification Review

Providers submit requests for review directly to HSM via the Web.

A review for initiation of a service(s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically indicated and appropriate. These are called continued stay reviews.

Day treatment services are reviewed for medical necessity and appropriateness. This service must be entered via HSM's Web Utility to receive a Treatment Authorization Number (TAN). *A TAN is required to receive reimbursement for services effective October 1, 2010 going forward.* See Section XII of this manual for special implementation guidelines.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review. Required form and instructions are included in the *Forms and Instructions* section.

Review Type	Timeframe	Required Documentation
Admission/ Precertification request:	At least 7 business days prior to initiation of day treatment services.	<p><i>*Web submission allows direct upload or bar code fax of required documents.</i></p> <ul style="list-style-type: none"> • Web the required information to HSM. • Upload the completed caretaker/guardian agreement form via .tif, .jpeg or .pdf file. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed and signed caretaker/guardian agreement form.
Continued Stay/Recertification request:	At least 7 business days prior to the last date certified by HSM.	<ul style="list-style-type: none"> • Web the required information to HSM. • Upload the completed caretaker/guardian agreement form via .tif, .jpeg or .pdf file. <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed and signed caretaker/guardian agreement form.

It is the responsibility of the day treatment service provider to request a continued stay review seven business days prior to the next review point (Last Day Certified), but no earlier than seven business days. If the day treatment service provider submits after the last day certified, backdating will not be allowed.

Note: Cases may be selected for quality or post payment reviews. Please refer to the **Quality Review Process Manual** and **Community Mental Health Services Manual** on the HSM Web site at www.hsom.org.

B. Processing of Review Requests

HSM has a diverse group of professionals that assist at various stages of the review process. Our clinical staff is composed of registered nurses, behavioral health consultants, physicians/psychiatrists and physician consultants. These highly qualified professionals make certification review determinations for day treatment services. The following table describes our staff's functions.

Staff	Functions
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> • Apply DOM policy. • Apply explicit DOM approved medical necessity clinical guidelines. • Apply quality of care triggers and screens. • May request additional information. • Approves services based on policy or criteria. • Refer requests that cannot be approved for physician/psychiatrist determination.
Second level reviewers (Physician/Psychiatrists)	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. That decision is: <ul style="list-style-type: none"> - Based on documentation that supports medical necessity and appropriateness of setting.* - Patient-centered and takes into consideration the unique factors associated with each patient care episode. - Sensitive to the local healthcare delivery system infrastructure - Based on his or her clinical experience, judgment and generally accepted standards of healthcare. • May request additional information. <p>*The physician/psychiatrist reviewer may request additional information and attempt to contact the day treatment clinical director to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p>Note: See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review cannot proceed because ...	Then ...	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	<ul style="list-style-type: none"> • Preadmission • Continued Stay 	One business day.

C. Notification of Review Outcome

HSM provides written notification of review results to the day treatment provider via the Web or by fax and to the youth’s legal guardian or representative/responsible party when services are denied. Verbal notification of approvals will only occur if the provider is unable to receive written notifications via Web or auto-fax. Providers also receive verbal notice of denials.

The day treatment provider/director and youth’s legal guardian/representative/responsible party may request a reconsideration of a denial determination. A second physician/psychiatrist, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the youth’s legal guardian/representative/responsible party may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information.

The following table contains the details of the review outcome notification process based on review outcome.

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> Written notification of approval review results is sent to the day treatment provider.
Denial	<ul style="list-style-type: none"> If HSM determines that services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply. Written notification of denial determination is sent to the day treatment provider and the youth’s legal guardian/representative/responsible party. Verbal notice is also given to the day treatment provider. The youth’s legal guardian/representative/responsible party’s notice does not contain the medical basis for the denial.
Suspended	<ul style="list-style-type: none"> HSM will notify the requester (verbally and in writing) when additional information is required and the review will be pended. If the requested information is not submitted by the due date HSM issues a written notice of Review Suspended.

Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination and Verbal Notification	Written Notification
<ul style="list-style-type: none"> Preadmission Continued Stay 	Within seven business days of receipt of review request and necessary information.	Within one business day of review determination.

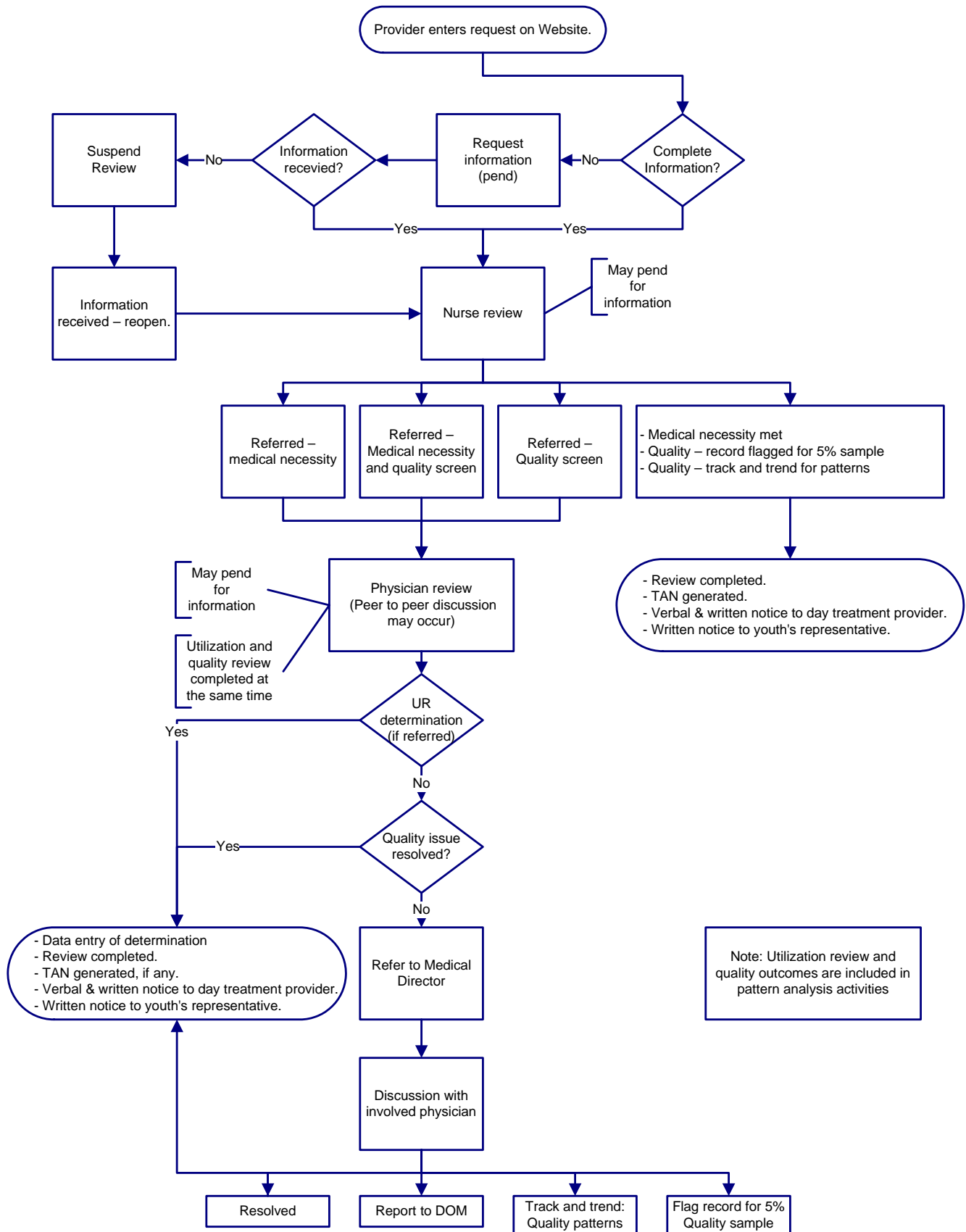
Content of Written Notices of Review Outcome

Written notifications of review certification (approval) and determinations involving denials are sent to the various parties as described in Section VI. C of this manual.

Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Continued Stay/Recertification
Certification (Approval)	Date of notice	✓	✓
	Brief statement of HSM's authority and responsibility for review	✓	✓
	Reason for determination	✓	✓
	Date(s) of service being approved	✓	✓
	Type service certified	✓	✓
	Number of units/days certified	✓	✓
	Total number services certified to date	✓	✓
	Total time span approved to date	✓	✓
	Treatment Authorization Number (TAN)	✓	✓
Denial	Date of notice.	✓	✓
	Brief statement of HSM's authority and responsibility for review.	✓	✓
	Principal and clinical reason for denial.	✓	✓
	Type of services, number of units, and dates of services being denied.	✓	✓
	Total number and time span for previously certified procedures or services.		✓
	Process for submitting a reconsideration request.	✓	✓
	Reconsideration timeframes.	✓	✓

D. Review Process Flow Chart



VII. Reconsideration Review

If any of the following parties disagrees with the determination made by HSM, a request for reconsideration may be requested.

- Beneficiary's legal guardian/representative/responsible party.
- Day treatment service provider.
- Attending Physician/Psychiatrist.

A second physician, one not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld, the beneficiary's legal guardian or representative/responsible party may appeal the decision directly to the Division of Medicaid.

Please see the ***Reconsideration Manual*** for additional details.

VIII. Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries, age 5 and younger, who are receiving day treatment services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by HSM.

HSM identifies aberrant patterns and/or trends by provider. Quality sampling may include health care services provided to all age groups.

Please see the ***Quality Review Process Manual*** and ***Community Mental Health Services Provider Manual*** for additional details.

IX. Utilization Analysis, Focused Studies, Outcome Reports and Proposals for Improving Health Care Delivery System

Under contract with DOM, HSM will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement, we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.

We look forward to working with DOM and the Medicaid provider community on this endeavor.

X. Form and Instructions

- Caretaker/Guardian Agreement Form

XI. Frequently Used Terms

Precertification/Admission – A review for initiation of a service(s) is referred to as a precertification/admission review.

Continued Stay - Subsequent reviews performed to determine if continuation of services is medically indicated and appropriate are called continued stay reviews.

Bar Coded Fax Coversheet - Web utility option that allows the provider to print a specialized cover sheet encrypted with bar code technology that links required documents directly to a specific review.

Upload - Web utility option that allows providers to link required documents in the form of .tif, .jpeg, or .pdf files directly from their computer to a specific review.

Treatment Authorization Number (TAN) - Number issued by HSM to providers verifying certification of a request; this number is entered in the PA field of the claim form used for Medicaid billing.

Pend - Request to provider from HSM staff requesting additional information to be submitted before a review can be completed.

Denial - Occurs when any portion of requested services are not approved.

XII. Special Implementation Guidelines

Beneficiaries, 5 years of age and under, who were admitted to day treatment before the prior authorization requirement was implemented on October 1, 2010 will need a Treatment Authorization Number (TAN) to continue to receive services after the implementation date.

Day treatment providers must enter the required information via HSM's Web Utility to receive a TAN. *A TAN is required to receive reimbursement for services effective October 1, 2010 going forward.*

The following table describes the guidelines providers will use to submit reviews for beneficiaries who were admitted to day treatment before the prior authorization requirement but will need to continue services after October 1, 2010.

If the beneficiary ...	Then ...	And...	Review Type	Required Form
Was admitted to day treatment services prior to October 1, 2010 and the day treatment provider feels beneficiary has a continued need for day treatment services beyond October 1, 2010:	A behavioral assessment must be performed to determine if day treatment is the most appropriate level of service available.	A caretaker/guardian agreement form must be completed and signed by the day treatment provider and parent/guardian/caretaker.	An admission/precertification review must be entered on HSM's Web. <i>See Section VI of this manual.</i>	A copy of the caretaker/guardian agreement form must be uploaded or faxed with bar coded cover sheet to process the review.

The special implementation guidelines listed in this section only applies to requests submitted in October 2010.

Mississippi Medicaid Day Treatment Election Statement Form (5 years of age and younger)



(Caretaker/Guardian Agreement)

Election Statement: Allow the individual's parent, legal guardian, or legal representative time to read closely. Have the individual's parent, legal guardian, or legal representative sign and date. **The day treatment provider's representative who is present must sign as the witness.**

The day treatment (5 years of age and younger) program has been explained to me in its entirety. I have been given the opportunity to discuss the program's potential benefits to my child, limitations of this program and the terms of the election statement.

I understand that by signing the election statement, I agree to the following conditions:

1. I understand that day treatment services provided by a site-based mental/behavioral health center program (or provided under alternate arrangements made by a designated day treatment provider) is a mental/behavioral health service.
2. I understand that a reassessment will be performed at a maximum of every six months (or earlier) to determine if day treatment is the most appropriate mental/behavioral health service available for my child. I understand that if my child no longer meets the requirements for day treatment services, the day treatment provider has the right to discharge my child.
3. I understand my child's diagnosis, listed below, as explained to me by the day treatment service provider.

I understand that I may discharge my child from day treatment services at any time by signing a statement to that effect, specifying the date when the discharge is to be effective and submitting the statement to the day treatment service provider. I understand my child's rights to other Medicaid and/or the CMHC services will continue, if he/she is Medicaid eligible.

Beneficiary Name		Beneficiary Medicaid Number
Date of Birth	Phone Number	Diagnosis

Address (Street Address, City, State and Zip Code)

By signing this statement, I am electing the below named day treatment program to provide my child with the services of the mental/behavioral health program.

Parent/Legal Guardian/Legal Representative's Name	Date
Print Name:	
Sign Name:	

Provider Signature (Must be present)	Date

Provider Name	Day Treatment Provider Number