

## ***Precertification of Psychiatric Residential Treatment Facility Admissions***

### ***Objective:***

Determine the medical necessity and quality of services to be provided in Psychiatric Residential Treatment Facility (PRTF) setting to adolescent/child (less than 21 years old) beneficiaries with psychiatric diagnosis(es), the appropriateness of the setting and the number of days reasonably required to treat the beneficiary's condition.

### ***Performed By:***

Utilization Review Coordinators (URC), Physician Advisor Psychiatrists (PA), Medical Director

### ***Policy:***

**All Psychiatric Residential Treatment Facility admissions** requested for Mississippi Medicaid beneficiaries under the age of twenty-one (21) **must be precertified** by HSM. PRTF admissions are considered not of an emergency nature.

PRTFs may choose to develop specialized programs for specific populations of adolescents/children. However, precertification/recertification criteria remain the same for all PRTF programs, regardless of their specialized nature. Any specialized treatment approach must produce documented progress toward treatment goals in order for continued stay to be approved.

Psychiatric Residential Treatment Facilities (PRTFs) **must** submit a monthly census report indicating the current patients, new admits (including date) and discharges (including date). The report for the month should be submitted to HSM no later than the last day of the month.

The beneficiary or his or her representative, the PRTF, and the physician have the right to request a reconsideration of any denial decision. The request for reconsideration may be submitted by telephone, FAX, or mail to HSM within thirty (30) calendar days of the date on the denial notice for non-expedited reconsiderations. Expedited reconsiderations must be submitted within three (3) business days of the date on the denial notice. Please refer to the *Reconsideration Process* Policy and Procedure section of this manual for additional information.

### ***Procedure:***

#### ***Precertification Review***

1. The PRTF/physician submits a request for precertification (HealthSystems of Mississippi Psychiatric Residential Treatment Facility Precertification Plan of Care Form), and an independent psychiatric or psychological evaluation to HSM at least seventy-two (72) hours prior to the planned admission date.

The independent evaluation must be performed by a licensed psychiatrist. The evaluation must be performed within sixty (60) days prior to the proposed admission date. If a beneficiary is in an acute care setting, a pre-discharge recommendation will be accepted in place of the independent evaluation. The examiner/referring treatment team must not have admitting privileges, serve on the PRTF treatment team, or receive financial benefits from the PRTF to which the beneficiary is proposed to be admitted. **For those beneficiaries who are determined to have retroactive Medicaid eligibility, the completed psychiatric**

**evaluation which was conducted at the time of admission to the PRTF, must be submitted. This evaluation must include IQ testing.**

The request for precertification may be submitted by FAX or mail. To expedite the precertification process, HSM encourages facilities or physicians to complete and attach or include all required information.

2. If the FAX or mail method is chosen for submitting a review request, the non-clinical review staff (clerical staff) review the form(s) to ensure that the non-clinical information on the form is complete, is legible, all pages are received, and the form is completed in all applicable areas (i.e., beneficiary's Medicaid number, physician's name and phone number, requestor's name and phone number, all applicable spaces on form are filled in, all pages of the review form were received, etc.) If it is incomplete or not legible, the non-clinical staff notifies the requestor verbally by telephone. The non-clinical review staff attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen.

Depending on the time of day a FAX review request is received and tracked into HSM's data system, the non-clinical staff allows either three (3) hours from the time of verbal notification or until 12:00 p.m. (CST) the next business day, whichever is longer, for receipt of the necessary information to initial review.

If the information is not received within the applicable timeframe, the non-clinical staff issues written notification (Lack of Information – Unable to Initiate Review) to the requestor that the review process cannot be initiated and that all information will have to be resubmitted to reinstate the review process.

3. Once the necessary information is received, the review request is forwarded to the Utilization Review Coordinator (URC) who has experience in psychiatric nursing.
4. The beneficiary's eligibility is verified. The PRTF and attending physician identification are also verified, including phone and FAX numbers.

If the beneficiary is not eligible, the PRTF/physician is notified via telephone with written follow-up (Notice of Receipt of Certification Request - Non-Medicaid Beneficiary). This ends the review process.

5. Once eligibility is verified, the URC assesses if there is sufficient information included in the documentation to make a determination. If additional information is required, the request will be made via telephone and in writing (Request for Additional Information) within twenty-four (24) hours (one [1] business day if the request is received on a Friday or the day before a holiday) of receipt of the request and the review will be pended. The facility/attending physician has three (3) business days to submit the requested information.
6. If the requested information is not received by HSM within three (3) business days, the review process will be closed. The facility and the attending physician will be notified (Notice of Incomplete Information - Certification Review Suspended) that the case has been closed.
7. Once all available information has been received, the URC performs the review of the case.  
The URC will:

- evaluate the proposed admission for medical necessity and appropriateness of the setting by screening the information contained in the request packet against the following criteria:
    - ⇒ DOM's Psychiatric Residential Treatment Facility Admission and Continued Care Criteria
  - evaluate the quality of the proposed care to ensure that it meets professionally recognized standards, according to HSM's Quality Assurance and Utilization Review: Quality Screening policy and procedure.
8. If the case meets criteria, and/or no quality screens are failed, and if the facility is determined to be capable/appropriate, then the URC certifies the admission, assigning an initial length of stay of thirty (30) days. The URC also assigns the next review date, seven (7) business days prior to the last day certified.
  9. The URC assigns a Treatment Authorization Number (TAN), notifies the PRTF via telephone within **twenty-four (24) hours (one [1] business day** if the determination is made on a Friday or the day before a holiday) of the determination, and sends written notification to the PRTF, attending physician and authorized representative of the beneficiary. Written notification includes the number of days certified.
  10. If the case does not meet criteria, the URC refers the case, within one (1) business day of determining that the case does not meet criteria, to the Physician Advisor (PA), who is licensed and board certified in adolescent/child psychiatry for review.
  11. The PA reviews the request and all available information, and if necessary, contacts the attending physician to obtain additional information. If additional information is required, a period of twenty-four (24) hours is allowed for submission of the information. The PA or URC may request information from the physician and, when appropriate, from the facility via telephone with written follow-up (Request for Additional Information).

If the requested information is not received by HSM within twenty-four (24) hours, the URC will close the case. The facility and attending physician will be notified (Notice of Incomplete Information - Certification Review Suspended) that the case has been closed. When the needed information is received, PA review is resumed.

12. The PA makes a determination, based on practice standards and his or her clinical experience and judgment, within **two (2) business days** of receiving the request from the URC and obtaining any necessary additional information from the attending physician.

If the PA's initial determination is to deny, verbal notification to the agency and/or the physician is made. PAs call the attending physician two (2) times prior to issuance of written denial determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial notification letter to maintain review timeframe completion requirements. During attempted telephone contacts the PA provides verbal instructions and contact information for the attending physician, affording the attending physician an opportunity to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

**NOTE: A peer-to-peer conversation that occurs following issuance of the denial determination notification in no way may change the PA's initial denial determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for reconsideration to HSM. Please refer to the Reconsideration Policy and Procedure for detailed information on this process.**

13. If the admission is approved, the URC enters the PA's documentation and completes the notification process outlined in step nine (9).
14. If the admission is denied, the Denial/Reconsideration Coordinator issues verbal notification to the PRTF within twenty-four (24) hours of the determination.
15. Written notification of the review determination - approval - is sent to the PRTF and the attending physician within twenty-four (24) hours of the determination.

Written notification of the review determination - denial - is sent to the authorized representative of the beneficiary, the PRTF, and the attending physician within twenty-four (24) hours of the determination.

**Notices of precertification approval will include the following information:**

- date of notice
- date(s) of service being approved
- the number of days certified for hospital admission
- the Treatment Authorization Number (TAN), and
- the Last Day Certified (LDC)

**Notices of precertification denial will include the following information:**

- date of notice
- date(s) of service being denied
- the principal and clinical rationale for the denial
- the process for submitting an reconsideration; and
- time frames in which to submit an reconsideration.

**NOTE: The beneficiary's notice will not contain the medical basis for the denial.**

17. Any denial determination may be reconsidered as described in the *Reconsideration Process* Policy and Procedure section of this manual.
18. If a quality issue is confirmed by the PA, the facility and/or physician have a right to request a quality re-review. Refer to the *Quality Re-review* Policy and Procedure section of this manual for additional information.

**Concurrent Review:**

1. For admissions which were precertified by HSM, the PRTF must determine if continued inpatient care is indicated. In instances where continued stay is required, the PRTF must submit a written request for extended certification (HealthSystems of Mississippi Psychiatric Residential Treatment Facility Concurrent Plan of Care Form).
  - For beneficiaries with a stay of less than 180 days, a copy of all treatment plans (*including updates*), psychiatric (physician) progress notes, all treatment notes (*group, individual, family, art, etc*), and all assessments (*psychiatric, psychological, education, dietary, education, history and physical*) must accompany the completed form.
  - For beneficiaries with a continued stay of greater than 180 days, the complete chart from the last day certified must be submitted. The request should be received by HSM at least seven (7) business days prior to the last day certified. To expedite the review process and to ensure that the most recent clinical information is available, HSM encourages PRTFs to hand deliver or overnight mail the information.
2. HSM issues written notification to PRTF providers of Medicaid cases requiring concurrent review five (5) working days prior to expiration of current certification when the request is not received within the required seven (7) working day timeframe.
3. If the FAX or mail method is chosen for submitting a review request, the non-clinical review staff (clerical staff) review the form(s) to ensure that the non-clinical information on the form is complete, is legible, all pages are received, and the form is completed in all applicable areas (i.e., beneficiary's Medicaid number, physician's name and phone number, requestor's name and phone number, all applicable spaces on form are filled in, all pages of the review form were received, etc.) If it is incomplete or not legible, the non-clinical staff notifies the requestor verbally by telephone. The non-clinical review staff attempts telephone contact two (2) times and documents the attempts in the electronic tracking notes screen.

Depending on the time of day a FAX review request is received and tracked into HSM's data system, the non-clinical staff allows either three (3) hours from the time of verbal notification or until 12:00 p.m. (CST) the next business day, whichever is longer, for receipt of the necessary information to reinstate review.

If the information is not received within the applicable timeframe, the non-clinical staff issues written notification (Lack of Information – Unable to Initiate Review) to the requestor that the review process cannot be initiated and that all information will have to be resubmitted to reinstate the review process.

4. Once the necessary information is received, the review request is forwarded to the Utilization Review Coordinator (URC).
5. The URC evaluates the concurrent review request and supporting information within **two (2) business days** of receipt, for changes in the beneficiary's condition or needs.
6. The URC screens the current information against criteria, and reapplies quality screens as described in step six (6) of the precertification section of this policy. Emphasis is placed on evaluating the progress made in the active individualized clinical treatment provided and on the documentation of appropriate discharge plans.

If the need for continuing inpatient services meets criteria, the URC certifies an additional 30-60 days or less (to coincide with a planned discharge date, if applicable) based on the needs of the beneficiary and assigns the next review date, seven (7) business days prior to the last day certified. The URC completes steps eight (8) and nine (9) of the precertification section of this policy except that the same TAN is assigned so the entire episode of care remains linked.

7. If the need for continuing PRTF services does not meet criteria and/or a quality screen is failed, the URC refers the case to a PA for review.
8. The PA follows steps eleven (11) and twelve (12) in the precertification section of this manual. The PA makes a determination, based on practice standards and his or her clinical experience and judgment, within **four (4) business days** of receiving the request from the URC and obtaining any necessary additional information from the attending physician.
9. If continuing PRTF services are approved, the URC enters the PA's review documentation and follows steps seven (7) and eight (8) of the precertification section of this policy.
10. If continuing PRTF services are denied, the Denial/Reconsideration Coordinator enters the PA's review documentation and follows steps fourteen (14) and sixteen (16) of the precertification section of this policy.
11. Any denial determination may be reconsidered as described in the *Reconsideration Process* section of this manual.
12. If a quality issue is confirmed, the facility and/or physician have a right to request a quality re-review. Refer to the *Quality Re-review Policy and Procedure* section of this manual for additional information.