Goals for this Presentation

• Describe utilization review resources on Qualis Health’s website
• Provide review of and updates for utilization review processes for the Alaska Medicaid Inpatient Psychiatric Program
• Demonstrate collaboration with the state and providers in the utilization review process
Care Management Services for Alaska Medicaid

• Inpatient acute and residential psychiatric utilization review services
  • Admission review
  • Master plan of care review
  • Continued stay review
  • Retrospective review
  • Peer review
  • Appeals

• Care coordination services
Tools to Support Your Review

Go to qualishealth.org > Healthcare Professionals > Alaska Medicaid Behavioral Health > Provider Resources

• Provider manual
• Provider training
• Late submission/retro review request forms
• Questionnaires for review processes
• Contact information for Qualis Health
• Alaska map of “home” regions
• RPTC bed availability in State of Alaska
• Link to state website
Website Orientation: qualishealth.org

“Healthcare Professionals”
“Alaska Medicaid-Behavioral Health”
List of Tools and Forms

Provider Manual and Appendices
- Inpatient Psychiatric Retrospective Review Request Form

Facility Bed Availability
- AK Residential Psychiatric Treatment Facilities (RPTC) Contact Information (Excel)
- Out-of-Alaska RPTC Contact Information (Excel)
- In-State Bed Availability

Report Forms
- Incident Report Instructions
- Incident Report Form (Excel)
- Incident Report Form (Word)

Geographic Region Information
- Alaska Regions
- Outpatient Providers by Regions in Alaska (Excel)
Provider Responsibilities

• Review submission and timelines
• Discharge planning
• Report discharges
• Travel authorization
• Sentinel events
Review Submission

• Providers to submit timely reviews via Qualis Health Web Portal, fax, mail or phone
• Providers to submit reviews for recipients who are also covered by other Third Party Liability (TPL) resources.
Review Submission (continued)

• Required list of demographics and other information
• Comprehensive answers to the appropriate review questionnaire
Prior Authorization Submission Timelines

- Acute care admissions
- In-State RPTC admissions
- Out of State RPTC admissions
- Continued stay reviews
Continued Stay Submission Timeline

- Next review date
- Continued stay reviews submitted beyond 30 days after the next review due date
Timeframes for Pended Reviews

• Qualis Health will notify the provider via iEXCHANGE
• Seven calendar days to submit the requested information
• Possible technical denial after seven calendar days
Travel Authorization

• Provider expecting to admit client is responsible for submitting the prior authorization review
• When certification (approval) is given, use the PA number assigned to the case
• Qualis Health PA numbers for travel for admissions
• Xerox is the authorized agency for travel
  
  *Toll-free in Alaska (800) 770-5650
  Outside of Alaska (907) 644-6800*
Utilization Review Processes
Updates, Reminders, and Tips
Admission Review

- All five digits of the DSM IV diagnostic codes
- All demographics answered in the admissions questionnaire in full
- Up to 7 days if travel is involved prior to anticipated admission for RPTC
- Up to 3 days if travel is not involved prior to anticipated admission for RPTC
- Up to 2 days if travel is involved prior to anticipated admission for acute care
- Day of admission if travel is not involved prior to anticipated admission for acute care
Admission Review (continued)

- Issues from the Mental Health Exam that are pertinent to the diagnostic considerations within the treatment planning should be submitted in the Admission Review Questionnaire.

- Must include mental health exam date, and identify practitioner
Plan of Care (POC) Review

- RPTC level of care
- Acute level of care
- Required elements to be addressed in the POC
Plan of Care

• A.2.04 – the POC is required to include a discharge plan prepared *at the time of admission*.

• A.2.05 – the POC is required to specify the approximate date for discharge.

• A.2.06 – the POC is required to be formulated in consultation with the recipient and the recipient's family, guardian, or other individual to whose care or custody the recipient will be released following discharge.
Plan of Care

• A.2.07 – the POC reviews are required to include updated discharge planning information that provides:
  • increasingly detailed information regarding the recipient's anticipated post-discharge service needs,
  • the recipient's prospective service providers,
  • and other provisions necessary for the transition to a less restrictive environment.
Plan of Care

- Master Plan of Care (MPOC) should be comprehensive, with treatment plans for the *entire expected length of stay*.
- Must include goals and objectives for family therapy, group therapy, and individual therapy that are connected to problem statement.
- If in OCS or JJ custody, must include goals and objectives for collaboration with case worker.
Plan of Care

Clearly document measurable goals and objectives

• Problem statement related to each diagnosis
• Goals and objectives related to problem statement
• Modalities in which goals and objectives will be addressed
• Update progress on goals and objectives in every review for each problem statement and for every type of therapeutic setting (individual, family and group psychotherapy)
Treatment Plan Goals and Objectives

Global goal/objective → Measurable goal/objective

Eliminate assaultive behavior

Eliminate episodes of hitting and slapping peers at school

Reduce verbal aggression

Reduce occurrences of saying “I’ll kill you” and “I’ll beat you up” to siblings and classmates by 80%
Medical Necessity Practice and Documentation

<table>
<thead>
<tr>
<th>Diagnostic Evaluation</th>
<th>Plan of Care (POC)</th>
<th>Progress Notes</th>
<th>Treatment POC Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Well supported mental health diagnoses</td>
<td>• Formulated in consultation with recipient and recipient’s custodians</td>
<td>• Document goal/objective being addressed from POC</td>
<td>• Evaluate &amp; document progress toward each goal/discharge criteria</td>
</tr>
<tr>
<td>• Specific behavioral health problems identified</td>
<td>• Goals/objectives directly relate to specific behavioral health problems identified in assessments</td>
<td>• Document interventions &amp; service modality from POC</td>
<td>• Identify any new problems (new assessment information)</td>
</tr>
<tr>
<td>• Conducted, signed &amp; credentialed by qualified staff</td>
<td>• Goals/objectives are individualized, measurable and achievable to the extent that treatment can be completed in the community</td>
<td>• Document progress toward treatment goal</td>
<td>• Clear summary of any changes to POC/discharge criteria</td>
</tr>
<tr>
<td></td>
<td>• Interventions &amp; service modalities designed to assist recipient to achieve treatment objectives</td>
<td>• Contain clinically relevant information about course of treatment</td>
<td>• Conducted, signed and credentialed by qualified staff</td>
</tr>
<tr>
<td></td>
<td>• Discharge plan based upon recipient achieving treatment objectives to the extent that treatment can be completed in the community</td>
<td>• Conducted, signed &amp; credentialed by qualified staff</td>
<td></td>
</tr>
</tbody>
</table>

(All services must be rendered in compliance with Medicaid Program rules, regulations, and statutes)
Continued Stay Review

- Updates on the diagnostic evaluation
- Updates on medication changes and effectiveness
- Updates on current behavioral impairments
- Updates on measurable treatment goals and progress made on the goals/objectives
- Updates on goals and objectives in each modality
57. Describe acute disturbances related to the behavioral disorder:

Patient is admitted due to suicidal threats, homicidal threats, aggression, and oppositional/defiant/impulsive behaviors.
Required Documentation for Admission

Please include all clinical documentation that supports the need for this level of care. Must include:

• Dates
• Seriousness
• Frequency of symptoms
• Current acuity (why now if this is chronic)
• What happened while in acute care that didn’t stabilize enough for a lower level of care
Required Documentation for Continued Stay

Please include all clinical documentation that supports the continued need for this level of care. Must include:

• Clear description
• Seriousness
• Frequency of symptoms
• Current acuity (this review period)
## Details to Use in Reviews

<table>
<thead>
<tr>
<th>USE THESE</th>
<th>NOT THESE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying at least 3 times daily, tantrums that include screaming, crying,</td>
<td>Cries frequently, Angry outbursts</td>
</tr>
<tr>
<td>yelling, and biting arms, excessive clinging</td>
<td></td>
</tr>
<tr>
<td>Hypervigilance, excessive fear (describe)</td>
<td>Nervous, afraid</td>
</tr>
<tr>
<td>Jumped into open part of frozen lake…, fire setting in last week</td>
<td>Risky behaviors, Hx Setting fires</td>
</tr>
<tr>
<td>Runaway less than 24 hours (48 hrs, X # days)</td>
<td>Runs</td>
</tr>
<tr>
<td>Self-injurious behavior by cutting arms leaving scars, hallucinations in</td>
<td>Hurts themselves, sees things</td>
</tr>
<tr>
<td>last week (specifically describe)</td>
<td></td>
</tr>
<tr>
<td>Drop in school grades (A to D in 6 Weeks)</td>
<td>Not doing well in school</td>
</tr>
</tbody>
</table>
# Details to Use in Reviews (continued)

<table>
<thead>
<tr>
<th>use these</th>
<th>not these</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal/homicidal ideation with/without plan, self harm that includes 3rd degree burn</td>
<td>Wants to hurt self</td>
</tr>
<tr>
<td>Detention @ least 2x in last 5 days, suspended</td>
<td>Made to stay after school</td>
</tr>
<tr>
<td>Impulsive, property destruction (describe)</td>
<td>Acts without thinking</td>
</tr>
<tr>
<td>Absent 5 days from work in last month</td>
<td>Misses work</td>
</tr>
<tr>
<td>Arrest/illegal activity in last month</td>
<td>Legal troubles</td>
</tr>
<tr>
<td>Socially withdrawn in last month</td>
<td>Stays to themselves, loner</td>
</tr>
</tbody>
</table>
Details to Use in Reviews (continued)

<table>
<thead>
<tr>
<th>USE THESE</th>
<th>NOT THESE</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last month</td>
<td>Has a history of</td>
</tr>
<tr>
<td>3x Week for last 6 months</td>
<td>Recently</td>
</tr>
<tr>
<td>In the last 48 hours</td>
<td>Frequently, often</td>
</tr>
<tr>
<td>In the last month</td>
<td>Seldom</td>
</tr>
</tbody>
</table>
57. Describe acute disturbances related to the behavioral disorder:

- Symptoms within the last 24 to 48 hours
- Dates, seriousness and frequency of symptoms
- Specific description of symptoms
Requirements to Support Admission Acuity (RPTC Care)

57. Describe acute disturbances related to the behavioral disorder:

• Symptoms within the last 60 days with emphasis on last 30 days
• Symptoms while in acute care
• Specific description of symptoms
• Lower level of care
• History of symptoms
Example of Documentation For Admission Acuity

57. Describe acute disturbances related to the behavioral disorder:

Patient is admitted today with homicidal and suicidal ideation.
Example of Documentation That Supports Admission Acuity

57. Describe acute disturbances related to the behavioral disorder:

Patient is admitted today after threatening to kill teachers and classmates and then self with his father’s 22 pistol. Patient has access to guns and bullets. He became angry and was swearing at teachers and punched a hole in the wall, threw over desk, and scattered papers all over the room.
Example of Documentation for Continued Stay Review Acuity

7. Describe acute disturbances, self care deficits or imminent risk to self or others or impaired safety or severely impaired role functioning:

Despite depression and SI, patient appears to participate in program and is participating well.
Example of Documentation for Continued Stay Review Acuity

7. Describe acute disturbances, self care deficits or imminent risk to self or others or impaired safety or severely impaired role functioning:

Patient struggles with depression on a daily basis as evidenced by her frequent statements of wishing she would die, telling peers when she leaves this facility she will hang herself, and her disclosures to her therapist that she thinks about death most of the day every day. She needs several prompts every day before she will take a shower or brush her teeth.
Discharge Planning

- Must begin upon admission per federal and state regulations
- Updated with each review
- Includes specificity
- Family/Guardian is actively involved
- Available lower level of care services being recommended and appropriate activity toward application
Reporting Discharges

- Qualis Health Provider Portal, fax or call after the recipient has discharged
- Discharge information to be submitted:
  - The identified services recommended for follow-up care. Include considerations regarding:
    - Placement
    - Educational services and contact made
    - Individual, family and group psychotherapies, as well as other identified therapeutic interventions that may be needed at time of discharge to include medication management and school supports
- The identified provider for services upon discharge
- The actual discharge date
Late Submission
Continued Stay Review Request

• Definition
• When to request it
• Require form
• Possible technical denial
Delayed Eligibility Reasons For Late Submission Reviews (Acute Care)

• Definition
• May submit all at once to catch up to date
  • Use the admission questionnaire
  • Must include the plan of care
  • Divide the review into weekly increments with details of *daily acuity* in these weekly increments
Payment is Contingent Upon

- Eligibility as determined by the Alaska Medicaid Program
  - Providers are to call the Eligibility Verification System
    - (800) 884-3223 (24 hour access)
    - In Alaska, toll free number (800) 770-5650
      - 8 am to 5 pm
- Compliance with the rules and regulations that govern Medical Assistance in Alaska
- Completion of the Medical Necessity Prior Authorization Review
Reporting Requirements for Sentinel Events

What is a sentinel event that requires provider reporting?
Reporting Requirements for Sentinel Events

Medical

• Incidents that require outside medical attention
• Burns
• Lacerations requiring medical attention
• Bone fractures or breaks
• Substantial hematoma
• Injuries to internal organ whether self inflicted or by someone else
Reporting Requirements for Sentinel Events

- AWOL (Absent without leave)
  - If gone overnight
  - If anything significant occurred during the AWOL
    Police intervention
    Use of substances
    Suspected abuse
    Injury requiring medical attention
Reporting Requirements for Sentinel Events

Sexual Acting Out / Physical Aggression

- Any activity or occurrence which must be reported to state Child Protective Service agencies
- Any time an Alaskan youth is the victim or the offender
- Suicidal attempt or serious suicidal gesture
Reporting Requirements for Sentinel Events

- Sentinel event form
- Providers *also* notify Qualis Health of these serious events
- Further review may be taken based on seriousness of incident
We Want To Hear From You

• How the review process works for you
• How well care coordination works for you
• Any issues or concerns that may arise
• Additional ways Qualis Health can assist you
• Process improvement opportunities
• Individual training requests
Questions and Answers
Contact Information

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Alaska State Department of Health & Social Services
- Contact information is available at www.qualishealth.org