Utilization Management (UM) Best Practices

for Psychiatric Residential Treatment Facility (PRTF) Services

March 2022

Mountain-Pacific Quality Health

Telligen®

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Agenda

- Introductions (10 min)
- Case examples/live demonstration (75 min)
  - Documenting against criteria in Qualitrac
  - Defining criteria in Children's Mental Health Bureau (CMHB) manual
  - Defining required documentation
- Responding to requests for additional information (RFI) (10 min)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Single Case Agreement (SCA) and Intellectual and Developmental Disabilities (IDD) (10 min)
- Question and answer (10 min)
- Closing (5 min)

Introductions

Trainers

Telligen

Jean McClurken, LCSW

Montana Department of Public Health and Human Services (DPHHS)

Mountain-Pacific Quality Health

Attendees

Introduce Yourself

Agency

Role in agency

Goal for attendance today

Continued Introductions

Why this topic now?

- RFI rate continues to be high
- 16 different providers, all with different documentation systems, all with staff turn over
- Several new psychiatric residential treatment facility (PRTF) providers to Montana Medicaid

Live Demonstration: Structure

- Demonstration will be a combination of slides and time spent in the Qualitrac system
- Case example:

Peter Pan

- 13-year-old male
- Oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD)
- Prospective PRTF out of state (OOS) case, then continued stay review (CSR) will be done

Defining Criteria in State Manual

Initial Medical Necessity

- Member must meet seriously emotionally disturbed (SED) and Functional Impairment Criteria
- The referring provider must document what specific treatment needs will be addressed with PRTF services
- The youth must require:
  - Intensive psychiatric review and intervention, which may include adjustment of psychotropic medications, evidenced by either rapid deterioration or failure to improve despite clinically appropriate treatment in a less restrictive level of care; and
  - Medical supervision 7 days a week/24 hours per day to develop skills necessary for daily living and to develop the adaptive and functional behavior that will allow the youth to live outside of the PRTF

Continuation of Defining Criteria in State Manual

- Less restrictive services are insufficient to meet the severe and persistent clinical and treatment needs of the youth and prohibits treatment in lower level of care, evidenced by at least one of the following:
  - The youth has behavior that puts the youth at substantial documented risk of harm to self;
  - The youth has persistent, pervasive and frequently occurring oppositional defiant behavior, aggression or impulsive behavior related to the SED diagnoses which represents a disregard for the wellbeing or safety of self or others; or
  - There is a need for continued treatment beyond the reasonable duration of an acute care hospital and documented evidence that appropriate intensity of treatment cannot be provided in a community setting.
- The prognosis for treatment at PRTF level of care can reasonably be expected to improve the clinical condition/SED of the youth or prevent further regression based upon the physician's evaluation.
- In the absence of PRTF treatment, the youth is at risk of acute psychiatric hospitalization or a readmission within 30 days of previous admission to an acute psychiatric hospital.

Continuation of Defining Criteria in State Manual continued..

CSR Medical Necessity

- All requirements from initial review.
- The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress.
- The youth and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the treatment plan.
- Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team must document a clinical rationale for any recommended changes in the discharge plan or anticipated discharge.

Exclusion Criteria

Youth may not be placed in a PRTF due to lack of room and board funding.

The primary problem is social, economic or physical health without concurrent major psychiatric episode.

Defining Documentation Requirements

Initial UM Request

- Certificate of Need (CON)
  - The provider must submit a CON in accordance with 42 CFR441.152 and 441.153 to the utilization review contractor no later than two business days prior to admission to the facility. The CON must be completed within 30 days before the admission of the youth to the requested level of care and signed before the youth receives treatment. The provider must maintain the original signed CON and send a copy to the department or the utilization review contractor.
- Clinical assessment must be sufficient for the clinical reviewer to make a determination regarding medical necessity
  - Confirm eligibility
  - Indicate specific treatment needs to be addressed
  - Include evidence to support PRTF-specific level of care
  - Contain evidence to support why lower level of care is not sufficient
  - Confirms justification for anticipated prognosis
  - Indicates risk of acute hospitalization

Defining Documentation Requirements continued…

- Out of State (OOS) Specific
  - Interstate Compact Agreement
  - Data on In-State Denials
    - Qualitrac Assessment
    - Uploaded details to support

CSR UM Request

- Certificate of Need (CON)
- Evidence of a physician-led evaluation of the youth within 24 hours of admission; and weekly treatment to the youth in order to make treatment adjustments to stabilize the psychiatric disorder of the youth which speak to the following:
  - Confirms eligibility and any changes to diagnoses, as applicable
  - Rationale for medication changes, if applicable

Defining Documentation Requirements continued

- Indicates specific treatment needs to be addressed
- Evidence to support PRTF-specific level of care
- Evidence to support why lower level of care is not sufficient
- Confirms justification for anticipated prognosis
- Indicates risk of acute hospitalization

– Description of behavioral management interventions and critical incidents
– Current medication list
– Updated treatment plan that shows the following:
  - Evidence that all legal representatives of the youth must be consulted and invited to participate in the development and review of the treatment plan
  - A comprehensive assessment of treatment progress related to admitting symptoms and identified treatment goals
– Discharge plan directly linked to the behaviors and/or symptoms that resulted in admission and estimated length of stay must be developed upon admission – present with first CSR
  - Subsequent CSRs will need changes to projected discharge date and clinically appropriate discharge plan citing evidence toward completion of that plan

Additional Documentation Requirements

Timeliness

Submission timeframes and deadlines

- Prior authorizations (PAs) and concurrents
- Continued stay reviews (CSRs)

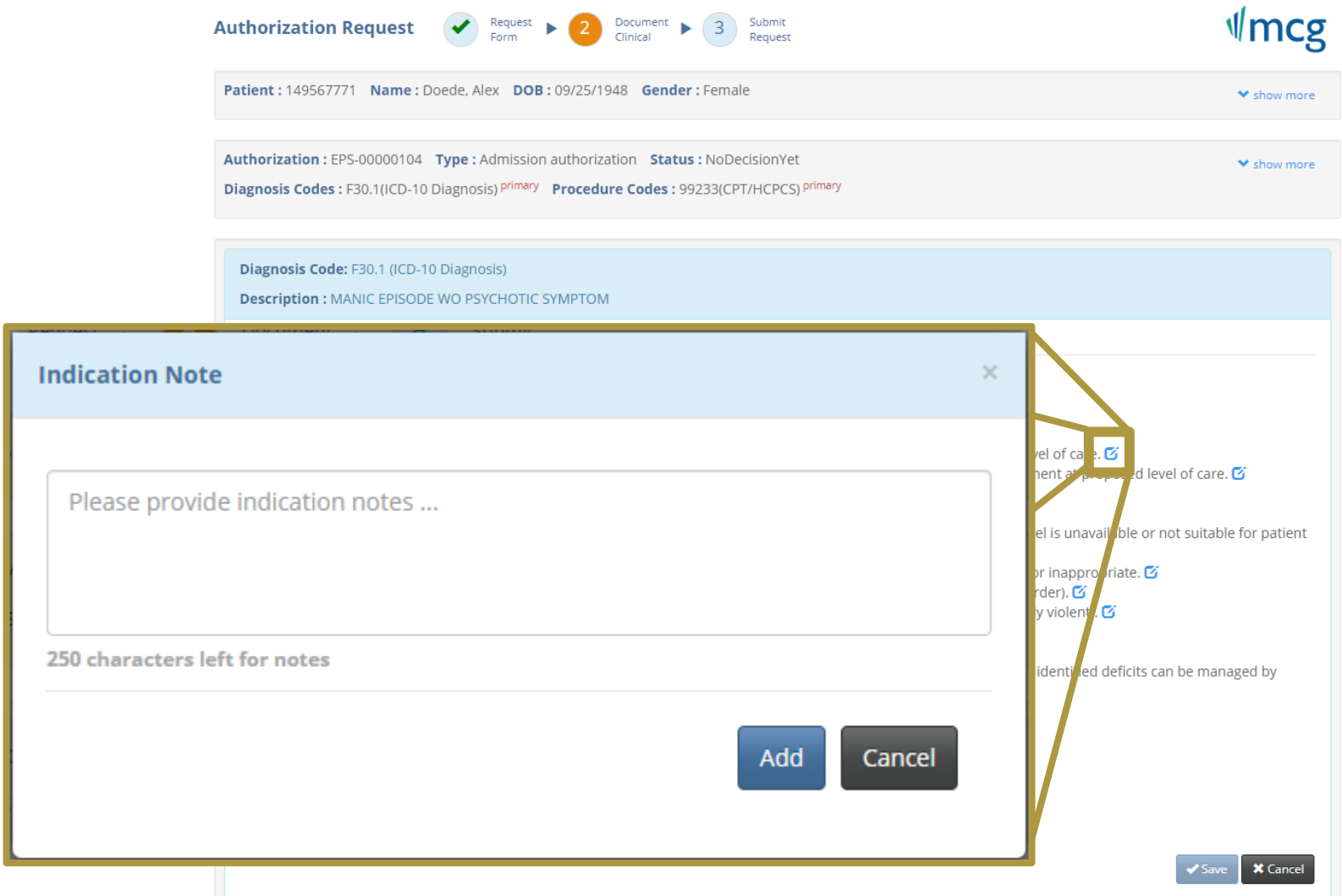
Supporting documentation timeliness

- Supplementing monthly treatment plans (MTP)
- Biopsychosocial (BPS) assessments
- Clinical notes (i.e., psychiatric progress notes and therapy notes)

QUALITRAC
DEMO

Continuing UM Best Practices PRTF Services Presentation

Defining Against Criteria in MCG



CSR MCG Examples

Criteria	MCG Example Less Helpful	MCG Example Most Helpful
Youth must meet the SED criteria as described in this manual	No changes	Provisional diagnosis of Bipolar added and ODD/ADHD removed – see psychiatric note dated 8/10
Referring provider must document what specific treatment needs will be addressed with PRTF services	Individual therapy, group therapy and behavioral interventions in milieu	See MTP goals dated 8/15 – pg. 3-5
Intensive psychiatric review and intervention, which may include adjustment of psychotropic medications evidenced by either rapid deterioration or failure to improve despite clinically appropriate treatment in a less restrictive level of care	See CON	Psych medication adjustments dated 8/10 and 8/16 - detailed on medication list pgs. 7 and 8
Medical supervision seven days per week/24 hours per day to develop skills necessary for daily living and to develop the adaptive and functional behavior that will allow the youth to live outside of the PRTF	See CON	Nursing notes detailing psychoeducation dated 8/12, 8/19, and 8/25; labs drawn 8/15 support clinical interventions relating to impulsivity and reinforcing medication management – see pg. 10
The youth has persistent, pervasive, and frequently occurring oppositional defiant behavior, aggression, or impulsive behavior related to the SED diagnosis which represents a disregard for the wellbeing or safety of self or others	Destruction of property, gang activity and runs away	Pattern of high-risk behavior including included manic impulsive behaviors, physical altercations and no sleep – see behavior log pg. 11 and milieu notes dated 7/20, 8/5, 8/16 and 8/19 pg. 14-16

Criteria	MCG Example Less Helpful	MCG Example Most Helpful
The prognosis for treatment at PRTF level of care can reasonably be expected to improve the clinical condition/ SED of the youth or prevent further regression based upon the physician's evaluation.	See CON	New diagnostic formulation based on 24/7 observation and milieu management; current plan to adjust medications based on new diagnostic formulation and re-evaluate in 2 weeks – see plan of psych note dated 8/16 pg. 9 and 1:1 note dated 8/25 pg. 13
In the absence of PRTF treatment, the youth is at risk of acute psychiatric hospitalization or a readmission within 30 days of previous admission to an acute psychiatric hospital.	Youth at risk of being readmitted	Based on medication monitoring and new case formulation, member is adjusting to new medications and interventions, not stable - see plan of psych note dated 8/16 pg. 9 and 1:1 note dated 8/25 pg. 13
The medical record documents progress toward identified treatment goals and the reasonable likelihood of continued progress.	See treatment plan	See treatment plan date 8/5 supported by therapy notes (1:1, group, family, and psych) – pgs. 5-15
The youth and family, if appropriate, are demonstrating documented progress toward identified treatment goals and are cooperating with the treatment plan.	See treatment plan	See family therapy note dated 8/20 – pg. 15
Demonstrated and documented progress is being made on a comprehensive and viable discharge plan. The treatment team must document a clinical rationale for any recommended changes in the discharge plan or anticipated discharge	Discharge set for 7/2021	Due to case presentation change and escalations during family therapy, new primary plan is for TGH as a step down and initial thoughts are for Aware; secondary plan is for home with new community-based rehabilitation services (CBPRS) – see discharge plan updates 8/25 pg. 17

Defining Against Criteria in MCG continued…

Helpful Reminders

Last step

Cannot be revisited/ edited upon completion

Use the text boxes

Be specific to pages/notes

Final checklist

Only upload/ check box if documentation meets criteria

Attestation piece

Based on your best professional opinion

Responding to RFIs

Reasons for RFI	▪ Missing, incomplete, discrepant, or untimely documentation ▪ Questioning clinical evidence of medical necessity criteria (MNC)
Format of requests	▪ Unable to find evidence for following criteria: (1), (2), etc. ▪ Unable to find more recent date in clinical than X business days prior to requested start date… and timeliness requirements for requesting this service were set at X business days ▪ Provide additional clinical documentation or let us know where uploaded documentation can be found

Intellectual and/or Developmental Disabilities

- The Children's Mental Health services for severe emotional disturbance (SED) and the IDD program both under Developmental Services Division are collaborating.
- Please reach out to Care Coordinators employed at Montana DPHHS with any flags of IDD for a child in your care.
  - Early detection and eligibility screenings are key!

Discharge Planning 1 of 2

- All PRTFs are required to have a comprehensive treatment plan that includes a discharge plan.
  - Discharge planning must start at admissions.
  - Reviewed every 30 days at multi-discipline treatment team meeting.
- The discharge plan must be a viable plan for services after PRTF treatment is complete.

Discharge Planning 2 of 2

- Upon discharge the PRTF must:
  - Provide the youth with a minimum of a 7-day supply of needed medication;
  - Schedule an outpatient visit with a prescribing provider in the youth's community and provide a written prescription for medication at least through the scheduled visit;
  - Document the medication plan in the youth's medical record; and
  - If the youth has disabilities, an individualized education program (IEP) must be in place.
- After discharge, the PRTF has 24 hours to submit discharge notification through Qualitrac Portal

Serious Occurrence Reporting

- Incident reporting
  - Requirements outlined in 42 CFR 483.347
- Serious occurrences that must be reported, include:
  - Resident's death;
  - A serious injury to a resident as defined in CFR 483.352; and
  - A resident's suicide attempt.
- Report must include:
  - Name of resident involved;
  - Description of the occurrence;
  - Facility name, street address, and telephone number.
- In the case of a minor, the facility must also notify the resident's parent(s) or legal guardian(s) as soon as possible, and in no case later than 24 hours after the serious occurrence

Closing Remarks

What will you take away?

What will you do differently as a result of this training, if anything?

CMHB Contacts 1 of 2

- Clinical Team
  - Care Coordinator
    - Dan Carlson-Thompson, Dcarlson-Thompson@mt.gov 406-444-1460
    - Tony Killebrew, Tkillebrew@mt.gov 406-655-7629
  - Regional Resource Specialist
    - Theresa Holm, THolm2@mt.gov 406-444-2958
    - Trish Christensen, Trish.christensen@mt.gov 406-329-1330
  - Clinical Supervisor
    - Katie Harlow, Katelyn.harlow@mt.gov 406-444-3814

CMHB Contacts 2 of 2

- Medicaid Program Officer
  - Brittany Craig, Brittany.craig@mt.gov 406-444-6018
- Utilization Review Technician
  - Alana Wilson, Alwilson@mt.gov 406-444-3819
- Medicaid Program Supervisor
  - Renae Huffman, Rhuffman@mt.gov 406-444-7064
- CMHB Bureau Chief
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