



Utilization Management Procedures
For
Statewide Inpatient Psychiatric Programs
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Florida Agency for Health Care Administration

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Utilization Management Procedures for Statewide Inpatient Psychiatric Program

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Utilization Management Procedures for Statewide Inpatient Psychiatric Program

I. Introduction

Statewide Inpatient Psychiatric Program (SIPP)

Historically, the Florida Medicaid program funded a wide array of community-based services and acute inpatient psychiatric services provided in psychiatric units of general hospitals for persons under the age of eighteen (18). There were however significant numbers of high-risk children and adolescents who did not respond adequately to intensive community-based services and/or experienced multiple or lengthy acute psychiatric inpatient admissions. The Florida Agency for Healthcare Administration (AHCA) received approval from the U. S. Centers for Medicare and Medicaid Services (CMS) for a waiver to allow the purchase of services for children in Statewide Inpatient Psychiatric Programs (SIPPs). SIPPs were designed to serve those high-risk youths that require a more intensive level of service than community-based services or acute psychiatric inpatient services.

Generally, these high-risk children and adolescents have very complex conditions that require more extended residential treatment in order to more adequately treat their psychiatric and psychosocial needs. These residential programs can improve outcomes for children and adolescents both by providing a course of active psychiatric treatment and by providing or facilitating access to community-based aftercare mental health services with linkages to schools, community resources and family/natural supports.

In order to maximize this continuity of care, each individual discharged from a SIPP is offered services by a children's mental health targeted case manager beginning one-hundred eighty (180) days prior to discharge. If targeted case management services are accepted, the case manager coordinates and facilitates implementation of aftercare services recommended in the discharge plan. The targeted case manager will continue to work with the individual to assess needs and to monitor the quality of and access to care. These aftercare services might include, but are not limited to, outpatient psychiatric services, assessments, clinical and in-home services or other services available under the Medicaid Community Mental Health Services Program. The case manager will also refer the child/adolescent to his or her assigned primary care physician or health maintenance organization for assessment and/or treatment.

Program Objectives

Treatment in a SIPP is seen as a component in the continuum of a child's care, with the goals of:

- Stabilization of presenting problems and symptoms and adequate resolution to allow safe return of the child to the family and community;

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- Reduction of recidivism of admission into acute psychiatric or SIPP services by providing aftercare services and/or linkages with appropriate community services;
- Design of aftercare treatment plans that can be effectively implemented; and
- For children in the state's custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with Family Safety.

Utilization Management for SIPPs

Each admission must be prior approved by an independent team that includes a physician advisor not employed by the program. Admissions must be reviewed regularly to ensure that a child continues to meet medical necessity for this level of care and is receiving active treatment, as defined in Code of Federal Regulation, CFR 441.151.

The SIPP Program includes the following utilization management components:

- 1) Prior authorization of all Medicaid SIPP admissions.
- 2) Continued stay reviews conducted for all Medicaid SIPP admissions: at least every twenty-one (21) days for children under 10 years of age and at least every thirty (30) days for children ages 10 years and older.
- 3) On-site annual reviews to evaluate medical necessity criteria and quality of care.

In summary, the SIPP waiver permits Florida's Medicaid Program to:

1. provide specialized psychiatric residential inpatient diagnostic and active treatment services to high-risk recipients under age 18;
2. provide utilization management to ensure appropriateness of admission, length of stay, quality of care; and
3. reduce recidivism by providing or facilitating aftercare services and/or linkages with appropriate community services.

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II. Definitions

Definition of Terms

The Florida Agency for Health Care Administration (AHCA) and First Health have provided certain definitions for services and patient status that will serve to provide a common reference point for consistent implementation of the program. These definitions are as follows:

- **Active Treatment:** Implementation of a professionally developed and supervised individualized plan of care, as described in 42CFR 441.155 and regulations thereunder.
- **Admission Review:** Medical record review performed at least 24 hours prior to the patient's admission to a SIPP to determine the medical necessity for admission.
- **Assessment:** The determination of a child's current and potential strengths, problems, and needs, by utilizing current intake, diagnosis, and evaluation information in order to identify service needs.
- **Case Management:** Care coordination, or the practice of planning, directing, and coordinating the provision and utilization of mental health and substance abuse services on an individual basis, as defined in the Medicaid Targeted Case Management Handbook.
- **CFR:** Code of Federal Regulations.
- **Community Aftercare Services:** On-going services received in a community-based outpatient setting following discharge from an inpatient facility.
- **Continued Stay Review:** Medical review conducted while the patient is in a SIPP to determine status of medical necessity for the continuation of services.
- **Culturally sensitive:** Applying knowledge and skills that respect the recipient's and family's individual and societal values, beliefs and attitudes to provide effective care and treatment for diverse populations.
- **Family:** The child's biological, adoptive or foster parent(s), guardian(s), sibling(s), grandparent(s), aunts and uncles, and other related or unrelated persons who have a significant relationship with the individual. For children placed pursuant to Chapter 39, F.S., the term family also includes the child's guardian ad-litem.
- **FirstHCM:** The name of the online prior authorization application used by First Health to conduct the utilization management process. Registered users may access this

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application to submit prior authorization and continued stay requests and view determination letters, notices, and the status of submitted requests via the Internet. Additional information is available at the following web address: <http://florida.fhsc.com>.

- **Good physical health**: A recipient is not suffering from a critical illness that requires extensive treatment measures.

- **Institution of Mental Diseases (IMD)**: A hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related service (A SIPP provider that has more than 16 beds is classified as an IMD). Pursuant to federal regulations regarding IMDs, children and adolescents in IMDs are not eligible for any other Medicaid benefit while they are SIPP services recipients. A SIPP provider is expected to provide routine medical care for individuals in good physical health. If more severe medical problems arise, an admitted recipient must be discharged from the SIPP provider in order to receive other medical benefits available to Medicaid eligible individuals.

- **Medical Necessity or Medically Necessary**: As defined in Section 59G.-1.010, F.A.C., "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:
 - (A) Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

 - (B) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

 - (C) Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

 - (D) Be reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide;

 - (E) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. Be furnished in accordance with Medicaid Policy.

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II. Definitions

- **Multidisciplinary Treatment Team:** Per 42CFR 441, and based on education and experience, preferably including competence in child psychiatry, a multidisciplinary team, also called an interdisciplinary team, must be capable of:
 - (1) Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
 - (2) Assessing the potential resources of the recipient's family;
 - (3) Setting treatment objectives; and
 - (4) Prescribing therapeutic modalities to achieve the plan's objectives.

The team must include, at a minimum, either:

- (1) A Board-eligible or Board-certified psychiatrist; or
- (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
- (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State psychological association.

The team must also include one of the following:

- (1) A psychiatric social worker or a Florida Licensed Clinical Social Worker.
- (2) A registered nurse with specialized training or one year of experience in treating individuals with mental illness.
- (3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating individuals with mental illness.

- **Primary Diagnosis:** The principle mental disorder that is the medically necessary reason for clinical care and the primary focus for treatment.
- **Pre-admission Review:** Review of a recipient's medical information prior to admission to the hospital to determine the medical necessity of admission. May also be called admission or initial review.
- **Prior Authorization:** Determination by First Health that the recipient's admission or continued-stay is appropriate and meets medical necessity criteria following the submission of a review.
- **Reconsideration:** Upon request of a provider or recipient, the review of an adverse determination previously rendered by First Health.
- **Treatment Plan:** The written compilation of the recipient's individualized treatment goals, measurable objectives and the treatment services to be provided. The treatment

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II. Definitions

plan is the goal-oriented, time-limited, individualized plan of action, which directs the treatment and services to be provided for the child and family.

- **Working Day**: 7:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday excluding holidays.

Utilization Management Procedures for Statewide Inpatient Psychiatric Program

III. Overview of Process

I. Overview of Process

On behalf of the Florida Agency for Health Care Administration, First Health Services of Florida, Inc. (FH) will perform all SIPP admission and continued stay reviews of services provided to Florida Medicaid recipients under the age of 18. Admission into a SIPP is voluntary and recipients may dis-enroll at any time. The program is limited to recipients in the following Medicaid eligibility categories:

- TANF- related,
- Supplemental Security Income (SSI), and
- SSI- related under age 18.

Recipients may not be admitted to a SIPP facility if any of the following applies

- They have Medicare coverage;
- They reside in a nursing facility or an Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD);
- They have an eligibility period that is only retroactive, or
- They are eligible as medically needy.

Reviews for SIPP hospitalizations consist of: (a) pre-admission reviews and certification of admissions, and (b) authorizations for continued stays. These reviews also verify the SIPP's compliance with applicable Medicaid regulations relating to pre-admission, admission, and utilization control.

Pre-admission and continued stay reviews must be submitted to First Health via the web-based application (FirstHCM). In special circumstances requests may be submitted telephonically. Specific information and instructions on enrollment for providers to use the FirstHCM application is posted on the First Health Services of Florida, Inc. web page;

<http://florida.fhsc.com>

Permission to submit telephonic reviews must be approved by First Health Services and the Florida Agency for Healthcare Administration.

Pre-admission information is expected to be submitted to FH at least twenty-four (24) hours prior to admission. Continued stay information is expected to be submitted to FH at least twenty-four (24) hours prior to the expiration of the last authorized stay, but no more than five (5) days prior to the expiration of the last authorized stay.

First Health, Inc. will make a decision for all pre-admission and continued stay requests within twenty-four (24) hours of receipt of a properly submitted request. The date of receipt of a properly submitted request is the date when all information needed to make a decision has been provided to FH. Board-certified FH physician advisors will make

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III. Overview of Process

all adverse decisions. Information on the status of the request is available to the SIPP facility within twenty- four (24) hours of the properly submitted request via the FirstHCM application. FH sends notification of the decision in writing to the recipient/legal guardian and to the SIPP within one business day of a denial or within one business day of receipt of the prior authorization (PA) number from the Medicaid fiscal agent. The letter may also be viewed via the FirstHCM application by the designated facility staff within one business day of a denial or within one business day of receipt of the prior authorization number from the fiscal agent.

The following minimum information is required to complete a pre-admission certification review or a continued stay review:

- A. A DSM IV-TR or ICD-9-CM Diagnosis on Axis I through V;
- B. A description of the initial treatment plan relating to the admitting symptoms;
- C. Current symptoms requiring SIPP treatment;
- D. Medication history;
- E. Prior hospitalizations;
- F. Documentation that the child or adolescent is mentally competent, has age appropriate cognitive ability and is sufficiently stable cognitively to benefit from treatment;
- G. Documentation that the child or adolescent is in good physical health, as certified by an MD, DO, Registered Nurse, Physician's Assistant or other professional who has the authority to perform physical examinations of a medical nature;
- H. Prior alternative treatment;
- I. Appropriate medical, social and family histories;
- J. Proposed aftercare placement/community-based treatment;
- K. Qualified Evaluator Network (QEN) assessment recommendation (for children and adolescents in the custody of the state).

Upon conclusion of the pre-admission review, FH will make one of the following determinations:

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- A. Treatment in a SIPP is medically necessary. A Certification of Need form (CON) will be completed by First Health Services and a letter of approval will be sent.
- B. If determined by a physician advisor that the recipient's condition does not require SIPP inpatient services; a letter of denial will be sent and will contain a description of the recipient's rights and the provider's rights to a formal reconsideration and a description of the appeal process.

Upon completion of the review, FH will notify all relevant parties in the following manner:

- A. The status and determination of the request will be available to the SIPP facility via the FirstHCM application.
- B. The recipient's legal guardian and the SIPP facility will be notified of the determination by mail. The notice will be mailed by FH within one business day of a denial or within one business day of receipt of the prior authorization number from the fiscal agent.

Admission Procedures

Children and adolescents must receive prior approval for admission into a SIPP. The provider is required to notify FH at least 24 hours in advance of the admission. It is recommended that the provider notify FH at least seventy-two (72) hours in advance when possible.

There are no emergency admissions into a SIPP. The following applies to all SIPP admissions.

- Medical clearance must be given by a medical doctor or physician advisor prior to admission.
- The child or adolescent must be in good physical health (no acute medical conditions or life threatening medical problems).
- Acceptance of a child or adolescent with chronic illness will be a joint decision between FH and the provider.
- The child or adolescent has age appropriate cognitive ability.
- The recipient's family or legal guardian must be contacted by the physician advisor or other designee to obtain admission approval. The family has the right to refuse the referral.
- Individuals who are in state custody may not be referred or admitted without an independent evaluation by a qualified evaluator in accordance with C 39.407, F.S., which concurs with the findings of medical necessity for this level of care.

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Continued Stay Procedures

Time-frames for continued stay reviews:

- (a) Recipients under 10 years of age: Reviews shall be conducted at least every twenty-one (21) days.
- (b) Recipients age 10 years and over: Reviews shall be conducted at least every thirty (30) days.
- (c) SIPP providers shall submit review information to First Health at least 24 hours (preferably 48 hours) prior to the recipient's last certified day to request additional certification. Continued stay review information submitted five (5) or more days prior to the end of an approved stay will not be reviewed unless approval for early submission is granted by AHCA and First Health Services.

Estimated Length of Stay and Discharge Planning

At each continued stay review, the facility should address the estimated length of stay for the recipient and plans for discharge. There should be basic agreement regarding length of stay and the anticipated date of discharge.

At each continued stay review, the facility should address the anticipated placement for the child or adolescent upon discharge, the identified support services needed upon discharge and the current status of referral and/or linkage to those services.

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IV. Certification of Need - Approval for Admissions

II. PRE-ADMISSION REVIEW AND CERTIFICATION OF NEED FOR SIPP ADMISSIONS

First Health Services will perform a pre-admission and Certification of Need (CON) review for all Medicaid SIPP admissions. To accomplish this, the facility will submit a request to FH at least twenty-four (24) hours (preferably 48 hours) prior to admission in order to complete the pre-admission review process.

There can be neither involuntary commitment admissions nor emergency admissions into a SIPP. A child being considered for admission into a SIPP must have medical clearance from a medical doctor or physician advisor. The medical doctor or physician advisor must certify that a recipient is currently in good physical health with no acute or chronic conditions requiring extensive medical treatment, and that the need for medical care, other than routine, is not anticipated. "Good physical health" means that a recipient is not suffering from a critical illness such as cancer, which requires extensive treatment measures. A recipient with a chronic but stable illness that can be managed with medication and routine monitoring can be accepted if FH and the provider agree. If, however, a recipient experiences a medical crisis, he or she will be discharged from the SIPP to receive other medical services. If a recipient is discharged for medical reasons, SIPP providers may maintain a bed for a period of time to be decided in consultation with FH but not to exceed seven (7) days. Acceptance of a recipient with a chronic but stable physical illness into a SIPP will be a joint decision between FH and the SIPP provider. If a disagreement results from this process, the provider may request a review by AHCA.

One of FH's licensed clinical reviewers will review the recipient's information to include:

- Demographic information
- Prior inpatient treatment
- Prior outpatient treatment
- Initial treatment plan with anticipated discharge date
- Estimated length of stay
- DSM IV-TR and/or ICD-9 diagnosis on Axis I through V
- Consent for psychotropic medications???
- Psychotropic medications currently being taken or which have been tried???
- Current symptoms requiring SIPP care
- Chronic behavior/symptoms
- Anticipated date of admission
- Comprehensive psychiatric, medical, psychosocial, social, and educational assessments initiated/completed
- QEN evaluations, if the child is in State custody.

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IV. Certification of Need - Approval for Admissions

If the admission does not clearly meet medical necessity criteria for admission or the information is insufficient, the clinical reviewer will place the information in “information pending” status with specific questions for the facility representative to provide additional information.

After further researching the record or conferring with the attending physician; the facility representative must submit additional information within one business day via the FirstHCM application. The FH clinical reviewer will review any additional information and defer the admission request to the assigned physician.

If no additional information is submitted within the one business day time frame; the case will automatically be deferred to a physician for review.

The FH licensed clinical reviewer will initiate a Certificate of Need (CON) and submit it to a FH physician to review in conjunction with the available information. If the information supports the need for SIPP treatment, the FH board-certified physician advisor will sign and date the CON approving the planned admission. The completed hard copy CON is stored at FH.

The FH physician will make a determination based upon available information. Information on the final determination is available on the FirstHCM application as soon as the request has been reviewed by the physician.

Within twenty-four hours of the posting of an adverse determination, the facility attending physician may request an informal telephonic peer review with the FH physician to discuss why the recipient cannot be treated less restrictively. The peer review must be scheduled within twenty-four (24) hours of posting of the adverse determination. The peer review must be completed within seventy-two (72) hours of the posting of an adverse determination. After the peer review is completed, the FH physician will approve or deny the authorization request. If the attending physician fails to complete a scheduled peer review, the adverse determination will remain. However, the legal guardian or provider may request a reconsideration of the findings in writing within forty (40) days of the adverse determination.

Approvals: Approved days may be authorized in blocks of up to twenty-one (21) days for recipients under age 10. For recipients age 10 and older, days may be authorized in blocks of thirty (30). In some circumstances, fewer than 21 or 30 days may be authorized.

Information on the determination status and the prior authorization number will be available to the provider on First Health secure web-site via the FirstHCM application. Notification letters are sent to the facility and to the recipient/legal guardian.

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IV. Certification of Need - Approval for Admissions

Denial: When a FH Board-certified physician advisor denies the authorization, a letter will be generated that includes the physician's statement of the action, the rationale for the action, and the medical necessity criteria that support the determination. A letter of denial will be sent to the SIPP facility and to the recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the SIPP facility to request reconsideration of the determination. The facility designated staff member may view the letter of adverse action via the FirstHCM application at any time within one business day of the determination.

The recipient/legal guardian or SIPP facility may request reconsideration within forty (40) days of the adverse determination. FH will complete the reconsideration request within seven (7) business days after the date the reconsideration request and hardcopy of the recipient record are stamped received by First Health Services.

**Florida Agency for Health Care Administration
Certification of Need
Medicaid Statewide Inpatient Psychiatric Services**

Recipient's Name _____
Medicaid ID Number _____
Facility _____

ICD-9 Codes _____
Axis I : _____
Axis II : _____
Axis III: _____
Axis IV: _____
Axis V : GAF: _____ HAF: _____

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient due to:

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician due to:

The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed based upon:

____ Certification of need is approved

____ Certification of need is denied

Reason for denial _____

Signature of Certification Team Physician

Date

Signature of Certification Team Registered Nurse

Date

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V. Medical Necessity Review for Continued Stays

III. CONTINUED STAY REVIEWS

It is the responsibility of the SIPP provider to contact FH for continued stay reviews. This is accomplished by entering a continued stay request via the FirstHCM application at least twenty-four (24) hours (preferably 48 hours) prior to the expiration of the current certified period of stay. FH conducts continued stay reviews for all SIPP admissions at least every twenty-one (21) days for recipients under age 10 and at least every thirty (30) days for recipients age 10 and older during a SIPP inpatient stay. The following information is required to complete a continued stay review:

- Current treatment plan;
- Current DSM-IV-TR or ICD-9-CM diagnosis on all five Axes;
- Assessment of treatment progress with regard to admitting symptoms
- Summary of treatment provided up to the point of review;
- Assessment of need for further treatment;
- Current discharge date and plan (presence of a well-written plan and implementation efforts);
- If discharge date changes, an explanation as to rationale for change;
- Current consent for any new psychotropic medications added.

A FH licensed clinical reviewer will review the information to make a determination. The reviewer will determine if the recipient continues to meet criteria for continued stay or defer the request to a FH physician to make a determination. Once a decision is made it will be immediately available to the provider via the FirstHCM application.

Approval: Days will be authorized, not to exceed twenty-one (21) days for recipients under age 10, or thirty (30) days for recipients age 10 and older. The FH clinical reviewer will complete the continued stay review based upon the information provided by the provider representative. The information must be sufficient for the clinical reviewer to make a determination that medical necessity criteria are met. FH generates a letter with the continued stay certification and mails a copy to the SIPP provider and to the recipient or legal guardian. The letter is mailed within one (1) business day of receipt of the prior authorization number assigned by the Medicaid fiscal agent. This letter may also be viewed via FirstHCM application by the provider's designated staff member.

If the continued stay request does not provide sufficient information to determine if it meets medical necessity criteria for additional days, the FH clinical reviewer will place the review in "information pending" status and allow the provider to provide additional information within one business day. The provider representative may enter additional information into the FH review database through the FirstHCM application.

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V. Medical Necessity Review for Continued Stays

If no additional information is provided; the review will automatically be deferred to a FH physician who will make a determination based upon the available information. The determination will be available to the SIPP provider via the FirstHCM application.

In case of a denial, the SIPP provider may request an informal telephonic peer review with the FH physician to discuss why the recipient cannot be treated less restrictively. The peer review must be scheduled within one business day of the denial determination. The review must be completed within 72 hours of notification of the denial. After the peer review, the FH physician may approve or deny the authorization request.

When an FH Board-certified psychiatrist denies the authorization, a letter will be generated that includes the physician statement of the action, provides the rationale for the action, and medical necessity criteria which support the determination. A letter of denial will be sent to the SIPP provider and recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the provider to request a reconsideration of the determination. This letter may also be viewed via the FirstHCM application by the provider designated staff member at any time within one business day of the determination.

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VI. Peer to Peer Reviews

IV. Peer to Peer Review Procedures

Notification to the SIPP provider of the decision for all pre-admission and continued stay requests is available through the FirstHCM application. This information is generally available within one business day of a properly submitted request. Once the intention to partially approve or deny has been determined, the provider's physician or assigned clinician may request an informal discussion of the recipient's case with the FH physician. If the option of the peer review is elected, then the provider representative must call FH within twenty-four (24) hours of the posting of the denial determination on the FirstHCM application to schedule an appointment time for the peer review. The peer-to-peer review is scheduled at the request of the attending physician but must be completed within seventy-two (72) hours of posting of the adverse action. The SIPP staff must consult with the attending physician prior to scheduling the peer-to-peer review in order to verify that the provider physician wants a peer-to-peer review and to discuss available appointment times. The attending physician's office staff or SIPP staff may schedule the peer review appointment. Should the provider physician be unable to complete the scheduled peer review with FH, the peer review may be rescheduled if FH receives notification **prior** to the scheduled time. FH is unable to reschedule peer reviews if notification is received after the scheduled time. After the completed peer review, the FH physician may approve or deny the authorization request.

FH will provide notification of the peer review decision in writing to the recipient/legal guardian, and the SIPP provider by the close of the third business day after the peer review is completed or upon receipt of the prior authorization number from the Florida Medicaid fiscal agent. The determination is also available to the provider through the FirstHCM application.

Approval: Following a peer-to-peer review the FH physician may authorize days not to exceed twenty-one (21) days for recipients under age 10 and thirty (30) days for recipients age 10 and older. A letter is generated and sent to the provider, and the recipient/legal guardian indicating that FH reversed the initial adverse determination through the informal peer review. The provider designated staff member may view this determination via the FirstHCM application at any time within one business day of the determination.

Denial: When a FH Board-certified psychiatrist denies further authorization following the informal peer review process, a letter will be generated that includes the physician statement of the action, the rationale for the action, and medical necessity criteria which support the determination. A letter of denial will be sent to the SIPP provider and to the recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the provider to request a reconsideration of the determination. The provider designated staff member may view this letter via the FirstHCM application at any time within one business day of the determination.

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VI. Peer to Peer Reviews

The peer-to-peer review process is provided as an additional step in the appeal process and does not supersede the formal reconsideration process for the recipient/legal guardian or provider.

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VII. Appeals

V. APPEALS PROCESS

The appeals process generally consists of two steps;

- Reconsideration that is available to the recipient/legal guardian or facility, and
- Fair hearing that is available only to the recipient/legal guardian.

Additional supporting information may be submitted at the time the formal written request for reconsideration or fair hearing is made.

RECONSIDERATION

The recipient/legal guardian or provider may request a reconsideration of any adverse determination. The request for reconsideration must be made in writing to FH. A hard copy of the medical record must be submitted with the request for reconsideration.

Upon receipt of the request, a board-certified FH psychiatrist not involved in the initial determination will review all submitted documentation and render a determination within seven (7) business days of receipt of the request. If the second FH psychiatrist agrees with the original determination, the decision is upheld and the reconsideration process is completed. FH will provide written notification of the reconsidered determination within three (3) business days to the recipient/legal guardian and SIPP facility. The written notification will advise the recipient/legal guardian of the right to a fair hearing as the next level of appeal. The determination and written notification will be available to the SIPP provider through the FirstHCM application.

If the second FH psychiatrist reverses the original adverse determination, the case is overturned and the reconsideration process is complete. Written notification will be provided to the recipient/legal guardian and SIPP provider within twenty-four (24) hours of receipt of the prior authorization number from the fiscal agent. The determination and written notification will be available to the SIPP provider through the FirstHCM application.

The written request for reconsideration must be sent to:

First Health Services of Florida, Inc.
Reconsideration Unit
4300 Cox Road
Glen Allen, VA 23060

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VII. Appeals

REQUEST FOR FAIR HEARING

The recipient/legal guardian has the right to request a hearing for any adverse determination subsequent to the reconsideration determination, or at any time during the appeals process. Fair hearing is a process managed by the Department of Children and Families- Office of Appeals. First Health Services participates by providing documentation and staff testimony of FH determinations in the prior authorization process.

The request for a fair hearing must be made in writing to:

Agency for Health Care Administration
Bureau of Medicaid Services
Long Term Care, Behavioral Health, and Quality Improvement Unit
2727 Mahan Drive, Mailstop #20
Tallahassee, Florida 32308

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VIII. Hours of Operation

VI. HOURS OF OPERATION

First Health's hours of operation are from 7:00 a.m. until 6:00 p.m. Eastern Time, Monday through Friday. First Health Services maintains a toll-free telephone line for questions regarding clinical issues, specific cases and for scheduling peer reviews. FH staff may be reached during office hours by calling **1-800-770-3084**. After business hours callers may leave a voice mail message. FH staff will return the call by 12 noon of the following business day.

Providers are required to submit data via the web-based Online Prior Authorization (PA) (First HCM) system. A secure log-in is required to submit requests. Providers with the appropriate log-in may access this secure web-site through the FH web page at any time of the day or night. The web address is:

<http://florida.fhsc.com>

Additional information on this site includes but is not limited to:

- Provider manuals;
- Special information bulletins;
- Complaint instructions and forms;
- Data Correction Request forms and other forms;
- Satisfaction and other surveys.

FH maintains a toll-free line for providers who have questions regarding accessing the FirstHCM application or are experiencing difficulty in accessing and using the site. The number is;

1-800 241-8726

Staff are available to provide assistance in accessing the web-based application (FirstHCM) from 8:00 am until 8:00 pm Eastern Time.

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IX. Admission Criteria

VII. FLORIDA ADMISSION CRITERIA FOR STATEWIDE INPATIENT PSYCHIATRIC PROGRAMS

The following criteria are to be used for admission to a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients:

1. All admissions are non-emergency and voluntary.
2. Medical clearance must be given by a physician prior to admission.
3. The child or adolescent has age appropriate cognitive ability.
4. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP.
 - A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community.

To meet this requirement, one (1) of the following shall be established.

1. A lower level of care will not meet the recipient's treatment needs. Examples of lower levels of care include:
 - a. Family or relative placement with outpatient therapy
 - b. Day or after-school treatment
 - c. Foster care with outpatient therapy
 - d. Therapeutic foster care
 - e. Group child care supported by outpatient therapy
 - f. Therapeutic group child care
 - g. Partial hospitalization
 - h. Custodial Care.
 2. An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.
- B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement all of the following criteria must be met:

1. An ICD-9 diagnosis is present and has been established through a documented comprehensive bio-psychosocial diagnostic

Utilization Management Procedures for Statewide Inpatient Psychiatric Program

IX. Admission Criteria

assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly diagnosed psychotic disorders. A concurrent Axis I substance abuse disorder may be present.

2. The rating on DSM IV Axis V at admission is less than fifty (50).
3. The recipient is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one (1) of the following categories designated as a, b, c or d:
 - a. Self-care Deficit (not Age Related): Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the recipient's mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g. refuse medications)

OR

- b. Impaired Safety (Threat to Self or Others): Evidence of intent to harm self or others caused by the recipient's mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:
 - (1) Severely depressed mood
 - (2) Recent loss
 - (3) Recent suicide attempt or gesture or past history of multiple attempts or gestures
 - (4) Concomitant substance abuse
 - (5) Recent suicide or history of multiple suicides in family or peer group,

OR

- c. Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent

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that the patient cannot negotiate his basic environment, nor participate in family or school (paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm.

Indicators:

- (1) Disruption of safety of self, family, peer or community group.
- (2) Impaired reality testing sufficient to prohibit participation in any community educational alternative.
- (3) Not responsive to outpatient trial of medication or supportive care.
- (4) Requires sub acute diagnostic evaluation to determine treatment needs

OR

- d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes which place the recipient at risk.

Indicators (one of the following):

- (1) Family environment is causing escalation of recipient's symptoms or places recipient at risk.
 - (2) The family situation is not responsive to available outpatient or community resources and intervention.
 - (3) Instability or disruption is escalating.
 - (4) The situation does not improve with the provision of economic or social resources.
 - (5) Severe behavior or established pattern of behavior prohibits any participation in a lower level of care, e.g. habitual runaway, prostitution, repeated substance abuse.
4. The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self care, etc.) as evidenced by documented presence of:

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- Deficits in cognition, control, or judgment due to diagnosis(s)
 - Circumstances resulting from those deficits in self care, personal safety, social/family functioning, academic or occupational performance, or
 - Prognostic indicators which predict the effectiveness of treatment.
5. The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational and substance abuse needs. Specifically:
- a. Services shall be under the supervision of a physician advisor.
 - b. Intervention of qualified professionals shall be available twenty-four (24) hours a day.
 - c. Multiple therapies (group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the recipient. Family therapy with families or surrogates must be involved unless clinically contraindicated, with an expectation of two family sessions per week.
- C. The services can reasonably be expected to improve the recipient's condition within a reasonable time frame of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
- 1. The treating facility shall provide a description of the plan for treatment illustrating the required services available at SIPP level of care.
 - 2. The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable and time-framed discharge criteria.
 - 3. The benefits of SIPP care are expected to result in maintaining or improving the recipient's level of functioning.

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IX. Admission Criteria

Exclusion Criteria

Children and adolescents meeting any one of the following criteria are not considered appropriate for care in a SIPP.

1. Less intensive levels of treatment will appropriately meet the needs of the child or adolescent.
2. The primary diagnosis is substance abuse, mental retardation or autism.
3. The recipient is not expected to benefit from this level of treatment.
4. The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment.
5. The youth has a history of long standing violations of the rights and property of others.
6. A pattern of socially directed disruptive behavior (e. g., gang involvement) is the primary presenting problem.
7. Recipients cannot be admitted to a SIPP if they have Medicare coverage; reside in a nursing facility or ICF/DD; or have an eligibility period that is only retroactive or are eligible as medically needy.
8. Lack of medical clearance from a physician for admission.

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X. Continued Stay Criteria

VIII . FLORIDA CONTINUED STAY CRITERIA FOR STATEWIDE INPATIENT PSYCHIATRIC PROGRAMS

The following are criteria to be used for continued stay in a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients.

Requirements A, B, and C shall be met for continued stay:

- A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)).

To meet this requirement, one (1) of the following shall be established.

1. A lower level of care is unsafe and will place the recipient in imminent danger of harm.

Examples of lower levels of care include:

- a. Family or relative placement with outpatient therapy
 - b. Day or after-school treatment
 - c. Foster care with outpatient therapy
 - d. Therapeutic foster care
 - e. Group child care supported by outpatient therapy
 - f. Therapeutic group child care
 - g. Partial hospitalization
 - h. Custodial care
2. Clinical evidence exists that a lower level of care will not meet the recipient's treatment needs.
 3. The recipient's mental disorder could be treated with a lower level of care; but because the recipient suffers one or more complicating concurrent disorders, SIPP care is medically necessary.

Example: Major Depressive disorder with epilepsy

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X. Continued Stay Criteria

- B. Proper treatment of the recipient's psychiatric condition continues to require services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, all of the following criteria must be met:

1. The patient continues to have a psychiatric condition or disorder which is classified as an ICD-9 diagnosis. A concurrent Axis I substance abuse disorder may be present.
2. The rating on DSM IV Axis V continues to be less than fifty (50) for the primary diagnosis
3. The recipient continues to experience problems related to the mental disorder diagnosed in B.1 above in one (1) of the following categories designated as (a), (b), (c) and (d):
 - a. Self-care Deficit (not Age Related): Impairment of ability to meet physical needs which place the recipient at risk of self-harm.

Indicator:

- (1) Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe.

- b. Impaired Safety (Threat to Self or Others):

Continued evidence of intent to harm self or others caused by the recipient's mental disorder, provided that such intent does not constitute a clinically emergent situation.

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X. Continued Stay Criteria

Indicators:

- (1) Continued suicidal/homicidal ideation with expression of plan of intent
- (2) Potential for aggressive behavior requiring infrequent seclusion or restraint

c. Impaired Thought and/or Perceptual Processes (Reality Testing):

Inability to perceive and validate reality to the extent that the patient cannot negotiate his basic environment, nor participate in family or school (paranoia, hallucinations, and delusions) and it is likely that the recipient will suffer serious harm.

Indicators:

- (1) Disruption of safety of self, family, peer or community group.
- (2) Impaired reality testing sufficient to prohibit participation in any community educational alternative.
- (3) Requires continued sub acute diagnostic evaluation to determine treatment needs.

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes which place the recipient at risk of serious harm.

Indicators (one of the following):

- (1) Family contacts and interaction and/or family environment are causing escalation of recipient's symptoms and place the recipient at risk of serious harm.

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X. Continued Stay Criteria

- (2) Instability or disruption is escalating.
 - (3) Severe behavior prohibits any participation in a lower level of care, e.g. habitual runaway, prostitution, repeated substance abuse.
 4. The child or adolescent has a serious impairment of functioning compared with others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self care, etc.) as evidenced by documented presence of:
 - Deficits in cognition, control, or judgment due to diagnosis
 - Circumstances resulting from those deficits in self care, personal safety, social/family functioning, academic or occupational performance, or
 - Prognostic indicators which predict the effectiveness of treatment.
 5. The facility has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at this level of care; specifically:
 - a. Services shall be under the supervision of a physician advisor.
 - b. Intervention of qualified professionals shall be available twenty-four (24) hours a day.
 - c. Multiple therapies (group counseling, individual counseling, recreational therapy, expressive therapies, family therapy, etc.) shall be actively provided to the recipient.
- C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
1. The treating SIPP facility has developed a plan for continuing treatment illustrating the required intensity of services available at a SIPP level of care.

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X. Continued Stay Criteria

2. The treating SIPP facility has provided a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan was initiated as soon as the initial assessment was completed and included discrete, behavioral, and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.

3. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued SIPP hospitalization would be required or would result in regression.

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XI. Transfer and Discharge Criteria

IX. FLORIDA TRANSFER AND DISCHARGE CRITERIA FOR STATEWIDE INPATIENT PSYCHIATRIC PROGRAMS

Transfer Criteria

Transfer of a child or adolescent from one SIPP into another SIPP may occur only under the following conditions:

- The patient/provider relationship is not mutually acceptable and this finding is confirmed by FH, the Agency, and the Department of Children and Families (DCF);
- The recipient's condition or illness could best be treated by another provider type;
- The SIPP facility determines that it is not able to provide effective treatment to a recipient due to the recipient's non-compliant behavior, subject to a case review by FH in collaboration with DCF or the child's caregiver. If FH in conjunction with DCF or the child's caregiver, determines that the SIPP should be able to address the child's needs, FH will recommend that the plan of care be revised and the SIPP provider continues to serve the child. However, if in good faith, the SIPP provider and FH continue to determine that the SIPP cannot meet the individual's needs AHCA will not force the provider to continue services and the individual may be discharged to a more appropriate provider.

The SIPP provider will keep a recipient as a client until another SIPP facility or acute care setting for recipients under age 18 is available, if the child or adolescent continues to meet the criteria for this level of care.

Following approval by FH, a SIPP facility must notify a participant and parent or legal guardian in a direct and timely manner of a provider's decision to discontinue treatment. The participant may request reconsideration of this decision according to the reconsideration and appeals process.

Data regarding requests for dis-enrollment or transfer to another SIPP provider under this program will be tracked by AHCA. If data indicate repeat requests for dis-enrollment by one provider, it will trigger a program review and evaluation.

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XI. Transfer and Discharge Criteria

Discharge Criteria

The following requirements shall be met prior to discharge from a SIPP facility:

- The recipient has received maximum benefit from his or her present plan of care;

OR

- The child has failed to benefit from a reasonable course of SIPP care, **and** documentation supports that a suitable alternative placement is established which will meet the child's needs, **and** the discharge plan includes input from family or surrogate family and DCF-Substance Abuse and Mental Health program office;

OR

- Severe medical problems have arisen which cannot be managed by the SIPP facility. If it is determined that a child will require extensive medical attention, the SIPP may work with the Medicaid area office to dis-enroll the child from the SIPP, so that other Medicaid services can be accessed.

Note: In order to provide for continuity of care for the child, the SIPP Request for Proposals (RFP) requires that providers hold a bed for a child for up to seven (7) days if the child is undergoing an acute medical or psychiatric admission and is expected to return to the SIPP.

The provider is required to demonstrate detailed aftercare planning services are recommended and developed by the treatment team that identify treatment needs and provide access to resources for continuing treatment upon return to the community. Aftercare planning must include liaison with the recipient's school and other appropriate agencies and community resources such as Targeted Case Management; DCF-Substance Abuse and Mental Health and Family Safety; Department of Juvenile Justice; and Vocational Rehabilitation. The goal of aftercare planning is to promote a coordinated transition into the community.

SIPP providers should be mindful of the requirements for discharge and transfers as outlined in the 2004 SIPP RFP. A SIPP provider will be dis-enrolled from Medicaid and the agreement terminated as a result of the provider's failure to comply with enrollment requirements or provisions of the contract.