ValueOptions Colorado Partnerships
Provider Alert

Inpatient Authorization Requirement Update

The purpose of this Provider Alert is to notify in-network facilities of new requirements regarding authorizations for acute inpatient services when Medicaid is secondary.

Effective Date: February 1, 2016

ValueOptions, in collaboration with our partners (CHP and FBHP), has made the determination that pre-certification and concurrent reviews for acute inpatient level of care will no longer be required when Medicaid is secondary to Medicare, employee health plans or other third party medical insurance.

What this means is that when a member is in need of admission to an acute inpatient level of care, there is no longer a need to contact ValueOptions Care Management for an authorization prior to admission, **when the member has other primary coverage**. In addition, concurrent reviews will not be required. However, appropriate, timely, and collaborative continuity of care communications are still required with the Mental Health Center (MHC) staff to coordinate discharge plans with the MHC, for ongoing care post discharge (see attached Section 4 of the Provider Handbook, Mental Health Inpatient Care Requirements).

When a member is covered by Medicare, employee health plan or other third party medical insurance the claim must first be filed with the primary carrier. Facilities must submit a copy of the Explanation of Benefits (EOB) that includes the primary payer's determination when submitting claims to ValueOptions. If ValueOptions Claims Department discovers that the member's primary payer denied the inpatient stay (e.g., coverage is exhausted, not meeting medical necessity, non-covered benefit) the claim will be denied and the facility will be notified of the need to submit the chart for a retrospective review to ValueOptions.

Facilities are encouraged to follow ValueOptions utilization management procedures in cases where it is known that a member has exhausted their primary payers' benefits or in non-covered benefit situations.

Resources:
If you have any questions or concerns regarding these requirements you may contact ValueOptions Provider Relations at 800-804-5040 or email coproviderrelations@valueoptions.com.

Provider Alerts can be accessed at:
http://www.coloradohealthpartnerships.com/provider/prv_info.htm
http://fbhpartners.com/providers/alerts.html

Provider Handbooks can be accessed at:
http://www.coloradohealthpartnerships.com/provider/prv_hbk.htm
http://fbhpartners.com/providers/index.html

ATTACHMENT

Mental Health Inpatient Care Requirements

Inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled psychiatric nursing care, daily medical evaluation and management and a structured treatment milieu are required. Inpatient services settings must provide the following:

Within 24 hours of admission:

- An initial visit with a psychiatrist, or other practitioner with prescriptive authority (e.g., Physician Assistant, Nurse Practitioner, Resident Physician) with psychiatrist consultation, for evaluation and treatment planning.
    - A comprehensive bio-psychosocial history including at a minimum:
        - History of Presenting Illness
        - Psychiatric History
        - Past and Present use of alcohol and other drugs
        - Medical History
        - Family History
        - Social History
        - Current Medications
        - Allergies
    - Comprehensive Review of Systems
    - Full mental status examination
    - Initial Psychiatric Assessment/Formulation including current Diagnostic and Statistical Manual based diagnoses
    - Risk Assessment
    - Comprehensive, individualized, treatment plan including psychopharmacologic treatment plan when appropriate
    - Complete documentation as detailed in Section 17 of this Handbook

- An initial medical assessment
    - History and Physical Examination with neurological emphasis
    - Laboratory and other medical testing as appropriate
    - Urine toxicology screen if not completed at the time of admission

- Communication with the inpatient liaison or other appropriate representative of the member's attributed Community Mental Health Center (CMHC) within 24 hours
    - Exchange of Pertinent History
    - Establishing connection
    - Discharge planning

Within 48 hours of admission:

- A discharge plan including Member/family/guardian input, and signed by the Member/family/guardian, has been included in the patient record within 48 hours of the Member's admission, or when the Member is clinically able to meaningfully participate in discharge planning.

- In cases where the discharge plan is delayed beyond 48 hours after admission, the patient record shall include documentation of the clinical reason for the delay.

Post-admission Hospital Days

- A documented daily visit with an attending, licensed, prescribing provider.
    - Collection and review of interim history
    - Evaluation and documentation of the member's current mental status
    - Assessment of the member's progress in relation to their presenting problems
    - Justification of continued need for inpatient care
    - Update of the treatment plan, including medication strategy
    - Progress note documentation as required in Section 17 of this Handbook

- Other daily interventions.
    - Individual psychotherapeutic intervention focused on presenting problems (may be part of the prescriber visit)
    - Group/milieu activity
    - Safety planning as indicated
    - Discharge planning

- Frequent coordination of care and unrestricted communication with the CMHC inpatient liaison or other appropriate representation of the CMHC, including:
    - Contact by a practitioner involved with the member's care (i.e. an active representative of the treatment team such as the member's assigned social worker, therapist or prescriber) with the inpatient liaison/CMHC representative at least 3 days per week
    - Face to face meetings when requested by the liaison or other CHMC representative
    - Calls/emails from the liaison/CMHC representative returned within 24 hours or by the next business day

Discharge

- Communication by a practitioner involved with the member's care with the inpatient liaison/CMHC representative and/or provider(s) responsible for post discharge care regarding all pending discharges. Ideally to be completed 24 hours prior to discharge.
- Documentation of the discharge plan including follow-up appointments per Handbook guidelines, discharge medications, and emergency contacts delivered to the patient in writing with a face to face review.
- Provision of a 30 day prescription for discharge medications with confirmation the member has the resources to obtain medications or documentation that a new prescription is not required.