

State of Alaska
Department of Health and Social Services

Behavioral Health Inpatient Psychiatric Review Provider Manual

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Table of Contents

Section 1–Care Management Program Overview..... 1
Organizational Overview..... 1
Purpose of Care Management..... 1
Definitions of Utilization Management and Care Coordination..... 2
Comparison between Utilization Management and Care Coordination..... 2
History of Medicaid Utilization Review and the QIO Program in Alaska..... 3
Qualis Health's Background and Experience..... 3
Qualis Health's Professional Expertise..... 4

Section 2–Communications with Qualis Health..... 6
Introduction..... 6
Contacting Qualis Health via Internet..... 6
Contacting Qualis Health by Mail..... 6
Contacting Qualis Health by Phone..... 6
Contacting Qualis Health by Fax..... 7
Qualis Health's Communication of Review Determinations..... 7

Section 3–Compliance with URAC's Utilization Review Standards..... 8
Frequently Asked Questions about Utilization Review Decisions..... 8
1. Who makes the utilization review decision?..... 8
Initial Clinical Review..... 8
Peer Clinical Review..... 8
Appeal Process..... 8
2. Why is a peer-to-peer conversation important?..... 8
3. What are the timeframes for peer-to-peer conversation?..... 9
4. What recourse is there when we disagree with a Qualis Health determination? 9
5. What is considered an urgent review?..... 9
6. How are review timelines determined?..... 10
7. What are the timeframes for completion of urgent reviews?..... 11
8. What are the timeframes for completion of non-urgent reviews?..... 12

Section 4–HIPAA..... 14
Business Associate Standing..... 14
National Provider Identification..... 14

Section 5–Provider Billing Concerns..... 15
Claim Discrepancies..... 15

Contingency for Payment ……. 15

Section 6–Eligibility andReview Limits…….. 16
Overview……. 16
Review Scope…… 16
Review Limits……. 17

Section 7–Utilization Review Methods of Submission…… 18
Submission Methods…… 18
Provider Responsibility for Automated Voice Response……. 19
ID Cards and Coupons……..... 19
Automated Voice Response System (AVRS)……..…… 19

Section 8– Processes for Utilization Review Submissions……. 20
Purpose…… 20
Responsibility…….. 20
Requirements…….. 20
Process and Procedures…… 20
Submission…….. 21
Required Review Documentation……. 21
Medical Necessity Screening…… 22
Second-level Peer Review……. 22
Non-certifications……. 22
Questionnaires……. 23
Process and Procedures for Urgent Inpatient Admissions……..….. 23
Procedures for Admission Reviews and Continued Stay (Concurrent) Reviews Due on Weekends and Holidays……..….. 24
Late Submission Requests for Reviews……..... 24
Chart Requests…….. 24

Section 9–Prior Authorization for Admissions …….. 26
Purpose……..…. 26
Responsibility……..… 26
Requirements…… 26
Non State Custody Youth Processes and Procedures for Admissions…….. 27
Information Needed for the Review…….. 27
Timeframes for Submission of Prior Authorization Reviews……. 28
Timeframes for Pended Reviews…… 29

Medical Necessity Review Process…….. 29
Transfer (Admission) Reviews……... 29
Eligibility Established During an Inpatient Admission…… 30

Section 10–Continued Stay (Concurrent) Utilization Reviews…….. 31
Purpose……... 31
Responsibility……. 31
Requirements……. 31
Process and Procedures…….. 31
Information Needed for the Review……. 31
Medical Necessity Review……. 32
Timeframes for Continued Stay Review Submissions…… 33
Timeframes for Pended Reviews……. 33
Therapeutic Transition Days (TTD) …… 33
Review Process for TTD…… 33
TTD Criteria …… 34
Indicators to Certify TTD…… 34

Section 11– Retrospective Reviews…….. 35
Definition and Purpose……. 35
Process for Submitting a Request for a Retrospective Review…….. 35
Methods for Submitting Retrospective Reviews, Once Approval for Submission Has Been Attained…… 35
Submitting Retrospective Reviews Via Web-based Review System 35
Chart Requests…….. 35
Medical Necessity Screening…….. 36
Non-certifications……... 36

Section 12–Leave of Absences…… 38
Approved Leave of Absence…….. 38
Unapproved Leave of Absence……. 38
Admission to a Different Facility……. 38
Incarceration of a Youth…… 38
PRTF Therapeutic Leave of Absence Policy……. 39
Coverage…….. 39

Billing/Reimbursement……..…. 40

Section 13—Serious Occurrences and Sentinel Events…… 41
The Code of Federal Regulations (42CFR483.374)…… 41
Reporting Requirements of Providers from the State of Alaska, Department of Health and Social Services, Behavioral Health…… 42
Alaska Behavioral Health's Clarification of Providers' Reporting Requirements…. 42

Section 14 —Treatment for Sexual Offenders…….…….. 44
Assessments of Sex Offenders for Treatment Planning Purposes…… 44

Section 15–Onsite Reviews and Seclusion & Restraint Standards…….. 45
Overview of Potential Quality of Care Concerns…….. 45
Site Reviews ……... 45
Seclusion and Restraints ……. 45

Section 16-Utilization Review Appeals…….. 46
Overview…….. 46
Expedited Appeals……. 46
Definition……. 46
Process and Procedures…….. 46
Standard Appeal…… 47
Definition…….. 47
Process and Procedures…….. 47
Department of Health and Social Services Appeal Procedure…….. 48
Fair Hearing Rights for Recipients…….. 48
Second Level Appeal Rights for Providers…… 49

Section 17-Care Coordination…… 50
Overview…….. 50
Discharge Planning Across the Continuum of Care……. 50
Availability of Services within Alaska…….. 50
Discharge Planning Process Outcomes…… 52
Tracking Bed Availability and Treatment Programs……. 53
Case Consultation with State Officials…… 53
State of Alaska's "Bring The Kids Home Initiative" (BTKH) ……... 54

Appendices

Appendix A – Glossary of Terms…….. 55
Glossary of Terms…….. 57
Acronyms……. 62
Appendix B – Alaska State Medicaid Program Acute Psychiatric Hospitalization Medical Necessity Criteria……... 64
Appendix C – Alaska State Medicaid Program Residential Psychiatric Treatment Center (PRTF) Medical Necessity Criteria…….…. 71
Appendix D – Alaska Medicaid Mental Health Review; Review Requirements Summary Sheet and Definitions……. 78
Appendix E - Alaska Medicaid Mental Health Review; Timeframes for Reviews… 86
Appendix F - Contact Information……... 90
Appendix G - Commonly Used Phone Numbers and E-mail Addresses…….. 95
Appendix H - List of Example Exhibits……... 101
Exhibit 1 – Prior Authorization Admissions Example Flow Chart ……..… 104
Exhibit 2 – Continued Stay Review Example Flow Chart……..…… 106
Exhibit 3 – Expedited Appeal Process Example Flow Chart ……..... 108
Exhibit 4 – Standard Appeal Process Example Flow Chart……. 110
Exhibit 5 – Late Submission Review Example Process Flow Chart ……. 112
Exhibit 6 – Retrospective Eligibility Review Example Process Flow…….. 115
Exhibit 7 – Example Admissions Review Questionnaire……. 117
Exhibit 8 – Example Continued Stay Review Questionnaire……... 121
Exhibit 9 – Referral Form for Potential Out of State Admission……. 128
Exhibit 10- Certificate of Need (CON) Form…….. 131
Exhibit 11 – Retrospective Review Request Form/Late Submission Request……. 133
Exhibit 12 – Behavioral Health Recipient Incident Report ……. 135
Exhibit 13 - PRTF Leave of Absence Request Form …….. 139
Exhibit 14 –Standards for Site Reviews…….. 140
Exhibit 15 – Standards for Seclusion and Restraints…… 141
Exhibit 16- Intellectual/Developmental Disabled Waiver (IDD) Form link…….. 151

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Section 1–Care Management Program Overview

Organizational Overview

Qualis Health's mission is to generate, apply, and disseminate knowledge to improve the quality of healthcare delivery and health outcomes. In executing Qualis Health's mission and striving toward Qualis Health's vision to be recognized for leadership, innovation, and excellence in improving the health of individuals and populations, Qualis Health is guided by the following set of core values:

- **Integrity and professionalism—**Qualis Health performs its work in an objective and unbiased manner and interacts with providers, Medicaid recipients, and program stakeholders in a respectful and professional manner. Qualis Health's employees receive comprehensive training and continuing education to ensure they are highly skilled and knowledgeable, and Qualis Health monitors their own performance as Qualis Health strives to assure accuracy and high technical quality in the review services Qualis Health provides.
- **Collaboration—**Qualis Health promotes collaborative relationships, both internally and externally. Qualis Health values diversity of opinion, background, and perspectives among Qualis Health's employees, clients, and collaborators. Qualis Health follows established processes and procedures that promote both collaboration and quality in the provision of review services, and Qualis Health collects and report on relevant review data that can be used to identify opportunities to improve the delivery of healthcare and patient outcomes.
- **Stewardship—**QualisHealthconducts work knowing that the primary objective of clients is to maximize healthcare value by assuring high quality and cost effectiveness. Qualis Health seeks to apply technical and professional innovations that assist us in serving as good stewards of healthcare resources.

Purpose of Care Management

The purpose of Qualis Health's Care Management program for the State of Alaska, Department of Health and Social Services, is to provide utilization review and care coordination services. Qualis Health's services help ensure appropriate medical services are provided to Alaska Medicaid recipients at a reasonable cost and in accordance with state and federal regulations, statutes, and policies. Qualis Health has been providing care management services for Alaska Medicaid for more than 20 years.

Definitions of Utilization Management and Care Coordination

Qualis Health's care management programs use the following definitions for utilization management (UM) and care coordination (CC):

- **Utilization Management (UM)** —Evaluation of the medical necessity, appropriateness, and efficiency in the use of behavioral healthcare services under the provisions of the applicable health benefits plan; evaluations are also known as "utilization review."

UM and **CC** work together for:

- Appropriate use of behavioral healthcare services
- Efficiency or cost–effectiveness
- Quality of care

Care Coordination (CC) — A service that assists Psychiatric Residential Treatment Facility providers to connect youth with special behavioral healthcare needs to services and resources within the State of Alaska, in a coordinated effort to maximize the potential outcome for the youth. Care coordination seeks to ensure optimal behavioral healthcare for youth.

Comparison between Utilization Management and Care Coordination

The table below compares UM and CC services.

UM Services	CC Services
• Reactive (responding to requests for services provided for all level 5 and 6 psychiatric treatment)	• Proactive (contacting providers to discuss services and discharge placement needs of youth who are currently or have been receiving residential psychiatric treatment outside the State of Alaska).
• Focused on specific treatment/units of service	• Focused on treatment progress, length of stay, timely discharge, and promoting appropriate transition of care
• Targeted interaction with providers	• Active communication and facilitation with providers
• Goal is to determine medical necessity of requested services	• Goal is to support the timeliness and appropriateness of the discharge plan.
• Goal is to review the Plans of Care (POC) to ensure all the required elements are present	• Goal is to ensure provider knowledge of resources and services available to youth in Alaska to facilitate youth returning to Community.

History of Medicaid Utilization Review and the Quality Improvement Organization (QIO) Program in Alaska

Medicaid, an entitlement program created by the federal government, is the primary program financing basic health and long-term care services for low-income Alaskans. The Alaska Department of Health and Social Services maintains the Medicaid core services for the State of Alaska. The Alaska Medicaid program provides both mandatory prior authorization review and optional care coordination facilitation services. Eligibility for Medicaid services is determined by medical necessity and the eligibility category of the recipient.

The federal government has expended significant dollars in developing and supporting the utilization review of inpatient hospital care. This type of review has been required by law for Medicare and state Medicaid programs since 1972.

Alaska Department of Health and Social Services has historically contracted with a peer review organization (PRO)—now called a quality improvement organization (QIO)—to review selected inpatient admissions for medical necessity and appropriateness. A QIO is an organization that meets federal requirements for utilization and quality control review and holds a Medicare contract with the Centers for Medicare & Medicaid Services (CMS).

Qualis Health, the CMS Medicare QIO for the states of Washington and Idaho, has been an Alaska Medicaid contractor since 1985, performing utilization reviews and prior authorization services. Reviews are performed on admission, concurrent continued stay, or retrospective basis.

Qualis Health's Background and Experience

Qualis Health is a private, nonprofit healthcare QIO with 32 years of experience in providing utilization review, case management, and quality improvement services. Qualis Health is based in Seattle, Washington. Qualis Health also has regional offices in Birmingham, Alabama; Anchorage, Alaska; Irvine, California; Boise, Idaho; and Albuquerque, New Mexico.

Established in 1974, Qualis Health started out as a professional standards review organization (PSRO) for Medicare in the State of Washington. As a PSRO for the first legislated Medicare quality review program, Qualis Health conducted retrospective reviews of hospitalizations to determine whether they were medically necessary. Qualis Health's Medicare review activities expanded to Alaska in 1984 and to Idaho in 1986.

Qualis Health began offering utilization review services to the Medicaid population in Washington State in 1975. In 1985, Qualis Health was awarded the utilization review contract with Alaska Medicaid. Qualis Health currently serves as a Medicaid contractor in the states of Alabama, Alaska. Idaho, New Mexico, and Washington.

Qualis Health started offering utilization review services to private industry in 1979. Qualis Health has been a presence in the private-sector market in Alaska since 1984, when the first care management client was added.

Today, Qualis Health continues to serve all three sectors—Medicare, Medicaid, and private industry. Because Qualis Health is a third-party that is not affiliated with any provider organizations nor with the insurance industry,the organization is able to objectively evaluate the medical necessity and quality of healthcare provided to the clients served.

For Medicaid and private-sector customers, Qualis Health offers a range of programs designed to control healthcare costs while improving the quality of healthcare delivered to consumers. These programs include traditional utilization management services, including psychiatric review services, such as pre-service admissions, concurrent, retrospective chart, and retrospective telephonic reviews; coding validation; and medical consultation.

In the late 1980s, Qualis Health launched nurse case management services for Medicaid and the private-sector. Qualis Health's Medicaid case managers work with patients who have catastrophic illnesses and injuries. They also work with these patients' families, providers, physicians, and Alaska Medicaid to promote the right care at the right time and in the right setting. Qualis Health's case management program is nationally recognized for excellence and superior results.

Qualis Health's offices in Seattle and Anchorage have full accreditation from URAC for their Health Utilization Management and Case Management programs, demonstrating compliance with the highest industry standards for pre-service, concurrent, retrospective reviews, and case management services. The URAC accreditation for Health Utilization Management assures providers, physicians, and patients that the review processes Qualis Health follows are fair and impartial, and that URAC standards for review timeframes, reviewer qualifications, appeal procedures, and confidentiality of information are met, thus resulting in high quality services and objective review decisions.

Qualis Health's Professional Expertise

More than 200 Qualis Health professionals, including department leaders, medical directors, clinical reviewers, case managers, Care Coordinators, quality improvement specialists, biostatisticians, communications specialists, information technology specialists, and administrative support staff, work hard to serve the needs of various clients. In addition, Qualis Health has an extensive network of more than 300 physicians who serve as consultants to the organization and provide collaborative clinical peer review services. The network includes physicians representing all 24 of the
specialty boards recognized by the American Board of Medical Specialties as well as dentists, chiropractors, naturopaths, and other complementary and alternative medicine practitioners.

Qualis Health's employees have well-established relationships with facilities and health plans, allowing for effective collaboration in healthcare evaluation and improvement. As part of a continuing effort to work in cooperation with the community, Qualis Health is actively pursuing new provider and physician partnerships.

Section 2–Communications with Qualis Health

Introduction

Qualis Health's review process is flexible and is set up to handle review requests received via the internet, telephone, fax, and mail. Qualis Health offers secure web-based review capability using the internet to create a two-way link that can be used to exchange care management data, thus facilitating real-time, online approvals. Qualis Health also maintains toll-free, dedicated phone and fax numbers for Medicaid providers to use to request review services.

Qualis Health's regular business hours are 8:00 am to 5:00 pm Alaska Time, Monday through Friday; excluding scheduled holidays (see Appendix G). Qualis Health staff members are available to handle telephonic review requests received from 8:00 am to 5:00 pm on regular business days.

Contacting Qualis Health via the Internet

Providers submitting web-based review requests will need to obtain a User ID andpassword to log in and access the web-based review system. Trained providers can log in and directly enter information for the admission (i.e. initial review; continued stay/concurrent review, or retrospective review request).
For more information, or to learn how to submit web-based review submissions, please visit http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-education or contact Qualis Health at (877) 200-9046 or (907) 550-7620.

Contacting Qualis Health by Mail

Requests for prior authorization certification for admissions and concurrent (continued stay) treatment services, and requests for retrospective reviews may be submitted on the web via the web-based review system (preferred method), fax, phone, or mail.
Requests submitted by mail to Qualis Health's Anchorage office should be sent to:

Qualis Health
Attn: Utilization Review Department
PO Box 243609
Anchorage, AK 99524-3609

Contacting Qualis Health by Phone

To reach Qualis Health's telephonic review services, call (877) 200-9046 or (907) 550-7620. In the event your call is after business hours, or an attendant is not available, your call will be directed to Qualis Health's 24-hour voice mail system.

During regular business hours, Qualis Health monitors the voice mail system checking messages and ensuring callbacks are handled in a timely manner. Messages left after 5:00 pm, on weekends or holidays are retrieved on the next business day and calls are returned by 12:00 pm Alaska Time.

Contacting Qualis Health by Fax

Providers may fax review requests to Qualis Health at (877) 200-9047 (The preferred method of submitting a review is electronically via the Web-based review system). Faxed submissions must be legible and include all required demographic and clinical information that is found on the questionnaire forms (see Appendix H, Exhibits 7 and 8). Completed questionnaires can be faxed to (877) 200-9047.
A fax cover sheet with a confidentiality disclaimer is highly recommended.

The following are suggestions in submitting your fax

- No bold font
- No italics
- No underlining
- No all caps
- If possible no special characters, i.e., * or = (quotes are OK)
- Sans serif fonts
- Normal spacing (i.e., looks like a normal document not written in a column that takes up a horizontal third of the page)
- Typed is preferred over handwritten

Please answer all questions as detailed as possible. If the answer to a question is unknown, please write in that the information is unknown.

Qualis Health's Communication of Review Determinations

Our secure web-based prior authorization review system offers immediate feedback from Qualis Health concerning the request for review—pended awaiting review, certified, pended for further review, or additional information required. For requests submitted through web-based review system, an internet-based notification of the final determination and certification number is posted for the provider. Providers using the web-based system for their request submissions will not need to wait for a phone call or for the transmission of a fax or mailed document to learn of the final determination.

For requests that are not submitted through the web-based review system, Qualis Health will communicate the determination and the Prior Authorization number (i.e., the certification number) to the provider via phone or fax. Qualis Health will send letter notifications for all non-certified reviews (adverse decisions) and appeal reviews within one business day after the determination is given. These notifications will be sent to the recipient, State of Alaska Division of Behavioral Health, the attending physician, and the facility within one business day of the date the decision is made.

Section 3–Compliance with URAC's Utilization Review Standards

Frequently Asked Questions about Utilization Review Decisions

Qualis Health complies with URAC health utilization management (UM) standards when performing utilization reviews (UR). These standards provide a process for conducting a utilization review that is clinically sound and respects recipients' and providers' rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process; that a reasonable and timely appeals process is in place; and that medical decisions are based on valid clinical criteria. Some frequently asked questions about the process of making utilization review decisions are answered in the following section.

1. ***Who makes the utilization review decision?***
   URAC (formerly known as Utilization Review Accreditation Committee) Health Utilization Management Accreditation requires Qualis Health to use a three-step process to determine if a proposed medical treatment or service is medically necessary:

- **Initial Clinical Review**—A licensed mental health professional conducts this first critical step of the review process using Alaska State Medicaid Program Medical Necessity Criteria and review protocols. If the clinical information provided does not meet current Alaska State Medicaid Program Medical Necessity Criteria and review protocols for inpatient services, or if, in the clinical reviewer's judgment, a physician should review the case, it is referred for peer clinical review.
- **Peer Clinical Review**—A licensed physician qualified to render a clinical opinion about the proposed treatment or service performs a peer clinical review by reviewing all available information and then making a decision about certifying care. When a potential non-certification decision is made, the attending physician has the opportunity to discuss the review and proposed care with a Qualis Health physician, prior to final determination. If the result of that conversation is not satisfactory for the attending physician, an appeal process is available.

- **Appeal Process—**The provider or recipient may initiate an appeal when the final determination is unsatisfactory. The appeal review is performed by a qualified, Board-certified physician within the same specialty but not involved in the initial review decision. The process may be expedited, if requested (See Section 13).

2. ***Why is a peer-to-peer conversation important?***
   The goal of the peer-to-peer conversation is to allow the treating provider an opportunity to discuss a UM determination before the non-certification decision is finalized. It is hoped that some differing opinions can be resolved without the need for a formal appeal process.

3. What are the timeframes for peer-to-peer conversation?

Qualis Health offers a peer to peer conversation for potential adverse decisions (non-certifications), within URAC timeframes, when the Qualis Health's physician reviewer is unable to authorize a review based on the information provided. A Qualis Health representative will notify the facility utilization review staff of the potential non-certification and offer the option of a peer-to-peer discussion. If a peer-to-peer conversation is desired by the attending physician, it is necessary to call Qualis Health and complete the peer review by 5:00 pm Alaska Time. If the attending physicianis not able to call within the stated time frame, and an extension is desired, the facility UM staff may request an extension from Qualis Health within the timeframes given in the offer for the peer review.

If the case is non-certified after the peer-to-peer conversation, the stay will be non-certified retroactively to the day medical necessity was determined as not met. If the attending physician does not call within the timeframes given in the offer for the peer review, and other arrangements have not been made by the facility within the allotted timeframes, the case will be non-certified.

The physician may call Qualis Health at (877) 200-9046 or (907) 550-7620 to make arrangements for the peer review conversation.

4. What recourse is there when we disagree with a Qualis Health determination?

Qualis Health's written notice of non-certification decision contains instructions of initiating an appeal of the non-certification. Please see Section 16of this manual for details on the appeal process. If, after an appeal, you still disagree with the Qualis Health determination, your appeal letter will outline the steps that must be taken to request a hearing with the State of Alaska Behavioral Health.

5. What is considered an urgent review?

An urgent review is performed when a case involves urgent care and the application of the time periods for making non–urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a psychiatrist with knowledge of the recipient's behavioral health condition would subject the recipient to severe risk that cannot be adequately managed without 24/7 inpatient psychiatric care.

6. How are review timelines determined?

The number of days allotted for each type of review for this Alaska Medicaid program is based on URAC Utilization Review Standards and on Alaska State Medicaid Program Medical Necessity Criteria and review protocols. Review timelines differ for urgent reviews and non-urgent reviews. If the review requires additional information, additional time is allotted. Tables of review timeliness are shown in following pages under questions 7 and 8 of this section.

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, it is the provider's responsibility to provide Qualis Health the additional information requested to complete the review. If the information is not received within five business days, the review will be completed with the information already received, putting the case at risk of a potential non-certification.

In rare instances, Qualis Health may choose to exercise a single extension of up to 15 calendar days on non-urgent reviews for both acute and Psychiatric Residential Treatment Facilities (PRTF) care when there are reasons beyond the control of the organization that require an extension. When this occurs, Qualis Health must inform the provider (by the date the notice the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision.This single extension is only allowed on non-urgent reviews; it is not allowed for urgent care reviews.

7. What are the timeframes for completion of urgent reviews?

When all necessary clinical information has been received and no referral for clinical peer review is needed, the timeframes for completion of urgent reviews are as follows:

Review Type for Prior Authorization-- Urgent	Timeframes for Completion from Date of Notification to Qualis Health
Prior Authorization Admission (Pre-service) Review—Urgent	Determination and notification are made within 72 hours of receipt of request.
Prior Authorization Concurrent (Continued Stay) Review—Urgent	Determination and notification are made within 24 hours of the request provided the request is made at least 24 hours prior to the expiration of the certified period of time. If the request is not made at least 24 hours prior to the expiration of the certified period, the determination and notification is made within 72 hours after the receipt of the request for review.

When additional information is required to complete the review, the timeline is adjusted accordingly.

8. What are the timeframes for completion of non-urgent reviews?

When all necessary clinical information has been received and no referral for clinical peer review is needed, the timeframes for completion of reviews are as follows:

Review Type for Non-Urgent	Timeframes for Completion from Date of Notification to Qualis Health
Prior Authorization Admission (Pre-service) Review—Non-Urgent	Determination and notification are made within five calendar days of receipt of request.
Prior Authorization Continued Stay (Concurrent) Review—Non-Urgent	Determination and notification are made within four calendar days of receipt of request.
Retrospective Review	30 calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the additional information required to complete the review.

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Section 4–HIPAA

Business Associate Standing

Qualis Health provides care management services on behalf of its clients and is considered a “Business Associate” of these clients under the Health Insurance Portability and Accountability Act (HIPAA) “Administrative Simplification” regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) and the Security Standard (“Security Rule”).

National Provider Identification

JIVAis currently accommodating Alaska Medicaid client and provider identification numbers in compliance with HIPAA. Covered entities under HIPAA are required to use National Provider Identifiers (NPIs) in standard transactions. Providers are responsible for obtaining their NPI from the National Provider System (NPS). The NPS is now contained within the National Plan and Provider Enumeration System (NPPES). This notice was published on May 30, 2007, in the Federal Register/Vol.72, No. 103, Pages 30011–30014, establishes the data that are available from the NPPES.

Section 5–Provider Billing Concerns

Claim Discrepancies

Providers are encouraged to thoroughly examine discrepancies in claims for accuracy prior to contacting Qualis Health. Xerox, the fiscal agent for the Alaska Department of Health and Social Services, has a provider inquiry telephone line for this purpose. Providers may contact the fiscal agent at (800) 770-5650 (toll-free in Alaska) or (907) 644-6800.

Providers may call Qualis Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. Some examples of such discrepancies are as follows:

- The date(s) on the Qualis Health review does not match the certified admission or discharge date on the claim.
- Admitting or principal diagnosis codes on the Qualis Health review do not match the code(s) on the claim.
- Incorrect recipient Medicaid Identification number indicated on the Qualis Health review.
- The Prior Authorization number used for billing does not match the Prior Authorization number on the Qualis Health review (**Note:** Prior Authorization Number must be noted on the claim).

Contingency for Payment

Qualis Health certification indicates only that the admission is medically necessary. **This certification (approval) does not guarantee payment for services rendered.** Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska**.**

Section 6–Eligibility and Review Limits

Overview

The Alaska Medicaid Mental Health review program has been established to provide treatment providers a way to prior authorize medical necessity before services are rendered. The Federal and State Medicaid program was established as a prior authorization system and is regulated by Federal and State Codes.

There are times when Alaska Medicaid recipients could be covered under another insurance or program, and the requirements for review may vary. The following examples will assist you in determining which review requirements will apply.

Review Scope

Admission and continued stay reviews will be required for acute inpatient psychiatric services provided through specialized psychiatric hospitals, medical surgical hospitals, and Psychiatric Residential Treatment Facility services.

Under Age 21 Acute Inpatient Psychiatric Treatment Services and Residential Psychiatric Treatment Services

Acute inpatient psychiatric services and residential psychiatric treatment services are for those individuals under the age of 21 who are receiving necessary psychiatric services provided within an acute care hospital including an Institute for Mental Disease (IMD) or residential psychiatric treatment services. These services are under the direction of a physician designed to achieve the recipient's discharge to a lower level of care at the earliest possible time.

Ages 21 - 64 Acute Inpatient Psychiatric Treatment Services

Acute inpatient psychiatric services provided within a medical surgical hospitalother than an IMD (as defined in 42 CFR 456.601) for recipients between the ages of 21 and 64.

Age 65 and Older Acute Inpatient Psychiatric Treatment Services

Acute inpatient psychiatric services provided to a recipient age 65 or older by an inpatient program in a psychiatric facility, an IMD, or a medical surgical hospital.

Review Limits

All inpatient psychiatric (acute care) and inpatient residential psychiatric services (PRTF care) must be prior authorized in order to be reimbursed by Alaska's Medicaid Program.

There are limits to the scope of reviews that Qualis Health is authorized to perform in the Alaska State Medicaid Program:

1. Qualis Health does not perform reviews for clients who are 21 to 64 years of age and are admitted to a free standing inpatient psychiatric facility. Alaska Medicaid does not cover admissions in these facilities for this age group.
2. Qualis Health does not perform reviews for CAMA Medicaid recipients. Medical Programs are established for CAMA Medicaid recipients under the Chronic and Acute Medical Assistance Program.
3. No inpatient psychiatric reviews are authorized for substance abuse or substance dependency treatment if those are the primary disorders being diagnosed and/or treated.
4. If the primary coverage is Medicare Part A and secondary coverage is Medicaid, no Medicaid review is required unless inpatient Medicare benefits have been exhausted or services are not covered by Medicare, in which case Qualis Health will proceed with a review for Medicaid.
5. No reviews are authorized for recipients over the age of 21 in a PRTF, unless the recipient is already receiving treatment in the treating facility when the recipient turns 21 years old. When this is the case, coverage is available until the recipient's 22nd birthday.

Section 7–Utilization Review Methods of Submission

Submission Methods

Qualis Health will accept review requests submitted by providers over the internet (*internet is the preferred method of review*), or via telephone, fax, or mail.

See the updated questionnaire within the provider manual at *http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources*

You will need to answer these review questions and include demographics in your submission (See Appendix I, Exhibits 7 and 8).

Submission Mode	Description
Internet (Qualis Health Provider Portal (QHPP))	***Internet is the preferred method of review.***Providers log in to web-based review system and directly enter information for prior authorization for admission, concurrent (continued stay), or retrospective review request.
Fax	Providers may request prior authorization for admission, concurrent (continued stay), or retrospectivereviews by faxing the request to Qualis Health's toll free fax number: (877) 200-9047. Include a cover sheet regarding confidentiality, and your admission information from the medical record.
Phone	Providers may request prior authorization for admission, concurrent (continued stay), or retrospectivereviews by calling Qualis Health's toll-free number: (877) 200-9046 or (907) 550-7620. Providers who call after hours or on holidays and week-ends will be prompted to leave a message or call back on the next business day.
Mail	Requests can be mailed to Qualis Health's Anchorage office: Qualis Health Attn: Utilization Review Department PO Box 243609 Anchorage, AK 99524-3609

Provider Responsibility for Automated Voice Response

Providers are responsible to verify recipient eligibility for prior authorization of admission, continued stay, or retrospective review. The following information is available to assist the provider in the Automated Voice Response process.

ID Cards and Coupons—The Department of Health and Social Services, Public Assistance, produces and distributes medical assistance identification cards and medical coupons. These verify that a recipient is eligible to receive services from the Alaska Department of Health and Social Services in a given month. Cards and coupons contain the eligible recipient's name, identification number, date of birth, eligibility month and year, and eligibility code. Please note that the Resource Code on the coupon or ID card will indicate if the recipient has a payment source in addition to Medicaid. Refer to your Provider's billing manual from XEROX, the State's fiscal agent, for further clarification.

Automated Voice Response System (AVRS)—The State's fiscal agent (Xerox) provides and maintains the Automated Voice Response System (AVRS) to help providers determine the eligibility of the recipients. Each enrolled provider receives a unique AVRS PIN number and instructions for using AVRS. A provider with a touch-tone telephone can use the AVRS identification number to verify recipient eligibility 24 hours a day, seven days a week. The AVRS may be accessed by calling (800) 884-3223. Providers may receive Automated Voice Response by contacting Xerox, at (800) 770-5650 (toll-free in Alaska) or (907) 644-6800.

Section 8–Processes for Utilization Review Submissions

Purpose

Qualis Health has adopted a browser-based product that uses the internet to create a two-way link between healthcare providers and Qualis Health Utilization Management/Mental Health Review to facilitate the prior authorization review process. The web-based review system allows providers to submit utilization review requests to Qualis Health using a secure internet connection and is available to the provider 24 hours a day, seven days a week. Reviews submitted during non-office hours will be processed as received on the next business day (See Appendix G).

Responsibility

Providers are responsible for submitting all review requests as required by Alaska State Medicaid Program Medical Necessity Criteria and review protocols. Providers are responsible to submit all reviews to Qualis Health in a timely manner as required by Alaska Department of Health and Social Services. Providers are also responsible for submitting reviews to Qualis Health for recipients who are covered by other Third Party Liability (TPL) resources for admission and continued stay if utilizing Alaska Medicaid as a form of reimbursement.

Requirements

Use of the web-based review system requires internet access and establishment of provider logon information for each user. Training is conducted by Qualis Health via WebEx sessions. If you are interested in receiving training, please see Qualis Health's website at:
http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources
You may also contact Qualis Health's Team by calling
(800) 949-7536 x 2800 or by email to ProviderPortalHelp@qualishealth.org.

Process and Procedures

Submission—If you have already received web-based review submission training from Qualis Health, submit your review requests via the internet 24 hours per day at the following web address:
https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Operational hours for Qualis Health Alaska Medicaid Behavioral Health reviews are: 8:00 am to 5:00 pm Alaska Standard Time Monday through Friday except for designated holidays (See Appendix F)

The provider may submit the prior authorization review request to Qualis Health via **web-based review system (preferred method)**, or by phone, fax, or mail (See Section 7).

How to Reach Qualis Health	
Qualis Health Provider Portal	https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin
Phone	(877) 200-9046, or (907) 550-7620
Fax	(877) 200-9047
Mail	Qualis Health Attn: Utilization Review Department PO Box 243609 Anchorage, AK 99524-3609

Calls to the above listed phone number will connect to a Qualis Health representative. In the event that no one is immediately available, callers may leave a message in the confidential voice mail system. Instructions are clearly stated for accessing the electronic voice mailboxes, which are monitored so that calls may be returned in a timely and efficient manner.

Required Review Documentation—Provider will complete the questionnaire for admission or continued stay reviews. Use the most recent questionnaire (either the admissions or continued stay questionnaire) to prepare for the questions that will be asked in the review process. Please see Appendix H, Exhibit 7 for the ***Admission Review Questionnaire*** and Appendix H, Exhibit 8 for the ***Continued Stay Review Questionnaire***.
Additional information listed in Sections 9 and 10 and Appendices E and H of this manual are also needed for each review/request.

Document the following information in the Communication field:

- contact name and phone number of the person providing the review information
- type of review being submitted: (e.g., Admission review, Continued Stay review, or Retrospective review)
- actual admit date and discharge date
- verification of the recipient's Medicaid eligibility

Medical Necessity Screening—Once the information for the specific review period has been received, Qualis Health's clinical reviewer will assess the medical information using Alaska State Medicaid Program Medical Necessity Criteria and review protocols to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements for the level of care and the type and number of days of services requested. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the Qualis Health clinical reviewer will issue a Prior Authorization number and the review will be certified (See Appendix H, Exhibit 1). For additional information on medical necessity information required for determinations, see Appendices B & C.

Second-Level Peer Review—Cases that clinical reviewers have determined do not meet criteria are referred to a Qualis Health physician reviewer (medical director or physician consultant). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. If a peer-to-peer conversation is requested, Qualis Health's physician reviewer and the recipient's attending physician will discuss the treatment issues, current clinical information, as well as appropriate alternatives. Following the discussion, Qualis Health will either certify or non-certify the medical review

Non-certifications—If the Qualis Health physician reviewer non-certifies the medical review, a Qualis Health representative will notify the appropriate facility by web-based review system or by fax. If the peer review offer is not accepted or completed by the timeframe given in the offer, Qualis Health will send the non-certification letter within one business day to the following parties: the guardian or parents of recipient (if minor), recipient (if an adult), attending physician, facility, and State of Alaska Behavioral Health.

If the attending physician is not able to call within the stated timeframe and **an extension is desired,** the provider must notify Qualis Health of their request for an extension within the timeframe given in the peer review offer.

The non-certification letters (adverse determinations) will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health's initial non-certification determination (See Appendix H, Exhibits 3 and 4).

The Alaska Department of Health and Social Services will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a result of an appeal review performed by Qualis Health or a second level provider appeal or recipient Fair Hearing by the State.

Questionnaires—Questionnaires and checklists within the web-based review system are associated with specific behavioral health medical necessity review requirements. Use the updated questionnaires for your review process (See Appendix H, Exhibits 7 and 8). Both questionnaires are also available online via https://qualishealthpp.zeomega.com/cms/ProviderPortal/Controller/providerLogin Questionnaire templates within web-based system provide many selection drop-down boxes that save time in the review process.

The Web-based Review Training Manual (Qualis Health Provider Portal) may be accessed at:http://www.qualishealth.org/sites/default/files/QHPP-User-Guide.pdf

Process and Procedures for Urgent Inpatient Admissions

When an urgent admission is necessary, providers are required to notify Qualis Health of their request for urgent admission reviews within one business day. This can be accomplished by web-based review system (preferred method), or by calling/faxing the toll-free number during normal business hours. A Qualis Health representative will review the detailed message that can be left on the electronic voice mail system. In order for Qualis Health to prioritize callbacks appropriately, the pertinent information must be given when leaving a message. This includes:

- Your name
- Your telephone number, including area code, beeper number, or extension
- Physician's full name
- Recipient name (with the correct spelling)
- Recipient ID number (Medicaid)
- Recipient date of birth
- Facility name
- Date and time of admission
- ICD-10 Code

Leaving the information in the electronic voice mail system does not complete the review process nor does it automatically certify the review. All other requirements of the review process must also be completed. Qualis Health will return your call and assist you with completing the review process.
The care and treatment of the recipient should *never* be delayed, particularly in urgent situations, in order to obtain Qualis Health certification.

Procedures for Admissions or Continued Stay (Concurrent) Reviews—Due on Weekends and Holidays

In those instances where the concurrent review date falls on a weekend or holiday, the following procedure is to be followed:

If the concurrent review is due on Saturday, Sunday or a holiday, the concurrent review will take place on the following Qualis Health business day. Non-certificationcan be retrospective to the first day the recipient was not meeting the level of care criteria or protocols.

Late Submission Review Requests

If the provider submits a request for a review *within 30 days of the next review due date*,the review is handled as any other concurrent (continuedstay) review.

Requests for Admissions that are *not made within 30 days* of admission and before the recipient discharged from the facility, or Continued Stay Reviews that are not made within 30 days of the end certification date are late submission reviews. Late submission reviews require that the fully completed Late Submission/Retrospective Review Form (See Appendix H, Example Exhibit 11). This form must be sent to Qualis Health prior to submitting the clinical information for review. On this request from the provider it must include the reasons for the extenuating circumstances causing the delay in submitting the review.

The review may proceed once the late submission/retro review request form (Appendix H, Example Exhibit 11) is received by Qualis Health giving the reasons for the late submission.

Chart Requests

Qualis Health may request the chart of a recipient to verify quality of care or accuracy of the information provided. The chart request may be made telephonically, through the web-based review system, or in writing.

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Section 9 – Prior Authorization for Admissions

Purpose

The purpose of a prior authorization review is to determine if the inpatient services are medically necessary and appropriate. The Alaska Medicaid Behavioral Health review program has been established to provide treatment providers a way to prior authorize before services are rendered. The Federal and State Medicaid program was established as a prior authorization system and is regulated by Federal and State codes. Providers are required to submit reviews in a timely manner.

Responsibility

Providers are responsible for obtaining the prior authorization review from Qualis Health. Qualis Health will accept information for prior authorization review from *receiving providers*. The clinical reviewer will receive all of the relevant clinical information to satisfy Alaska State Medicaid Program Medical Necessity Criteria and review protocolsbefore the prior authorization review will be certified.

Requirements

All inpatient psychiatric (acute care) and inpatient Psychiatric Residential Treatment Facility care must be certified by Qualis Health in order to be reimbursed by Alaska Department of Health and Social Services.

The psychiatric evaluation must document aprimary Behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99) excluding any form of substance abuse disorder, intellectual disability, or developmental disorder. Diagnosis and/or treatment for a substance abuse disorder must be secondary to diagnosis and/or treatment for the mental health disorder in order to seek authorization for services. For neurodevelopmental disorders there must be documented evidence that the individual has the ability to benefit from PRTF services that would enable them to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

The provider may submit the prior authorization review request to Qualis Health via web-based review system (QHPP *preferred method*), phone, fax, or mail (See Sections 7 and 8).

Non-State Custody Youth Processes and Procedures for Admissions to Out-of-State Psychiatric Residential Treatment Facilities (Both Urgent and Non-Urgent)

There is a specific process providers must use in order to receive Prior Authorization from Qualis Health for an admission to an out-of-state PRTF for a recipient. When the Acute Care Hospital, PRTF, or community provider recommend placement for a non-State custody youth, aged 21 or under, to an out-of-state PRTF, the following steps must be completed for approval:

- The referring agency must contact the Alaska Behavioral Health Utilization Review team and provide required clinical and discharge planning information (See Appendix I, Exhibit 9 for the link to the referral form).
- The State of Alaska Behavioral Health Utilization Review team will explore potential and available in-state resources that could meet the recipient's treatment needs.
- The State of Alaska Behavioral Health Utilization Review team will send a fax to the referring agency and Qualis Health indicating Qualis Health is to review for medical necessity.
- The referring agency may then proceed with plans to discharge the recipient to the out-of-state PRTF. The out-of-state PRTF will submit the prior authorization admission review request and required clinical information to Qualis Health to review for medical necessity.

Information Needed for the Review—Qualis Health representatives will collect all information required for clinical reviews. Please see Appendix H, Exhibit 7 of this manual for the ***Admission Review Questionnaire*** and Appendix H, Exhibit 8 of this manual for the ***Continued Stay Review Questionnaire***. Both questionnaires are located on the Qualis Health website at http://www.qualishealth.org/healthcare-professionals/iexchange/provider-resources

- Recipient name
- Recipient birth date and age
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis codes (ICD-10 code)
- Physician name, address, and phone number
- Physician Medicaid provider number
- Facility name, address and phone number
- Facility Medicaid provider number

- Type of review requested
- Verification of Certificate Of Need(CON)[see sample form in Exhibit 10]
- Source of referral
- Primary and secondary reason for treatment
- Prognosis
- Ethnicity
- Admit date
- Reason for secure care
- Adopted or biological parents
- Name of guardian parent, adoptive parent, or social worker
- Custody status
- Region of home community
- Living situation
- Previous treatment history
- Level of cognitive functioning
- Individualized Education Plan
- Level of intellectual function
- Trauma history
- Date of last Mental Status Exam (MSE)
- Certification of person who performed or supervised MSE
- Current outpatient provider(s) prior to admit
- Risk factors
- Sex offender
- Co-Morbidity
- Plan of Care to include treatment proposed/provided
- Verification of Plan of Care being formulated in consultation with recipient (and guardian when a minor)
- Diagnostic evaluation
- Justification for the hospitalization and precipitating event
- Anticipated discharge date
- Brief psychosocial history
- Medication history
- Safety precautions in place
- Discharge planning details to include placement (provider)

Timeframes for submission of Prior Authorization Reviews

- Acute care admissions – on the day of admission or one day before.
- In-State PRTF admissions – on the day of admission, or up to two business days before the anticipated admission. If transportation needs arise, reviews may be submitted no earlier than five business days prior to the anticipated admission date.
- Out-of-State PRTF admissions – Up to five business days prior to the anticipated calendar date.

Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via web-based review system and/or phone. The provider has no more than five business days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.

Medical Necessity Review Process

During the prior authorization review, Qualis Health's clinical reviewer will review the medical record and evaluate the medical necessity for admission at the requested level of care. See Appendices B, C and H for more information regarding requirements for medical necessity reviews. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the Qualis Health clinical reviewer will issue a Prior Authorization number and the review will be certified (authorized for payment). Please refer to the process and procedures outlined in Section 8 of this manual.

Transfer (Admission) Reviews

Medical transfers require a separate admission review to be completed from the receiving provider and a discharge from the referring facility. This includes inter-facility transfers, such as discharge from one level of care to another as well as discharges to different facilities. Thus, each facility will have a unique Prior Authorization number to use on their claim form. The following special considerations apply:

- If the recipient is not admitted to the transferring facility as an inpatient, the receiving facility does not need to obtain pre-certification, as this is not considered a transfer for review purposes.
- All transfers from one inpatient setting to another require a prior authorization admission review with the receiving facility. Transfers will be evaluated to ensure that the recipient continues to meet severity of illness and intensity of service criteria for that level of care.

Both emergency and non-emergency transfers of service require a discharge followed by a new admission review and prior authorization number. Before authorization, a physician, or other qualified healthcare worker must medically evaluate the recipient. Some of the situations that require transfer of a recipient are:

- Transferring treatment from a medical facility to an acute psychiatric facility (e.g., moving a recipient after hospitalization for a medical procedure that leads to diagnosis of a psychiatric disorder of such a serious nature as to require acute inpatient psychiatric services).

- Transferring from a medical service to a psychiatric service within the same facility (e.g., moving a recipient to a psychiatric service after hospitalization for self-inflicted injuries).
- Transferring from one level of care to another (e.g., moving a recipient from acute to PRTF care) requires a discharge from the one level of care and a new PA Review before admission to the other level of care.
- Transferring from one facility to another facility with the same level of care, i.e., to access services that are:
    - More specialized
    - More or less secure or structured, or
    - Closer to home to receive services which cannot be delivered at a less restrictive level of care in the state of Alaska

Eligibility Established During an Acute Inpatient Admission

When eligibility is established after admission to a facility, the facility will submit clinical information for the entire length of stay in the initial review following the procedures noted below. The submission of the review from the facility needs to be timely—i.e. within a few days of notification that recipient is Medicaid eligible. The date of eligibility notification must be documented in the review notes and the review is to be performed in the following manner:

- Perform the admissions/initial review in the web-based review system (preferred method)—use the Admissions Review Questionnaire, and include the Plan of Care Review (see Plan of Care Questions in the Continued Stay Review Questionnaire); furthermore,
- As required in the Qualis Health questionnaire, information for the master plan of care review must be submitted in clinical findings as opposed to entering it into the Continued Stay questionnaire; and
- Information for the continued stay must be submitted in seven day increments for acute in-patient treatment, and one month increments for residential psychiatric treatment, answering the questions in the Continued Stay Review Questionnaire, to the current date.

Partial approvals may occur within the timeframe of more lengthy reviews.

Section 10–Continued Stay (Concurrent) Utilization Reviews

Purpose

The purpose of the continued stay review process is to evaluate whether the patient requires an extension of inpatient services and meets medical necessity. During the continued stay review, the Qualis Health clinical reviewer evaluates what services have already been provided to the patient and the plan for continuing in-patient treatment. Providers should submit reviews in a timely manner.

A continued stay (concurrent) review takes place during the time in which a recipient is receiving inpatient treatment at the acute care or residential care facility. If the first review was submitted before the recipient discharged from the facility, the subsequent reviews will be considered continued stay reviews through the patient's discharge date.

Responsibility

Providers are responsible for obtaining certification for continued stays from Qualis Health. The clinical reviewer will receive all of the appropriate detailed clinical information for the requested review period to satisfy Alaska State Medicaid Program Medical Necessity Criteria and review protocolsbefore the continued stay review will be certified. Provider is responsible to assure that the information submitted in the review is accurate for the time frame of the review and documented in medical record of chart.

Requirements

The psychiatric evaluation must document a primary Behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99) excluding any form of substance abuse disorder, intellectual disability, or developmental disorder. Diagnosis and/or treatment for a substance abuse disorder must be secondary to diagnosis and/or treatment for the mental health disorder in order to seek authorization for services. For neurodevelopmental disorders there must be documented evidence that the individual has the ability to continue to benefit from PRTF services that would enable them to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

Process and Procedures

The provider will submit the continued stay review request to Qualis Health via web-based system (preferred method), phone, fax, or mail. Please refer to Section 7 and 8 of this manual for methods of and processes for submission. Refer to Appendix H, Exhibit 8 for a copy of the ***Continued Stay Questionnaire***.

Information Needed for the Review

The ***Continued Stay Review Questionnaire*** collects the basic information needed by Qualis Health representatives to complete the review. See Appendix H, Exhibit 8 for a copy of the questionnaire.

The clinical reviewer will review the medical record and evaluate the necessity of admission, appropriateness of service, and continued need for placement at the current level of care. During the review, the following types of information will be considered:

- Diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
- Current acuity or behavioral issues that support the need for continued care at the current level of care
- Appropriateness of diagnostics, therapies, procedures, and other services
- Complications, if any
- Quality of care
- Length of stay
- Discharge planning progress and needs

Should discharge planning issues be identified, the clinical reviewer may make a referral to the medical director for peer clinical review and potential discussion with the attending physician. For out-of-state PRTF reviews, referral to the Care Coordinator will occur to assist with the discharge planning process. Additionally, the State of Alaska Behavioral Health Utilization Review team will be included in clinical discussion to assist with this process.

If the submitted documentation supports the Alaska State Medicaid Program Medical Necessity Criteria and review protocols, the clinical reviewer will approve the continued stay and assign a next review date.

Continued Stay Review Process—Once the information for the review has been received, the Qualis Health clinical reviewer will assess the documentation submitted using Alaska State Medicaid Program Medical Necessity Criteria and review protocols to determine whether the condition of the recipient meets criteria for the level of care and the type of services requested. See Appendices E and H for more information regarding requirements for medical necessity reviews. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, the review will be certified (authorized for payment). Refer to the process and procedures outlined in Section 8 of this manual.

Once the provider has initiated a continued stay review with Qualis Health, the review process will continue until one of the following occurs:

- The recipient is discharged, upon which the facility will place the actual discharge date and updated discharge information in web-based review system or by phone or fax.
- Continued stay (concurrent) review is non-certified by Qualis Health
- The recipient loses Medicaid eligibility
- The recipient becomes eligible for Medicare Part A after admission

During the prior authorization review, the next review date is set for continued stay review. Qualis Health will establish the date when a concurrent review will be due if the recipient has not been discharged before this date. Providers are responsible for submitting current informationfor continued stay review if the client has not discharged. Providers are to contact Qualis Health and submit the next continued stay review within the following timeframes

Timeframes for Continued Stay Review Submissions

- Acute Inpatient Master Plan of Care Review (second review) and Continued Stay Reviews should be submitted on (or no more than two days prior to) the assigned next review date.
- PRTF Master Plan of Care (due 14 days following admit), Continued Stay and Therapeutic Transition Day reviews may be submitted up to three days prior to the assigned next review date.
- Specific questions for each type of Continued Stay Review (Master Plan of Care, Continued Stay and PRTF TTD) are found in the Continued Stay Review Questionnaire.

Timeframes for Pended Reviews

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via Qualis Health Provider Portaland/or phone. The provider has no more than seven calendar days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.

Therapeutic Transition Days (TTD)

A calendar day related to a hospitalization in a PRTF that is authorized by Alaska Behavioral Health for payment of services for a recipient who has not yet reached their 22 birthday and who has been stabilized and therefore is ready for transition or discharge 7AAC 150.990 (40).

Therapeutic Transition Days (TTD) are designed to allow Psychiatric Residential Treatment Facility (PRTF) health providers to continue delivering care and receiving certification for services while facilitating difficult discharge plans that include movement to a less intense level of care. Qualis Health reviewers will identify and track patients who are candidates for the Therapeutic Transition Days. The facility may contact QualisHealthcare Coordinators for assistance in facilitating discharge plans in particularly difficult cases for those youth in TTD status. If the recipient is not discharged within 60 days of being placed in TTD, the provider may contact the

State of Alaska Division of Behavioral Health to request additional TTD days. The purpose of TTD is to allow additional time for appropriate discharge planning in difficult cases.

Review Process for TTD

- Provider contacts Qualis Health for a continued stay review.
- Qualis Health reviewers may determine that the recipient appears to be nearing completion of their treatment objectives in the PRTF setting. The reviewer will notify the provider of the impending TTD status and recommend to the provider that *TTD status may be considered for the next review requested.*
- Upon request of the next review, if TTD status appears appropriate, the reviewer will confirm with the provider that they accept TTD status. Qualis Health reviewers will use TTD criteria to certify TTD status for the review.
- Qualis Health will continue to perform reviews during the TTD of treatment to monitor discharge planning efforts.
- If the provider does not wish to use TTD status, the review will proceed by applying the PRTF criteria and may be referred to the Qualis Health physician for review.
- The usual appeal process is available should decertification of the continued stay occur. (See Section 13)

TTD Criteria – to certify for TTD, the following conditions must be met:

- Symptoms exhibited by recipient as documented by provider indicate that psychiatric treatment for admitting symptoms and behaviors is no longer expected to either improve recipient's condition or prevent regression of symptoms.
- Available information from the provider indicates that the symptoms of the primary diagnosed psychiatric disorders (ICD-10 Code) exhibited by recipient and treated upon admission have stabilized.
- Available information from the provider indicates the identified residual chronic symptoms are unlikely to improve significantly with more intensive or aggressive residential psychiatric treatment services.

Indicators to Certify TTD

- There are no current suicidal or homicidal ideations or self-injurious behaviors.
- Incidences involving impulsivity, assaultive behavior, self-mutilation, serious physical destructive acts, or other similar problem behaviors are documented as reduced or as not ameliorable to further improvement at the level of care and within a reasonable period of time.
- Deficits in psychosocial functioning or in self-care are documented as improved by residential psychiatric treatment or as not ameliorable to further improvement by such treatment within a reasonable period of time.
- The treatment for the admitting behaviors/symptoms has addressed the acuity and symptomatic behaviors and the recipient can now be treated in a less restrictive level of care.
- Required medication management has succeeded to the point the recipient can

be treated in a less restrictive level of care.
- Psychotic symptoms, including thought disorders and perceptual disturbances, have been addressed and are abated by treatment and treatment can now be carried out in a less restrictive level of care.
- Discharge planning, including placement needs, has become the focus of care of the inpatient interdisciplinary team, as the treatment for the psychiatric symptoms causing admission have been addressed.

Section 11–Retrospective Reviews

Definition and Purpose

A retrospective review for medical necessity is indicated after services have been rendered and after client has been discharged. If discharge has not yet occurred; or if an initial admission review was submitted prior to the patient's actual discharge, the review will be conducted according to the concurrent review format. Please follow the process for Eligibility Established during an Inpatient Admissionas described in Section 8 of this manual.

Providers are required to submit the request for a retrospective review within the allotted timeframe of 12 months after discharge. For eligibility issues, providers must submit retrospective review within the 12 months plus 30 days of determination of recipient Medicaid eligibility. Retrospective reviews submitted in excess of 12 months after discharge are subject to consideration by the State of Alaska Division of Behavioral Health before the review can proceed.Provider is responsible to assure that the information submitted in the review is accurate for the time frame of the review and documented in medical record of chart.

Process for Submitting a Request for a Retrospective Review

The provider must send to Qualis Health the ***Late Submission/Retrospective Review Request Form*** in Appendix H, Exhibit 11 of this manual, stating the reasonfor the request for a retrospective review. Qualis Health will then send a determination regarding the request to submit a retrospective review by the end of the next business day. Once the request is approved, the provider may submit the retrospective review.

Methods for Submitting Retrospective Reviews Once Approval for Submission Has Been Attained.

The provider will submit the retrospective review to Qualis Health via web-based review system, phone, fax, or mail. Please see Section 7 of this manual for more information about methods of submitting reviews.

Web-based submission is the preferred method for submitting all reviews.

Submitting Retrospective Reviews Via Web-based Review System

All requests for retrospective reviews will be initiated by the provider. Providers should include sufficient information for the clinical reviewer to complete the review. The entire review may be submitted into the web-based systemin seven day *(one week)* increments.

Submit the following in one week increments:

- Completed Admission Questionnaire
- Plan of care review questions from the Continued Stay Questionnaire (this may be filled out in the Clinical Findings section).
- The questions for the Continued Stay Reviews

Document the following information in the Communication field:

- Contact name and phone number
- Type of review: Retrospective review
- Admit and discharge date and complete discharge information
- Statement Medicaid eligibility verified

Medical Necessity Screening—The Qualis Health clinical reviewer will review the information provided for the retrospective review and will apply Alaska State Medicaid Program Medical Necessity Criteria and review protocols. If the Alaska State Medicaid Program Medical Necessity Criteria and review protocols are met, Qualis Health will issue a retrospective certification number. Qualis Health certification indicates that the admission was medically necessary. The fiscal agent will be notified via electronic data transfer of the determination.

Second-level Peer Reviews are not available for Retrospective Reviews

Non-certifications—If the Qualis Health physician reviewer non-certifies the request for payment authorization, the determination status will immediately be posted in the web-based review system and a non-certification letter will be mailed out by the end of the next business day to the following parties: the guardian or parents of recipient (if a minor), the recipient (if an adult), the attending physician, the facility, and State of Alaska Behavioral Health.

The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health's initial non-certification determination. Refer to Section 16 and Appendix H, Exhibits 3 and 4of this manual for a detailed description of the appeal procedure.

The Alaska Department of Health and Social Services will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a result of an appeal review by Qualis Health or a provider appeal or recipient Fair Hearing by the State.

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Section 12–Leave of Absences

Approved Leave of Absence

An approved leave of absence (LOA) is an absence in which the treatment team of the facility has established that the purpose is to further the treatment goals. It is expected that the approved leave of absence is part of the treatment/discharge planning; i.e., is for clinically appropriate reasons (based on the Medicaid payment protocols and criteria). These leaves will be reported in the normal continued stay review process, and must be documented in the chart. If the recipient is absent for more than 12 days in a calendar year, a form requesting the additional LOA days must be submitted through Alaska Division of Behavioral Health (see Example Exhibit 13).

Unapproved Leave of Absence

If the recipient leaves without permission from a facility and returns within 72 hours, then no action between Qualis Health and the facility is required. If a recipient leaves and returns after 72 hours, then Qualis Health will consider the absence a discharge that began on the date the recipient left the facility. When a facility holds a bed for the return of a recipient so he/she could return and complete his/her treatment program, the facility must submit a discharge notification to Qualis Health, and a re-admission to the treatment program, as required by the Alaska State Medicaid program. It is the facility's responsibility to notify Qualis Health of the absence and to request re-admission review as required.

Admission to a different facility

If the recipient is admitted to a different facility (i.e. hospital, acute inpatient psychiatric care, lateral transfer), Qualis Health will consider the absence a discharge that began on the date the recipient left the facility. It is the facility's responsibility to notify Qualis Health to obtain a new prior authorization admission review.

Incarceration of a Youth

If the recipient is incarcerated, the absence is considered a discharge that began on the date the recipient left the facility. It is the facility's responsibility to notify Qualis Health and obtain a new prior authorization admission review if the client returns to the facility.

Psychiatric Residential Treatment Facilities
Therapeutic Leave of Absence Policy

Psychiatric Residential Treatment Facilities (PRTFs) will receive payment for days that recipients are on a Therapeutic Leave of Absence (LOA). The purpose of a therapeutic LOA is to facilitate successful transitions from an inpatient residential setting to a less restrictive or to community based behavioral health services upon discharge. Examples of therapeutic LOAs include:

- Therapeutic home passes for the recipient at the family home, foster home, or other less restrictive residential or outpatient treatment options
- Overnight leave with family in conjunction with onsite family treatment at the PRTF

COVERAGE

In order to qualify for reimbursement, therapeutic LOAs must be planned and requested at least 14 days in advance of travel and documented as medically necessary (to further treatment goals and increase successful transitions) in the recipient's medical record.

Clinical documentation providing support for therapeutic LOAs must include:

- a crisis plan that identifies behavioral health services provider/s that will support and facilitate treatment should a crisis occur (contact person name, credentials, phone number)
- goals and objectives of the therapeutic LOA; and documentation of previous LOA's and
- how the therapeutic pass will assist the youth and family in achieving treatment objectives
- departure and return dates

In addition to the above, clinical documentation for therapeutic LOAs for the purpose of a therapeutic home pass must include:

- appointment/s with the identified community-based provider/s of behavioral health services and/or residential services
- appointment with the youth's school is highly recommended

Coverage of up to 12 therapeutic LOA days per calendar year will be reimbursed without prior approval. Additional days require prior approval from the Division of Behavioral Health.

When requesting approval of therapeutic LOA days beyond the 12-day service limitation, please complete the *PRTF Leave of Absence Request Form* Appendix H Exhibit 13 and submit required clinical documentation as specified on the form to:

Division of Behavioral Health
3601 C Street, Suite 934
Anchorage, AK 99503
Attention: Clinical Staff
FAX: (907) 269-8166

BILLING/REIMBURSEMENT

Billing for therapeutic LOA days requires a specific revenue code, corresponding units, and charges as follows:

- Accommodation revenue code 0183 is designated for “Therapeutic Leave”
- Number of units billed needs to correspond with the number of total days for “Therapeutic Leave”
- Total charges needs to correspond to the daily rate (per diem) multiplied by the number of days (units)

Billing for non-covered LOA (patient convenience, non-therapeutic, non-approved) requires the PRTF to utilize a different revenue code, corresponding units, and charges as follows:

- Accommodation revenue code 0189 is designated for “Other” LOA
- Number of units billed needs to correspond with the number of total days for non-covered “Other” LOA
- Total charges needs to correspond to the daily rate (per diem) multiplied by the number of non-covered leave days (units)

NOTE:Therapeutichome passes may result in the patient being discharged from your facility, or otherwise not returning to complete treatment. In these circumstances, the discharge date is the date that the recipient left the facility on the therapeutic leave of absence.

Section 13–Reporting Serious Occurrences and Events

Reporting of Serious Occurrences and Events

JCAHO standards define a sentinel event as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

It is the provider's responsibility to report all serious occurrences and sentinel events to the State and other authorities as indicated below. This section is included in order to help with the education of providers regarding their responsibilities under the law.

The Code of Federal Regulations (42 CFR 483.374) requires these actions in these situations:

[Part b of this Code] Reporting of serious occurrences: The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State-designated Protection and Advocacy system. Serious occurrences that must be reported include a resident's death, a serious injury to a resident as defined in Sec. 483.352 of this part, and a resident's suicide attempt. Definition of a serious injury as defined in Sec.483.352 means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

[Part c of this Code] Reporting of deaths: In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare & Medicaid Services CMS) regional office.

(1) [sic Provider] Staff must report the death of any resident to the CMS regional office by no later than close of business the next business day after the resident's death.
(2) [sic Provider] Staff must document in the resident's record that the death was reported to the CMS regional office.

[66 FR 7161, Jan. 22, 2001, as amended at 66 FR 28116, May 22, 2001]

Reporting Requirements of Providers from the State of Alaska, Department of Health and Social Services, Division of Behavioral Health

- Any death must be reported to the State of Alaska Division of Behavioral Health staff no later than the close of business the next business day after the resident's death.
- Any incident which requires investigation by an investigating body is to be reported to the State of Alaska Division of Behavioral Health staff no later than the close of business the next business day.
- Providers are to report these occurrences to any of the State of Alaska Division of Behavioral Health staff at (907) 269-3600.

Alaska Behavioral Health's Clarification of Providers' Reporting Requirements

It is also the provider's responsibility to report all serious occurrences as indicated below.

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

AWOL (Absent Without Leave)

- If gone overnight
- If anything significant occurred during the AWOL
    - Police intervention
    - Use of substances
    - Suspected abuse

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

Providers are to report serious (sentinel) events and occurrences using the form that can be accessed through the link in exhibit 12. Report these occurrences to the State of Alaska Division of Behavioral Health team members at (907) 269-3600 or via fax at (907) 269-8166. The form is to be filled out completely when submitted to the State of Alaska Division of Behavioral Health.

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Section 14–Treatment for Sexual Offenders

Sex Offender Treatment

Basic premises of sex offender treatment include resolving emotional issues associated with the youth's sexual offenses, increasing awareness of high risk situations and triggers to the youth's sexual offending, and learning and applying individualized skills to decrease each offender's unique pattern of abusing others. These premises are essential in successfully treating this specific population. Addressing these issues in treatment is likely to decrease the probability of further offending, and increase the probability that the youth will reach their potential for developing meaningful relationships and live safely with their family and community.

Sexual offenders may exhibit surface compliance in a residential setting. Their behaviors need to be carefully *assessed* and *monitored*. In particular, behaviors that tend to be exploitative or demeaning should be addressed in treatment and relapse prevention plans. Daily progress notes and daily review documentation should address these sex offending behaviors. Progress in diminishing their frequency and intensity will be used to determine progress in treatment.
The provider will update the plan of care every 30 days including progress in treatment, changes in treatment interventions and whether any new behavioral health problems have been identified. Any unresolved diagnostic conditions to be readdressed every 30 days.

Providers will work with the guardian to arrange for relapse prevention planning and aftercare upon release from the program as part of the resident's discharge plan.

Providers will clearly document medical necessity for continued treatment as outlined in the review process. Much of this documentation will require communicating progress made in accomplishing the goals and objectives identified in the treatment plan.

Section 15–Onsite Reviews and Seclusion & Restraint Standards

Overview Potential Quality of Care Concerns

Qualis Health is committed to promoting optimum quality of care for all recipients and will therefore assess quality of care in various settings while performing reviews. The facility and attending physician are responsible for delivering the utmost quality of care for their patients. The Qualis Health clinical reviewer is responsible for identifying potential quality of care concerns regarding State of Alaska Division of Behavioral Health Medicaid recipients. Potential quality of care concerns may be identified during all types of reviews, including retrospective chart reviews.

If a Qualis Health Representative determines that the recipient's quality of care is *currently*or potentially being compromised, a Qualis Health physician will be consulted. If the Qualis Health physician concurs that there is a potential quality of care concern, Qualis Health will refer the case to the State of Alaska Division of Behavioral Health for further action.

On Site Review Standards

Site review/Site Visit: The Code of Federal Regulations (42 CFR 452.606) requires the State of Alaska to inspect PRTFs annually if they are currently providing services for an Alaska Medicaid Recipient. This site visit requires personal contact with the recipient and review of the records to ensure the health needs and the rehabilitative and social services are met for each recipient. The site visit team will consist of at least a mental health clinician and RN. This team may include members of Behavioral Health, Office of Children's Services, and Division of Juvenile Justice. Additionally, 42 CFR 456.607 states there may only be 48 hours or less of notification before the site visit. See Appendix H Exhibit 14

Restraint and Seclusion Standards

The Facility's policy and procedures regarding Restraint and Seclusion (R&S) will be reviewed to ensure compliance with the Code of Federal Regulations 42 CFR 483.350 through 42 CFR 483.376 during site reviews. Also, all incidents of R&S documented in Alaska Medicaid recipients' charts will be reviewed for CFR compliance. See Exhibit 14 for R&S regulations Behavioral Health will use during the site reviews.

Section 16–Utilization Review Appeals

Overview

Qualis Health offers an appeal process in all cases involving an adverse determination. When a review determination is to non-certify a review request, Qualis Health will generate written notification of the adverse decision within one business day of the date the decision is made. Qualis Health's non-certification notification will include rights for an appeal review. Qualis Health's appeal process features a second opinion by a physician who specializes in the services under review. URAC requires that appeal reviews be conducted by individuals who:

- Are clinical peers
- Hold an active, unrestricted license to practice medicine or a health profession
- Are board-certified by the American Board of Psychiatry
- Are in the same profession and in a similar specialty as typically manages the psychiatric condition
- Are neither the individual who made the original non-certification nor the subordinate of such an individual
- Have no conflicts of interest with the patient, attending physician, or facility being reviewed.

There are two types of appeals potentially available—expedited or standard. Instructions on how to initiate each type of appeal are included in the non-certification letter Qualis Health sends when the adverse determination is made.

Expedited Appeals

Definition

An expedited appeal is an appeal of a non-certification in a case involving urgent care.

Process and Procedures

A request for an expedited appeal may be made by telephone, fax, or mail within two business days of the date that appears at the top of the Non-Certification Letterif the recipient has not yet been discharged. If an expedited appeal request is filed after two business days, Qualis Health will respond to that request through the standard appeal process.

Requests for expedited appeals should be directed as follows:

How to Request an Expedited Appeal	
Call	(877) 200-9046 or (907) 550-7620
Fax	(877) 200-9047
Write	Qualis Health PO Box 243609 Anchorage, AK 99524-3609

Upon receipt of the request for an expedited appeal, the following will occur:

- Qualis Health will notify all appropriate parties of the request.
- Qualis Health will, if needed, request that any additional medical information necessary for the appeal review be submitted to us within two hours.
- The case will be referred to a Qualis Health physician reviewer who is licensed and/or accredited in the appropriate specialty or subspecialty who is not the same individual who initially reviewed and non-certified the review.
- The physician reviewer will review the medical information.
- If the physician reviewer reverses the non-certification decision, the Qualis Health representative will issue a certification number and length of stay (if applicable) and will notify all appropriate parties telephonically and in writing.
- If the physician reviewer modifies the decision or upholds the non-certification, the requesting physician or facility will be notified telephonically and in writing.
- The Department of Health and Social Service'sMMIS will be updated electronically accordingly if decision is either reversed or modified.
- Notification with the review outcome, including clinical rationale will be sent to the recipient, attending physician, and facility.

If the recipient, attending physician, or facility disagrees with the expedited outcome, a standard appeal may be filed.

Standard Appeal

Definition

A standard appeal is an appeal of a non-certification. It is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. *However, standard appeals may also include secondary appeals.*

Process and Procedures

A request for a standard appeal may be made by telephone, fax, or mail within 180 days of the date shown on the non-certification notice. Requests for standard appeals should be directed as follows:

How to Request a Standard Appeal	
Call	(877) 200-9046 or (907) 550-7620
Fax	(877) 200-9047
Write	Qualis Health Appeal Review PO Box 243609 Anchorage, AK 99524-3609

Any request for appeal of a non-certification will be reviewed by a Qualis Health physician/practitioner consultant licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician, but will not be the same

individual(s) who initially non-certified the review or the expedited appeal, if applicable.

Qualis Health will issue the appeal decision within 30 days of receipt of the request for a standard appeal.All appropriate parties will be notified in writing of Qualis Health's determination to uphold, reverse, or modify the initial non-certification decision.

Qualis Health's appeal decision will take precedence over the initial non-certification decision or the expedited appeal decision, if applicable. For example, if the appeal review certifies more facility days than the original review, then more facility days will be recommended for certification. (See Exhibit 4).

Department of Health and Social Services Appeal Procedure

Fair Hearing Rights for Recipients

The Department of Health and Social Services Fair Hearing procedure is the process by which recipients can contest the Qualis Health non-certification decision. Recipients may request a fair hearing by phone or in writing to the Fair Hearing representative at Alaska Department of Health and Social Services, within 30 days of the date on Qualis Health's standard appeal determination letter non-certifying the service. The request must state the rationale for requesting a Fair Hearing. The address and phone number to request a fair hearing:

Attn: Fair Hearing Representative
Xerox, Inc.
1835 S. Bragaw Street, Suite 200
Anchorage, AK 99508
(907) 644-6800

If the recipient has been getting a service paid by Alaska Department of Health and Social Services that is stopped, suspended, or reduced by an action Qualis Health takes, the recipient may ask that the service be continued. If the recipient wants to have the service continued while awaiting a hearing decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or reduce the service. If the recipient asks for the service to be continued and the hearing decision determines that the Alaska Department of Health and Social Services was correct to stop, suspend, or reduce the service, the State may require the recipient to repay the cost of the services provided. (*Regulatory References: 42 CFR 431.230(b) and 7 AAC 49.200).*

Second Level Appeal Rights for Providers

An additional appeal process is available to providers through the Alaska Department of Health and Social Services. A provider may request a second level appeal when they are not satisfied with the results of the first level appeal decision by Qualis Health. A second level appeal must be requested in writing and postmarked within 60 days of the date of the first-level appeal decision by Qualis Health. A telephone call does not serve as notification that a second level appeal is being requested.

Providers should submit second level appeals to:

Division of Behavioral Health
Claims Appeal Section
3601 C Street Suite 878
Anchorage, AK 99503

Include a copy of the Qualis Health first level decision and supporting documentation considered relevant with the written appeal request.

Providers will be notified in writing of the final decision by the Alaska Department of Health and Social Services. If the recipient has been getting a service paid by the Alaska Department of Health and Social Services that is stopped, suspended, or reduced by an action Qualis Health takes, the recipient may ask that the service be continued. If the recipient wants to have the service continued during the time awaiting an appeal decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or to reduce the service. If the recipient asks for the service to be continued and the appeal decision determines that the Alaska Department of Health and Social Services was correct to stop, suspend, or reduce the service, the state may require the recipient to repay the cost of the services provided. ***(****Regulatory References: 42 CFR 431.230(b), 42 CFR 431.231(a), 7 AAC 49.190 and 7 AAC 49.200)*

Section 17 - Care Coordination

Overview

The scope of Care Coordination extends to Children (up to age 21 years) who are covered by Alaska Medicaid and receiving services in a residential psychiatric treatment center both in Alaska and out-of-state. Care Coordination may extend to children who are at risk for admission to residential or inpatient psychiatric levels of care if determined by the State.

Care Coordination Provided by Qualis Health is a process that links youth(in residential psychiatric treatment)and their providers to services and resources in a coordinated effort that maximizes the potential of youth and provides them with optimal behavioral healthcare upon discharge.

Care Coordinators will network with the out-of-state and in state providers, with Qualis Health clinical review staff, and consult with the State of Alaska Behavioral Health Utilization Review team.

Goals of Care Coordination services:

- Facilitate access to community resources
- Assess family resources and needs
- Identify barriers to lower level of care services
- Promote continuity of care
- Track length of stay in Psychiatric Residential Treatment Facilities
- Track and post on website available beds and services
- Share information with providers and families to facilitate a smooth transition of their clients to community based services within Alaska.

Care coordination involves monitoring treatment progress, conducting family assessments, tracking length of stay, and facilitating and sharing information to assist the providers in their discharge planning processes across the continuum of care.

Family Resource Needs Assessment

Care Coordinators will contact parent or guardian 30 to 60 days after admission/placement in residential treatment facility. They will collect information from the family or guardians including but not limited to: former providers, family concerns, barriers to services, needs for additional case management, and family education. In additions, care coordinators will share information specific to the family/patient through consultation with residential treatment program staff (therapists, case managers, etc.,) to facilitate transitions or discharge.

Care Coordinators will share information with the family and providers through provision of a list of resources and options for planning for continued treatment.

Family Discharge Readiness Assessment

Care Coordinators will reconfirm agreement by the family to the plan for continuity of care services andtheir readiness to implement the family's (guardian's) portion of the discharge plan prior to discharge through conducting a Family Discharge Readiness Assessment. Care Coordinators will share information specific to the family/patient through consultation with residential treatment program staff (therapists, case managers, discharge planners, etc,) to facilitate transition or discharge and make them aware of other services/provider options that are supported by the family (guardian).

Discharge Planning across the Continuum of Care

The continuum of care is the range of health, social, and human services, treatments, and resources offered in a variety of settings that provide appropriate services to meet the patients' needs.

Availability of Services within Alaska

Recipients with mental health issues have several different settings and levels of care options within Alaska. The Care Coordinators will assist the providers to know what is available in Alaska as close to the home region of the recipients as possible. Qualis Health's website at http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources will be updated daily regarding availability of services in Alaska.

The Care Coordinators will educate and support providers regarding the range and levels of care for behavioral health services that are appropriate for each youth in Alaska based on family assessment. If there are needed services that are not covered by Medicaid, the Care Coordinator may work with the State of Alaska's Behavioral Health Utilization Review team to identify alternative funding sources that could be disbursed to providers, enabling the recipients with special needs to access those services.

Care Coordinators will work in close communication with the discharge planners of both the PRTFs and the receiving facility/setting of care in Alaska prior to discharge. The Care Coordinators support the discharge planners at the facility and with the outpatient providers through facilitation of communication on discharge placement needs.

The following Discharge Planning Process Outcomes chart describes the four phases of the discharge planning process, the desired outcomes, and the associated activities of the facility's discharge planners and the Qualis Health Care Coordinators.

During all phases of the discharge planning process, Qualis Health's Care Coordinators are there to assist and support the discharge planners to address any unnecessary delays and to accomplish a timely and appropriate discharge.

Discharge Planning Process Outcomes

Phase 1–Patient Identification

- **Facility and/or Care Coordination team** identifies incoming patients based on admit or State recommendation
- **Facility** provides Care Coordinators with basic information needed for tracking length of stay, and progress toward meeting discharge goals, family guardian information.
- **Care Coordination team** facilitates information flow between the sending and the receiving facility

Phase 2–Discharge Planning Evaluation & Family Assessment(30 – 60 days after admit)

- **Facility** conducts evaluation of the client's post-discharge needs, including self-management capabilities and availability of appropriate services and specific providers in identified discharge location
- **Care Coordinator** conducts Family Resource Needs Assessment and supports discharge planning by providing information about available resources in the identified discharge location, available services, information regarding family needs, and potential gaps and or barriers to services.

Phase 3–Reassessment of the Discharge Plan

- **Facility**re-evaluates reportedplan with family in light of the client's progress in treatment and clinical situation, makes corresponding suggestions regarding the discharge plan or service availability to meet the needs of the client as indicated by the treating clinician.
- **Care Coordinator** communicates with the facility to receive any updates to the plan and investigates the availability of any additional services that may be needed (calls facility, confirms needs, and offers assistance to facilitate information exchange between discharging and receiving service provider)

Phase 4–Confirmation and Implementation of the Discharge Plan

- **Facility** finalizes the discharge plan and provides Care Coordinator with the specific providers of services as outlined in the discharge plan, and updated information 30-60 days prior to the anticipated discharge date.
- **Care Coordinator** Conducts Family Discharge Readiness Assessment, provides feedback regarding any concerns to

the provider, and confirms the availability of appropriate services of the viable care transition plan

- **Facility** uses feedback from Care Coordination team to modify or adjust discharge plans to best meet needs of client and family if necessaryandprovides actual discharge date to Care Coordination team

Desired Outcomes

- Work in a collaborative way to bring the youth closer to their home region as soon as appropriate treatment is found to be available and accessible
- Reduced length of stay in residential programs
- Improved continuity of care that meets the individual patient's needs based on family resources and needed supports
- Improved patient and family satisfaction
- Decrease of readmissions to residential services'

Tracking Bed Availability and Treatment Programs

Qualis Health updates and maintains the care coordination website, providing pertinent information on both in-state and out-of-state treatment programs. This site gives information about current availability of inpatient and outpatient resources. *Providers are requested to send information regarding their available beds **on a daily basis** to Qualis Health.*

To access information on available beds and services, please go to http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources and scroll down to view the *Facility Bed Availability* section.

Case Consultation with State Officials

Upon request or on a case-by-case basis, the Care Coordinator provides consultation on information pertaining to the recipient's discharge planning needs, networking with Department of Health and Social Services, Office of Children's Services, Division of Juvenile Justice, Division of Senior and Disability Services, and the Behavioral Health Utilization Review team.

State of Alaska's Provider/Workgroup Meetings

The Care Coordinators participate in various meetings with providers in various areas of the state (previously called Bring The Kids Home BTKH Meetings). These meetings are held with various agencies in the state to discuss service availability and the needs of youth transitioning back to Alaska from out of state PRTF facilities. The purpose of these meetings is to identify appropriate resources so youth can be brought closer to their home region as soon as appropriate treatment is found to be available and accessible.

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Appendix A
Glossary of Terms and Acronyms

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Appendix A
Glossary of Terms

Active Treatment:
Active treatment refers to the planning, delivery, and monitoring of a dynamic set of inter-related, effective, culturally appropriate, and individualized behavioral health services designed to meet the behavioral health service needs of the recipient. Active treatment includes the use of specific and clear intervention strategies that target those behaviors identified in the diagnostic evaluation, **individualized** POC, and designed to improve functioning, reduce or eliminate negative symptoms, demonstrate ongoing measurable progress, and enhance the quality of the recipient's life. Qualified team must provide active treatment to a recipient and his/her legal guardian(s).

Acute Care: Critical care administered to a patient with a rapid onset acute condition, and following a short but severe course. Examples of acuity may include serious impaired thought processes such as hallucinations, delusions, loose associations, paranoia, or other acute disturbances that put recipient at imminent risk of harm; severely dysfunctional patterns of behavior related to the acute disturbances pertaining to the primary and (if any)secondary diagnoses.

Adverse Determination: The services do not meet Medicaid Medical Necessity Criteria or review protocols, so the request for Medicaid authorization is not certified.

Appeal: An appeal is a request for reconsideration for a disputed review decision.

Case ID Number (Request Identification): A number assigned to the review at the time of submission.

Certification of Review: After the provider submits the clinical information for review, the Qualis Health clinical reviewer may authorize, or certify, that medical necessity is met. When the provider receives a "Certification," then a claim may be submitted to the fiscal agent. Certification is not a guarantee of payment.

Certification of Need (CON): A federally mandated, physician-certified document, required for each recipient at the time of admission to inpatient psychiatric services, which declares that inpatient services are, or were, needed upon admission. This evaluation must be completed before the Medicaid agency authorizes care. Re-certification must be made at least every 60 days after certification (Code of Federal Regulations – 42 CFR 456.160, and 441.152). However, under 42 CFR Ch. IV 441.155 (b)(c) "The plan must be reviewed every 30 days by the team specified in 441.156 to—(1) Determine that services being provided are or were required on an inpatient basis, and (2) recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient." See form in Appendix H Exhibit 10

Continued Stay (Concurrent) Review: The process of reviewing for continued stay medical necessity based on updated clinical and treatment planning documentation furnished by the provider

Delayed Eligibility: Review of cases for recipients not eligible at the time of admission and determined eligible prior to patient's discharge from facility

Emergency or Urgent Admission: An emergency admission is one in which the attending physician believes that there is a likelihood of serious harm to the recipient or others and that the recipient requires both immediate intervention and an immediate or "soon as possible" protective environment. Also see the definition of "Urgent Care Services".

End Certification Date: Services have been authorized for payment through this "next review" date. The provider must submit the next review on a day before the "end certification" or "next review" date.

Fair Hearing: The legal forum provided by the State of Alaska for a recipient and/or representative in disagreement with a Qualis Health determination to reduce, non-certify, or suspend authorization.

Family Psychotherapy: A form of therapy in which members of a family or individuals sharing a household who are considered "family members" attend psychotherapy sessions for the treatment of relationships within the family or household to achieve better emotional, behavioral, or social adjustments of all the individuals within the family or household.

Group Psychotherapy: Group therapy delivered by a mental health professional clinician (7 AAC 43 1990.22)

Health Insurance Portability and Accountability Act (HIPAA): Relating to the uses and disclosures of Protected Health Information.

Inpatient Interdisciplinary team (IIT): Team comprised of the following members: psychiatrist, clinical social worker, registered nurse who has specialized training or 1 years' experience, depending on the needs of the client an occupational therapist or psychological associate licensed with a master degree in clinical psychology may be part of the team (7AAC 140.405)

Late Submission: Reviews performed by Qualis Health in cases where the admission review was not submitted or the certification span has expired, the client has not yet discharged, and the provider submits a late request for authorization.

Leave of Absence Policy (LOA): Overnight leave from the facility to have been determined to be medically necessary by the treatment team. Up to 12 calendar days per year may be allowed and billed by the facility.

Medical Necessity: Refers to the medical necessity of inpatient psychiatric care as based on the Alaska Medicaid Medical Necessity Criteria and as determined by Qualis Health review staff.

Next Review Date: The next review date is the date assigned to submit the next review. Certifications are given from (date) to (next review date). The day before the next review date is the last date certified for possible payment based on the medical review.

Non-certification: An adverse determination. The services do not meet Medicaid Medical Necessity Criteria or protocols.

Onsite Family therapy travel requests: Travel authorizations for onsite family therapy are covered when the PRTF determines it is medically necessary and it is written in the POC. It is covered not more than every 90 days. The travel to onsite family therapy is for one parent/guardian to attend. For an exception to be made it must be medically justified with very clear and specific treatment goals, interventions and expectations in the POC.

Partial Certification: A determination that the number of days that meet medical necessity is different from the days requested by the provider.

Peer-to-Peer: A telephone review between the facility physician and Qualis Health physician reviewer to discuss any information that supports the medical need for the requested services.

POC: Plan of Care/Individualized Treatment Plan; Master Treatment Plan.

Primary Diagnosis: The diagnosis of a disorder determined through appropriate clinical assessments as the chief cause of the admission to a facility for behavioral health services.

Prior Authorization (Pre-service) Review: The process whereby Qualis Health reviews clinical information from the provider to determine medical necessity for specific inpatient psychiatric services. A Prior Authorization Number (PA number) is assigned when the review is certified, and the provider uses this PA number for billing purposes and for making travel arrangements.

Provider: An individual, firm, corporation, association, or institution providing or approved to provide medical services to an Alaska Department of Health and Social Services Medicaid recipient.

Provider Medicaid ID Number: Number assigned to each provider by Xerox fiscal agent for Alaska Department of Health Social Services.

Recipient: An individual eligible for benefits under the Alaska Department of Health and Social Services.

Retroactive Eligibility Review: Review of cases for recipients not eligible at the time of admission and determined eligible at a later date.

Retrospective Review: Retrospective reviews are submitted and performed when the eligibility is determined after the recipient has discharged from the facility, or when extenuating circumstances have prevented the submission of a review before the recipient was discharged from the facility. A retrospective review is a review for medical necessity after services have been rendered. Retrospective Reviews are reviews that have not yet been submitted as an initial review, and discharge has occurred.

Urgent care services: A case is considered to involve urgent care whenever the application of the time periods for making non–urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient's medical condition, would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

Xerox: Fiscal agent for the Alaska Department of Health and Social Services performing services related to claims adjudication and prior authorizations for services such as transportation and accommodation.

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Acronyms

AAC: Alaska Administrative Code
CC: Care Coordinator at Qualis Health
CFR: Code of Federal Regulations
CMS: Centers for Medicare & Medicaid Services
CON: Certificate of Need
CPT: Physicians' Current Procedural Terminology
DBH: Division of Behavioral Health, of the DHSS
D/C: Discharge
DD: Developmentally Disabled
DHSS: Department of Health and Social Services
DOB: Date of Birth
DS: Discharge screening criteria indicative of patient stability and readiness for discharge
DSDS: Division of Senior and Disability Services of DHSS
DSM: Diagnostic and Statistical Manual of Psychiatric Disorders
IDD: Intellectual and Developmental Disability
IIT: Inpatient Interdisciplinary Team/Treatment Team
DJJ: Division of Juvenile Justice, of HSS
HIPAA: Health Insurance Portability and Accountability Act
ICD-10: International Classification of Diseases (10th Edition,)
LOA: Leave of Absence
LOC: Level of Care
LOS: Length of Stay
OCS: Office of Children's Services of HSS
PA: Prior Authorization
POC: Plan of Care
QIO: Quality Improvement Organization
PRTF: Psychiatric Residential Treatment Facility
SI: Severity of illness
TEFRA: Tax Equity and Fiscal Responsibility Act of 1982
TTD: Therapeutic Transition Days

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Appendix B
Alaska State Medicaid Program
Acute Psychiatric Hospitalization
Medical Necessity Criteria

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Appendix B
Alaska State Medicaid Program
Acute Care Medical Necessity Criteria
Effective April 15, 2009

In order to receive Certification, Criteria A, Band C must be met:

Criterion A: Ambulatory care resources providing less restrictive levels of care that are available in the community do not meet the treatment needs of the recipient. 42 CFR 441.152(a) &7AAC 43.552 (C) (2) (A).

To meet this criterion, Al and A3, or A2 and A3 of the following must be established:

A. I. ☐ Documentation that the recipient is diagnosed with a primary behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (f01-F99): and that the mental illness causes the person to present a likelihood of serious harm (imminent risk) to that person or others within the past week for children and past 48 hours for adults.

For example: Suicidal ideation with a plan; in possession of a weapon with intent to hurt another; a recent episode with intent to do severe bodily harm; making credible threats of harm; recent psychotic episode causing debilitating hallucinations.

OR

A.2. ☐ Documentation that the youth recipient's condition is severely impaired as a result of mental illness and substantially interferes with or limits the youth's role functioning in family, school, or community activities. For adults, documentation that the recipient's condition is gravely disabled and role functioning is severely impaired as a result of mental illness and substantially interferes with their ability to engage independently in personal care or community living activities and function independently in the role of worker, student, or homemaker. For both adult and youth, the recipient's symptoms and maladaptive behavior are not a result of intellectual, physical, or sensory deficits.

For example: Severe impairment in role functioning due to committing serious acts of destruction in home or classroom; person's hallucinations, delusions, or disorganized thinking severely impact their ability to meet needs for nutrition, sleep, hygiene, rest or housing.

AND

A.3. ☐ Documentation that less restrictive levels of care available in the community do not meet the treatment needs of the recipient or that a less intense level of care is unavailable or inaccessible for meeting the treatment needs; and, there is specific documentation showing how services can reasonably be expected to either improve

recipient's condition or prevent regression so that the services will no longer be needed.

For example: Community behavioral health services may not provide required 24 hour care; psychiatric services needed may not be available at the frequency needed to maintain recipient in the community; the plan of care documents treatment goals and interventions that specifically relate to the primary and (if any) secondary diagnoses and identify discharge criteria to the extent the recipient can be treated in the community.

Criterion B: Documentation that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. 42 CFR 441.152b-2 & 7AAC 43.552 (C) (2) (B).

To meet this criterion, ALL of the following must be established:

EITHER (for BI):

B.la. ☐ The Certificate of Need (CON) for Elective, or NON-EMERGENCY ADMISSIONS: Must be certified with the signature of two (2) members of the Inpatient Interdisciplinary Team (IIT):

☐ A physician member of the IIT; AND

☐ Another member of the IIT have both signed and certified need for admission according to 7AAC43.552 (f) (1,3).

OR

B.lb. ☐The CON Question for EMERGENCY ADMISSIONS: "Has an appropriate physician certified need for hospitalization?"

AND

B.2. ☐ The psychiatric evaluation documents that the recipient has a primary behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorder (F01-F99). Any treatment for a substance abuse disorder must be secondary to the treatment for the mental health disorder.

In relation to B.2 criterion, please note:

- A seven (7) day maximum allowable limit on payment is placed on the following diagnostic codes if they are primary diagnoses unless documentation supports an imminent risk of serious harm to self or others if discharged; or unless a more specific diagnosis has been documented and included in the Plan of Care:
    - Oppositional Disorder (F91.3)
    - Conduct Disorders (F91.1, 91.2, 91.8, 91.9)

- A fourteen (14) day maximum allowable limit on payment is placed on the following diagnostic codes if they are primary diagnoses unless a more specific diagnosis has been documented and included in the Plan of Care:
    - Depression NOS (F32.8 and 32.9)
    - Unspecified Mental Health Disorder Non-Psychotic (F99)

AND

B.4. ☐ Documentation that the recipient is currently experiencing acute disturbances related to the Mental, Behavioral, Neurodevelopmental disorders diagnosed in B.2 above.

For example: Impaired thought processes such as hallucinations, delusions, loose associations, paranoia, or other acute disturbances that puts recipient at imminent risk of harm; severely dysfunctional patterns of behavior related to the acute disturbances pertaining to the primary and (if any) secondary diagnoses; recent psychotropic medication changes that put patient at high risk for acute disturbance if not monitored in inpatient setting.

Criterion C: The services can reasonably be expected to improve the recipient's condition or prevent further regression so that acute care services will no longer be needed. 42 CFR 441.155, 441.156 & 7AAC. 43.552(C) (2) (C)

To meet this criterion, ALL of the following must be established:

C.I. ☐ The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for acute care.

C.2.☐The individualized Plan of Care clearly documents goals and measurable objectives derived from the diagnostic evaluation.

C.3.☐The individualized Plan of Care is developed by a team of professionals in consultation with the recipient. If the recipient is a youth, his or her parents and/or legal guardians in whose care she or he may be released after discharge are included in this team.

C.4.☐The individualized Plan of Care clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently within their own environment.

C.5.☐ The individualized Plan of Care clearly documents a comprehensive discharge plan that is based on treatment goals and objectives to extent inpatient services are no longer necessary or treatment can be completed in the least restrictive environment (or lower level of care), specifies approximate discharge date based on achievement of those stated objectives, post-discharge service needs including any prospective post-discharge service providers and any other provisions necessary for transition to a lesser

restrictive environment and adult services. Discharge plans must be continually updated to reflect changes and progress in treatment planning.

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Appendix C
Alaska State Medicaid Program
Psychiatric Residential Treatment Facility (PRTF)
Medical Necessity Criteria

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Appendix C

Alaska State Medicaid Program
Residential Psychiatric Treatment Center (PRTF)
Medical Necessity Criteria

PRTF Care Criteria: The psychiatric evaluation must document a primary Behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99) excluding any form of substance abuse disorder, intellectual disability, or developmental disorder. Diagnosis and/or treatment for a substance abuse disorder must be secondary to diagnosis and/or treatment for the mental health disorder in order to seek authorization for services. For neurodevelopmental disorders there must be documented evidence that the individual has the ability to benefit from PRTF services that would enable them to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

In order to receive Certification for PRTF admission or continued stay, Criterion A, B, and C must be satisfied (42 CFR 441.152, 7AAC 43.552(C)(2)(A, B, C) & AS Sec. 47.07.032[1]

Criterion A

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient. 42 CFR 441.152a-1, 7AAC 43.552(C)(2)(A) & AS Sec. 47.07.032.

Instructions: Criterion A can only be met when all three categories (Accessibility, Treatment Effectiveness, and Severity) are verified.
Category 1: Accessibility

Instructions: One of the following 3 conditions must be present to satisfy this categorical requirement

A.1. A less restrictive level of care within the State of Alaska will not meet the recipient's treatment needs.

[1] Alaska Statute 47.07.032 asserts (a) Alaska Behavioral Health may not grant assistance for inpatient psychiatric services to a person under 21 years of age who is in an out-of-state psychiatric hospital facility or an out-of-state residential psychiatric treatment center unless Alaska Behavioral Health determines that the assistance is for:

(1) Psychiatric hospital services that are consistent with the person's clinical diagnosis and appropriately address the person's needs and that these services are unavailable in the state; or

(2) Residential psychiatric treatment center services that are consistent with the person's clinical diagnosis and appropriately address the person's needs and that these services are unavailable in the state.

Examples: Family or relative placement, community wraparound services, day or after school treatment, therapeutic foster care, residential or group home.

A.2. An appropriate, less restrictive level of care within the State of Alaska is unavailable or inaccessible.

Examples: There are no PRTF beds open for admission; PRTF beds open for admission do not meet clinical needs of the recipient.

A.3. Factors related to the recipient's family or community prevents effective treatment at a less restrictive level of care within the State of Alaska.
Examples: Recipient lacks adequate support, family persistently hampers treatment, making treatment ineffective, severe family disruption, or recipient's behavior persists despite appropriate treatment in a less restrictive level within the State of Alaska.

Category 2: Treatment Effectiveness
Instructions: One of the following 2 conditions must be present to satisfy this categorical requirement.

A.4. Therapeutic services provided (within the State of Alaska) in a less restrictive setting have been tried and found ineffective.

Examples: Clinical documentation supports the need for safety and structure of treatment provided in inpatient setting due to history of running away, compounding medical conditions, and harm to self or others.

A.5. Child has a documented history of multiple admissions to less restrictive therapeutic residential settings within the State of Alaska and has not progressed sufficiently or has regressed.

Examples: Family placements, therapeutic foster care, outpatient clinical and rehabilitative services, residential and group home care.

A 6. For individuals with cognitive impairments or organic brain syndrome, there is documented evidence that the individual has the ability to benefit from Residential Psychiatric treatment services that would enable them to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

Category 3: Severity
Instructions: One of the following 2 conditions must be present to satisfy this categorical requirement.

A.7. Assessment material conducted by a qualified mental health professional clinician, documents the need for active provision of multiple therapies in inpatient setting with 24-hour awake supervision.

A.8. The recipient's behavioral health disorder may be treated at a less restrictive level

of care. However, the recipient suffers one or more complicating concurrent disorders that determine residential psychiatric care medically necessary.

Examples: Multiple conditions of physical and psychiatric natures, eating disorders, severe depression and FASD, Diabetes, HIV and other complicating conditions.

Criterion B

B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. 42 CRF 441.152a-2 & 7AAC 43.552(C)(2)

Instructions: To meet Certification on Criteria B, all 4 of the following requirements must be met:

B1. A "physician" member of the Inpatient Interdisciplinary Team (IIT), according to 7AAC 43.552(f)(1) has certified need for admission; AND

Another member of the IIT according to 7AAC 43.552(f)(3) has certified need for admission.

B2. Must have a primary behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99) excluding any form of substance abuse disorder, intellectual disability, or developmental disorder. Diagnosis and/or treatment for a substance abuse disorder must be secondary to diagnosis and /or treatment for the mental health disorder in order to see continued authorization for services. For neurodevelopmental disorders there must be documented evidence that the individual has the ability to benefit from PRTF services that would enable them to self-regulate behavior, modulate emotional reactivity, and improve developmentally appropriate functioning in major life domains.

B3. Psychosocial ICD-10 Diagnosis Code (s) (Injury, Poisoning, and Certain Other Consequences of External Causes (T07-T88) and Factors Influencing Health Status and Contact with Health Services (Z00-Z99))

B4. The recipient is currently experiencing severely dysfunctional problems related to the psychiatric disorder diagnosed in B2, as demonstrated in one of the following areas.

B.4.a) Self-Care Deficit

Examples: Refusal to comply with treatment, impaired hygiene skills, refuses medication, persistent and severely depressed mood, self-care deficit may also place recipient in life threatening situations.

B.4.b) Impaired Safety

Examples: Runs away, history of chronic and severe loss of impulse control,

repeated aggressive or destructive behavior toward self, others or property, recent suicide or history of in family or peer group, presence of suicidal ideation, gestures, or attempts

B.4.c) Severely impaired role functioning in the family, school or community.

Examples: The family's situation is not responsive to outpatient interventions, difficulty performing at grade level, chronically truant, or repeated problems within the community with law enforcement.

Criterion C

C. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that PRTF services will no longer be needed. 42 CFR 441.155, 441.156 & 7AAC 43.552(C)(2)(C).

Instructions: To meet Certification on Criteria C, all 5 of the following requirements must be met:

C.1. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for PRTF care.

C.2. The individualized POC clearly documents goals and measurable objectives derived from the diagnostic evaluation.

C.3. The individualized POC is developed by a team of professionals in consultation with the recipient, his or her parents, and legal guardians in whose care she or he may be released after discharge.

C.4. The individualized POC clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently in their own environment.

C.5. The individualized POC clearly documents a comprehensive Discharge Plan that is based on completed treatment goals and objectives, specifies approximate discharge date, post-discharge service needs, identified post-discharge service providers to ensure continuity with the recipient's family, school, and community upon discharge and any other provisions necessary for transition to a lesser restrictive environment. In continued stay cases, the treatment has stabilized the recipient's behavioral health condition, and the facility and the guardian are diligently pursuing an appropriate lower level of care.

Appendix D
Alaska Medicaid Mental Health Review Requirements Summary Sheet And Definitions

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Appendix D
Review Requirements Summary Sheet and Definitions

Active Treatment
Active treatment refers to the planning, delivery, and monitoring of a dynamic set of inter-related, effective, culturally appropriate, and individualized behavioral health services designed to meet the behavioral health service needs of the recipient. Active treatment includes the use of specific and clear intervention strategies that target those behaviors identified in the diagnostic evaluation, **individualized** POC, and designed to improve functioning, reduce or eliminate negative symptoms, demonstrate ongoing measurable progress, and enhance the quality of the recipient's life. Qualified team must provide active treatment to a recipient and his/her legal guardian(s).

Appeal: An appeal is a request for reconsideration for a disputed review decision. Within 180 days of the notification letter.

Certificate of Need (CON): (42 CFR Ch. IV 441.152 and 441.153)
The clinical file must contain documentation per the CFR, which includes for urgent /emergency admissions:

- A physician certifies that the recipient is in need of inpatient services.
- The certification is made at the time of admission, or if an individual applies for Medicaid assistance while in the hospital before the Medicaid agency authorizes payment.

The Certificate of Need (CON) for NON-EMERGENCY ADMISSIONS: Must be certified with the signature of two (2) members of the Inpatient Interdisciplinary Team (IIT):

a. A physician member of the IIT; AND

b. Another member of the IIT have both signed and certified need for admission according to 7AAC43.552(f)(1,3). See CON listed in Appendix I Exhibit 10.

Clinical Records
A provider of psychiatric services shall maintain a clinical record of services provided to a recipient. A clinical record must include:

- The Certificate of Need information for inpatient psychiatric services in accordance with CFR 456.60.
- Diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care.
- The results of required Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings.
- An individualized Plan of Care (POC).
- Update Plan of Care (POC) reviews.
- **Individualized** discharge plan to include specific discharge information. Documentation of active discharge planning at time of admission and continually updated to include contacts made, disposition of the contact, efforts to collaborate and coordinate with referring agency, receiving agency, receiving school (to include special education), barriers identified, and any other information effecting discharge planning. The clinical record must document the

parent/legal guardian's active engagement in the discharge process and the facility's efforts to contact and engage the parent/guardian in the process when there is no or limited participation.

- Progress notes that document the service provided, the date of the service, duration of service, active interventions provided, the recipient's response to the intervention, and the recipient's progress toward identified treatment goals and objectives. The provider of the service must sign each progress note and include his/her professional credentials.

Family Psychotherapy Requirements:
Requirements for family psychotherapy for parental custody recipients:

- In Acute Inpatient hospitals, family psychotherapyis required once` per week with the identified family.
- In PRTF facilities, family psychotherapy is required once per week with the identified family to include siblings when clinically appropriate.

Requirements for family psychotherapy for state custody recipients—BOTH of the following are required:

- In acute inpatient hospitals, family psychotherapyis required a minimum of once per week with the identified family, when one exists, *to include siblings when clinically appropriate.*
- In PRTF facilities, family psychotherapyis required once per week with the identified family, when one exists
- AND: Required contacts with State of Alaska representatives of custody youth-- once a week to exchange current treatment information and help facilitate discharge planning, whether or not an identified family is involved.

If family psychotherapyis clinically contraindicated:

- If family psychotherapyis contraindicated for a recipient and the clinical justification is documented in the chart, weekly contact with the parents and/or guardians is required, even when there is no family psychotherapy, in order to communicate treatment progress.
- The timeframe for which family psychotherapyis contraindicated must also be documented in the Plan of Care.
- Family psychotherapyis required to resume as soon as clinically indicated.

Family psychotherapy for Over 18: If a recipient of inpatient services is 18 years or older, Family Therapy sessions are required as outlined in protocol. A Release of Information must be signed by the recipient and recorded in the clinical record. Exceptions to this requirement must be documented in the clinical record.

Family, Individual and Group Psychotherapy Documentation and Requirements: Must be performed on a weekly basis. A chart note must include a goal, an objective and an active intervention identified in the plan of care. The note records the recipient's response to the intervention and progress. A progress note includes: date, time, duration of service signature and credentials of service provider and meet the following treatment setting specific requirements:

- **Acute Care**
  - **Four therapeutic interventionsmust occur weekly** in any combination of the following three types of therapy:
    - **Individual therapy**must occur a minimum of one time per week.
    - **Group therapy** that is pertinent to the diagnostic needs of the recipient must occur a minimum of one time per week.

    - **Family therapy**must occur a minimum of one time per week.
    - If a recipient is in Office of Children's Services (OCS) or Division of Juvenile Justice (DJJ) custody, contact with the appropriate caseworker must be held one time per week to discuss treatment progress and discharge planning in addition to the required weekly family therapy with the identified family.
    - Medication management/medication administration services to occur as needed.
    - Crisis intervention services to occur as needed.

- **PRTF Care** – to include all of the service requirements listed under Acute Care plus:
  - Family therapy must occur a minimum of one time per week. If a recipient is in Office of Children's Services (OCS) or Division of Juvenile Justice (DJJ) custody, contact with the appropriate caseworker must be held one time per week to discuss treatment progress and discharge planning in addition to the required weekly family therapy with the identified family.
    - Group Skill Development services, and
    - Individual Skill Development services.
    -

Initial Plan of Care

- Due at time of admission
- Diagnosis
- Problem statement related to the diagnosis
- Goals, objectives and interventions
- Must have discharge date, specific discharge providers identified, and special needs which may be needed at discharge.
- Requires signatures of all members of the IIT which included the MD, the RN, the clinical team member according to Alaska regulations, the parent/guardian if under the age of 18 and the client.

Master Plan of Care (42CFR Ch. IV 441.155 and 7 AAC 140.405):

- Due to be written, signed, and implemented <u>within 14 days of admission (441.153)</u>
- Due to be submitted (electronic review system (QHPP) preferred) for review on the 14th day after admission, which is the assigned review date (the end-certification) date

<u>Must Include:</u>

- Specific Problems relating to diagnoses are identified for treatment

- Measurable Objectives for each problem identified above are specified
- Projected timeframes for achievement of identified problems
- Integrated program of appropriate therapies (services) are listed as they relate to the identified problems and objectives above. Required therapies include group psychotherapy, family therapy, and individual psychotherapy and include experiences designed to develop the recipient's ability to function independently in the recipient's own environment.

- Diagnostic evaluation using primary Behavioral ICD-10 Diagnosis Code (s) (Mental, Behavioral, and Neurodevelopmental Disorders (F01-F99)) excluding any substance abuse disorder, intellectual disability, or developmental disorder. If there is an intellectual or a neurodevelopmental disorder it does not significantly interfere with the child's ability to participate in one or more life domains at a developmentally appropriate level and within culturally appropriate context.
  - Diagnostic evaluation that includes examination of the psychological, social, behavioral developmental aspects of the recipient's situation, medication management plan. and reflects the need for inpatient psychiatric care

  - Diagnostic evaluation of the client's medical conditions including:
    - Medications
    - Treatments
    - Restorative and rehabilitative services
    - Dietary needs
    - Assessments
  - 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
  - Signatures of the recipient and/or the parent, guardian, or legal custodian, and the treatment team members
  - The signed and dated authorization statement of the treating physician or mental health professional required by regulation
  - Post discharge plans begin at time of admission and updated during the recipient's inpatient stay as the recipient's psychiatric needs change, that specifies the following:
    - The approximate dates for discharge
    - The recipients; anticipated post-discharge service needs
    - The recipient's identified services providers, and other provisions necessary for the transition to a less restrictive environment
    - Related community services to ensure continuity of care with the recipient's family, school, and community upon discharge.
  - See the Continued Stay Review Questionnaire for more requirements (see updated version) http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-behavioral-health/provider-resources

- Plan of Care must be reviewed/updated every 30 days (441.155) by the inpatient interdisciplinary team (IIT) (for regulated IIT makeup, see 441.156)
  - Determined services provided are required on an inpatient basis

- Recommend changes in the plan as indicated by the recipient as an inpatient

Medical Necessity Requirements Summary

A medically necessary behavioral active treatment health service is designed to:

- Assess the nature and extent of the psychiatric disorder and its impact upon the recipient's ability to meet the demands of daily living, social, occupation, or educational functioning.
- Diagnose the psychiatric disorder
- Treat the psychiatric disorder
- Provide rehabilitation for the psychiatric disorder
- Prevent the relapse or deterioration of the recipient's condition due to the psychiatric disorder

In making a determination as to whether the proposed services are medically necessary, the Qualis Health reviewer will consider the following:

- Recommendations of the Inpatient Interdisciplinary Team (IIT).
- The recipient's diagnosis and level of functioning.
- The risk of harm from the recipient to self or other individuals.
- The appropriateness of the level of care and the need for inpatient or residential care.
- Whether interventions target specific symptoms, behavioral, social dysfunction, and are clearly related to the diagnostic evaluation.
- Whether proposed services in the individualized Plan of Care (POC) are consistent with generally accepted treatments and practices for the treatment of the specific symptoms and behavior and/or social dysfunction.
- Whether the recipient and/or legal guardian agree with the IIT regarding the focus of treatment and the POC will address the symptoms, behavioral and social dysfunctions targeted for intervention.
- The extent to which past and/or current treatment has been successful in treating the symptoms, behaviors, and/or social dysfunction.
- The extent to which less restrictive treatment is not available in the State of Alaska.
- The extent to which the units of service requested are no more than are necessary to meet the treatment or rehabilitation needs of the recipient.
- The extent to which the duration of services requested are no more than are necessary to reach the recipient-approved goals outlined in the individualized POC.
- The requested services are reasonably expected to improve the recipient's condition or prevent regression so that services at the current level of care will no longer be needed.
- The extent to which social functioning is improved through interventions provided as active treatment, targeted toward specific therapeutic goals and objectives and included in the individualized treatment plan.
- The extent to which the discharge plan is related to the accomplishment of goals and objectives with specific information addressing the approximate date for discharge, the recipient's anticipated post-discharge service needs, the recipient's identified

service providers, and other provisions necessary for the transition to a less restrictive environment.

Payment for services determined not medically necessary under this section is subject to recovery under 7 AC 43.081.

Mental Status Exam upon Admission: The date of the last Mental Status Exam must be within seven (7) days prior to submission of the review and performed by a mental health professional.

Peer Review: Completed by the end of the next business day after notification of the Offer of a Peer Review.

Plan of Care Reviews: Must be updated every 30 days for PRTF(441.155), and signed by the physician and appropriate treatment team members (7AAC 140.405; 42CFR Ch. IV 441.156 (b)(5)(c); 441.152; 441.153). Required elements to be included, but not limited to, are to include: Comprehensive discharge plan with anticipated discharge date; DSM 5 diagnoses and ICD 10 code(s)Individual psychotherapy, Family psychotherapy, and Group psychotherapy; Identified Problems/Goals to be treated that address the diagnoses, and updated with documented progress toward measurable goals and objectives in all therapies on continued stay reviews; Consultation with recipient and family or guardian completed.

Retrospective Appeal: Provider must submit the request for reconsideration on a retrospective review within the allotted timeframe of 180 business days.

PRTF Statute Requirement:

Alaska Statute 47.07.032 asserts (a) Alaska Behavioral Health may not grant assistance for inpatient psychiatric services to a person under 21 years of age who is in an out-of-state psychiatric hospital facility or an out-of-state Psychiatric Residential Treatment Facility unless Alaska Behavioral Health determines that the assistance is for:

(1) Psychiatric hospital services that are consistent with the person's clinical diagnosis and appropriately address the person's needs and that these services are unavailable in the state; or

(2) Psychiatric Residential Treatment Facility services that are consistent with the person's clinical diagnosis and appropriately address the person’s needs and that these services are unavailable in the state.

Appendix E
Alaska Medicaid Mental Health Review Timeframes for Review Submissions

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Appendix E
Alaska Medicaid Mental Health Review
Timeframes for Review Submissions
Submitting Requests for Prior Authorization Reviews

If a review is submitted before these timeframes, the review will be pended and the provider will be requested to submit updated clinical information within these timeframes.

Admissions

- Acute care admissions – on the day of admission, or a day before (when travel is an issue, call as necessary before the date of admission)
- PRTF admissions—on the day of admission, or up to two days before (when travel is an issue, call as necessary before the date of admission)

Timeframes for Continued Stay reviews submissions

- PRTF Master Plan of Care Review— on the 14th day after admission; Federal regulations --42CFR Ch. IV 441.154 require the Master plan of care to be…
    - (a) "developed and implemented no later than 14 days after admission for PRTF; and (b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.
    - The request for review of the written Master Plan of Care is to be submitted on the 14th day after admission for PRTF services and no later than on the 7th day after admission for acute care; i.e., the next review date assigned after admission.
    - The review questions for the Master Plan of Care are in the Continued Stay Review Questionnaire—See the section of questions dedicated to "Written Master Plan of Care Review" or the MPOC Assessment in JIVA.
- Acute care continued stay—Submit the review on the assigned "Next Review Date," or up to two days before the Next Review Date.
- PRTF care continued stay-- Submit the review on the assigned "Next Review Date," or up to three days before the "Next Review Date".

Timeframes for Pended reviews:

When a review has been submitted and is pended awaiting clinical/required information, Qualis Health will notify the provider via QHPPand/or phone. The provider has no more than seven calendar days to submit the requested information before Qualis Health will proceed with the information already submitted. This may result in an adverse determination due to lack of documentation to support the certification of the review.

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Appendix F
Contact Information

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Appendix F
Contact Information

Business Hours:
Monday through Friday
8:00 am to 5:00 pm Alaska Standard Time

Holiday Schedule:
New Year's Day, Martin Luther King Jr. Day, Presidents' Day, Seward's Day, Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day, Christmas Day

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Social Services Program Coordinator
DHSS/DJJ-CO Anchorage
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courtney.king@alaska.gov

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Appendix G
Commonly Used Phone Numbers & E-mail Addresses

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Appendix G
Commonly Used Alaska State Phone Numbers, E-mails, Websites and Addresses

Department of Health and Social Services
Behavioral Health
3601 C Street, Suite 878
Anchorage, Alaska 99503 (907) 269-3600 or (800) 770-3930
Alaska Behavioral Health - http://www.hss.state.ak.us/dbh/
Alaska Administrative Code - http://www.legis.state.ak.us/cgi-bin/folioisa.dll/aac

Teri Keklak
Manager of Medicaid and Quality Section
DHSS/DBH/Medicaid and Quality Section
(907) 269-2050
teri.keklak@alaska.gov

Medical Assistance Administrator with OCS (Alaska State Office of Children's Services):
Shannon Sexton
Medical Assistant Admin I
DHSS/OCS
(907) 465-8420
8:00 am– 4:30 pm Alaska Time
shannon.sexton@alaska.gov

Travel Authorizations through Xerox Inc:

When traveling, provider is responsible to call the numbers below:

Phone Calls (Toll Free in Alaska)	(800) 770-5650 Weekdays: 8:00 am- 4:00 pm Saturday 8:00am to 5:00pm Sunday: 8:00am - 12:00pm Hours are Alaska Time.
Phone Calls	(907) 644-6800 Weekdays: 8:00 am- 4:00 pm Saturday 8:00am - 5:00pm Sunday: 8:00am -12:00pm Hours are Alaska Time.
Fax to:	(907) 644-8131 24-hour access
Mail to:	Xerox, Inc/Travel Authorizations P.O. Box 240769 Anchorage, AK 99524-0769

Claims Status, Electronic Media Claims (EMC) and Billing Procedures through Xerox, INC.:

Phone Calls (Toll Free in Alaska)	(800) 770-5650 8:00 am - 5:00 pm Hours are Alaska Time.
Phone Calls	(907) 644-6800 8:00 am - 3:30 pm Hours are Alaska Time.
Fax to:	(907) 644-8126 24-hour access
Mail Claims to:	Xerox, Inc/Travel Authorizations Claims Dept. P.O. Box 240769 Anchorage, AK 99524-0769

Prior Authorization and Continued Stay Reviews and Qualis Health

Phone Calls	(877) 200-9046 8:00 am - 5:00 pm Hours are Alaska Time.
Phone Calls (Web Support) or Email: Providerportalhelp@qualishealth.org	(800) 949-7536, ext. 2800 8:00 am - 5:00 pm Hours are Alaska Time.
Fax Documentation to:	(877) 200-9047 24-hour access
Mail Documentation to:	Qualis Health PO Box 243609 Anchorage, AK 99524-3609

Provider Relations – Anchorage Office

Phone Calls (Toll Free) to:	(877) 200-9046 or (907) 550-7620
Phone Calls to: Betty M. Robards, MS, LPA Director, Alaska Medicaid Behavioral Health Services Email: bettyr@qualishealth.org	(800) 949-7536 ext. 7626 (907) 550-7626
Fax to:	(877) 200-9047
Mail to:	Qualis Health PO Box 243609 Anchorage, AK 99524-3609

Eligibility Status:

Phone Calls (AVRS-automated system) to:	(800) 884-3223 24-hour access
Phone Calls (In-State Toll Free) to:	(800) 770-5650 8:00 am - 5:00 pm Hours are Alaska Time.
Phone Calls to:	(907) 644-6800 8:00 am - 5:00 pm Hours are Alaska Time.
Fax to:	(907) 644-8126 24-hour access
Mail to:	Xerox, Inc./ Eligibility Status P.O. Box 240769 Anchorage, AK 99524

Appendix H
List of Example Exhibits

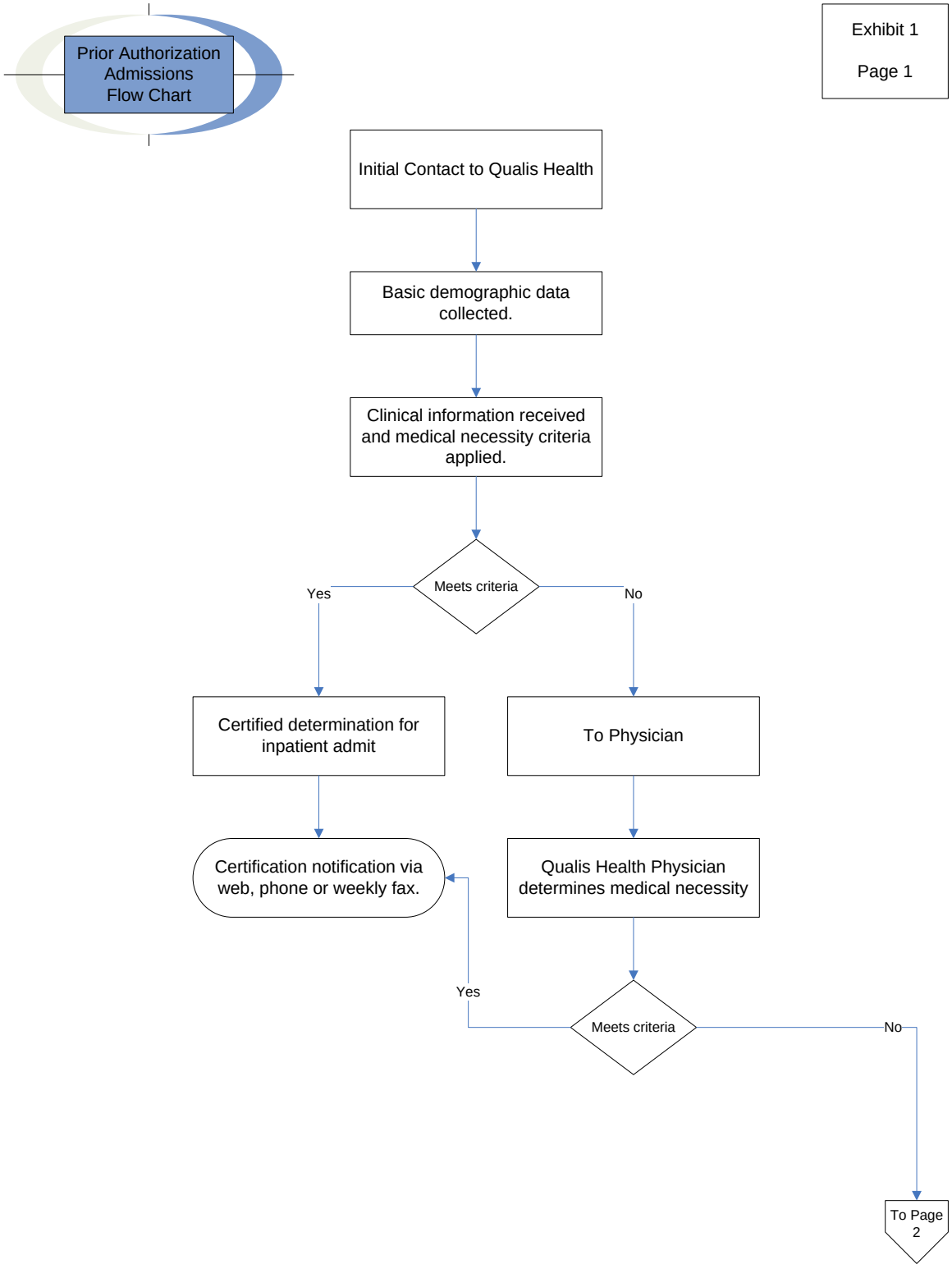
Appendix H

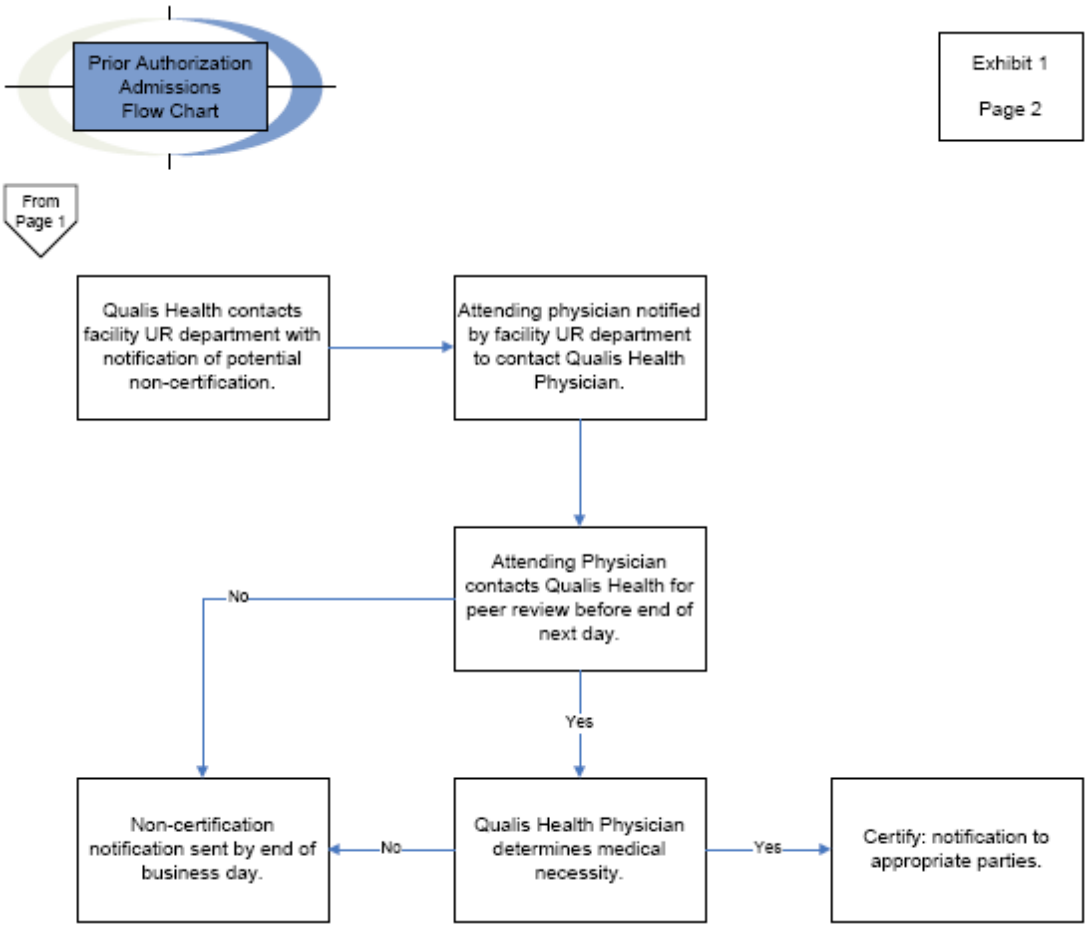
List of Example Exhibits Be aware of need for Link

Exhibit 1	Prior Authorization Admissions Example Flow Chart
Exhibit 2	Continued Stay Review Example Flow Chart
Exhibit 3	Expedited Appeal Process Example Flow Chart
Exhibit 4	Standard Appeal Process Example Flow Chart
Exhibit 5	Late Submission Review Process Example Flow Chart
Exhibit 6	Retrospective Eligibility Review Process Example Flow Chart
Exhibit 7	Example Admissions Review Questionnaire
Exhibit 8	Example Continued Stay Review Questionnaire
Exhibit 9	Referral form for Potential Out of State Placement Link within document
Exhibit 10	Certificate of Need (CON) Form
Exhibit 11	Retrospective Review Request Form/Late Submission Request
Exhibit 12	Behavioral Health Recipient Incident Report: http://www.qualishealth.org/sites/default/files/Word-97-2003-Incident-Report-Form.doc
Exhibit 13	PRTF Leave of Absence RequestForm for more than 12 days
Exhibit 14	Standards for Site Reviews
Exhibit 15	Restraint and Seclusion Review
Exhibit 16	Intellectual and Developmental DisabilitiesWaiver Form: http://dhss.alaska.gov/dsds/Pages/dd/default.aspx

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Example of Prior Authorization for Admission Flow

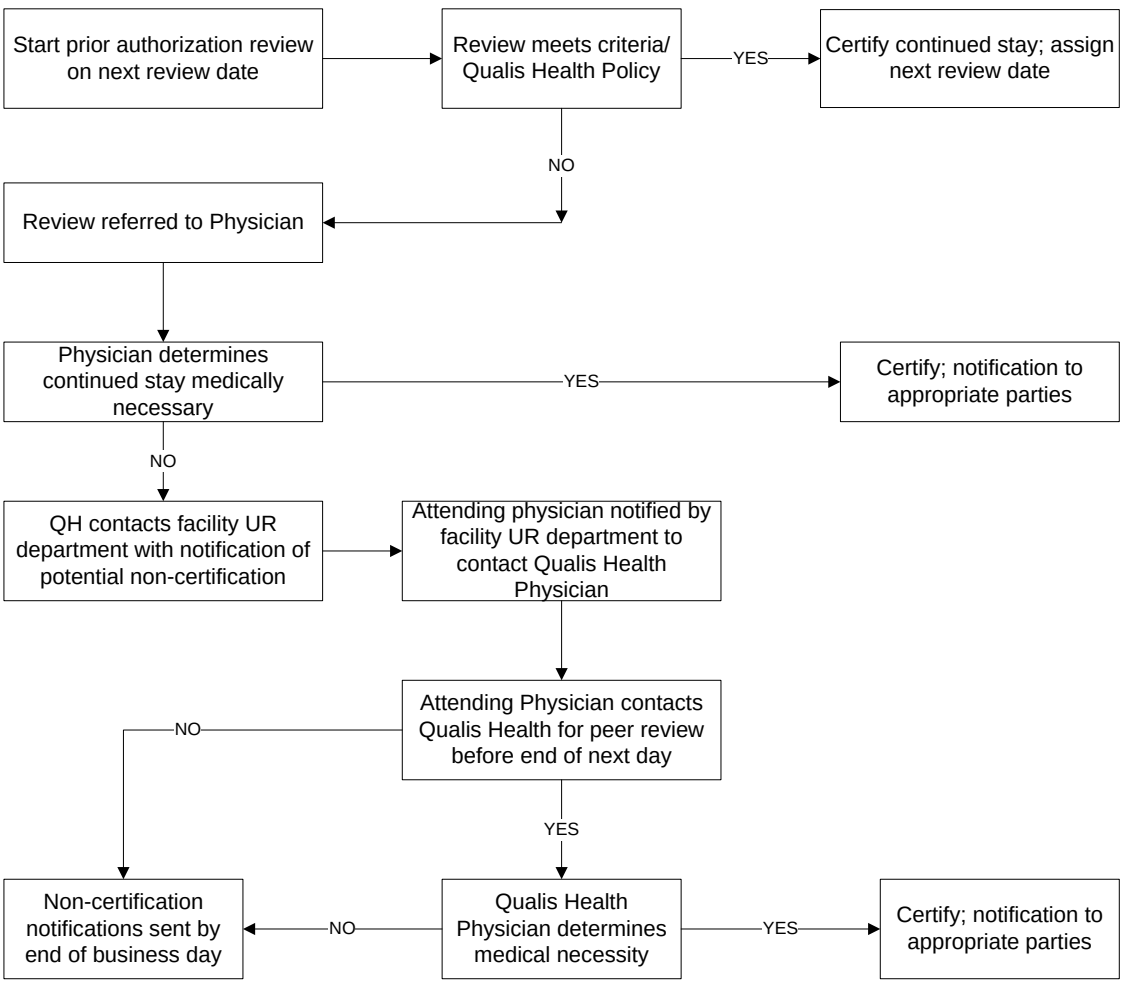



Prior Authorization Admissions Flow Chart
Exhibit 1
Page 2
From Page 1
Qualis Health contacts facility UR department with notification of potential non-certification.
Attending physician notified by facility UR department to contact Qualis Health Physician.
Attending Physician contacts Qualis Health for peer review before end of next day.
No
Yes
Non-certification notification sent by end of business day.
No
Qualis Health Physician determines medical necessity.
Yes
Certify: notification to appropriate parties.

Example of Continued Stay Review Flow

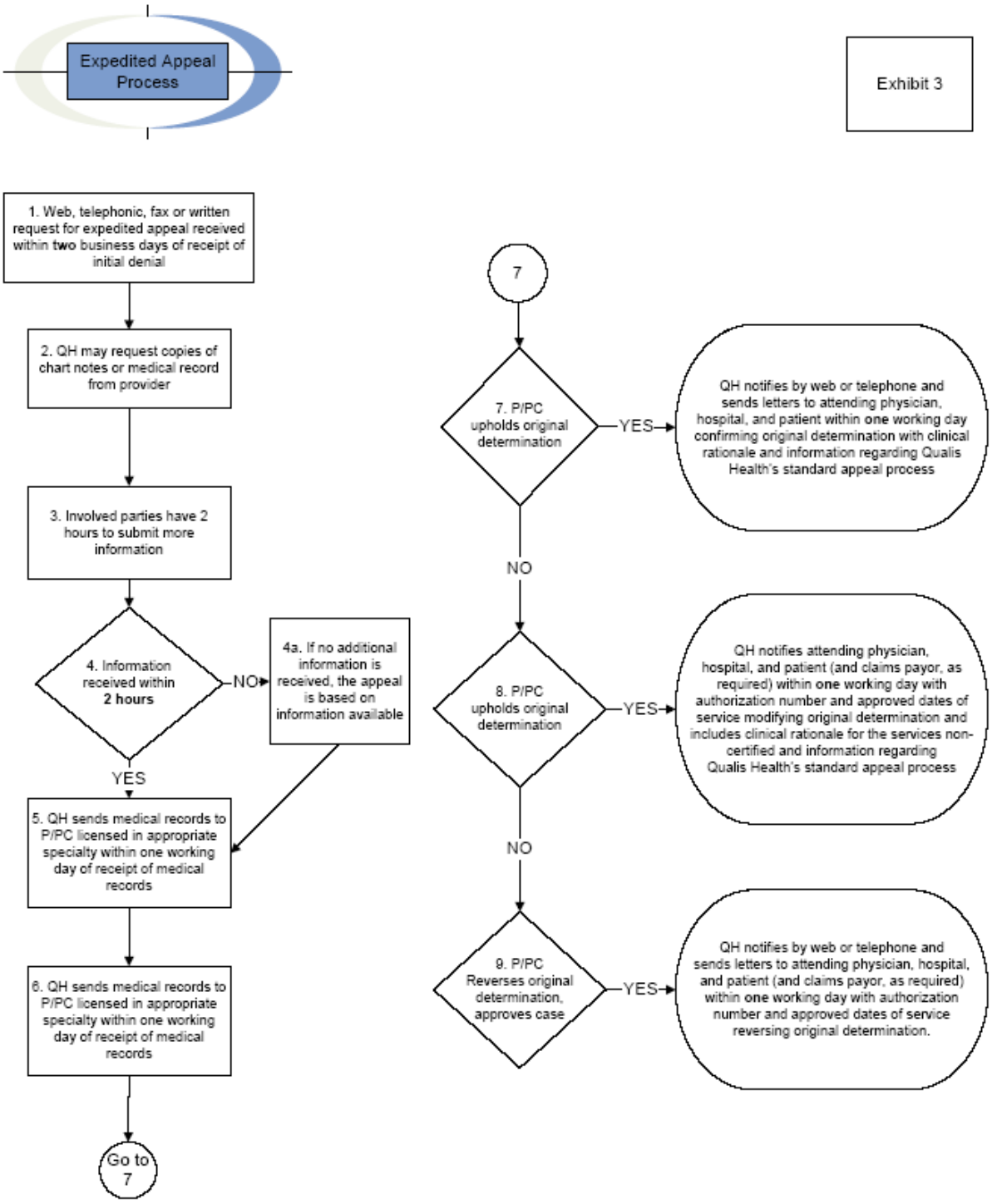
Continued Stay Review Flow Chart

Exhibit 2



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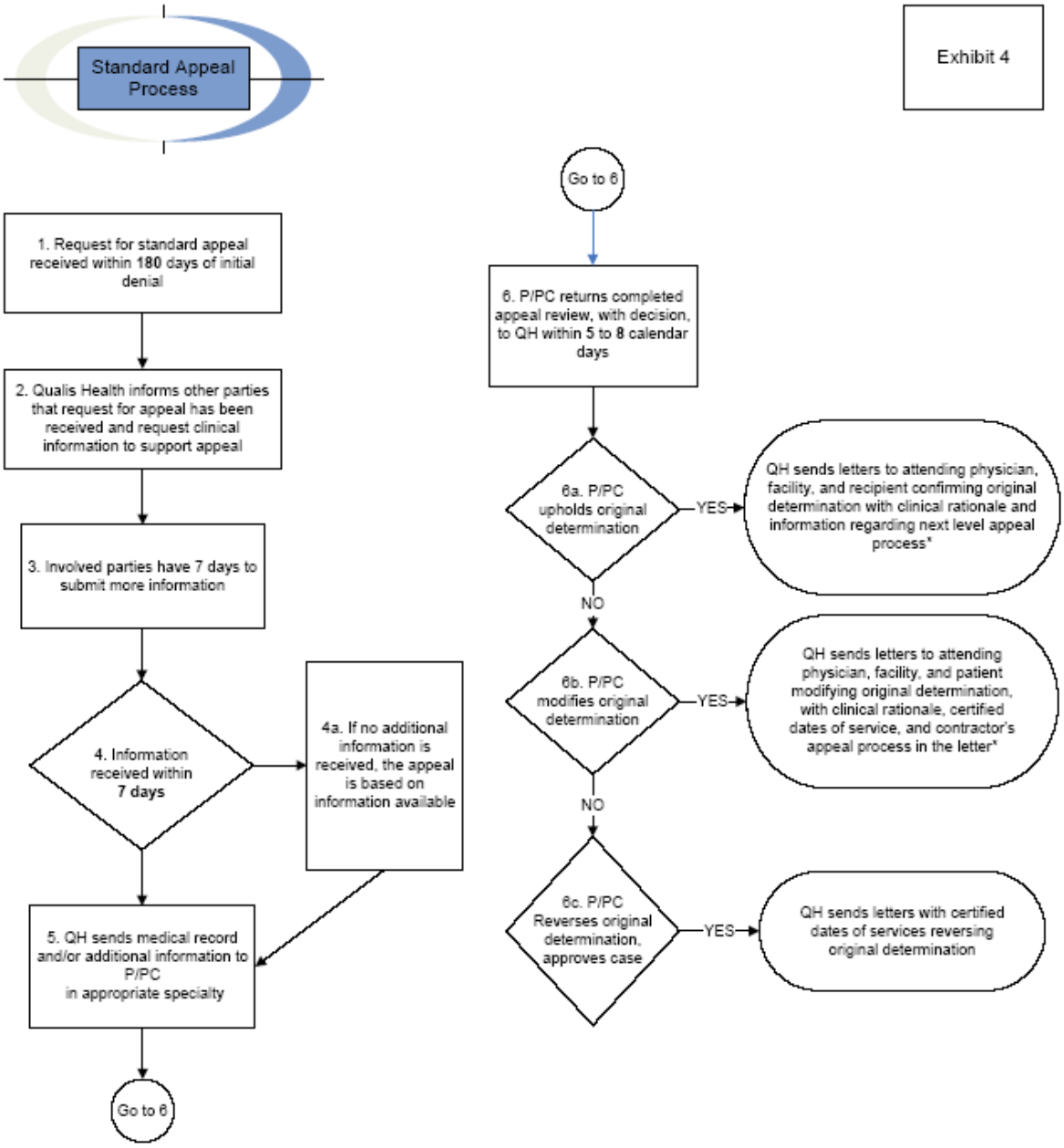
Example of Expedited Appeal Process Flow



P/PC = Physician/Practitioner Consultant
Expedited Appeal = An appeal of non-certification in a case involving urgent care.

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Example of Standard Appeal Process Flow



P/PC = Physician/Practitioner Consultant

*Review completed and letters mailed within 30 days of receipt of request to perform standard appeal.

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Example of Late Submission Review Process Flow

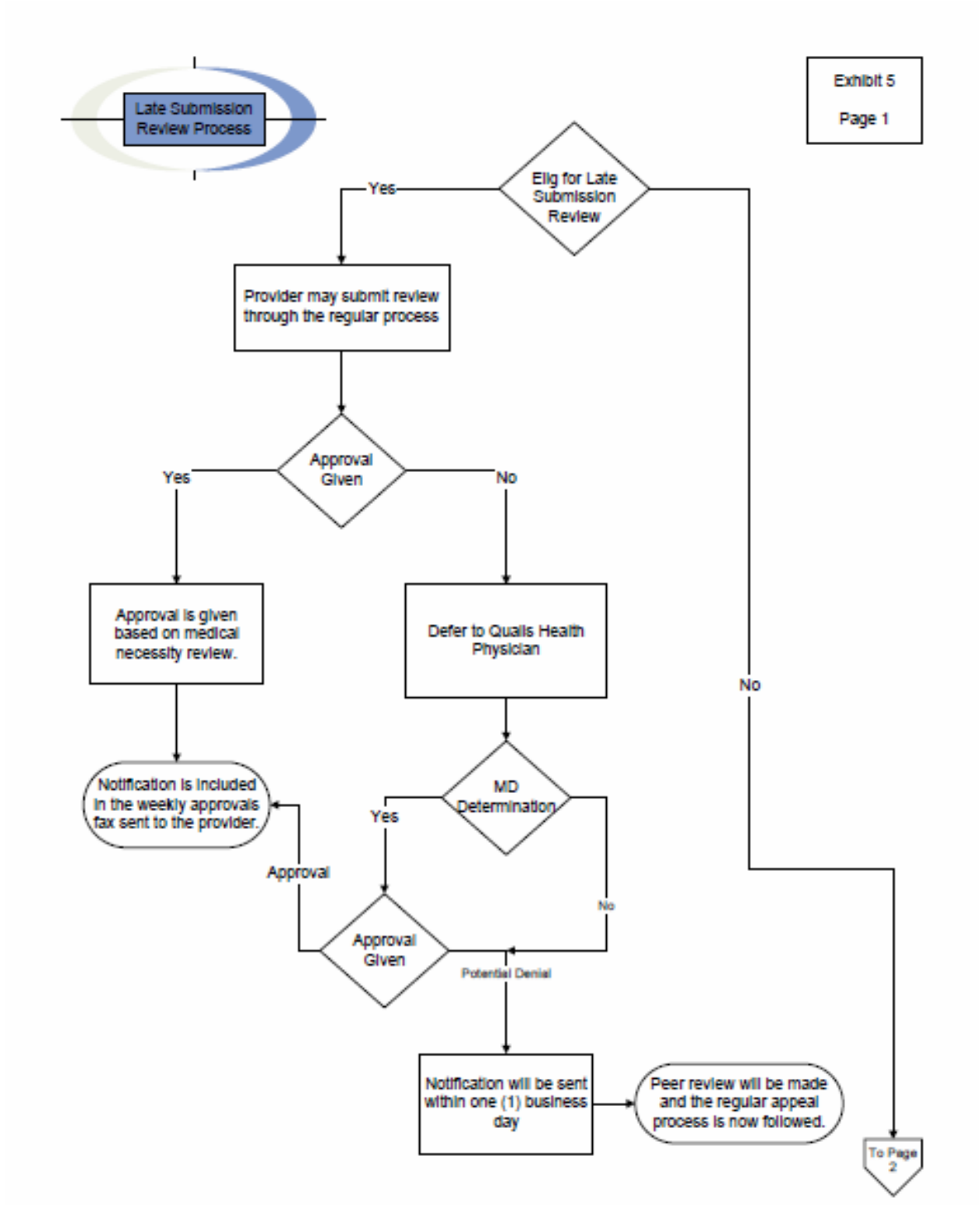
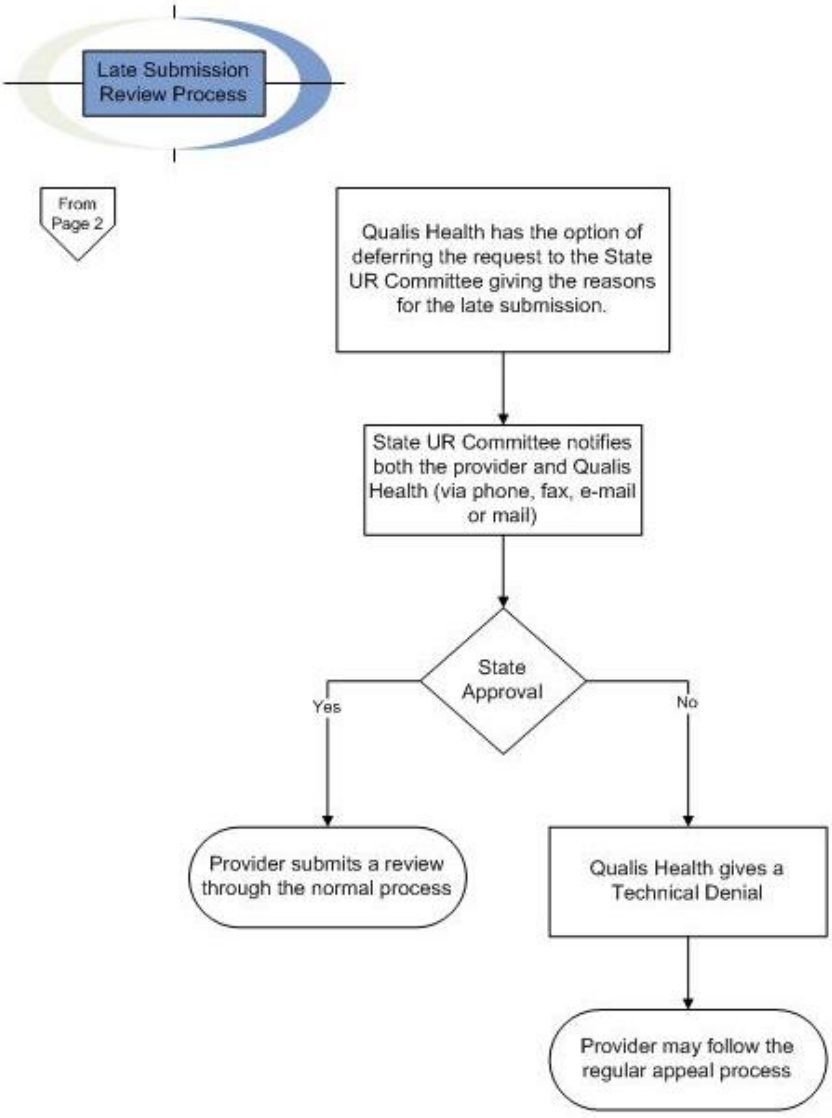


Exhibit 5

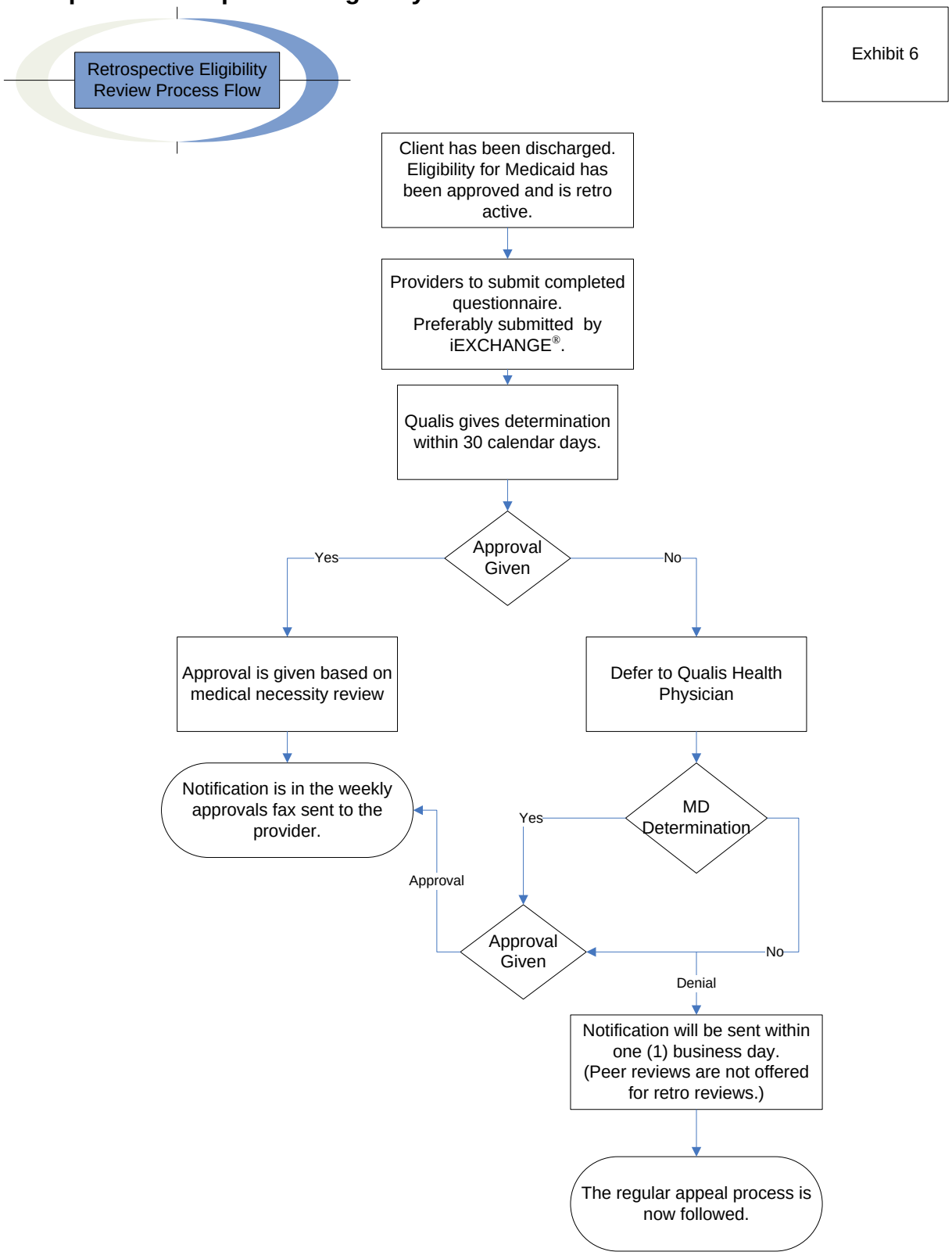
Page 2



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Example of Retrospective Eligibility Review Process Flow

Exhibit 6



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Admissions Review Questionnaire (Example)

Exhibit 7

AKBH Admission Review Questionnaire

Date of Review:

Name of Person providing Information:

PATIENT:
Name:
Medicaid ID # (if known):
Sex:
Date of Birth:
Age:
Ethnicity:
Plan Code: State of Alaska Behavioral Health
Client Code: State of Alaska Behavioral Health

CASE:
Notify (Date call received):
Treatment Setting: (IP/IP-OSS/RPTC):
Admit Date: (Actual date or proposed admit date):
Type: (Psychiatric or Residential):
Source: (Urgent or Non-Urgent):
Discharge (BLANK unless call for D/C):

DIAGNOSIS:
Axis I (Primary) Code:
Axis I (Secondary) Code:
Additional DX:
Additional DX:
Additional DX:

PROVIDER:
Facility Name:
Facility ID Number (if known):
Primary facility? Y or N:
Attending Physician/Psychiatrist Name:

TREATMENT PLAN:
Requested # of Days:
Begin Date:
To Date:
Notified Date: (Date of call/fax/submission to Qualis Health)
Source: Telephonic review or FAX review

1. Select Type of Review

- Acute: Emergency Admission ☐
- Acute: Non-Emergency Admission ☐
- RPTC: Expedited Admission ☐
- RPTC: Non-Emergent Admission ☐
- Retrospective (Use only if discharged) ☐

2. Have the appropriate physician and/or persons certified the need for admission?

- Yes ☐
- No ☐

AKBH Admission Review Questionnaire

3. Select Source of Referral (Select One):

- ☐ Acute Care-API
- ☐ Acute Care-Prov/Discovery
- ☐ Acute Care-North Star/Bragaw
- ☐ Acute Care- North Star/Main
- ☐ Acute Care-Other (Psychiatric General H)
- ☐ In-state RPTC-North Star/Debarr
- ☐ In-state RPTC-North Star/Palmer
- ☐ In-state RPTC-ACS
- ☐ In-state RPTC-Prov RPTC
- ☐ In-state RPTC-McCann
- ☐ BRS
- ☐ Private Clinic
- ☐ JJ
- ☐ RPTC OOS
- ☐ OCS
- ☐ Parent
- ☐ Foster Parent
- ☐ CBHC
- ☐ Police
- ☐ Hospital/Emergency Room
- ☐ Other: Enter information next question

4. Enter 'other' Referral Source _____

5. Select reason for Treatment Referral (Primary) (Select One):

- ☐ Suicidal Ideation/Attempt
- ☐ Homicidal Ideation/Attempt
- ☐ Aggression to Others
- ☐ Aggression to Self/Others
- ☐ Dual Dx
- ☐ Requires Locked Facility
- ☐ Running
- ☐ Sexual Acting Out
- ☐ Sexually Reactive Behaviors
- ☐ Self-Mutilating
- ☐ Psychotic Symptoms
- ☐ Eating Disorder

6. Select reason for Treatment Referral (Secondary)(Select One):

- ☐ Suicidal Ideation/Attempt
- ☐ Homicidal Ideation/Attempt
- ☐ Aggression to Self/Others
- ☐ Dual Dx
- ☐ Requires Locked Facility
- ☐ Running
- ☐ Sexual Acting Out
- ☐ Sexually Reactive Behaviors
- ☐ Self-Mutilating
- ☐ Psychotic Symptoms
- ☐ Substance Abuse
- ☐ Multiple Risk Factors
- ☐ Eating Disorder

7. Select Prognosis:

- ☐ Conditional
- ☐ Fair
- ☐ Good

AKBH Admission Review Questionnaire

8. Select primary reason for Secure Care (Select One):

- ☐ Dangerous to Self
- ☐ Dangerous to Others
- ☐ Dangerous to Property
- ☐ Runaway Behavior
- ☐ Impulsive/Out of Control Behavior
- ☐ Other: Enter information next question

9. Enter 'other' primary reason for Secure Care: _____

10. Ethnicity:

- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ Other
- ☐ Pacific Islander
- ☐ Unknown
- ☐ White

11. Has the recipient been adopted (by non-biological parents)?:

- ☐ Yes
- ☐ No

12. Name of guardian parent, adoptive parent, or social worker: _____

13. Select Custody Status:

- ☐ Non-custody
- ☐ JJ - Juvenile Justice
- ☐ OCS - Office of Children's Services

14. Select Region of Home Community (Select One):

- ☐ Anchorage
- ☐ Northern
- ☐ Southwest
- ☐ Southeast
- ☐ South-Central
- ☐ Mat-Su

15. Select Living Situation prior to this admission (Select One):

- ☐ Detention
- ☐ Family
- ☐ Foster Family
- ☐ Group Home
- ☐ Adopted Family
- ☐ Shelter
- ☐ RPTC
- ☐ Friends
- ☐ Relatives
- ☐ Homeless
- ☐ Other: Enter information next question

16. Enter 'other' Living Situation: _____

17. Name Last OOS RPTC: _____

18. Last OOS RPTC Admission Date (mm/dd/ccyy format): _____

19. Last OOS RPTC Discharge Date (mm/dd/ccyy format): _____

20. Name Last Acute Care (Psychiatric): _____

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Continued Stay Review Questionnaire(Example)Exhibit 8

AKBH Continued Stay Questionnaire

1. Select type of Continued Stay Review: Answer ONLY the questions that are PERTINENT to the TYPE OF REVIEW you are requesting. For TRIAL DISCHARGE HOME PASS, please answer ONLY if review period is before 11/01/2010):

- Concurrent questions 1-14 ☐
- Master POC 1-3 & 16-27 ONE TIME ONLY ☐
- Trial Discharge Home Pass 1-3 & 29-34 ☐
- TTD – Same as Concurrent ☐

2. Select current Custody Status:

- Non-custody ☐
- JJ - Juvenile Justice ☐
- OCS - Office of Children's Services ☐

3. Enter Anticipated Discharge Date (Date of discharge must be based on individualized goal achievement per psychiatric treatment progress/needs, rather than program completion. mm/dd/ccyy format):

_____

4. Enter Axis II Diagnosis Code: _____

5. Enter Axis II Description: _____

6. Document answers #7-14 for CONCURRENT Review in Additional Comments at the bottom of the previous page. Use the Copy and Paste function. Highlight, right click, select Submit Questionnaire, paste (right click) into Clinical Findings box.

7. Describe acute disturbances, self care deficits or imminent risk to self, others, impaired safety or severely impaired role functioning (e.g. thought disorders or other acute disturbances pertaining to the primary and (if any) secondary diagnoses):

_____

8. Updated Plan of Care Treatment Goals (Updated diagnosis and treatment plan. Specify the measurable goals and progress on treatment plan and in weekly Individual, Family and Group Psychotherapies):):

_____

9. List Safety Precautions in place: _____

10. ANY Medication changes (Date ordered and D/C, Dosage/Route, Frequency, Compliance, Drug level, if applicable and effectiveness):

_____

11. Legal charges during this review period: _____

12. Medical services provided during this review period: _____

13. Updated DC Plan (Placement, Tx needs, anticipated providers, education svcs, community supports, individualized svcs, respite svcs, medical needs. Add contact information. List concerns and efforts towards timely discharge):

_____

14. List Diagnostic testing planned with results and recommendations since last review:

_____

15. MASTER PLAN OF CARE (MPOC) Questions #16-27 are to be answered ONE TIME ONLY with MPOC REVIEW.

16. Select the elements included in the written MPOC for this recipient (Select all that apply):

- ☐ Activity and Recreational Therapies
- ☐ Baseline Assessment of Functioning
- ☐ Collaboration with Care Coordinator
- ☐ Contacts with JPO, OCS, JJ, if required
- ☐ Crisis/Safety Plan Intervention
- ☐ Educational Needs Assessment/Plan
- ☐ Evaluation of Recipient's Strengths
- ☐ Family Psychotherapy
- ☐ Further Diagnostic Evaluation
- ☐ Group Psychotherapy
- ☐ Group Skill Development Services
- ☐ Identified Strengths of Recipient
- ☐ Individual Psychotherapy
- ☐ Individual Skill Development Services
- ☐ Measurable Objectives for each Problem
- ☐ Neuropsych Testing
- ☐ Nutritional/Diet Screening and Planning
- ☐ Pharmacologic Management
- ☐ Physical Examination
- ☐ Psychosocial History
- ☐ Substance Abuse Assessment
- ☐ Tx Goals/Problems Identified
- ☐ Other: Explain in Question #17 and/or #18

17. Explain 'other' element (as above): _____

18. Explain 'other' element (as above): _____

19. Enter Axis II code: _____

20. Enter Axis III Description OR Code: _____

21. Has the MPOC been formulated in consultation with the recipient and/or the recipient's family or guardian?

- ☐ Yes
- ☐ No: Explain in next question

22. If the previous answer is 'No', please explain: _____

23. MPOC ONLY - Document the answers to #24-27 in Additional Comments at the bottom of the previous page. Use the Copy and Paste function. Highlight, right click, select Submit Questionnaire, paste (right click) into the Clinical Findings box.

24. ALL Medications (Date ordered and D/C, Dosage/Route, Frequency, Compliance, Drug level, if applicable, and effectiveness):

_____

25. List Safety Precautions in place: _____

26. List the identified problems statement and their measurable goals according to their related diagnosis. Note specific measurable goals related to Individual, Family, and Group Therapies:

_____

27. Discharge Plan (Based on treatment goals and objectives, specifies approx DC date based on achievement of those stated objectives and post D/C svcs. Must be continually updated to reflect changes and progress in treatment planning):

_____

28. TRIAL DISCHARGE HOME PASS ONLY - Questions #29-34 (Please answer ONLY if review period is before Nov. 1, 2010):

29. Start date of Pass (mm/dd/ccyy format): _____

30. End date of Pass (mm/dd/ccyy format): _____

31. Enter name of escort: _____

32. Enter name of therapist requesting home pass: _____

33. Document the answer to the following question in Additional Comments at the bottom of the previous page. Use the Copy and Paste function. Highlight, right click, select Submit Questionnaire, paste (right click) into the Clinical Findings box.

34. Plan of Care for Trial Discharge Home Pass: Include-Goals & Objectives, Crisis Plan, OP Tx with names, dates and agreed upon goal. Describe any plan to make contact with the school:

_____

AKBH Admission Review Questionnaire

21. Last Acute Care (Psychiatric) Admission Date (mm/dd/ccyy format): _____

22. Last Acute Care (Psychiatric) Discharge Date (mm/dd/ccyy format): _____

23. Name Last In-state RPTC: _____

24. Last In-state RPTC Admission Date (mm/dd/ccyy format): _____

25. Last In-state RPTC Discharge Date (mm/dd/ccyy format): _____

26. Name Last BRS (BRS=Behavioral Rehabilitation Services Level II, III, IV): _____

27. Last BRS Admission Date (mm/dd/ccyy format): _____

28. Last BRS Discharge Date (mm/dd/ccyy format): _____

29. Name Last Group Home: _____

30. Last Group Home Admission Date (mm/dd/ccyy format): _____

31. Last Group Home Discharge Date (mm/dd/ccyy format): _____

32. Select Level of Cognitive Functioning:

- ☐ IQ Above 70 (Average)
- ☐ IQ 55-70 (Mild)
- ☐ IQ 35-54 (Moderate)
- ☐ IQ 20-34 (Severe)
- ☐ IQ Below 20 (Profound)
- ☐ IQ Unknown

33. Does the recipient have an IEP?

- ☐ Yes
- ☐ No
- ☐ Unknown

34. Select applicable Trauma (Select all that apply):

- ☐ Natural Disaster
- ☐ Physical Abuse
- ☐ Domestic Violence (Witnessed)
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Death/Suicide
- ☐ Multiple Placements
- ☐ Neglect
- ☐ Multiple Losses
- ☐ Adopted
- ☐ None Identified
- ☐ Other: Enter information next question

35. Enter 'other' Trauma: _____

36. Enter date of last Mental Status Exam (mm/dd/ccyy format): _____

37. Select certification of person who performed or supervised the MSE:

- ☐ Physician
- ☐ Mental Health Professional
- ☐ Other

AKBH Admission Review Questionnaire

38. Was the recipient receiving Outpatient Services (OP) prior to this admission?
- ☐ Yes
- ☐ No
- ☐ Unknown

39. If yes, enter name of the Primary OP provider and service provided: _____

40. Select Risk Factor/s (Select all that apply):
- ☐ Flight Risk
- ☐ Suicide Risk
- ☐ Homicide Risk
- ☐ Problems with ADLs
- ☐ Sexually Acting Out
- ☐ Aggression
- ☐ Non-Compliance with Treatment
- ☐ Legal Problems
- ☐ Family History MH
- ☐ Family History Substance Abuse
- ☐ Hx self-Mutilating
- ☐ Property Destruction
- ☐ School Suspensions
- ☐ None Identified
- ☐ Other High Risk Behaviors, Enter next

41. Enter "other" High Risk Behavior/s: _____

42. Is recipient a Sex Offender?:
- ☐ Not applicable
- ☐ Adjudicated
- ☐ Non-Adjudicated
- ☐ Unknown

43. Enter Axis II Diagnosis Code: _____

44. Enter Axis II Description: _____

45. Enter Axis III Description OR Code: _____

46. Select Axis IV Problems/Stressors (Select all that apply):
- ☐ Problem with Primary Support Group
- ☐ Problem related to Social Environment
- ☐ Educational
- ☐ Occupational
- ☐ Housing
- ☐ Economic
- ☐ Access to Health Care Services
- ☐ Legal System
- ☐ Other Psychosocial and Environmental

47. Enter Axis V GAF Score (0-100): _____

48. Select Co-Morbidity (Select all that apply):
- ☐ Thought D/O
- ☐ Mood D/O
- ☐ Substance Abuse
- ☐ Complicated Medical
- ☐ Eating D/O
- ☐ Developmental D/O
- ☐ FASD
- ☐ Suspected FASD
- ☐ Hx of Brain Injury

Medical Disability ☐
None Identified ☐
Other: Enter information next question ☐

49. Enter 'other' Co-Morbidity: _____

50. Initial Plan of Care (POC) (Select all that apply):

Activity and Recreational Therapies ☐
Baseline Assessment of Functioning ☐
Collaboration with Care Coordinator ☐
Contacts with JPO, OCS, JJ, if required ☐
Crisis/Safety Plan Intervention ☐
Educational Needs Assessment/Plan ☐
Evaluation of Strengths ☐
Family Psychotherapy ☐
Further Diagnostic Evaluation ☐
Group Psychotherapy ☐
Group Skill Development Services ☐
Identified Strengths of Recipient ☐
Individual Psychotherapy ☐
Individual Skill Development Services ☐
Measurable Objectives for each Problem ☐
Neuropsych Testing ☐
Nutritional/Diet Screening and Planning ☐
Pharmacologic Management ☐
Physical Examination ☐
Psychosocial History ☐
Substance Abuse Assessment ☐
Tx Goals/Problems Identified ☐
Other: Explain in #50 ☐

51. Enter 'other' Planned Treatment: _____

52. Has the POC been formulated in consultation with the recipient (for adults) or recipient and the guardian (for minors)?

Yes ☐
No ☐

53. The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for acute care.

Yes ☐
No ☐

54. Enter Anticipated Discharge Date (Enter in mm/dd/ccyy format): _____

55. Document the answers to the following questions **in Additional Comments at the bottom of the previous page**. Use the Copy and Paste function. Highlight, right click, select Submit Questionnaire, paste (right click) into Clinical Findings box.

56. Anticipated Discharge Plan (Must clearly specify post-discharge service needs including any prospective post-discharge service providers and any other provision necessary for transition to a lesser restrictive environment and adult services):

_____

57. Describe acute disturbances related to the behavioral disorder:

_____

AKBH Admission Review Questionnaire

58. Brief description of Psychosocial History (include explanation of trauma events):

_____

59. Initial Plan of Care (Goals and objectives that are measurable and individualized):

_____

60. Medication History-List medication history, including a statement on current medications. Note any medication concerns, or compliance issues for each medication, if that history is known:

_____

61. List Safety Precautions in place: _____

Exhibit 9

Referral form for Potential Out of State admission Link to web site

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Certificate of Need for Admissions **Exhibit 10**

Medicaid Inpatient Psychiatric Services
Medical Evaluation Certifying Need for Inpatient Care

Check One: ☐ Acute Inpatient ☐PRTF

Upon admission, a physician member of the Interdisciplinary Treatment Team, according to 70AAC 43.552(f)(1); and another member of the Interdisciplinary Treatment Team, according to 7AAC 43.55(f)(3) must certify need for care by documenting why the recipient requires inpatient treatment.

Recipient's Name: _____ Medicaid ID Number: _____

61. Document in your chart: (A) why Ambulatory care resources available in the local community do not meet the treatment needs of the recipient, and for out-of-state treatment, (B) why in-patient care within the State of Alaska will not meet the treatment needs of the recipient:
    (A) _____
    _____
    (B) _____
    _____

62. Document why proper treatment of the recipient's psychiatric condition requires services on an in-patient basis under the direction of a physician:
    _____
    _____

63. Document how the proposed services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed:
    _____
    _____

_____
Print Name and Credentials of IIT Physician/Psychiatrist Date

_____
Signature of IIT Physician/Psychiatrist Date

_____
Print Name and Credentials of another IIT member Date

_____
Signature of another IIT member Date

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Exhibit 11

QUALIS HEALTH
advancing healthcare • improving health

State of Alaska Behavioral Health Inpatient Psychiatric Review

☐ **Retrospective Review Request**
☐ **Late Submission Request**

CLIENT INFORMATION		**Request Date:**	
Client Name		Client Date of Birth	Insurance ID #

Insurance Information: ☐ AK Medicaid

FACILITY INFORMATION

Facility	Admit Date	Discharge Date	Physician
UR Contact Person		UR Phone #	Fax #

Request Reason (PLEASE CHECK ALL THAT APPLY):

☐ **Delayed Eligibility** _____

Date facility was notified of eligibility _____

☐ Late Submission (post 30 days) _____

☐ Retrospective (client has discharged and no initial review has been submitted) _____

Please write a statement below showing reasons for the late submission request.

Additional Information may be requested.

NOTE:

Please submit retro reviews via Qualis Health Provider Portal (preferred method).

Fax completed form to Qualis Health
AK Medicaid Patients: 877-200-9047

For Internal Use Only – Calls Made for Additional Information

☐ _____ ☐ _____ ☐ _____
date date date

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Exhibit 12

Department of Health and Social Services

Children's Residential Incident Report Form

This incident report form is to be used to report critical incidents to the Alaska Department of Health and Social Services (DHSS) agencies. The agencies include Behavioral Health, Certification and Licensing, Juvenile Justice, Office of Children's Services and Senior and Disabilities Service.

Make sure you follow incident reporting requirements for all DHSS agencies. This incident report form does **not** change reporting requirements for any of the DHSS agencies. You may be required to submit the same incident report to multiple DHSS agencies.

For specific information related to each agency's incident report requirements, refer to the following:

Incident Report Instructions - http://www.qualishealth.org/sites/default/files/AKBH-Childrens-Residential-Incident-Report.pdf

Incident Report Form in Excel: http://www.qualishealth.org/sites/default/files/Excell-97-2003-Incident-Report-Form.xls

Incident Report Form in Word: http://www.qualishealth.org/sites/default/files/Word-97-2003-Incident-Report-Form.doc

Behavioral Health - Inpatient Psychiatric Alaska Medicaid Provide Manual at http://www.qualishealth.org/sites/default/files/AK-Behavioral-Health-Provider-Manual-current.pdf

Certification and Licensing – Alaska Administrative Code: 7 AAC 50.140

Juvenile Justice and Office of Children'sServices-
http://www.hss.state.ak.us/ocs/ResidentialCare/forms.htm

Senior and Disabilities Services -
http://www.hss.state.ak.us/dsds/policies/PDFS/CritIncReporting_15-1.pdf

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State of Alaska, Division of Behavioral Health

Residential Psychiatric Treatment Center (RPTC)

Leave of Absence Request Form Beyond Service Limits

Please complete this form to request approval of a therapeutic leave of absence (LOA) beyond the 12-day per calendar year service limitation.

Please fax this form with supporting documentation to the Division of Behavioral Health Utilization Review staff at (907) 269-8166.

Date of Request: _____

Recipient Name: _____

Medicaid ID#: _____

LOA Treatment/LOA Travel Escort:

☐ Name of Family Member (s):

_____

_____

_____

☐ Name of Responsible Party/Escort:

_____

Date of LOA Departure: _____

Date of LOA Return: _____

Supporting documentation to include:

☐ Plan of Care/Treatment Plan

☐ Crisis Plan

☐ Purpose of LOA (*stated goals and objectives include outpatient appointments)*

Anticipated Discharge Date: _____

Form submitted by: _____
(Name and Title)

Date: _____ Phone: _____ Fax: _____

Facility Name: _____

Maintain this form in the medical record of recipient.

.....

Behavioral Health

Approved by: _____ Date: _____

Exhibit 14

Individual Chart Review Findings

Confidential

Plan of Care Standards

A1.01	The POC is based on the diagnostic evaluation. *Citation: 42 CFR 441.155 (b) (1)*
A1.02	The POC states treatment objectives based on the diagnostic evaluation. *Citation: 42 CFR 441.155 (b) (3)*
A1.03	The services available in the facility are adequate to meet the health, rehabilitative and social needs of the recipient. *Citation: 42 CFR 456.609 (a) (1)*
A1.04	The POC is 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 after discharge. *Citation: 42 CFR 441.155 (b) (2)*
A1.05	Changes in the POC are made as indicated be the recipient's overall adjustment as an inpatient. *Citation: 42 CFR 441.155 (c) (2)*
Al.06	The POC and POC updates are developed and reviewed by the required IIT. *Citation: 42 CFR 441.155 (b) (2) and 7 AAC 140.405 (d)*
A1.07	The POC includes a discharge plan that is began upon admission and identifies post discharge service needs including prospective services providers and other provisions necessary for the transition to a less restrictive environment. *Citation: 42 CFR 441.155 (b) (5) and 7AAC 140.410 (6)*

Progress Note Standards

A2.01	All ordered services, including dietary orders, are provided and properly recorded. (RN to score this standard). *Citation: 42 CFR 456.610 (a)*
A2.02	Physician and nursing progress notes are made as required and appear to be consistent with observed condition of the recipient. (RN to score this standard). *Citation: 42 CFR 456.610 (d)*
A2.03	Test and observations indicated be the medication regimen are made at appropriate times and properly recorded (RN to score this standard). *Citation: 42 CFR 456.610 (c)*
A2.04	The attending physician reviews prescribed medication at least every 30 days (RN to review this standard). *Citation: 42 CFR 456.610 (b) (1)*

A3.01	Progress notes meet R/S regulations identified in the CFR. *Citation: 42 CFR 483.350 through42 CFR 483.376*

Exhibit 15

Restraint and Seclusion Review

42 CFR 483.350 through 42 CFR 483.376

GENERAL REQUIREMENTS	
◉ Met ○ Not Met	441.182 A psychiatric residential treatment facility must meet the requirements in 441.151 through 441.182
◉ Met ○ Not Met	441.151 In patient psychiatric services to individuals under 21 must be: under direction of physician, provided by a psychiatric hospital or an inpatient. Psych program in a hospital, accredited by JCAHO, CASF or CARC; provided before the individual reaches 21, certified in writing to be necessary in the setting in which services will be provided.
◉ Met ○ Not Met	441.152 (a) A team specified in 441.154 must certify that ambulatory care resources in the community don't meet treatment needs, proper treatment of psych condition requires services on inpatient basis under direction of physician, services can reasonably be expected to improve recipient's condition or prevent further regression so services will no longer be needed.
◉ Met ○ Not Met	441.152(b) the certification specified in this section and 441.153 satisfies the utilization control requirement for physician certification in 456.60, 456.160, 456.360.
◉ Met ○ Not Met	441.153(a) Team certifying need for services: includes a physician, has competency in diagnosis and treatment of mental illness preferably in child psychiatry, has knowledge of the individual's situation.
◉ Met ○ Not Met	441.153(b) For an individual who applies for Medicaid while in the facility of program, the certification must be made by the team responsible for the plan of care as specified in 441.156 and cover any period before application for which claims are made. For emergency admissions, the certification must be made by the team responsible for plan of care within 14 days after admission.
PROTECTION OF RIGHTS	
◉ Met ○ Not Met	483.356 Protection of residents: The facility must establish a policy for use of any emergency safety intervention, which is defined in this subpart as the use of restraint or seclusion (R&S) as an immediate response to an emergency situation. The facility policy should address all requirements set forth by this condition of participation to ensure protection of residents which includes ensuring safety both during and after R&S, specifying the required elements of an order for R&S, identifying staff who are responsible for continual assessment during R&S as well as defining the minimal physical and

	psychological elements that must be assessed. The facility's definition of R&S must correspond with definitions specified by CMS.
◉ Met ○ Not Met	483.356(a)(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience , or retaliation.
◉ Met ○ Not Met	483.356(a)(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
◉ Met ○ Not Met	483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only…
◉ Met ○ Not Met	483.356(a)(3)(i) To ensure the safety of the resident or others during an emergency situation and
◉ Met ○ Not Met	483.356(a)(3)(ii) until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the R&S order has not expired.
◉ Met ○ Not Met	483.356(a)(4) R&S must not be used simultaneously.
◉ Met ○ Not Met	483.356(b) Emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior and the resident's age, size, gender, physical, medical, and psychiatric condition and personal history.
◉ Met ○ Not Met	483.356(C)(1) Notification of facility policy. At admission the facility must: inform both the resident and in case of a minor, the parents or legal guardian of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation;
◉ Met ○ Not Met	483.356(c)(2) Communicate its R&S policy in a language the resident or parents or legal guardian understands and when necessary, the facility must provide interpreters or translators;
◉ Met ○ Not Met	483.356(c)(3)Obtain an acknowledgment in writing from resident, parent or legal guardian if a minor, that they have been informed of facility's policy on use of R&S in an emergency safety situation. Acknowledgment must be filed in patient's record.
◉ Met ○ Not Met	483.356(c)(4) Provide a copy of the facility policy to the resident and parent or legal guardian if a minor.
◉ Met ○ Not Met	483.356(d) The facility's policy must provide contact information, including phone number and mailing address for the appropriate State Protection and Advocacy organization.
ORDERS FOR SECLUSION & RESTRAINT	
◉ Met	483.358 Orders for R or S must be by a physician or other licensed

○ Not Met	practitioner permitted by the state and the facility to order R or S and trained in use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for recipients under 21 are provided under direction of a physician.
◉ Met ○ Not Met	483.358(b) If the resident's treatment team physician is available, only he or she can order R or S.
◉ Met ○ Not Met	483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order R or S must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
◉ Met ○ Not Met	483.358(d) If the order for R or S is verbal, it must be received by a RN or other licensed staff while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner must be available to staff for consultation, at least by telephone, throughout the period of the emergency intervention.
◉ Met ○ Not Met	483.358(e) Each order for R or S must be limited to no longer than the duration of the emergency situation and not to exceed 4 hrs for ages 18-21, 2 hours for 9-17, and 1 hour for under age 9.
◉ Met ○ Not Met	483.358(f) Within 1 hour of initiation of the emergency safety intervention, a physician or other licensed practitioner trained in use of emergency interventions and permitted by the state and facility to assess physical and psychological well being of residents, must conduct a face to face assessment of the physical and psychological well being of the resident including but not limited to the resident's physical and psychological status, resident's behavior, appropriateness of intervention, and complications resulting from the intervention.
◉ Met ○ Not Met	483.358(g) each order for R or S must include name of person order, date and time of order, specific R or S ordered and maximum amount of time resident may be restrained or secluded;
◉ Met ○ Not Met	483.358(g)(1) The name of the physician or other licensed practitioner permitted by the state and facility to order R or S;
◉ Met ○ Not Met	483.358(g)(2) The date and time the order was obtained; and
◉ Met ○ Not Met	483.358(g)(3) The emergency safety intervention ordered including the length of time for which the physician or other licensed practitioner authorized its use.
◉ Met ○ Not Met	483.358(h) Staff must document the intervention in the patient's record by the end of the shift in which the intervention occurs. If the intervention doesn't end during the shift in which it began, documentation must be

	completed during the shift in which it ends. Each documentation must include all of the following:
◉ Met ○ Not Met	483.358(h)(1) each order for R or S as required in paragraph (g) above;
◉ Met ○ Not Met	483.358(h)(2) The time the emergency safety intervention actually began and ended;
◉ Met ○ Not Met	483.358(h)(3) The time and results of the 1-hour assessment required above;
◉ Met ○ Not Met	483.358(h)(4) The emergency safety situation that required the resident to be restrained or put in seclusion;
◉ Met ○ Not Met	483.358(h)(5) The name of staff involved in the emergency situation.
◉ Met ○ Not Met	483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
◉ Met ○ Not Met	483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order R or S must sign the R or S order in the resident's record as soon as possible.
CONSULTATION WITH TREATMENT TEAM PHYSICIAN	
◉ Met ○ Not Met	483.360 If a physician or other licensed practitioner…orders the use of R or S, that person must contact the resident's treatment team physician, unless the ordering physician is in fact the resident's treatment team physician. The person ordering the use of R or S must consult with the resident's treatment team physician as soon as possible and inform the team physician of the emergency safety situation that required the resident to be restrained or placed in seclusion and
◉ Met ○ Not Met	483.360(b) document in the resident's record the date and time the team physician was consulted.
MONITORING OF RESIDENT IN AND IMMEDIATELY AFTER RESTRAINT	
◉ Met ○ Not Met	483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.
◉ Met ○ Not Met	483.362(b) If the emergency situation continues beyond the time limit of the order, a RN or other licensed staff must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order R or S to receive further instructions.
◉ Met	483.362 (c) A physician or other licensed practitioner permitted by the state and facility to evaluate the resident's well-being and trained in the used of

○ Not Met	emergency safety interventions, must evaluate the resident's well being immediately after the restraint is removed.
MONITORING OF THE RESIDENT IN AND IMMEDIATELY AFTER SECLUSION	
◉ Met ○ Not Met	483.364 Clinical staff trained in use of emergency interventions must be physically present in or immediately outside the seclusion room, continually assessing, monitoring and evaluating the physical and psychological well being of the resident in seclusion; and video monitoring does not meet the requirement.
◉ Met ○ Not Met	483.364(b) A room used for seclusion must allow staff full view of the resident in all areas of the room and
◉ Met ○ Not Met	483.364 (b)(2) be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.
◉ Met ○ Not Met	483.364(c) If the emergency situation continues beyond the time limit of the order, a RN or other licensed staff must immediately contact the ordering physician or other licensed practitioner….to receive further instructions.
◉ Met ○ Not Met	483.364(d) A physician or other licensed practitioner permitted …must evaluate the resident's well-being immediately after the resident is removed from seclusion.
NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN(S)	
◉ Met ○ Not Met	483.366 If the resident is a minor, the facility must notify the parent or legal guardian of the resident who has been restrained or secluded as soon as possible after the initiation of each emergency safety intervention. <see regulation & facility policy>
◉ Met ○ Not Met	483.366(b) The facility must document in the resident's record that the parents or legal guardian has been notified of the emergency safety intervention, including the date and time of notification and the name of the staff person providing the information.
APPLICATION OF TIME OUT	
◉ Met ○ Not Met	483.368 A resident in time out must never be physically prevented from leaving the time out area.
◉ Met ○ Not Met	483.368(b) Time out may take place away from the area of activity or from others residents, such as resident's room (exclusionary) or in the area of activity of other residents (inclusionary).
◉ Met ○ Not Met	483.368(c) Staff must monitor the resident while he or she is in time out.
POST INTERVENTION DEBRIEFINGS	
◉ Met	483.370 Within 24 hours after use of R or S, staff involved in the emergency

○ Not Met	intervention and the resident must have a face to face discussion.
◉ Met ○ Not Met	483.370(b) Within 24 hours after use of R or S, all staff involved in the emergency intervention and appropriate supervisory and administrative staff must conduct a debriefing session that includes a review and discussion of the emergency safety situation that required the intervention, including discussion of precipitating factors;
◉ Met ○ Not Met	483.370(b)(2) Alternative techniques that might have prevented the use of R or S;
◉ Met ○ Not Met	483.370(b)(3) The procedures, if any, that staff are to implement to prevent any recurrence of the use of R or S;
◉ Met ○ Not Met	483.370(b)(4) The outcome of the intervention including any injuries that may have resulted from use of R or S.
◉ Met ○ Not Met	483.370(c) Staff must document in the resident's record that both debriefing sessions took place and must include in that documentation: names of staff present for debriefing, names of staff excused from debriefing, and any changes to resident's treatment plan that result from debriefings.
MEDICAL TREATMENT FOR INJURIES RESULTING FROM AN EMERGENCY SAFETY INTERVENTION	
◉ Met ○ Not Met	483.372 Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention
◉ Met ○ Not Met	483.372(b) The PRTF must have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the Medicaid program that reasonable ensure that…
◉ Met ○ Not Met	483.372(b)(1) A resident will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
◉ Met ○ Not Met	483.372(b)(2) Medical and other information needed for care of th4e resident in light of such a transfer will be exchanged between the institutions in accordance with State medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
◉ Met ○ Not Met	483.372(b)(3) Services are available to each resident 24 hours a day, 7 days a week;
◉ Met ○ Not Met	483.372 (c) Staff must document in the resident's record all injuries that occur as a result of an emergency safety intervention including injuries to staff resulting from that intervention.

◉ Met ○ Not Met	483.372(d) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.
FACILITY REPORTING	
◉ Met ○ Not Met	483.374 Each PRTF that provides inpatient psychiatric services to individual under age 21 must attest, in writing, that the facility is in compliance with CMS' standards governing the use of R or S and this attestation must be signed by the facility director.
◉ Met ○ Not Met	483.374(a)(1) A facility with a current provider agreement with the Medicaid agency must provide its attestation to the state Medicaid agency by 7/21/2001 and a facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency.
◉ Met ○ Not Met	483.374(b) The facility must report each serious occurrence (death, serious injury, suicide attempt) to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system.
◉ Met ○ Not Met	483.374(b)(2) In the case of a minor, the facility must notify the resident's parents or legal guardian as soon as possible and no later than 24 hours after the serious occurrence.
◉ Met ○ Not Met	483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system including the name of the person to whom the incident was reported.
◉ Met ○ Not Met	483.374(c) In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Centers for Medicare and Medicaid Services (CMS) regional office.
EDUCATION AND TRAINING	
◉ Met ○ Not Met	483.376 The facility must require staff to have ongoing education, training, and demonstrated knowledge of…
◉ Met ○ Not Met	483.376 (a)(1) techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;
◉ Met ○ Not Met	483.376(a)(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
◉ Met ○ Not Met	483.376(a)(3) The safe use of R or S including the ability to recognize and respond to signs of physical distress in residents who are restrained or in

Exhibit 16

Intellectualand Developmental Disabled (IDD) Waiver& Services

Below is a link with information for the State of Alaska, Division of Senior and Disability Services, Intellectual and Developmentally Disabled (IDD) Waiver Program.

You may also contact a QualisHealth Care Coordinator for assistance with this resource by calling toll free (877) 200-9046, or (907)550-7620

http://www.hss.state.ak.us/dsds/dd/eligible.htm