Addictive and Mental Disorders Division (AMDD) Provider Training

Montana Severe Disabling Mental Illness (SDMI)
Welcome

Today’s Presenters:

Aaron Hahm, Medicaid State Plan Program Officer

Barbara Graziano, LCSW, Clinical Program Manager

Colleen Boltman, Magellan Medicaid Administration

Staci Lindsay, Magellan Medicaid Administration
Training Topics

Rulemaking process overview

Introduction and review of the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, May 1, 2018

Important changes

The SDMI and Level of Impairment (LOI) Worksheet
Prior Authorization and Continued Stay Requests

Overview

Prior Authorization and Continued Stay Requests Submission Process

Approval Process

Appeal Submission Process
Rulemaking Objective

Adopt and Incorporate into Administrative Rule a new Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, May 1, 2018

Adopted in ARM 37.88.101 and 37.27.902

Consolidates information into one easily accessible document
Rulemaking Process

1. Proposal published in Montana Administrative Register (MAR)
2. Notification sent to Interested Parties list
3. Public hearing and comment period
4. Adoption Notice
MAR

Rules affected

Rule text

Statement of reasonable necessity

Comment submission information

Public hearing information
Public Hearing and Comment Period

Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing.

Written data, views, or arguments may also be submitted to the Department as detailed in the MAR notice by mail, fax, or email.
Interested Parties List

http://dphhs.mt.gov/amdd

Submit written requests to:

Interested Parties Coordinator
Department of Public Health and Human Services
100 North Park, Ste 300
PO Box 202905 Helena, MT 59620-2905
fax (406) 406-444-9389 or e-mail
hhsamdemail@mt.gov
Manual – Mental Health

Introduction/Purpose/Definitions

Section 1: Utilization Management

Section 2: Medicaid Adult Mental Health Services

Section 3: Medicaid Substance Use Disorder Services
Introduction

SDMI Definition

SDMI Diagnosis list

Level of Impairment (LOI) worksheet
Section 1 Utilization Management

Prior Authorization (PA) and Continued Stay Reviews (CSR)

Reconsideration Review Process

Notifications

Retrospective Reviews

At–A–Glance Table
Section 2 – Adult Mental Health Medicaid Services

Adult Mental Health Services

Provider Requirements

Medical Necessity Criteria

Service Requirements

Utilization Management
Section 3 – Medicaid Substance Use Disorder

Medicaid Substance Use Disorder Services

Provider Requirements

Medical Necessity Criteria

Service Requirements

Utilization Management
Services

Outpatient Mental Health Individual and Group Therapy

Mental Health Targeted Case Management (TCM)

Proposed fiscal year limits have been removed

Limit: Group therapy limited to 16 members
Services

Intensive Community Based Rehabilitation (ICBR)

Program for Assertive Community Treatment (PACT)

Crisis Stabilization Program

Adult Group Home

UM: Magellan
Services

Acute Partial Hospitalization Program (PHP)

Adult Foster Care (AFC)

Dialectical Behavioral Therapy (DBT)

Illness Management and Recovery (IMR)

UM: N/A
Community Based Psychiatric Rehabilitation and Supports (CBPRS)

Changed – Limit: 2 hours/day (Individual and Group)

Day Treatment (Day TX)

Unchanged – Limit: 3 hours/day
Forms and Worksheets

http://dphhs.mt.gov/amdd

SDMI Level of Impairment (LOI) worksheet

Adult Mental Health Prior Authorization and Continued Stay
SDMI Definition

SDMI is defined as an adult 18 years or older who presently or any time in the past 12 months has had a diagnosable mental illness that has interfered with functioning and has resulted in significant difficulty in community living without supportive treatment or services of a long-term or indefinite duration. These individuals struggle daily with severe mental illness that is chronic and persistent resulting in impaired functioning.
SDMI Eligibility

Automatic Eligibility if the member:

Has been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital within the past 12 months, or

Has a diagnosis within the Schizophrenia Spectrum Disorder category. (F20.0, F20.1, F20.2, F20.5, F22, F25.0, or F25.1)

If one of the above is not met, then the member must meet one of the following diagnostic categories with a level of impairment score.
SDMI criteria

**Diagnosis category I**

- Bipolar I and II Disorders
- Major Depressive Disorders, Severe
- Posttraumatic Stress Disorder
- Borderline Personality Disorder
- Autism Spectrum Disorder
SDMI criteria

*Diagnosis category II*

- Major Depressive Disorders, Moderate
- Dissociative Disorders*
- Panic Disorders
- Generalized Anxiety Disorder*
- Obsessive Compulsive Disorder
- Persistent Depressive Disorder*
- Feeding and Eating Disorders*
- Gender Dysphoria*

*added
SDMI Level of Impairment

**Level A**
3 areas of at least moderate level impairment for a total score of 6 or above; or
4 areas of at least moderate level impairment for a total score of 8 or above

**Level B**
3 areas of at least moderate level impairment for a total score of 9 or above; or
4 areas of at least moderate level impairment for a total score of 12 or above

**ELIGIBILITY DETERMINATION FORMULA**

*To determine SDMI eligibility, diagnosis category must meet the following level of impairment:*

Category I diagnosis and Impaired Level of Functioning A or B.
Category II diagnosis and Impaired Level of Functioning B.
SDMI Level of Impairment

Used to determine if a member has a SDMI. The form must be completed by a licensed mental health professional, as indicated with a signature.
<table>
<thead>
<tr>
<th>LOI</th>
<th>Description of Mental Health Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No problems in this area: Able to care for self and provide for own needs: hygiene is good; demonstrates acceptable grooming; follows treatment recommendations/medication compliant at this time</td>
</tr>
<tr>
<td>1</td>
<td>Mild level of impairment: No assistance needed in caring for self and obtaining basic needs; household cleanliness and/or hygiene are sporadic; misses 1 of 4 appointments; medication compliant 5 out of 7 days</td>
</tr>
<tr>
<td>2</td>
<td>Moderate level of impairment: occasional assistance required in caring for self and obtaining basic needs; household cleanliness and/or hygiene are marginal; regularly misses 50 percent of appointments; medication compliant 50 percent of the time</td>
</tr>
<tr>
<td>3</td>
<td>High level of impairment: assistance needed in caring for self and obtaining basic needs due to inability to care for self with poor household cleanliness and hygiene, lack of groceries and/or basic needs; inconsistent treatment and medication compliance</td>
</tr>
<tr>
<td>4</td>
<td>Severe level of impairment: unable to care for self and obtain basic needs in safe and sanitary manner (will only attend to grooming with assistance, will not grocery shop without assistance, not taking medication)</td>
</tr>
<tr>
<td>5</td>
<td>Gravely disabled: in extreme need of complete supportive care (shut in and requires grocery delivery, not taking medication)</td>
</tr>
<tr>
<td>LOI</td>
<td>Description of Mental Health Impairment</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>No problems in this area: has an adequate income, housing, and manages finances appropriately at this time</td>
</tr>
<tr>
<td>1</td>
<td>Mild level of impairment: problems in this area are by report only with minimal consequences</td>
</tr>
<tr>
<td>2</td>
<td>Moderate impairment: occasional problems due to limited income, some difficulties with finances (pays bills but often 30+ days behind), reprimands at work/school (2 or more incidents of absenteeism/tardiness, inappropriate behavior in the past 30 days); received housing complaints</td>
</tr>
<tr>
<td>3</td>
<td>High level of impairment: assistance needed in managing finances (impulsive with money, debt higher than income due to spending habits); job/school instability/insecurity due to disciplinary action in last 60 days; housing instability due to eviction or living in group home</td>
</tr>
<tr>
<td>4</td>
<td>Severe level of impairment: easily overwhelmed by finances (has not maintained checkbook in past 60 days or has a representative payee); easily overwhelmed by demands of work/school; unable to work/attend school; homeless, living with family/friends, couch surfing</td>
</tr>
<tr>
<td>5</td>
<td>Gravely disabled: severe and chronic difficulties; no income, risky/inappropriate financial behaviors (collection/garnishment/repossession); homeless with no options, living on the street/homeless shelter</td>
</tr>
<tr>
<td>LOI</td>
<td>Description of Mental Health Impairment</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>No problems in this area: has an adequate support system with family and friends; gets along well with others</td>
</tr>
<tr>
<td>1</td>
<td>Mild level of impairment: problems in this area are by report only with minimal consequences</td>
</tr>
<tr>
<td>2</td>
<td>Moderate impairment: difficulty developing or maintaining healthy relationships (difficulty meeting/greeting people, lack of eye contact, presents as odd, identifies 1+ friends); strained family relationships</td>
</tr>
<tr>
<td>3</td>
<td>High level of impairment: Inadequate relational skills resulting in tenuous and strained relationships (argumentative, lack of give and take, does not wait turn, identifies 1 friend but not close)</td>
</tr>
<tr>
<td>4</td>
<td>Severe impairment: impaired relational skills resulting in poor relationship formation and maintenance (poor boundaries, intense love/hate interactions, impulsive, frequent angry outbursts)</td>
</tr>
<tr>
<td>5</td>
<td>Gravely disabled: interpersonal relationships are virtually nonexistent (has no friends, isolative or others avoid due to strange or intense behaviors/interactions)</td>
</tr>
<tr>
<td>LOI</td>
<td>Description of Mental Health Impairment</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>No problems in this area: mood within normal limits, cognitive and thought process are appropriate</td>
</tr>
<tr>
<td>1</td>
<td>Mild level of impairment: mild impairment in mood, exhibits cognitive impairment 10% of the time (poor judgment, memory loss, insight, orientation); thought disturbance 10% of the time (worries, ruminations, obsessions, compulsions)</td>
</tr>
<tr>
<td>2</td>
<td>Moderate impairment: moderate impairment in mood, exhibits cognitive impairment 25% of the time (poor judgment, memory loss, insight, orientation); odd or impoverished thought process/content 25% of the time (worries, ruminations, obsessions, compulsions)</td>
</tr>
<tr>
<td>3</td>
<td>High level of impairment: severe impairment in mood, exhibits cognitive impairment 50% of the time (poor judgment, memory loss, insight, orientation); odd or impoverished thought process/content 50% of the time (worries, ruminations, obsessions, compulsions)</td>
</tr>
<tr>
<td>4</td>
<td>Severe impairment: severe impairment in mood, persistent cognitive impairment 75% of the time (poor judgment, memory loss, insight, orientation); odd or impoverished thought process/content 75% of the time (worries, ruminations, obsessions, compulsions)</td>
</tr>
<tr>
<td>5</td>
<td>Gravely disabled: severe impairment in mood, chronic impairment resulting in a higher level of care; thought processes are disorganized and tangential; persistent disruption in communication; extreme disconnection from reality</td>
</tr>
<tr>
<td>LOI</td>
<td>Description of Mental Health Impairment</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>No problems in this area: no self-harm; suicidal thoughts or behaviors; thoughts of harm to others or aggressiveness toward others</td>
</tr>
<tr>
<td>1</td>
<td>Mild impairment: in the past 90 days, thoughts of self-harm and/or suicide 1 to 2 times with no plan or intent; thought about harming others 1 to 2 times with no intent or plan; no history of aggressive behaviors</td>
</tr>
<tr>
<td>2</td>
<td>Moderate level of impairment: in the past 12 months, has recurrent thoughts of self-harm and/or suicide with no plan or intent; recurrent thoughts of harming others with no plan, intent, or actions</td>
</tr>
<tr>
<td>3</td>
<td>High level of impairment: has a history of self-harm behaviors but no thoughts of suicide; intent of self-harm behavior is not death; has a history of harming others that is impulsive without intent to harm others; verbal attacks</td>
</tr>
<tr>
<td>4</td>
<td>Severe impairment: recurrent thoughts of suicide; history of suicide attempts; recurrent aggressive behavior that is intended to cause injury or pain; verbal aggression leading to physical altercation</td>
</tr>
<tr>
<td>5</td>
<td>Gravely disabled: demonstrates imminent harm and/or danger to self or others</td>
</tr>
</tbody>
</table>
SDMI Level of Impaired Functioning (LOI) Areas

Category I diagnosis

Self care/Basic needs = 0
Employment/Education/Housing/Financial = 4
Family/Interpersonal = 0
Mood/Thought Functioning = 2
Self-Harm Behaviors/Harm to Others = 2

Level A Diagnosis: Scored in 3 areas for a total of 8 points – Qualifies as SDMI
SDMI Level of Impaired Functioning (LOI) Areas

Category II diagnosis

Self care/Basic needs = 0
Employment/Education/Housing/Financial = 0
Family/Interpersonal = 1
Mood/Thought Functioning = 2
Self-Harm Behaviors/Harm to Others = 3

Level B Diagnosis: Scored in 3 areas for a total of 6 points – Does not qualify as SDMI
The SDMI LOI worksheet provides an objective and consistent assessment tool to determine the appropriate level of care and assist in developing the individualized treatment plan.
Agenda

- Utilization Management—Purpose and goals
- UM Time frames
- Faxed Submission Timelines
- Medical Necessity Criteria
- Prior Authorizations
- Information Pend Status
- Determinations and Notifications
- Reconsideration Process
- Continued Stay Reviews
- Active CSR Process
- Retro-eligibility Reviews
- Q&A
Purpose of Utilization Management

- Prevent the delivery of unnecessary and inappropriate care to consumers

- Need to establishing both necessity for care and appropriateness of care requests as well

- When both clinical necessity for treatment and the appropriateness of the treatment request are established, an authorization (or certification for care) for the treatment requested is issued by UM staff

Authorization for care is not a guarantee of payment. All authorized items and services are subject to member eligibility, benefit coverage guidelines and provider eligibility for payment at the time of service. Providers are responsible for following all billing guidelines as outlined in the Provider Handbook.
Goals for today’s training

- **Share** with providers core concepts of UM and UR that enable providers to understand the thinking of UR staff when the provider requests a PA for treatment—”being on the same page”
- **Enhance providers’ awareness** of what data/information UR staff is looking for to justify the provider request for treatment
- **Increase** efficiency and speed of PA approval procedure
- **Avoid denials** of PA requests
Utilization Management

• Magellan Medicaid Administration (MMA) is contracted with Addictive and Mental Disorders Division (AMDD) to provide Utilization Management (UM) Reviews for adults receiving Medicaid funded mental health services
• The following levels of care will require prior authorization, continued stay and active continuation of care Medical Necessity reviews:
  - ICBR-Intensive Community Based Rehabilitation
  - PACT-Program for Assertive Community Treatment
  - AGH-Adult Group Home
  - *Crisis Stabilization - continued stay review only*
## UM Timelines—PA and CSR

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Prior Authorization Request Timeline</th>
<th>Continued Stay Request Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICBR</td>
<td>No earlier than 5 business days prior to admission.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial authorization for up to 180 days.</td>
<td>No earlier than 5 business days prior to the end of the current authorization period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSR for up to 180 days</td>
</tr>
<tr>
<td>PACT</td>
<td>No earlier than 5 business days prior to admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial authorization for up to 180 days.</td>
<td>No earlier than 5 business days prior to the end of the current authorization period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSR for up to 180 days</td>
</tr>
<tr>
<td>AGH</td>
<td>No earlier than 5 business days prior to admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial authorization for up to 120 days.</td>
<td>No earlier than 5 business days prior to the end of the current authorization period</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSR for up to 90 days</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>No review required on admission</td>
<td>No earlier than 3 days prior to the end of the initial 5 days or current certification period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSR for up to 5 days</td>
</tr>
</tbody>
</table>
# Magellan UM Timelines

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Request Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization Request</td>
<td>Clinical Reviewer will complete the review process within 2 business days of receipt of complete information. If approved, notification will be mailed within 24 hours of determination.</td>
</tr>
<tr>
<td>(Initial)</td>
<td></td>
</tr>
<tr>
<td>Continued Stay Request</td>
<td>Clinical Reviewer will complete the review process within 3 business days of receipt of complete information. If approved, notification will be mailed within 24 hours of determination.</td>
</tr>
<tr>
<td>Deferral to MD</td>
<td>If the request does not appear to meet Medical Necessity Criteria (MNC), the case will be deferred to a Board Certified Physician for review and determination. MD will complete review and make determination within 4 business days or receipt of clinical information from reviewer.</td>
</tr>
</tbody>
</table>
Faxed Submission Guidelines

- MH Prior Authorization and Continued Stay Forms
  - Found at: http://dphhs.mt.gov/amdd/FormsApplications
- Forms must be typed
  - Handwritten forms will be returned
  - List of required documents to include are listed on form
- Fax required forms and documents to Magellan at 1-800-639-8982
- To avoid delays:
  - Ensure forms are filled out completely
  - Clinical information is complete for all sections
  - Avoid generalities/ vague descriptions
  - Include required documentation
Medical Necessity Criteria

Member must meet criteria as described in the Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health, May 1, 2018 available online at: http://medicaidprovider.mt.gov/ (Under Resources by Provider Type) or http://dphhs.mt.gov/amdd

Clinical documentation should support and provide evidence of all aspects of the Medical Necessity Criteria, including (but not limited to):

- Need for intensive intervention at requested level of care
- Evidence that patient can be reasonably expected to improve with treatment
Montana Prior Authorization Workflow

**MMA Reviewer**
- MMA Reviewer or Provider enters/submits Prior Authorization (PA) Request into the System
  - PA Request is Not Complete
    - Information from Provider Pending *
  - PA Request is Complete
    - MMA Reviewer Performs Review
      - Can MMA Reviewer Authorize Care?
        - YES
          - Care is Authorized
        - NO
          - PA Request is Not Complete
  - Info Received Within 5 Business Days
  - Info Not Received Within 5 Business Days
    - Technical Denial is Issued
      - MMA Reviewer Sends Case to Board Certified Physician
  - PA Notification Letter Generated

**MD Reviewer**
- MD Performs Clinical Review (Determination must be made within 3 business days)
  - Care is Approved or Partially Approved
    - PA Notification Letter Generated
  - Denial is Issued
    - Notification Letter of Denial Generated (Appeal May Be Requested)

**Request Specifics**
- Prior Authorizations can be submitted no earlier than 5 business days prior to admit. The PA will be Technically Denied if received earlier than 5 business days.
- Clinical reviewer will complete the PA within 3 business days of receipt of complete information.
- If information submitted is incomplete, the reviewer will request additional information via fax request to fax number provided.
- The provider has 5 business days to submit the requested information.
- If all required paperwork is submitted, but additional information is not received, the review will be processed with clinical available.
- If required clinical/paperwork is missing and additional information is not received, the review will be Technically Denied.

* Additional information may be requested at this point and resubmitted for review. If the Provider does not submit additional info as requested within 5 business days, a technical denial is issued. Technical denials can only be appealed to AMDD regarding procedural issues.
Information Pend Status

- When required information or forms are missing, the request will be put in “Information Pending Status”

- The reviewer will contact the identified submitter by fax with request for missing information
  - Fax Submittal requests will be made via fax with the contact information provided on the form

- Provider has 5 business days to provide missing information before a Technical Denial is issued
Determinations:

- **Approval** – approval of requested services
- **Denial** – does not meet medical necessity criteria; all days requested are denied
- **Partial Denial** – volume of days approved is less than volume of days requested
- **Technical Denial** – indicates that the request and/or information was out of specified timeframes or was incomplete
Partial Denials — What does it mean?

Scenarios that could receive a Partial Denial include:

- Medical necessity criteria was not met for the level of care, but additional days are allowed for discharge and transition of care planning.

- Member was found to be appropriate for continued treatment at current level of care, but or less time than was requested.
Partial Denials – Provider options

- Provider can request a reconsideration of the adverse determination
- Provider can arrange for discharge and transition of member to alternate level of care on or before the last certified day that was authorized
- In the event new information comes to light, a new PA request can be submitted within 5 days of the end of the current authorization
Notification Process:

- **Formal Notification**
  - Mailed within 24 hours via USPS. Each notification gives dates certified or if denied, gives justification of denial and details the appeal process.
  
  - Formal notifications are sent to both the provider and the Responsible Party.
Reconsideration Process:

- **Peer to Peer Reconsideration**: A telephonic conversation with the provider authorized representative and an MMA MD. Based on original documentation that was submitted to provide clarification on clinical to support providers request.
  
or

- **Desk Reconsideration Review**: Documentation is supplied to MMA and reviewed by an MMA MD, different from who made the original adverse determination. Based on original documentation that was submitted to provide clarification on clinical to support providers request for continued stay.

- **Administrative Review**: Completed by AMDD. Prior to requesting an administrative review for denied claims, provider must exhaust all administrative remedies available.

- **New Prior Authorization**: If new clinical information becomes available after denial of reconsideration, a provider may submit a new Prior Authorization request, based on the new information.

The appeals process is always outlined in the notification letter.
## Reconsideration Timelines

<table>
<thead>
<tr>
<th>Reconsideration Type</th>
<th>Provider Timeline</th>
<th>Magellan Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer to Peer</td>
<td>Must be requested within 10 business days of adverse determination letter date</td>
<td>Must be scheduled by the physician reviewer within 5 business days of the request</td>
</tr>
<tr>
<td>Desk Review</td>
<td>Must be requested within 15 days of the most recent adverse determination letter date</td>
<td>Must be performed by the physician within 5 business days of the written request and supporting documentation</td>
</tr>
</tbody>
</table>
Technical Denials

- When an adverse determination is based on procedural issues and not on medical necessity criteria, the result will be a technical denial.

- If a technical denial is issued for submission of information outside the allowable timeframes, a provider may submit a new prior authorization request to Magellan. Requesting a new prior authorization after a technical denial does not waive the right to request an administrative review/fair hearing of the technical denial. A new prior authorization request may not be back dated and must provide sufficient clinical information to support an authorization.
Provider Receives a Denial or Partial Approval Determination for a Prior Authorization Request

Provider Requests Peer-to-Peer Review Within 10 Business Days of Adverse Determination Letter *(Optional)*

Provider Requests Desk Review for 2nd Opinion Within 15 Business Days of Adverse Determination (Optional)

MD Performs Peer Review

MD Performs Desk Review (Must Be Completed Within 5 Business Days of Submitted Written Request and Supporting Documentation)

Notification Letter Generated

Decision Partially Reversed (Denied with some additional days approved for discharge planning)

Decision is Upheld/Denied

Reversed/Approved

Notices Letter Generated

Notification Letter Generated

Decision Partially Reversed (Denied with some additional days approved for discharge planning)

Decision is Upheld/Denied

Reversed/Approved

PA Notification Letter Generated

PA Notification Letter Generated

PA Notification Letter Generated

* To be scheduled between Advocating Clinician (chosen by member/legal representative or authorized representative and Magellan Physician).

* A Desk Review can be requested in lieu of a Peer-to-Peer Review.

Last Updated: March 1, 2018
Continued Stay Requests

- Reviews of requests for continued stay authorization are based on the MH Continued Stay Request form.
  - Clinical info provided should cover the **days of treatment since the last authorization** rather than being historical in nature.

Each Continued Stay request must include:

- **Changes to** current DSM-V **diagnosis**/diagnoses, if applicable
- **Justification for continued services** at this level of care, describing current symptoms and behaviors
- **Behavioral Management Interventions/ Critical Incidents** *include dates*
- Assessment of treatment **progress** related to admitting symptoms and identified treatment goals
- **Current list of medications**, as well as change dates or discontinuation dates of meds or start dates of any new meds
- **Projected discharge date** and clinical rationale for any change in projected discharge date
- Clinically appropriate **discharge plan**, citing evidence of progress toward completion of that plan
Continued Stay Reviews

- See above slides for:
  - Information Pend Status
  - Determination and Notification
  - Reconsideration Process
Beginning May 1, 2018, all members currently receiving services subject to new utilization review requirements must have authorization for continuation of services at the current level of care.

A Mental Health Continued Stay Request must be submitted utilizing the guidelines listed above. Include the initial assessment and treatment plan and the most recent assessment and updated treatment plan.

Provide specific examples from the past 30–45 days which speaks to the member’s level of functioning/impairment and diagnosis.
Active CSR Process

- Providers are requested to stagger submissions for Active CSRs during the implementation process.
  - Submit one half of CSRs by May 14th, 2018.
  - Submit the remainder by May 28th, 2018.
  - AMDD will monitor submissions to identify providers needing assistance.
Active CSR Process

- During the implementation process the department will utilize a grace period for active CSRs.

- If the CSR does not appear to meet medical necessity criteria, a PA number will be issued with the following Grace Period* to allow for discharge and transitional care planning.
  - ICBR – 60 days
  - Group Home – 60 days
  - PACT – 30 days

*Grace Period is considered a partial denial, which means a CSR cannot be submitted at the end of the certification.
Montana Active CSR Workflow

**MMA Reviewer**
- MNA Reviewer or Provider Enters / Submits Prior Authorization (PA) Request into the System
- MMA Reviewer Assesses PA Request for Completeness
  - PA Request is Complete
    - MMA Reviewer Performs Review
    - Info Received Within 5 Business Days
      - Yes
        - Can MMA Reviewer Authorize Care?
          - Yes
            - PA Notification Letter Generated
          - No
            - Info Not Received Within 5 Business Days
              - Technical Denial is Issued
              - MMA Reviewer Sends Case to Board Certified Physician
    - No
      - Info Received Within 5 Business Days
        - PA Request is Not Complete
          - Information from Provider Pending?
            - Yes
              - PA Request is Complete
            - No
              - Information from Provider Pending
                - PA Request is Not Complete
                  - Information from Provider Pending
                    - PA Request is Not Complete
                      - PA Request is Not Complete

**MD Reviewer**
- MD Performs Clinical Review (Determination Must be Made within 3 Business Days)
- Care is Approved or Partially Approved
  - PA Notification Letter Generated
- Technical Denial is Issued
  - Notification Letter of Denial Generated (Appeal May Be Requested)

**Request Specifics**
- Provider submits the CSR form for the LOC that is currently being provided and requested to continue.
- Provider submits Initial Assessment and Treatment Plan and most recent Assessment and updated Treatment Plan.
- Information submitted is incomplete, the reviewer will request additional information via fax request to fax number provided.
- The provider has 5 business days to submit the requested information.
- If all required paperwork is submitted, but additional information is not received, the review will be processed with the clinical information that is available.
- If required clinical/paperwork is missing and additional information is not received, the review will be technically denied.

* Additional information may be requested at this point and resubmitted for review.

If the provider does not submit additional info as requested within 5 business days, a Technical Denial is issued.

Technical Denials can only be appealed to AMDD regarding procedural issues.

Last Updated: April 18, 2018
Retrospective Reviews:

- A provider may request a retrospective review when:
  - the member becomes Medicaid Eligible after the admission or
  - when the provider has not enrolled in Montana Medicaid prior to the admission of the member
- Retrospective Request should be faxed
  - Within 14 days after Montana Medicaid is established if prior to discharge of the member
  - Within 90 days after Montana Medicaid is established if after the member has discharged
- Fax Authorization Review Form and notification of eligibility to MMA
- Clearly indicate on submission that this is a RETRO Request
AMDD will facilitate weekly coaching calls for providers during the utilization review implementation process. A WebEx agenda is posted on the AMDD website.
For inquiries about the PA/CSR process, the best number to call is 866–545–9428. This number can ring to all UM staff and gives the best likelihood of reaching a live person.

- Staci Lindsay, LCPC, Senior Manager, Clinical Care Services
  - (406) 781–1521
  - sslindsay@magellanhealth.com

- Gina Davis, RN, Clinical Reviewer
  - (406) 426–0274
  - gdavis@magellanhealth.com

- Jiff McAnally, RN, Clinical Reviewer
  - (406)–490–4567
  - jmcanally@magellanhealth.com

- Tami Williams, Administrative Support
  - 866–545–9428
  - tjwilliams@magellanhealth.com

**Please do not email PHI**
Thank you!