

Prior Authorization and Continued Stay Criteria for Adult Serious Mentally Ill (SMI) Behavioral Health Residential Facility

AUTHORIZATION CRITERIA FOR BEHAVIORAL HEALTH RESIDENTIAL FACILITY, ADULT Title XIX SMI

Determination Timeline: Prior authorization for Title XIX Adult SMI Behavioral Health Residential Facility must occur prior to admission to a residential facility. Mercy RBHA determines medical necessity for expedited decisions within three (3) business days and standard decisions within fourteen (14) calendar days upon receipt of the request. If appropriate, Mercy RBHA may issue an extension of an additional fourteen (14) calendar days to request additional documentation.

Documentation Required Prior to Determination

Initial authorization: The Adult Recovery Team will submit prior to admission an updated treatment plan indicating the specific treatment goals for the Behavioral Health Residential Facility to address with the member. These goals must be focused on the signs and symptoms of the psychiatric disorder that resulted in the member being unable to continue to live in his/her usual living situation. An active treatment plan should aim to return the individual to his/her customary environment and functional status at the earliest possible time. A tentative discharge plan, a recent psychiatric evaluation that reflects current concerning behaviors, functioning and diagnoses, and an Adult Recovery Team note indicating the team's recommendations must accompany the submitted treatment plan. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission into residential treatment as per SAHMSA guidelines (See Provider Manual).

There must be evidence that the individual has agreed to and is willing to participate in treatment. Specifically, the member/guardian has signed an informed consent acknowledging that residential is a time-limited placement for active treatment prior to authorization of this service.

It is not expected that all behavioral or psychological difficulties will be resolved by the time of discharge from the facility.

Re-authorizations: Mercy RBHA will coordinate with the residential provider to coordinate a concurrent review two weeks prior to the expiration of the authorization.

Prior authorization for admission duration: Prior authorization for admission to a Behavioral Health Residential Facility is valid for up to forty-five (45) days after approval. If a member has not been admitted or scheduled for admission prior to the expiration of the authorization, the clinical team will need to submit an update prior to the expiration of the forty-five (45) days, providing current clinical information documenting evidence that all the initial reasons for approval continued to remain present for the past sixty days for re-determination of the initial authorization.

If the member, family or guardian, or other community stakeholder is interested and/or advocates for a specific provider and/or location based on the treatment needs of the member, the request of the member will be in the forefront. Given that systems resources are limited, Mercy RBHA will provide

member choice of up to two (2) referrals in a thirty (30)-day period based on identified needs and the availability of providers to meet these needs. Mercy RBHA will look to the clinical team to facilitate discussions of placement in consideration of the member accepting one of the first two referrals and pursue any other desired choice after discharge when the member is in an inpatient setting.

Length of Authorization:

Initial Admission Authorization: up to 45 days for initial authorization with initial concurrent review to occur within 30 days

Concurrent Re-authorization: must be requested by provider and clinical team with authorization up to 60 days maximum per request, based on continued stay criteria.

ADMISSION CRITERIA

A. DIAGNOSIS (must meet this criterion)

There is clinical evidence that the individual has a primary SMI-qualifying ICD-10 diagnosis as per the Mercy RBHA POLICY AND PROCEDURES MANUAL POLICY ATTACHMENT 106.1 Serious Mental Illness (SMI) Qualifying Diagnoses (<http://www.azdhs.gov/bhs/policy/documents/attachments/bhs-policy-attachment-106.1.pdf>) that is amenable to active psychiatric treatment. Any co-occurring diagnoses must be identified and documented prior to admission into residential treatment.

B. BEHAVIOR AND FUNCTIONING (must meet 4 of the criteria below with and at least one in each category B.1 and B.2)

As a result primarily of an SMI-qualifying -diagnosis, the adult member has a risk history of self-harming behaviors or disturbance of mood, thought or behavior which renders the adult member incapable of developmentally-appropriate self-care or self-regulation as evidenced by:

B.1 –Risk Behaviors:

1. History of self-harming behaviors but is not actively suicidal or at imminent risk
2. Significant impulsivity with poor judgment or insight and a clear and persistent inability of environmental supports to safely maintain the individual despite adequately intensive outpatient services or supports
3. Risk of physiologic jeopardy which threatens health and functioning, renders the person acutely incapable, due primary to their SMI/ psychiatric disorder, to perform appropriate self-care or self-regulation

B.2- Functioning:

Significant functional impairment that is not developmentally appropriate for self-care or self-regulation as evidenced by:

1. Inability to independently self-administer medically necessary psychotropic medications without rehabilitative or facilitative interventions. There is documentation that appropriate alternative strategies have been tried (or considered inappropriate), including medication education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications

2. Neglect or disruption of ability to attend to a majority of basic needs such as personal safety, hygiene, nutrition or medical care without rehabilitative or habilitative interventions
3. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment primarily as a result of psychiatric or affective/mood symptoms or other major psychiatric disorders

C. INTENSITY OF SERVICE *(must meet all criteria)*

1. Adult Behavioral Health Residential Facilities are specific psychiatric and chemical dependency treatment services provided by an DHL-licensed behavioral health agency as set forth in 9 A.A.C. 10, Chapter 7 and Title XIX certified by ADHS/ALS that provide a structured treatment setting with twenty-four (24) hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services.
2. Adult Residential Facilities provide the programming, the structure and supervision of a twenty-four (24) hour, seven day per week mental health treatment program to develop the skills to manage the symptoms of mental illness, skills necessary for activities of daily living, and to develop the adaptive and functional behavior that will allow him/her to live outside of a residential treatment setting.
 - a. The services provided must be evidence-based and individualized to the needs of the member and the individual must be able to participate in therapies and therapeutic activities as outlined in his/her ISP and targeted treatment goals.
 - b. Active treatment with the services available at this level of care can reasonably be expected to improve the adult's psychiatric and/or substance use condition in order to achieve transition from this setting at the earliest possible time to an independent living setting with appropriate continued supports. The individual is medically and psychiatrically stable enough to receive safe treatment at this level of care and does not require the twenty-four (24) hour medical/nursing monitoring or procedures provided in an acute inpatient setting. The individual must be capable of managing their own physical/medical health needs without rehabilitative and habilitative interventions.
3. Treatment should be in the least restrictive setting consistent with the individual's behavioral health needs and therefore should not be instituted unless there is documentation of a failure to respond to, or an inability to be safely managed in a less restrictive setting. These should be documented in the evaluation and/or clinical team's note accompanying the request for authorization. Exclusions would be related to those members with TBI, dementia or having the need for long-term custodial care without habilitative and rehabilitative interventions when there are expectations of minimal improvement in a time limited treatment setting.
4. Medically necessary outpatient behavioral health services do not meet the treatment needs of the individual and there is documentation of a failure to respond to or an inability to be safely

managed in a less restrictive setting. The individual's treatment goals must be focused on the signs and symptoms of the psychiatric disorder identified as the reason for admission into residential treatment, which renders him/her incapable of developmentally appropriate self-care or self-regulation without rehabilitative or habilitative interventions:

- a. These treatment goals must be defined prior to admission, and include a discharge plan recommendation.
- b. It is not expected that all behavioral or psychological difficulties will be resolved by the time of discharge from the facility.
- c. A lack of available outpatient services or housing is not, in and of itself, the sole criterion for admission into residential treatment.

D. EXPECTED RESPONSE *(must meet all criteria)*

1. Active treatment with the services available at this level of care can reasonably be expected to improve the member's condition in order to achieve discharge from the residential treatment facility at the earliest possible time and to facilitate his/her return to an independent living or other living arrangement with or without supports and/or family living.
2. There is evidence that the individual has agreed to and is willing to participate in treatment. The member/guardian has signed an informed consent acknowledging that residential is a time-limited placement for active treatment prior to authorization of this service.
3. It is not expected that all behavioral or psychological difficulties will be resolved by the time of discharge from the facility.

E. DISCHARGE PLAN *(all must apply)*

1. There is a written plan for discharge with specific discharge criteria, behaviorally measurable goals, and with recommendations for aftercare treatment that includes involvement of the Adult Recovery Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment, as well as being in conformance with federal and state clinical practice guidelines.
2. The discharge plan will be provided at the time of admission and reassessed with each concurrent review.
3. The discharge plan includes a description of the setting /placement that may meet the resident's assessed and anticipated needs after discharge.

F. EXCLUSION CRITERIA

There is documentation that the admission to a Behavioral Health Residential Facility is not to be used primarily and therefore clinically inappropriate, as:

1. An alternative to incarceration, or as a means to ensure community safety in an individual exhibiting primarily antisocial behavior
2. The equivalent of safe housing, permanent placement, or an alternative to guardians' or other agencies' ability or willingness to provide for the adult
3. As a behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs
4. As a primary placement to provide ongoing personal care services where habilitative and rehabilitative interventions are required

CONTINUED STAY CRITERIA

A. DIAGNOSIS

There is clinical evidence that the individual continues to have a primary SMI-qualifying diagnosis as per the Mercy RBHA POLICY AND PROCEDURES MANUAL POLICY - Serious Mental Illness (SMI) Qualifying Diagnoses (<http://www.azdhs.gov/bhs/policy/documents/attachments/bhs-policy-attachment-106.1.pdf>) that is amenable to active psychiatric treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission into residential treatment.

B. BEHAVIOR AND FUNCTIONING (*Documented evidence that all of the following have been present for the past sixty days*)

1. There is evidence of recent, recurring, or intermittent episodes of risk of harm; or continued significant functional impairment with disturbance of mood, thought or behavior which substantially impairs developmentally appropriate self-care or self-regulation without rehabilitative or habilitative interventions or new high risk symptoms or functional impairments have been documented
2. There is evidence that a significant regression of the member's condition would be expected without continuity at this level of care
3. Efforts to secure a less restrictive placement suitable to the behavioral health and recovery needs of the member are actively being pursued within a reasonable time frame

C. INTENSITY OF SERVICE: There is documented evidence that the person requires and has been receiving all of the following during the past sixty days:

1. Active, individualized, evidence-based treatment, with direct supervision/oversight by professional behavioral health staff, only available at this level of care, is being provided by the residential facility on a twenty-four (24) hour basis, and these interventions are

reasonably expected to impact the severity of disturbances of mood, thought or behavior which were identified as reasons for admission

2. The treatment is empowering the member to gain self-care or self-regulation skills to successfully function in his/her family and community
3. The Adult Recovery Team is meeting at least monthly, or more frequently as clinically indicated, to review progress, and has revised the service plan to respond to any lack of progress

D. EXPECTED RESPONSE

There is documented evidence in the past sixty days that:

1. Active treatment is provided that is reducing or can be reasonably expected to reduce the severity of disturbances of mood, thought or behavior which were identified as reasons for admission, or
2. There has been a re-evaluation and subsequent change in the treatment plan.

AND

3. Continued treatment in this type of service can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

Active treatment with the services available at this level of care can reasonably be expected to improve the member's condition in order to achieve transition from the residential treatment facility at the earliest possible time and to facilitate his/her return to independent living setting with or without supports and/or family living. . The member/guardian has signed an informed consent acknowledging that residential is a time-limited placement for active treatment prior to authorization of this service.

It is not expected that all behavioral or psychological difficulties will be resolved by the time of discharge from the facility.

E. DISCHARGE PLAN

There is a written plan for discharge and transition of care with specific discharge criteria, written as behaviorally measurable goals, and with recommendations for aftercare treatment. The aftercare plan must include involvement of the member's Adult Recovery Team. The plan complies with current standards for medically necessary covered behavioral health services, evidence-based care, cost effectiveness, and least restrictive environment and is in conformance with federal and state clinical practice guidelines.

The discharge plan will be reassessed with each concurrent review.

The discharge plan includes a description of the setting/placement that may meet the resident's assessed and anticipated needs after discharge

F. EXCLUSION CRITERIA

There is documentation that the continued stay at a Behavioral Health Residential Facility is not being used primarily and therefore clinically inappropriately as:

1. An alternative to incarceration, or as a means to ensure community safety in an individual exhibiting primarily antisocial behavior
2. The equivalent of safe housing, permanent placement, or an alternative to guardians' or other agencies' ability or willingness to provide for the adult
3. As a behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs
4. As a primary placement to provide ongoing personal care services where habilitative and rehabilitative interventions are required.