INPATIENT

Provider Education

Behavioral Health

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Welcome to Magnolia Health|Cenpatico!

We thank you for being part of Magnolia's network of providers, hospitals, and other healthcare professionals participating in the Mississippi Coordinated Access Network (MississippiCAN). Our number one priority is the promotion of healthy lifestyles through preventive healthcare. Magnolia works to accomplish this goal through close relationships with the providers who oversee the healthcare of Magnolia members.

This presentation is only intended to provide guidance to providers regarding Magnolia's policies and procedures related to inpatient services for the MississippiCAN Program. It is always the responsibility of the provider to determine member eligibility and also determine and submit the appropriate codes, modifiers and charges for the services provided to Magnolia members.

Cenpatico (CBH)

- Cenpatico is the Behavioral Health Network that services the members of Magnolia Health. Cenpatico is a division of Centene Corporation. We have managed Medicaid and other public sector benefits since 1994, and operate in multiple states with an active local presence. Our members receive care from **local teams** that truly understand the specific needs of their communities. We continually introduce innovative clinical initiatives and network strategies in all markets, designed to create quality service delivery systems.

- **Cenpatico's expertise lies in managing benefits for vulnerable populations.**

- To learn more, visit our website at www.cenpatico.com

Clinical Protocols

Cenpatico affirms that utilization management decision making is based only on appropriateness of care and service and the existence of coverage. Magnolia does not specifically reward practitioners or other individuals for issuing denials of service or care. Consistent with 42 CFR 438.6(h) and 422.208, delegated providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Cenpatico has adopted DOM approved utilization review criteria developed by McKesson InterQual® products to determine medical necessity for behavioral healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical, behavioral health and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from providers. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. Cenpatico's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Agenda Topics

- Provider Enrollment
- Credentialing Requirements
- MississippiCAN Eligibility
- Cultural Awareness
- Inpatient Regulatory Requirements
- Care Coordination
  - Inpatient Prior Authorization
  - Clinical Documentation
  - Initial Review- Examples
  - Precipitating Events- Examples
  - Initial Review- Additional Questions
  - Concurrent Review
  - Inpatient Summary
  - Review Criteria/Clinical Appeals
  - Emergent/Weekend/Holiday Admissions
  - Observation
- Claims Submission
- Contact Information
- Accessing Medical Care Management
- Quick Reference

Provider Enrollment

- Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #. Providers must also be properly credentialed by Magnolia or other designated authority prior to treating Magnolia members. Behavioral Health Providers must also be credentialed by Cenpatico prior to treating Magnolia members.

- Prior Authorizations must be obtained for services provided by out of network providers, except for emergency and post-stabilization services, and these services will only be reimbursed at 80% of the Medicaid fee schedule.

- Contract request forms can be found on Cenpatico's website at www.cenpatico.com click on Mississippi then Join Our Network and follow the prompts.

- Cenpatico's credentialing team is required to render a decision on all credentialing applications within ninety (90) calendar days of receipt of a complete credentialing package.

- Providers will be designated in Cenpatico's claims payment system as a participating provider within thirty (30) days of approval of their credentialing application.

Required Items for Facility Credentialing

- Hospital/Ancillary Credentialing Application
- State Operational License
- Other applicable State/Federal licensures (e.g. Clinical Laboratory Improvement Amendment (CLIA), Drug Enforcement Administration (DEA), Pharmacy, Department of Health, etc.)
- Accreditation/certification by a nationally-recognized accrediting body (i.e. The Joint Commission (TJC), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other designated authority)
  - If not accredited by a nationally-recognized accrediting body, please include site evaluation results from a governmental agency
- Current general liability coverage (showing the amounts and dates of coverage)
- Medicaid/Medicare certification
  - If not certified, please provide proof of participation
- W-9
- Ownership and Disclosure form

MississippiCAN Eligibility

Eligibility for MississippiCAN will be determined by the Division of Medicaid (DOM) according to rules approved by the Division of Medicaid. DOM follows eligibility rules mandated by federal law.

Categories of Eligibility (COE):

Mandatory Populations	COE	New COE	Age
SSI - Supplemental Security Income	001	001	19 – 65
Working Disabled	025	025	19 – 65
Breast and Cervical Cancer	027	027	19 – 65
Parents and Caretakers (TANF)	085	075	19 – 65
Pregnant Women (below 194% FPL)	088	088	8 – 65
Newborns (below 194% FPL)	088	071	0 – 1
Children TANF	085	071 – 073	1 – 19
Children (< age 6) (< 143% FPL)	087, 085	072	1 – 5
Children (< age 19) (< 100% FPL)	091, 085	073	6 – 19
Quasi-CHIP (100% - 133% FPL) (age 6-19) (previously qualified for CHIP)	099	074	6 – 19
CHIP (age 0-19) (< 209% FPL)	099	099	1 – 19
Optional Populations*	**COE**	**New COE**	**Age**
SSI - Supplemental Security Income	001	001	0 – 19
Disabled Child Living at Home	019	019	0 – 19
DHS – Foster Care Children – IV-E	003	003	0 – 19
DHS – Foster Care Children – CWS	026	026	0 – 19

*Native Americans are allowed to opt out of MississippiCAN, as well.

Verify Eligibility

It is the provider's responsibility to verify member eligibility on the date services are rendered using one of the following methods:

- Log on to the Medicaid Envision website at: www.ms-medicaid.com/msenvision/
- Log on to the secure provider portal at www.magnoliahealthplan.com
- Call our automated member eligibility interactive voice response (IVR) system at 1-866-912-6285
- Call 866-912-6285 to reach a Cenpatico team member

Member ID Cards Are Not a Guarantee of Eligibility and/or Payment.

Cultural Awareness and Sensitivity

Providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.

- Medical care is provided without consideration to the member's race/ethnicity or language and its impact/influence of the member's health or illness.

Inpatient Regulatory Requirements

Providers must adhere to all requirements outlined in applicable State Plan Amendments and the Administrative Code.

State Plan Amendments (SPAs)

- The following SPAs are mandated by the Division of Medicaid and are available for viewing on its website:
  - SPA 15-002 Increased Primary Care Provider Payment
  - SPA 15-005 Physician Upper Payment Limit (UPL)
  - SPA 15-008 All Patient Refined Diagnosis Related Groups (APR-DRG) Public Commenting Period
  - SPA 14-009 Health Care Acquired Conditions (HCAC)
  - SPA 15-010 Mississippi Coordinated Access Network (MSCAN)
  - SPA 15-012 Mississippi Hospital Access Program (MHAP) Transition Payment and Inpatient Hospital UPL Program Elimination
  - SPA 14-016 All Patient Refined Diagnosis Related Groups (APR-DRG)

Administrative Code

- Title 23, Part 202, Inpatient Services
- Miss. Admin. Code Part 300, Rule 1.1
- Miss. Code Ann. §§ 43-13-117, 43-13-121
- Magnolia's policies strictly comply with all Division of Medicaid State Plan Amendments and Administrative Code. http://www.magnoliahealthplan.com/for-providers/provider-resources/

Cenpatico- What We Do For Members

Our staff is available 24 hours a day, 365 days a year by calling the following number:

(866) 912-6285

Customer Service Center in Mississippi

- Staff available 8 a.m. - 5 p.m. CST
- Eligibility Verification
- Referrals
- Integrated Case Management between providers of varying levels of care
- Care Coordination to assure Members have adequate access to providers

NurseWise

- Nurse triage & other services available 24/7/365 (may issue authorizations after hours with follow up from local care coordinator the next business day)

Care Coordination

We recognize that multiple co-morbidities will be common among our membership. The goal of our program is to collaborate with the member and all treating providers to achieve the highest possible levels of wellness, functioning and quality of life.

Cenpatico's care coordination model uses an integrated team of:

- Licensed mental health professionals
- Registered nurses
- Social workers
- Non-clinical staff

Cenpatico's care coordination model is designed to:

- Educate members on the importance of treatment compliance;
- Help members obtain needed services;
- Assist in coordination of covered services, community services, or other non-covered venues;
- Identify members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desired outcomes;
- Work collaboratively with the facility, physician, member, family / significant other and support services to implement and individualize a plan of care.

PRIOR AUTHORIZATION

The authorization process ensures that members are receiving the proper treatment and intensity of services on the inpatient unit while addressing their ongoing outpatient needs.

CLINICAL DECISIONS: Magnolia affirms that utilization management decision-making is based only on appropriateness of care and service and existence of coverage. The treating provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member.

Prior Authorization (cont.)

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- For hospital Behavioral Health (BH) inpatient services, if authorization for level of care cannot be determined at first level review by the UM reviewer, the care will be reviewed by a Mississippi licensed Medical Director. The attending physician may request a peer-to-peer discussion with said Medical Director.

- Cenpatico will make determination for urgent concurrent, expedited continued stay, and/or post-stabilization review within twenty-four (24) hours of receipt of the request for services.

- If all necessary clinical information has been received from the provider and Cenpatico is still unable to make a determination within these timeframes, it may be extended up to fourteen (14) additional calendar days upon the request of the member or provider, or if Cenpatico, Magnolia Health Plan and the Division of Medicaid determine that the extension is in the member's best interest.

Inpatient Authorization Process

Provider must contact CBH **within 24 hours** of an emergent inpatient admission. The Provider should contact Cenpatico via telephone (preferred), fax, mail, secure email or through our website with the appropriate clinical information to request an authorization. After-hours calls will be taken by Nursewise and authorized next business day when a live review is done.

All inpatient reviews are conducted via live telephonic review.

InterQual medical necessity criteria are applied to all mental health cases, and ASAM criteria are applied to all chemical dependency cases.

Failure to obtain authorization for hospital inpatient care may result in denial of the claim!

CLINICAL DOCUMENTATION- INITIAL REVIEW

- Detailed clinical information is essential for determining medical necessity. The **Initial Revie**w documentation must include:
- Facility
- Name and contact number of Utilization Reviewer
- Date of admission
- Legal status – voluntary vs. court commit admission
- Member's guardian, if any

Initial Review-continued

- **Precipitating Event**

Clear details are needed regarding symptoms and behaviors of the member leading to admission.

For example:

- Triggers to the episode, if known
- Actual physical injury of self or others
- Medical treatment needed
- Termination of the behavior – did they stop on their own or did someone else intervene?
- Objects or actions used
- Time frames – how long ago did the precipitating event occur, and how is the member presenting now?

Precipitating Events-examples

- **Suicide Attempt**

Example 1: A member presents status post suicide attempt by overdose on medications.
Important questions to be answered:

What kind of pills and the approximate number of pills ingested?

What events led up to the attempt?

What happened afterward - did someone find the member, did member call for help?

What treatment was administered in the ER – charcoal, lavage?

Does the member regret the overdose?

Example 2: A member presents status post suicide attempt by hanging.
Important questions to be answered:

Did the member actually hang himself?

How far did he/she get in the process?

What materials did he/she use?

What interrupted the attempt?

Were there any injuries from the attempt?

Precipitating Event – Aggression

Example : A child presents for admission due to aggressive behavior.

- What are the specific aggressive behaviors?
- Who is the member targeting?
- Does the behavior occur in more than one setting?
- When did this behavior start?
- Has there been a recent change in intensity and frequency of the behavior? When did this occur?
- Are there certain circumstances that trigger the aggression?
- Is the behavior so severe that it can't be managed on an outpatient basis?

Precipitating Event – Psychosis

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Example : An adult presents for admission due to psychotic behavior.

Important questions to be answered:

- Are there auditory or visual hallucinations?
- Are they command in nature?
- What is the content?
- When did these symptoms begin?
- Are they constant or fleeting?
- Are these symptoms stressful for the member?
- Are there delusions present?
- Are these delusions fixed? When did they start?
- Is there imminent danger to the member or others due to the psychosis?

Additional Questions for Initial Review

- Treatment history
- Medications prior to admission (both behavioral an medical), and compliance
- Substance use history
  - Past treatment, use pattern, drug screen results and alcohol level results on admission
- Social Factors impacting admission including:
  - Family history of substance abuse or behavioral health concerns, trauma or loss history
- Medical concerns of the member
  - Focus on integrated care

Additional Questions for Initial Review-cont.

- Height and weight
- Legal issues
- Education history
- Employment information
- Trauma History
- Cultural considerations: Ethnicity, Language preference, Sexual preference
- Current living situation
  - Foster Care placement status and any issues
- Contact information for the member
  - Or DHS social worker for children in foster care

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Additional Questions for Initial Review-cont.

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- Mental Status Exam (MSE) to focus on member's current state of mind at time of admission:
  - Appearance
  - Attitude
  - Behavior
  - Mood and affect
  - Speech
  - Thought process and content
  - Perception
  - Cognition
  - Insight
  - Judgment

Treatment Plan Considerations

- What is the focus of treatment for this member?
- What are the primary goals for this admission?
- Are the goals member-set and member-focused? Is Motivational Interviewing being utilized?
- Are the goals based on a model of recovery?
- Are the goals based on a model of integrated care?
- Are the member's strengths being identified, and how are these strengths reflected in their treatment plan?

S.M.A.R.T. Goal Development

- As you are creating member centered goals, ask yourself if the goals are...

- **S**pecific: What exactly are you expecting the outcome to be?
- **M**easureable: How are you going to be able to evaluate if the outcome was achieved?
- **A**ttainable: Is the member able to reach the desired outcome at some point in time?
- **R**ealistic: Can the member achieve the outcome in the time allotted?
- **T**ime Limited: Is there a clear time frame set for completing the goal?

Discharge Planning

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- Has the discharge planner been identified?
- Where will the member be living at discharge?
- Who will they see for outpatient follow up? Do they already have an appointment scheduled?
- Are there problem areas that our Care Coordination or Case Management staff may be able to assist with?
- Are their any cultural or religious factors that play a role in this member's discharge plan?

Cenpatico requires a follow-up appointment be scheduled and the member attend within 7 calendar days of discharge from the hospital.

Concurrent Review

- Cenpatico's clinical team will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning departments and when necessary, the member's attending physician. The individual identified on the Initial Review will be considered the appropriate point-of-contact for all discharge planning.

- An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment.

- The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures

Concurrent Reviews - Medications

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Documentation:

- Documentation of start date, change date, discontinuation date
- Documented monitoring of medication levels
- Detailed documentation of PRN and emergency meds

Additional questions:

- What is the MDs plan for the upcoming days?
- If MD is not making med changes, why?
- If MD is only giving PRNS, why?
- If the member is on a medication that requires a blood test to determine efficacy, when is that going to be drawn?

Especially for Fax Reviews:

- Med orders need to be VERY clear
- Can the reviewing UM easily tell what the medication regimen is and any updates that have been made to the medication regime?

Concurrent Reviews – Notes

- Are all modalities (MD, RN, group therapy, individual therapy, family therapy) being provided and documented?
- Does the MD note clearly document symptomology?
- Is there specific documentation regarding:
  - Suicidal/Homicidal ideation and plan or absence of plan?
  - Hallucinations – specifics regarding type and content?
  - Delusions – details about content?
  - Are symptoms fixed or expected to improve?
- Why does the member need to continue in acute care?

Concurrent Reviews – Notes-cont.

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- What places the member at risk if discharged now?
- Did the MD document ongoing plan for treatment?
  - If the member is not improving, what is the detailed plan to facilitate improvement?
- Is there a discrepancy between MD and RN notes?
  - If the MD and RN notes on the same day are incongruent, this should be explained.

Inpatient Summary

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Opportunities for Gathering Information

- Initial clinical review
- RN / MD notes
- Therapy / staff notes

Documentation

- Detailed
- Give examples
- Be specific
- Current

Discharge Planning

- Begins upon admission
- Coordinate with case management
- 7 day follow up appointment addressed

Treatment Planning

- Member driven
- Recovery based
- S.M.A.R.T. goal oriented
- Strengths and barriers identified and addressed

Review Criteria

- Cenpatico has adopted utilization review criteria developed by McKesson InterQual® products to determine DOM approved medical necessity for behavioral health services.

- Cenpatico's Medical Director reviews all potential medical necessity denials and will make a decision in accordance with currently accepted medical or behavioral health practices, taking into account special circumstances of each case that may require deviation from the norm in screening criteria. Denial notification will include the reason(s) for denial per section 17.A. of the contract.

- Providers may obtain the criteria used to make specific determinations by contacting Cenpatico at 1-866-912-6285.

CLINICAL APPEALS

- Members, authorized representatives or healthcare professionals with the member's consent, may request an appeal with Cenpatico related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Cenpatico
Attn: Appeals Coordinator
12515-8 Research Blvd. Suite 400
Austin, TX 78759
Fax: 1-866-694-3649

Emergent and Weekend and Holiday Admissions

- **Emergency and urgent care services never require prior authorization.**
- All hospital inpatient admissions require notification via a request for authorization to Cenpatico by the close of business on the **next business day** following admission. **(Failure to notify may result in denial of payment.)**
- Non-emergent hospital Behavioral Health inpatient admissions always require a prior authorization.

Observation Guidelines

- In the event that a member's clinical symptoms do not meet the criteria for an inpatient admission, but the physician believes that allowing the patient to leave the facility would likely put the member at serious risk, the member may be admitted to the facility for an observation period.
- An observation stay may last up to a maximum of twenty-three (23) hours. (Stays less than 8 hours of observation or greater than 23 hours are not allowed.)
- Providers are required to notify Cenpatico's Clinical Team of an observation stay by the next business day after discharge.
- A medical necessity determination will be made within twenty-four (24) hours of receiving all required information.

CLAIMS SUBMISSIONS

Claims Customer Service: (866) 324-3632

Ways to submit Claims:

Online www.cenpatico.com (Will need logon information)

Emdeon Payor ID 68068

Paper Claims Cenpatico

PO Box 7600

Farmington MO 63640-3809

Claims must be submitted within **180** days of the date of service.

Appeals must be submitted within **90** days of the denial.

Appeals: mail Cenpatico Appeals

PO Box 7600

Farmington MO 63640-3809

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IMPORTANT Contact information and phone numbers

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- ****Please go to WWW.CENPATICO.COM for Covered Services and Authorization Grid****
- **Provider Relations** -1ST Point of Contact
  (866) 912-6285
- **Authorizations** (Inpatient and Outpatient)
  (866) 912-6285
- **Care Management/Quality Improvement**
  (866) 912-6285
- **Claims Customer Service**
  (866) 324-3632

Local Network Contacts

- **Angela Stewart**
- Network Manager anstewart@cenpatico.com
  601-863-0738

- **Nakisha Montgomery**
- Provider Relations Specialist (Central and Southern MS)
  nmontgomery@cenpatico.com
  601-863-0745

- **Diandra Lee**
- Provider Relations Specialist (North MS and Hattiesburg)
  dilee@cenpatico.com
  601-863-2507

Accessing Care Management (Medical)

All Magnolia Health Plan members have access to Care Management services. Referrals from Providers can be made in any of the following ways:

Effective July 23, 2015, providers may log in to our Provider Portal and complete the Provider Referral Form for Care Management and Disease Management.

Go to our website www.magnoliahealthplan.com and fill out the Provider Referral Form for Care Management and Disease Management which is located under the Practice Improvement Resource Center (PIRC) section. Fax the completed form to 1-866-901-5813.

Call Magnolia Health at 1-866-912-6285, ext. 66415 to speak with the Care Management Department.

Call Magnolia Health at 1-866-912-6285 and choose the Provider prompt to speak with a Provider Services Representative who can assist you.

For assistance with **Prior Authorizations**, call 1-866-912-6215, ext. 66408 to speak with the Prior Authorization Department.

Magnolia Health Care Managers will contact the member and offer Care Management within 72 hours. Members who agree to Care Management services will be enrolled for the time necessary to address and stabilize the condition. Providers will be asked to provide a Plan of Care so our Care Management Team can target the Care Management to the specific needs of each member.

QUICK REFERENCE

- ***Please visit the Practice Improvement Resource Center (PIRC) at www.magnoliahealthplan.com Clinical Practice and Preventative Guidelines and other helpful information.***
- This powerpoint will be posted there for quick reference.

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- Thank you for assisting Cenpatico to coordinate holistic mental health care for our Magnolia Health Plan members.

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Thank you!