CENTENE® Corporation

Inpatient Clinical Documentation

Medical Necessity Criteria, Discharge Planning and Readmissions for Providers

Centene Advanced Behavioral Health

PROUDLY PARTNERING WITH HEALTH PLANS NATIONWIDE TO PROVIDE SUPERIOR SOLUTIONS TO ENHANCE BEHAVIORAL WELLNESS

AR	arkansas health & wellness
CA	Health Net; california health & wellness
FL	sunshine health
GA	peach state health plan
IN	mhs
IA	iowa total care
LA	louisiana healthcare connections
MS	magnolia health
MO	home state health
NE	nebraska total care
NV	silversummit healthplan
NH	nh healthy families
NC	carolina complete health
OK	oklahoma complete health
OR	Trillium Community Health Plan
SC	absolute total care

Agenda

- Introduction
- Philosophy
- Managed Care
- Clinical Documentation
- Medical Necessity Criteria
- Initial Reviews
- Concurrent Reviews
- Discharge Planning/Documentation
- Readmissions
- Questions / Wrap Up

Learning Objectives

- Describe Medical Necessity Criteria (MNC) and the importance of reflecting MNC in the clinical documentation
- Discuss when discharge planning starts and why it is important to address throughout treatment
- Discuss importance of 7 day follow up
- Identify components of Discharge Documentation
- Discuss what role discharge planning plays in ways to help prevent readmissions

Our Core Philosophy

CENTENE® Corporation

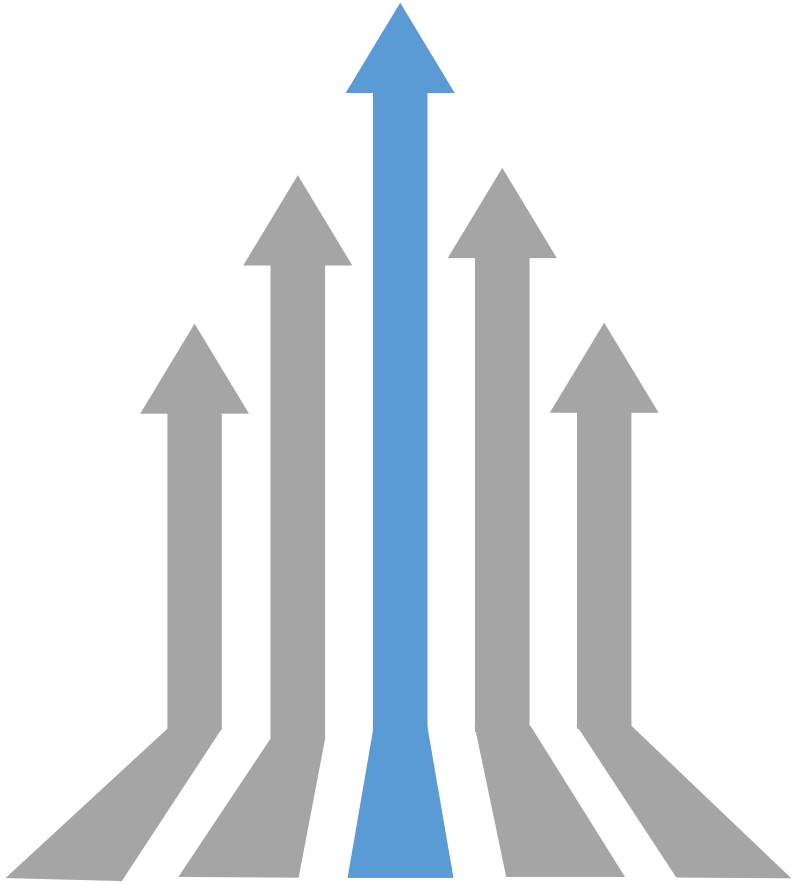
To engage individuals in the best most appropriate treatment is:
the right amount at the right time

Managed care is a health care delivery system organized to manage cost, utilization and quality

(Medicaid.gov, n.d.)

Benefits of Managed Care

- Focus on quality
- Responsible use of resources
- Collaboration
- Assistance with discharge planning



Clinical Documentation

Medical Necessity Criteria

What is Medical Necessity?

- **Contractual Scope** – what is covered in the contract
- **Standards of practice** – does treatment accord with professional standards
- **Patient Safety and Setting –** is setting safest and least intrusive
- **Medical Service-** is treatment medical as opposed to social or nonmedical
- **Cost –** is treatment cost-effective

We like to say: The right service, at the right time, in the right place.

- (Rosenbaum, Kamoie, Mouery, Walitt, 2003)

Decision Making Tools

- Mississippi Medicaid Administrative Code
- Centene Advanced Behavioral Health Policies
- Interqual
- The ASAM Criteria
- Clinical Judgement

Magnolia Clinical Policies:
https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html

(Change Health Care, n.d.)

Medical Necessity Criteria (MNC)

Ways to know if a service is medically necessary

What is Medical Necessity Criteria (MNC)?

- Data used to evaluate current needs of the member
- Guides determination on what form of treatment or level of care would be the most beneficial for the member at this point in time
- Symptom focused, examples of MNC are:
  - InterQual
  - The ASAM Criteria

Is Treatment Medically Necessary?

- Have traditional behavioral health services been attempted?
- Is the least restrictive level of care available?
- Does the functional impairment match the requested services?
- Does the provider engage the caregiver in the treatment process?
- Is the member engaged in service and making progress on the treatment goals?
- Are the services being titrated as needed and is there a plan for termination/discharge?

Other Questions to Consider for MNC

When was the last time the behavior occurred?	What is the duration of the targeted behavior?	What support systems does the member have?
How many times a day, a week, or a month does the behavior occur?	What is the precipitating event or any known triggers that initiate the behavior?	How has the member been successful in the past?
What does the member identify as the problem?	What area(s) of the member's life/functioning is impacted by the behavior?	What are the member's strengths?

Initial Clinical Review

UM staff follow a template in obtaining clinical information for review. The template starts with the following basic information:

- Facility
- Name of Utilization Reviewer
- Date of admission
- Legal status – voluntary vs. court commit admission
- Member's guardian, if applicable

Initial Clinical Review – 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 Event – 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 enrollee, did member call for help?
- What treatment was administered in the ER – charcoal, lavage?
- Does the member regret the overdose?

Precipitating Event – Suicide Attempt

Example 2: A member presents status post suicide attempt by hanging.

Important questions to be answered:

- Did the member actually hang himself/herself?
- 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 3: 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

Example 4: 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 and medical), and adherence capability / history
- Substance use history
- Past treatment, use pattern, drug screen results and alcohol level results on admission
- Abuse or trauma history
- Family history of substance use or behavioral health concerns
- Medical concerns of the enrollee
- Focus on integrated care

Additional Questions for Initial Review

- Height and weight
- Legal issues
- Education history
- Employment information
- Cultural considerations
  - Ethnicity
  - Language preference
  - Preferred Gender identity
- Current living situation
- Contact information for the enrollee

Additional Questions for Initial Review

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?

Treatment Plan Considerations

- What interventions will be provided to the member to meet these goals?
- What day did the goals begin, and how will you know when these goals have been completed?
- What needs to be accomplished before the member can discharge safely?
- What barriers exist that could prevent the member from being successful in treatment on an outpatient basis?

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?

Concurrent Reviews - Medications

Documentation:

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

Additional questions:

- What the MDs plan for 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?
- Has coordination been started with treatment team regarding medications upon discharge

Especially for Fax Reviews:

- Medication 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?

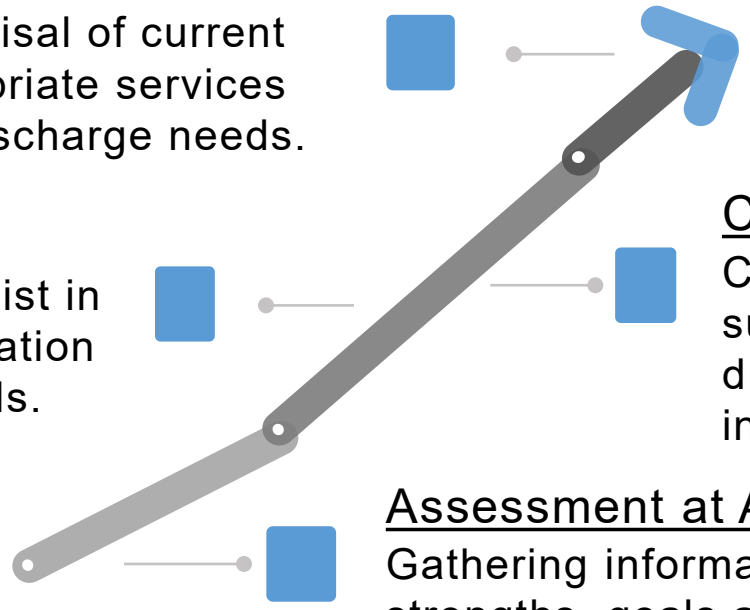
Concurrent Reviews – Notes

- 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

Clinical Documentation

Discharge Planning and Readmissions

Discharge Planning Process



Discharge Planning

An agreed upon plan to assist member in effective independent functioning.

Titrating services

Continuous appraisal of current needs and appropriate services which includes discharge needs.

Treatment Plan

SMART goals assist in constant re-evaluation of discharge needs.

Care Coordination

Collaborates with others to support the member after discharge and can be included in discharge plan.

Assessment at Admission

Gathering information about supports, strengths, goals and expectations for treatment, discussion of the importance of discharge

Discharge Question to be Answered and Sent to UM Prior to Discharge

Please send below information to our secure email box: AUGMississippiUM@cenpatico.com

1. CPS Custody? Social Worker name and contact info/has SW been involved in treatment (family sessions)
2. If parent placed name and contact information/Have they been involved in treatment (family therapy
3. If PRTF is the recommendation, have packets been sent out?
4. If therapeutic group home is recommendation has Residential Services App been sent out?
5. If MYPAC is recommendation, has application been started
6. Has 7 day OP follow up appointment been scheduled? When and where?
7. What are the barriers for discharge at this point?
8. Estimated date of discharge?
9. IS there CM involvement/if no send referral?
10. Who is the Discharge Planner?

Discharge Planning – Final steps

- Finalize the plan : Collaboration with provider, member and their supports, and any follow up providers
- Discharge documentation should include detailed information regarding medication.
- Identification of self-care instructions, including reminders to use skills learned in treatment, i.e. coping skills, problem solving skills, daily self-care activities etc.
- ***Discharge Appointment has to be made within 7 days of discharge***
- The Discharge Plan document should include any appointments with other providers and information on connection to formal and informal supports and how to return to care if needed.
- The Discharge Plan should be documented in the member's permanent record along with copies given to member, support persons, and service providers

Discharge Appointment has to be made within 7 days of discharge

Discharge Planning- Documentation

- 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 staff may be able to assist with?
- Are their any cultural or religious factors that play a role in this enrollee's discharge plan?

A follow-up appointment must be made for the member within 7 calendar days of discharge from the hospital

Readmissions

- A readmission is defined as an episode when a patient who had been discharged from a hospital is admitted again within a specified time interval (ex. 7, 30 or 90 days)

- Readmission rates have increasingly been used as an outcome measure in health services research and as a quality benchmark for health systems.

- Having a solid discharge plan in place that the member understands is helpful in preventing readmissions.

In Summary

Opportunities for

Gathering Information

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

Documentation

- MNC / Detailed
- Give examples
- Be specific
- Current

Discharge Planning

- Begins upon admission
- 7 day follow up appointment / discharge questions addressed
- Importance for readmission prevention

Treatment Planning

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

Questions?

References

- Change Health Care (n.d.) *InterQual level of care criteria.* https://www.changehealthcare.com/solutions/clinical-decision-support/interqual/level-of-care-criteria

- Rosenbaum, S., Kamoie, B., Mauery, D. R., Walitt, B. (2003). Medical Necessity in Private Health Plans: Implications for Behavioral Health Care. DHHS Pub. No. (SMA) 03-3790. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

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