Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

# MEDICAID MEMO

TO: All Residential Treatment providers participating in the Virginia Medical Assistance Program, Managed Care Organizations providing services to Virginia Medicaid recipients, and holders of the *Psychiatric Services* manual

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO Special

DATE 9/3/2004

SUBJECT: Changes to the Review Process for Residential Treatment Services

The purpose of this memo is to inform you of changes to the Medicaid-funded residential treatment services review process. The changes being made are in response to provider and locality representative requests for a less cumbersome preauthorization process. Although this correspondence contains a large amount of information, the brief overview of each required form is not new information, but rather a reminder of what information is required on each form. It is anticipated that by using the revised WVMI review forms and submitting the facility's Initial Plan of Care (IPC), the Comprehensive Individual Plan of Care (CIPOC), and the 30-day CIPOC Progress Update forms to request preauthorization, there will be less need to pend requests for additional information, resulting in timelier decisions rendered.

As you are aware, a preauthorization request for Medicaid reimbursed residential treatment services must be submitted to WVMI on an Initial Review form within one business day of the admission. DMAS staff has worked with providers to develop a process that is user-friendly and is expected to decrease the number of pended preauthorization requests. The following four changes will go into effect on October 1, 2004 to help streamline the preauthorization process. In addition, we have outlined the information that must be part of the WVMI submission to facilitate a timely turnaround by WVMI and prevent the pending of requests.

## PROGRAM CHANGES

1. Beginning October 1, 2004, the time frame for approvals will change from "no more than 31 days" to a maximum of 90 days. The length of approval, however, will be based on the medical necessity documentation. If, for example, a discharge date were noted for 60 days from the submission of the review, WVMI would only approve up to 60 days.

2. DMAS has revised the WVMI review forms and deleted information that may already be found on forms in use at your facility that meet federal, state, and licensing regulations. This should decrease the amount of duplicated information. The revised WVMI review forms, along with the forms already in use at your facility, will now be used for preauthorization purposes.

3. The Care In Progress form will no longer be required. An initial review is required for a child in placement for up to 14 days. If the child has been in placement for more than 14 days, a continued stay form will be required. In the case of retroactive recipient eligibility, please keep in mind information related to the timeframe under review will be necessary for submission to WVMI for retroactive review.

4. In order to provide you with an outline for proper documentation, DMAS developed the attached sample forms. You are not required to use these forms; however, use of the forms, along with proper documentation, will provide WVMI with the information they need to more efficiently review your request. These forms are the Initial Plan of Care (IPC), a Comprehensive Individual Plan of Care (CIPOC), and a CIPOC 30-Day Progress Update. Attached you will also find a copy of the sample Certificate of Need (CON). This form is to be completed by the referring source. Please be sure the CON submitted covers all the material noted on the sample.

The forms can be used as is, or can be used as examples of the documentation required to be included on provider-developed forms. However, beginning October 1, 2004, the facility's IPC, the CIPOC, and the CIPOC Update will be required for submission to WVMI for preauthorization purposes. The IPC will be required on the very first submission and the CIPOC and the most current CIPOC Update will be required for the Continued Stay Reviews.

The sample forms and the revised WVMI forms will be available on the DMAS website at www.dmas.virginia.gov, as well as available from Commonwealth-Martin by calling the DMAS Order Desk at 804-780-0076.

## INITIAL PLAN OF CARE (IPC)

The following is a brief overview of the required elements for the IPC. The following items have been identified as areas that are often insufficiently documented and lead to pends and denials.

- The DSM-IV diagnosis must be complete, including all five (5) axes.
- The symptoms, complaints and complications indicating the need for admission to residential care should correlate to the problems noted on the Certificate of Need completed by the Family Assessment Planning Team (for CSA cases), and by the Community Services Board (for non-CSA cases). For CSA cases, the reasons for admission should also correlate to the Child and Adolescent Functional Assessment Scale (CAFAS). These should be a child-specific description of problem behaviors that require 24-hour, intensive treatment.

- The order for therapies must be specific, noting the type of therapy, how often it is to take place, and for what period of time it will continue. If the therapy is expected to take place throughout the residential stay, note when it will be reviewed for efficacy.

- Family therapy must take place at a minimum of twice a month if family has contact with the child, and there is some plan for family reunification at some point. If there is a family dysfunction or relationship problem that impacts the child's treatment, family therapy is required weekly. At least one family session must take place face-to-face each month. If there is no family contact, and no plan for family contact, this should be noted.
- The order for therapies should also delineate the 21 treatment interventions required each seven (7) day period.
- The treatment goals should be measurable and should have measurable treatment objectives/interventions (i.e., how the goal will be broken down into manageable steps, how the goal will be met, what interventions will be used), as well as a target date for achievement. WVMI will be assessing progress on the goals for subsequent reviews, and will require child-specific, measurable goals and interventions.

**COMPREHENSIVE INDIVIDUAL PLAN OF CARE (CIPOC)**

The following is a brief overview of some of the required elements for the CIPOC. The following items have been identified as areas that are often insufficiently documented and lead to pends and denials.

- A minimum of three (3) long-term and three (3) short-term goals must be provided, must relate to the described need for residential treatment, and must be therapeutic in nature. Each measurable goal must have at least one measurable treatment objective/intervention and a target date for achievement. The format for documenting this is up to the facility.
- The Summary of Progress and Justification for Continued Stay should be child-specific and relate to the reason for admission and to the treatment goals and objectives/interventions. If the admitting problems are resolved, or other new problems are noted, a specific description that justifies the need for residential treatment is required. If there has been no progress in a 20-day period and there is no documented change in treatment to address this lack of progress, then the DMAS discharge criterion has been met.
- The discharge plan should be specific and relate to treatment. A description of the step-down placement, and the services that will be required can be refined at the time of each CIPOC progress update. Be sure to provide an alternative discharge plan if the primary plan does not appear likely to occur. Please keep in mind that this is a 24-hour intensive level of treatment and step-down to a less intensive level of care is expected to occur as soon as clinically indicated. It is not expected that all emotional and behavioral problems will be addressed prior to discharge. Many of these can be addressed at a lesser level of care.

## CIPOC 30-DAY PROGRESS UPDATE

The following is a brief overview of some of the required elements for the CIPOC 30-day Progress Update. The following items have been identified as areas that are often insufficiently documented and lead to pends and denials.

- Note any changes to the CIPOC, including changes to the diagnosis, medications, therapies and other treatment interventions.
- Note any changes to the goals and objectives/interventions. If a goal has been met, note this, and document any new goals. Be sure to indicate how the goal and objective/intervention can be measured. If there is no progress, note this and indicate how the treatment has changed.
- Describe the child's level of cooperation in treatment. If the child is not cooperative with treatment, describe whether the child is amenable to treatment at this time and at this level of care.
- Describe the need for continued care. Be child-specific. Describe the continuing problems or any new problems that have arisen.
- Be sure the discharge plan is specific, or if this is not possible at this time, explain why not.

## MEDICAL DOCUMENTATION

All documentation must be signed and dated at the same time. Dates must not be typed onto medical records in advance of the signature. A dictated treatment plan is not considered complete until the plan is signed and dated by the required professional and is available in the medical record. All therapy notes must be completed the day of service delivery and are required to be signed and dated by a qualified professional. If qualified staff does not provide the required therapy, the per diem for the residential stay is subject to retraction. Keep in mind the facility is responsible for ensuring the required number of planned therapeutic interventions are provided and well documented. The non-billable therapeutic interventions must also be documented. The type, duration and child's response should be documented the day of the intervention. The providers' dated signature is required.

**Please note that if a request is pended, WVMI will only be able to approve the request from the date that all required information is received by WVMI.** The WVMI pend notice that indicates the deadline for submitting the missing information does not mean the provider has additional time to submit the information. Approval will not be retroactive. Authorization requests are required to be complete and timely to prevent denial of services.

## CONTACT INFORMATION

If you have questions concerning any of the information in this correspondence, please contact Shelley Jones, DMAS Contract Monitor at (804) 786-1591.

If you have questions about a preauthorization request for residential treatment services, please continue to contact WVMI at 800-299-9864 or in the Richmond area at 804-648-3159.

## ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

## COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH provider manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

## "HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

| | |
|---|---|
| 786-6273 | Richmond area |
| 1-800-552-8627 | All other areas |

Please remember that the "HELPLINE" is for provider use only.

Attachments (6)

WVMI

Residential Treatment Services Facsimile Form

*Facsimile Local #: (804) 343-9782* *Local #: (804) 648-3159*

*Facsimile Toll Free #: (800) 439-9295* *Toll Free #: (800) 299-9864*

# Initial Review

All initial reviews are required to have this form fully completed before review can proceed. Areas with missing, insufficient or illegible information will result in a delay of the review and may delay payment for services. A request for information ('pending notification') may be returned for the purpose of clarification or the need for additional information. An entire facsimile review request form must be resubmitted with completion of the missing items and all required attachments.

***WVMI use only*** CPT Code: ___________

☐ Reject: _________ to _________ ☐ Pended on ________; due ________

☐ Denial: _________ to _________ ☐ Approval: _________ to _________

Auth number ___________________ WVMI Reviewer _______________ Date _________

Locality FIPS Code ______

Recipient last name: ________________ first: ________________ middle: ____________

Sex: M ☐ F ☐ Date of Birth ______________ Medicaid # ______________________

Facility Name ________________________________ Provider ID # _________________

Facility Address ____________________________________________________________

Contact Person ________________ Contact Phone # ____________ Fax # ___________

**Attach Initial Plan of Care**

**Attach Certificate of Need**

**Attach CAFAS (CAFAS is required only for CSA requests)**

**1) The recipient is:** ☐ **CSA** ☐ **Non-CSA (Fill out Question 5)**

**2) Start date requested: ________________ (Admission Date: ________________)**

**3) Y** ☐ N ☐ Are you requesting retroactive authorization due to Medicaid eligibility?

**4) Y** ☐ **N** ☐ List alternate placement tried or explored within last year

| | ***Name of Alternate Placement*** | ***Dates*** | ***Successful?*** |
|---|---|---|---|
| 1 | | | Y ☐ N☐ |
| 2 | | | Y ☐ N☐ |
| 3 | | | Y ☐ N☐ |

Recipient Name ________________
Submission Date ____________

**If placement not successful explain:**

1.______________________________________________________________________
______________________________________________________________________2
.______________________________________________________________________
______________________________________________________________________
3.______________________________________________________________________
______________________________________________________________________

## Fill Out Questions below, only if child is Non-CSA

**5)** Reasons for Admission - Check all that apply and include child-specific reasons:

☐Recipient is currently receiving community based care with evidence of failure at less restrictive level of care. (Describe services currently receiving and why residential level of care, is required. Is there a medical condition exacerbating the psychiatric problems?)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________

☐Recipient's identified condition is escalating. (Provide specifics and describe why a physician must direct treatment. Also explain how services can reasonably be expected to improve the recipient’s condition so that services will no longer be needed)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
________________________________________________

☐Recipient's condition is a reoccurrence of a previous acute psychiatric condition. (When was the most recent acute episode and describe condition treated)
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
__________________________________________________________________

WVMI

Residential Treatment Services Facsimile Form

*Facsimile Local #: (804) 343-9782* *Local #: (804) 648-3159*
*Facsimile Toll Free #: (800) 439-9295* *Toll Free #: (800) 299-9864*

## Continued Stay Review

All continued stay reviews are required to have this form fully completed before review can proceed. Areas with missing, insufficient or illegible information will result in a delay of the review and may delay payment for services. A request for information ('pending notification') may be returned for the purpose of clarification or the need for additional information. An entire facsimile review request form must be resubmitted with completion of the missing items and all required attachments.

***WVMI use only*** CPT Code: ____________
☐ Reject: __________ to __________ ☐ Pended on ________; due ________
☐ Denial: __________ to __________ ☐ Approval: __________ to __________
Auth number ____________________ WVMI Reviewer _______________ Date _________
Locality FIPS Code __________

Recipient last name: ____________________ first: __________________ middle: _______
Sex M ☐ F ☐ Date of Birth ___________ Medicaid # _______________________
Facility Name ________________________________ Provider ID # ________________
Facility Address ____________________________________________________________
Contact Name ______________ Contact Phone # _____________ Fax # ___________

☐ **For First Continued Stay Review Attach:**
Comprehensive Individual Plan of Care
Current CAFAS (for CSA requests)
Most recent CIPOC 30-day Progress Update (must be within last 30 days).

☐ **For Subsequent Continued Stay Review Attach:**
Most recent CIPOC 30-day Progress Update (must be within last 30 days)
For CSA request, also attach current CAFAS.

**1) The recipient is:** ☐ **CSA** ☐ **Non-CSA**

**2) Start date requested:** ________________
**Y** ☐ **N** ☐ Are you requesting retroactive authorization due to Medicaid eligibility?

**3)** Recertification of residential stay required at least every 60 days.
Date of current recertification: ___________________

Recipient Name ________________
Submission Date ___________

**4) Y** ☐ **N** ☐ Recipient used a day or overnight pass? If yes, document date and whether successful or not. (Since last review)

| Date of Pass | Type of Pass Day/Overnight | Pass with whom | Was pass successful (if no explain below) |
|---|---|---|---|
| | | | 1. Y ☐ N ☐ |
| | | | 2. Y ☐ N ☐ |
| | | | 3. Y ☐ N ☐ |
| | | | 4. Y ☐ N ☐ |
| | | | 5. Y ☐ N ☐ |
| | | | 6. Y ☐ N ☐ |
| | | | 7. Y ☐ N ☐ |

If pass(es) unsuccessful provide comments below.

1. ______________________________________________
______________________________________________
2. ______________________________________________
______________________________________________
3. ______________________________________________
______________________________________________
4. ______________________________________________
______________________________________________
5. ______________________________________________
______________________________________________
6. ______________________________________________
______________________________________________
7. ______________________________________________
______________________________________________

***SAMPLE***

**INITIAL PLAN OF CARE**

**Name:**

**Medicaid Number:**

**Admission Date:**

**DSM-IV**

**Axis I**
**Axis II**
**Axis III**
**Axis IV**
**Axis V**

**Describe Symptoms, Complaints, and Complications Indicating the Need for Admission to Residential Level of Care** (Include problem behaviors 7 days prior to admission)**:**

**Functional Level** (Medical issues, ability to do activities of daily living)**:**

**3 Long-Term Goals with Measurable Treatment Objectives/Interventions:**

1.

2.

3.

**3 Short-Term Goals with Measurable Treatment Objectives/Interventions:**

1.

2.

3.

**Orders for Medications (**note name, dosage and frequency**):**

**Orders for Therapies** (type, frequency, duration)

**Individual Therapy:**

**Family Therapy:**

**Other Therapies** (describe):

**Other Orders:**

**Plans for Continuing Care and for Review of the Plan of Care:**

**Discharge Plan (**including estimated date of discharge**):**

**Physician's Dated Signature** (Name, title, handwritten date)

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***SAMPLE***

## COMPREHENSIVE INDIVIDUAL PLAN OF CARE

**Resident Name:**

**Medicaid Number:**

**Admission Date:**

**DSM-IV:**

**Axis I**
**Axis II**
**Axis III**
**Axis IV**
**Axis V**

**Describe the Need for Residential Level of Care** (symptoms and behaviors)**:**

**3 measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions:**

**1.** ______________________________________________

**MEASUREABLE GOAL**

______________________________________________

**TREATMENT OBJECTIVE/INTERVENTION**

______________________

**TARGET DATE FOR ACHIEVEMENT**

**2.** ______________________________________________

**MEASUREABLE GOAL**

______________________________________________

**TREATMENT OBJECTIVE/INTERVENTION**

______________________

**TARGET DATE FOR ACHIEVEMENT**

**3.** ______________________________________________

**MEASUREABLE GOAL**

______________________________________________

**TREATMENT OBJECTIVE/INTERVENTION**

______________________

**TARGET DATE FOR ACHIEVEMENT**

**3 measurable short-term goals with target dates for achievement and each with measurable treatment objectives/interventions (**should relate to long-term goals**):**

**1.** ______________________________________________________________________
MEASUREABLE GOAL

______________________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

____________________________________
TARGET DATE FOR ACHIEVEMENT

**2.** ______________________________________________________________________
MEASUREABLE GOAL

______________________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

____________________________________
TARGET DATE FOR ACHIEVEMENT

**3.** ______________________________________________________________________
MEASUREABLE GOAL

______________________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

____________________________________
TARGET DATE FOR ACHIEVEMENT

**Orders for Medications** (note name, dosage and frequency)**:**

**Orders for Therapies** (note type, frequency, duration)**:**

**Individual Therapy:**

**Family Therapy:**

**List the 21 planned therapeutic interventions:**

**Other Therapies** (i.e. Group Psychotherapy, Occupational, Physical Therapy)**:**

**Other Orders:**

**Summary of Progress and Justification for Continued Stay** (if there is no progress, describe how treatment is being adjusted to address the lack of progress)**:**

**Discharge Plan (**including estimated date of discharge**):**

**Physician's Dated Signature**

SIGNATURE TITLE DATE

**Team Members' Dated Signatures**

SIGNATURE TITLE DATE

SIGNATURE TITLE DATE

SIGNATURE TITLE DATE

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***SAMPLE***

**COMPREHENSIVE INDIVIDUAL PLAN OF CARE**
**30-DAY PROGRESS UPDATE**

**Resident Name:**

**Medicaid Number:**

**DSM-IV-Note any changes from the CIPOC:**
**Axis I**
**Axis II**
**Axis III**
**Axis IV**
**Axis V**

**Describe the Continued Need for Residential Level of Care** (symptoms and behaviors that cannot be met at a lower level of care)**:**

**Describe recipient's involvement/cooperation in treatment:**

LONG-TERM GOALS UPDATE:
**3 measurable long-term goals with target dates for achievement and each with measurable treatment objectives/interventions** (note if previous goals have been met, and if new goals have been established for unresolved or new problems):

**1.** ____________________
MEASUREABLE GOAL

____________________
TREATMENT OBJECTIVE/INTERVENTION

____________________
TARGET DATE FOR ACHIEVEMENT

**2.** ____________________
MEASUREABLE GOAL

____________________
TREATMENT OBJECTIVE/INTERVENTION

____________________
TARGET DATE FOR ACHIEVEMENT

**3.** ____________________
MEASUREABLE GOAL

____________________
TREATMENT OBJECTIVE/INTERVENTION

____________________
TARGET DATE FOR ACHIEVEMENT

**SHORT-TERM GOALS UPDATE:**
**3 measurable short-term goals with target dates for achievement and each with measurable treatment objectives/interventions** (note if previous goals have been met, and if new goals have been established):

**1.** ______________________________________________________________
MEASUREABLE GOAL

______________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

______________________________
TARGET DATE FOR ACHIEVEMENT

**2.** ______________________________________________________________
MEASUREABLE GOAL

______________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

______________________________
TARGET DATE FOR ACHIEVEMENT

**3.** ______________________________________________________________
MEASUREABLE GOAL

______________________________________________________________
TREATMENT OBJECTIVE/INTERVENTION

______________________________
TARGET DATE FOR ACHIEVEMENT

**Note Changes to Orders for Medications** (note name, dosage and frequency)**:**

**Note Changes to Orders for Therapies** (note type, frequency, duration)**:**

**Individual Therapy** (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not)**:**

**Family Therapy** (List therapy dates documented for past 30 days. If therapy is not occurring as ordered, explain why not)**:**

**List any changes to the 21 therapeutic interventions:**

**Note any changes to Other Therapies** (i.e. Group Psychotherapy, Occupational, Physical Therapy)**:**

**Note Any Additional Orders:**

**Summary of Progress and Justification for Continued Stay** (if there is no progress, describe how treatment is being adjusted to address the lack of progress. If new problems have arisen, describe them and how the treatment plan will address them)**:**

**Note Changes to Discharge Plan (**including estimated date of discharge**):**

**Physician's Dated Signature**

| SIGNATURE | TITLE | DATE |
|---|---|---|

**Team Members' Dated Signatures**

| SIGNATURE | TITLE | DATE |
|---|---|---|
| SIGNATURE | TITLE | DATE |
| SIGNATURE | TITLE | DATE |

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***Sample form***

**CERTIFICATION OF NEED FOR ADMISSION**
**TO**
**RESIDENTIAL PSYCHIATRIC TREATMENT**

***Under each of the three sections below, a child-specific explanation must be provided.***

1. Ambulatory/outpatient care does not meet the specific treatment needs of the recipient:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

For children who are Medicaid recipients, this form must be completed and signed by the local CSA interdisciplinary team or FAPT and signed by a physician member of the team. The physician cannot be the treating physician at the facility to which the child will be admitted. If the child is in acute care, the acute care physician may complete the CON.

Team Signatures: ______________________Date_____ ______________________Date__________

______________________Date_____ ______________________Date__________

______________________Date______ ______________________Date_________

Physician Signature: ___________________________________ Date: __________________________

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