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

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Treatment Foster Care-Case Management Service providers participating in the Virginia Medical Assistance Program, Managed Care Organizations providing services to Virginia Medicaid recipients, and holders of the *Psychiatric Services* Provider Manual

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

MEMO Special

DATE 11/5/2004

SUBJECT: Changes to the Review Process for Treatment Foster Care-Case Management Services – Effective December 15, 2004

The purpose of this memo is to inform you of changes to the Medicaid-funded Treatment Foster Care-Case Management (TFC-CM) Services review process. The changes being made are in response to provider and locality representative requests for a less cumbersome authorization process. Although this memo 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 use of the revised WVMI (West Virginia Medical Institute) review forms, deletion of the Care In Progress form, and provision of sample forms will reduce the need to pend requests for additional information, resulting in timelier decisions rendered.

As you are aware, a pre-authorization request for Medicaid-reimbursed TFC-CM services is to be submitted to WVMI on an Initial Review form within 10 days of the admission. Subsequent reviews are due no later than the last day of the current authorization. DMAS staff has worked with providers to develop a process that is more user-friendly and is expected to reduce the number of pended pre-authorization requests. The following three changes will go into effect on December 15, 2004, to help streamline the pre-authorization process. In addition, this memo outlines 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. 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. These revised forms must be submitted to WVMI for pre-authorization purposes. The length of approval is based on the medical necessity documentation.

Requests could be approved for as much as six months. 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. The Care In Progress form will no longer be required. An initial review is required for a child in placement for up to 45 days. If the child has been in placement for more than 45 days, the Continued Stay form is required. Retroactive authorization is only available in the case of retroactive recipient Medicaid eligibility, and the additional information noted in item 2 of the review form will also be required.

3. In order to provide you with an outline for proper documentation, DMAS has 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 FAPT (Family Assessment and Planning Team) Assessment and a 30-day Narrative & Progress Update. Also noted below is a brief overview of the required 90-day Progress Report.

The revised WVMI forms and sample 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.

FAPT ASSESSMENT

The following is a brief overview of the minimum information required in the FAPT Assessment form. The provided information should reflect the locality's assessment and plan for the child. Any format is acceptable, as long as it includes the following information:

- Immediate and long-range therapeutic needs;
- Developmental priorities;
- Personal strengths and liabilities;
- Potential for reunification;
- Treatment objectives and modalities; and
- Dated signatures of at least three FAPT members.

30-DAY NARRATIVE & PROGRESS UPDATE

As you are aware, a 90-day Progress Report, current within 30 days, must be submitted to WVMI for pre-authorization purposes. If the 90-day Progress Report does not cover any of the 30 days prior to the authorization request date, then a 30-day Narrative & Progress Update will be required. The following is a brief overview of some of the required elements for the 30-day Narrative & Progress Update:

- The 30-day Narrative & Progress Update must be current, within 30 days of submission of an authorization request. This form is not necessary if the 90-day Progress Report is current, within 30 days of submission of the authorization request.

- Note any changes to the diagnosis, treatment goals, medications, treatment interventions, and discharge plans since the last 90-day Progress Report.
- If the current problem behaviors are not documented on the Child and Adolescent Functional Assessment Scale (CAFAS), it needs to be updated.

90-DAY PROGRESS REPORT

The following is a brief overview of some of the required information for the 90-day Progress Report. The following items have been identified as areas that are often insufficiently documented and lead to pends and denials:

- Note the treatment goals and objectives met, goals and objectives to be continued or added, the criteria for achievement, and target dates for each. Be sure to address the therapeutic goals, rather than just age-appropriate activities of daily living. Address the reasons for this level of care.
- Note descriptions of therapies, activities, and services provided during the previous 90 days that facilitated progress toward treatment goals and objectives.
- Describe the need for continued care. Be child-specific. Describe the continuing problems or any new problems that have arisen. This description should reflect the CAFAS scores. If not, the CAFAS may need to be re-scored to reflect current problem behaviors.
- Be sure the discharge plan is specific or, if this is not possible at this time, explain why not. The discharge plan should relate to the child no longer requiring this intensive level of daily case management, but not necessarily to discharge from the treatment foster care home.
- Address any discrepancies between the CAFAS scores and the reasons for the continued need for this level of care. The CAFAS scores should be updated if they do not reflect current behavior. The CAFAS scores must include individual scores for all scales, including Caregiver scales. There must be a minimum of one moderate impairment in a role performance area other than school.

MEDICAL DOCUMENTATION

All documentation must be signed and dated at the same time. Dates should 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.

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 must be complete and timely to prevent denial of services.

CONTACT INFORMATION

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

If you have questions about review requests, please call or fax WVMI using the following numbers:

Phone:	
804-648-3159	Richmond area
800-299-9864	All other areas (toll-free)

Fax:	
804-343-9782	Richmond area
800-439-9295	All other areas (toll-free)

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 on state holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (toll-free, in-state long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

Attachments: (4)

Example form for DMAS purposes only. This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.

FAPT ASSESSMENT

At a minimum, the assessment must include the following:

Immediate and Long-Range Therapeutic Needs:

Developmental Priorities:

Personal Strengths:

Personal Liabilities:

Potential for Family Reunification:

Treatment Objectives:

Therapeutic Modalities:

At a minimum, 3 signatures are required

FAPT TEAM MEMBER	DATE
FAPT TEAM MEMBER	DATE
FAPT TEAM MEMBER	DATE

Example form for DMAS purposes only. This example was developed to indicate the minimum information required and is not expected to meet licensing or other third-party payer requirements.

TREATMENT FOSTER CARE-CASE MANAGEMENT
30-DAY NARRATIVE AND PROGRESS UPDATE

This information must be submitted to WVMI only when the 90-Day Progress Report is not current to within 30 days of the pre-authorization request submission. Note only the information that is relevant to the timeframe not covered by the last quarterly report.

Recipient's Name:

Medicaid Number:

Dates Addressed:

DSM-IV-*Note only changes, with date and source of change* *(such as psychological exam, psychiatric reassessment, or testing results - please note the date)*

Axis I
Axis II
Axis III
Axis IV
Axis V

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

Note any changes to the Treatment Goals, Objectives/Interventions, and Target Dates for Achievement that support the need for continued care at this level. *Note progress since last quarterly report, or lack of progress that support the continued need for this level of care:*

Note Changes to Medications (note name, dosage, frequency, and date of change)**:**

Provide a description of therapies, activities, and services provided toward the treatment goals and objectives:

Note case manager's contacts with the child and the child's family:

Other Significant Events:

Note any changes to the discharge plan (this should address how the recipient will step-down to a less intensive level of treatment and include an estimated date of discharge**):**

Case Manager's Dated Signature

SIGNATURE TITLE DATE

DMAS 9
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WVMI

Treatment Foster Care 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 # ____________________
Provider Name ____________________________ Provider ID # _________________
Provider Address ____
Contact Person _______________ Contact Phone # ___________ Fax #__________

1) Start date requested: _______________ (Admission Date: _______________)
Y ☐ **N** ☐ Are you requesting retroactive authorization due to Medicaid eligibility?

2) DSM-IV:
AXIS I __________ __________ __________ 5 digit codes (list up to three)
AXIS II __________ 5 digit code
AXIS III __________
AXIS IV ________________________________ (please list applicable categories)
____
____
AXIS V (GAF) current: ________ highest level in past year: _______

3) Y ☐ N ☐ CAFAS/PECFAS completed? Date: __________________
(Attach the Youth Functioning and Caregiver Resources Profile sheets)

Recipient Name _______________
Submission Date _______________

4) Y ☐ **N** ☐ Approval of admission by CPMT? **(Please attach form)**
OR
Y ☐ **N** ☐ FAPT confirmation of medical necessity? **(Please attach form)**

5) Y ☐ **N** ☐ FAPT assessment completed? **(Please attach form)**

6) List services to be provided in first 45 days of placement:

____
____

7) Describe symptoms and behaviors immediately prior to admission:

____
____
____

8) Y ☐ **N** ☐ Alternative treatment placements tried or explored within the last year? If yes, list below:

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

9) If placement not successful, explain:
1) ______________________________________
2) ______________________________________
3) ______________________________________
4) ______________________________________

10) Current Medication:

Name of Medication	***Dosage***	***Frequency***

11) If no medication prescribed, explain:

____
____

12) Y ☐ **N** ☐ Recipient participating in outpatient psychotherapy? If no, explain:

____
____

Recipient Name ________________
Submission Date _______________

13) Reasons for admission - Check all that apply and provide specific description of the related need and/or behavior (*This should correlate to the CAFAS/PECFAS scores)*:

- [ ] Need for intensive supervision to prevent harmful consequences.
  ____
  ____
  ____
- [ ] Moderate/frequent disruptive or non-compliant behaviors in home setting which increase the risk to self or others.
  ____
  ____
  ____
- [ ] Unable to handle the emotional demands of family living.
  ____
  ____
  ____
- [ ] Needs assistance of trained professionals as caregivers.
  ____
  ____
  ____
- [ ] Has severe, disruptive peer and authority interaction that increase risk and impede growth.
  ____
  ____
  ____
- [ ] Significant impairment with severe risk factors. Must demonstrate risk behaviors that create significant risk of harm to self or others.
  ____
  ____

14) Projected discharge date: ______________

15) Discharge plan: If child will move, where to? How will child step-down to a less intensive level of treatment?

____
____
____
____
____
____
____

WVMI

Treatment Foster Care 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 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 <u>entire</u> 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 # __________________
Provider Name ___________________________ Provider ID # ______________
Provider Address ____
Contact Person ________________ Contact Phone # ___________ Fax #__________

<u>Please Attach Most Recent:</u>

- Comprehensive Treatment and Services Plan
- CAFAS/PECFAS 90-day Update
- Most recent 90-day Progress Report (and if this does not cover dates within the past 30 days, attach the 30-day Narrative & Progress Update)
- *If this is a new request for a child that has been in placement for more than 45 days and is not due to retroactive recipient Medicaid eligibility, also attach the Approval of admission by CPMT, or FAPT confirmation of medical necessity, and the FAPT assessment.*

1) Start date requested: _______________ (Admission Date:_______________)

2) Y ☐ **N** ☐ Are you requesting retroactive authorization due to recipient's Medicaid eligibility? **If Yes, attach the following**:

- Approval of admission by CPMT, or
- FAPT confirmation of medical necessity, and
- FAPT assessment

- Comprehensive Treatment and Service Plan and Progress Updates related to the requested dates of retroactive authorization, as well as current information

3) **Y** ☐ **N** ☐ Progress Report updated 90 days after placement and every 90 days thereafter?
4) **Y** ☐ **N** ☐ Case Manager narratives kept current within 30 days?
5) **Y** ☐ **N** ☐ Recipient participating in outpatient psychotherapy? If no, please explain:

____
____
____
____

6) Reasons for continued stay - Check all that apply and provide specific description of the related need and/or behavior: (This should relate to the CAFAS moderate to severe impairment scores)

☐ Need for intensive supervision to prevent harmful consequences.
____
____
____

☐ Moderate/frequent disruptive or non-compliant behaviors in home setting which increase the risk to self or others.
____
____
____

☐ Unable to handle the emotional demands of family living
____
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____

☐ Needs assistance of trained professionals as caregivers.
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☐ Has severe, disruptive peer and authority interaction that increase risk and impede growth.
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☐ Significant impairment with severe risk factors. Must demonstrate risk behaviors that create significant risk of harm to self or others.
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