Medical Necessity Criteria for Behavioral Health Inpatient Facility (BHIF) for Children & Youth.

BHIF services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when ambulatory care services in the community or services in a less restrictive therapeutic level of care do not meet their treatment needs and they require services under the direction of a Behavioral Health Medical Professional (BHMP). These services are designed for children and adolescents who have a DSM 5/ICD-10 psychiatric diagnosis, significant deficits in functioning, and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24-hour nursing services, comprehensive programming and treatment. Active treatment focuses on specific targeted goals identified by the Child and Family Team (CFT) and are designed to enable the child/adolescent to be discharged at the earliest possible time. A lack of available outpatient services or services in a less restrictive therapeutic level of care is not, in and of itself, the sole criterion for admission to a BHIF.

Admissions to a **Non-Emergent** BHIF level of care. All admissions must meet medical necessity criteria.

There are two types of BHIFs:

1. **Secure** - A BHIF which may employ security guards and/or uses monitoring equipment and alarms
2. **Non-secure** – A BHIF that is unlocked, and continuous supervision is provided by professional behavioral health staff.

Prior Authorization for BHIF Level of Care for Non-Emergent Admissions

Prior authorization must occur prior to admission to a BHIF for non-emergent admissions. The Health Plan determines medical necessity for standard decisions within 14 calendar days upon receipt of the request. If appropriate, the Health Plan may issue an extension of an additional 14 calendar days to request additional information. The Health Plan requires active involvement of the CFT to facilitate discussion of admission for all levels of care. Expedited authorization may be requested when the provider determines that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function. The Health Plan will look to the CFT to facilitate discussion of admission in consideration of the member when the member is in an inpatient hospital setting- expedited authorization may be granted. If approved, the Health Plan will issue an authorization for up to 45 days. Upon admission during the 45-day period, another authorization is activated to secure the date range. Providers are required to submit additional clinical documentation if the member does not admit within 45 days of approval.

Request for Prior Authorization for Admission to a BHIF must include the following, submitted via fax to (520) 694-0599:

- The Behavioral Health Prior Authorization Form,
- An updated Individual Service Plan indicating the goal for the admission to the BHIF,
- A recent psychiatric evaluation or psychiatric progress note that reflects current behaviors and functioning and diagnoses, and
- Certificate of Need (CON) (from the facility upon admission/ no later than 72 hours after admission)
- Out of Home Application,
- The most recent assessment or an assessment that has been updated in the past year,
- The Child Family Team (CFT) note indicating the team's recommendations,
- Any other reports from outpatient providers or other treatment providers, and
- Any psychological reports or other reports from specialty providers.

Criteria for BHIF Admissions

- **Diagnosis:** There is clinical evidence and documentation that the child/adolescent has a primary psychiatric ICD-10/DSM 5 diagnosis that is amenable to active treatment. Any co-occurring diagnosis or diagnoses must be identified and documented prior to admission.
- **Behavior and functioning;** Criteria a, b, c, and d below must all be met as follows:
    a. Symptoms or functional impairment of the individual's psychiatric condition are of a severe and persistent nature and
    b. Result in the member being a Danger to Self (DTS), Danger to Others (DTO) or unable to engage in daily activities safely in a less restrictive setting and
    c. Ambulatory care resources (outpatient behavioral health services in the community) or services in a less restrictive therapeutic level of care do not meet the treatment needs of the child/adolescent as demonstrated by unsuccessful treatment within the last month while the member received services in intensive community based treatment or TFC services or Behavioral Health Residential Facility, or a psychiatric hospital or the professional judgement that the youth's clinical needs cannot safely and comprehensively be met in a lower level of care and,
    d. The support system is unable to manage the intensity of child/adolescent symptoms to ensure safety and, the child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at the BHIF and the child/adolescent's Service Plan must be aligned with the facility care plan. Additionally, the provider must ensure comprehensive and ongoing assessment and treatment is planned for prior authorization and being provided for concurrent review authorization.

BHIF Exclusion Criteria

The admission cannot be used as an intervention for any of the following:

- An alternative to incarceration, preventative detention, or to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior including runaway behavior; or
- The equivalent of safe housing, permanency placement, or
- An alternative to parents'/guardian's or another agency's capacity to provide for the child or adolescent; or
- An intervention when other less restrictive alternatives are available and not being utilized.

Concurrent Review for BHIF

If the member requires a continued stay past the initial authorized days, provide clinical documentation to the UM Reviewer during the scheduled telephonic review.

Documents that must be submitted to support medical necessity for concurrent review:

a. Psychiatric notes,
b. concurrent Review Form,
c. CFT notes,
d. Medication List,
e. Discharge plan, and
f. After 30 days submit a Recertification of Need (RON).

For concurrent review authorization, if the youth is not demonstrating improvement, the facility care plan must be revised as part of the CFT process resulting in an expectation of improvement to achieve discharge from the BHIF at the earliest possible time and facilitate return to outpatient care or less restrictive therapeutic level of care. The child/adolescent

must be actively participating in treatment.

B – UHP bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. Frequency of the reviews are based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to MCG criteria. Authorization for BHIF will have a specified date and time by which requested clinical information/ documents will be required for review. This information will be provided to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Please note section on issuance of Administrative Denials when clinical information is not submitted timely or fully.

To justify remaining in a BHIF level of care, progress must be evident to show that the condition or its symptoms are treatment responsive, the member must ***continue*** to manifest symptoms justifying the principal DSM-5 diagnosis/ICD 10 code, and one or more of the following:

1. The intensity of service being delivered should be appropriate to the risk level that justified the admission
2. Persistence of symptoms such that continued observation or treatment is required
3. Increased risk of complications as a result of intervention or as a product of newly discovered conditions
4. Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a readmission to a more restrictive level of care.

Concurrent review documentation should include a description of the active treatment and interventions that are being provided (and documented in the clinical record) that is assisting the member in achieving identified service plan goals for a successful discharge. Active treatment services should include the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hour skilled medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis
5. Active and individualized ongoing positive behavioral management
6. School or vocational programming

Re-certification Of Need (RON)

A RON is a re-certification made by a physician, a nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that continued inpatient services in a BHIF are needed. A RON must be completed at least **every 30 days for a member under the age of 18 who is receiving services in a Behavioral Health Inpatient Facility**. The completion and review of the Service Plan in this circumstance meets the requirement for the re-certification of need. For a sample RON form go to Recertificate of Need.

The following documentation is needed on a RON:

- Fax RONS to 520-874-3411
- Proper treatment of the member's behavioral health condition requires services on an inpatient basis under the direction of a physician
- The service can reasonably be expected to improve the member's condition or prevent further regression so that the service will no longer be needed

- Outpatient resources available in the community do not meet the treatment needs of the member
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Administrative Denials During BHIF Hospitalization

An Administrative Denial is based on the following:

- Failure of the facility to submit ALL of the required documentation/clinical information to conduct comprehensive utilization review activities to determine medical necessity for admission and/or concurrent review/continued stay, and/or
- Failure to provide the services required, and /or
- Failure to provide telephonic review during the scheduled time

Administrative Denials are based on the lack of information timely submitted and/or deficiency in provision of services required and not based on medical necessity criteria. As a result, they do not require physician review or involvement in the denial decision. These denials will result in the termination of the authorization where there is a deficiency in documentation/information or services for the entire or remaining length of stay or denial of specified days where required documentation/information or services, for example a BHMP note is not provided during specified days.

Administrative denials will be issued for concurrent review/continued stay of BHIFs when there is lack of documentation/information to demonstrate required services have been provided consistent with the required interventions including the following:

1. Psychiatric services at a minimum of every other week, or more as indicated, to provide active psychiatric treatment including a focus on psychosocial interventions and pharmacotherapy to meet individualized needs
2. Clinical assessment at a minimum on a daily basis that includes close, continuous, 24 hours killed medical/nursing supervision
3. Individual and family therapy each a minimum of once a week or more to meet individualized needs. If family therapy is not being provided rationale must be documented in the clinical record
4. Group therapy and/or an individualized or family therapy service on a daily basis
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After an Administrative Denial has been issued, the facility can submit the claim/request as a Retrospective Review through the Claims Department. The request for reimbursement through a Retrospective Review must include an explanation as to why the facility was unable to submit timely and comprehensive clinical documentation required to determine medical necessity at the time of admission, concurrent review or the UM reviewer's request.

BHIF Discharge Criteria

The member is ready for discharge when any of the following criteria have been satisfied:

- The planned course of treatment has been completed.
- The member's symptom intensity or impairment in functioning no longer requires the level of observation or intensity of service at the requested level of care. Including, when a member presented with a danger to self or others, there is absence of thoughts of suicide, homicide or serious harm to another, or the thoughts of suicide/homicide, or serious harm to self or to another are present but are manageable/treatable at available lower level of care.
- Further professional intervention is not expected to result in significant improvement in the patient's condition
- The member leaves against medical advice (AMA)

BHIF Discharge Planning

The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post-discharge services, reduce unnecessary institutional and hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. Discharge planning is expected to begin on the date of admission. If the member is not enrolled with an outpatient behavioral health provider, the inpatient team must initiate a request to enroll the member with an outpatient agency chosen by the member or by zip code. Facilities should coordinate with the health plan UM reviewer when an urgent enrollment is needed for the member to ensure discharge and follow up care can be established. Timely identification and documentation of the member's outpatient behavioral health provider must also include active engagement of such providers in the discharge process. B – UHP Behavioral Health Department can provide assistance with facilitating urgent enrollment and the referral process by contacting: BUHPCareMGMTBHMailBox@bannerhealth.com.

Contracted behavioral health providers must develop and implement a discharge planning process to address the post-discharge clinical and social needs of members upon discharge. Discharge planning must be performed by a qualified health care professional and is initiated on the initial concurrent review, updated periodically during the inpatient stay and continued post discharge to ensure a timely, effective, safe and appropriate discharge. The following must be included as part of this process:

- The qualified health professional participating in the discharge planning process shall ensure the member/Health Care Decision Maker/ designated representative is a) involved and participates in the discharge planning process, b) understands the written discharge plan, instructions and recommendations provided by the facility and c) is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge.
- Coordination and management of the care shall include the following but are not limited to:
    - Follow up appointment with the BHMP/Specialist within 7 business days
    - Coordination and communication with the Health Plan to ensure a safe and clinically appropriate discharge placement, and community support services
    - Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team and other natural supports as applicable.
    - Access to prescription medications
    - Nursing Services or Medical equipment as applicable,
    - Referral to appropriate community resources
    - Referral to the Health Plan Care Management Programs as applicable
    - Coordination with the Health Plan even when the Health Plan is not the primary payer.
    - Coordination of care with the Health Plan including submission of Prior Authorizations for transfers before a is discharged to another Level I inpatient psychiatric facility or to an alternative level of care (including a BHRF).

Requirements for BHIF Discharge Plan/Summary

All facilities are required to submit the Discharge Plan/Summary to the Health Plan and the outpatient behavioral health provider within 24 hours of discharge. Discharge Plan/Summary must be submitted to: BUHPUMPAMailbox@bannerhealth.com.

At a minimum the Discharge Plan/Summary must contain the following information:

- Date of discharge
- Discharge diagnosis
- Discharge instructions, including follow up services and discharge appointments (required to have an appointment with prescriber or BHMP within 7 days)
- Discharge medications including the following: dosage, instructions, and number of days of medications provided if applicable (for hospitals and BHIFs)
- The Discharge Plan/Summary must include the follow up appointment with a BHMP even if the member is discharging to a BHRF.

Delays in submitting the Discharge Summary to the Health Plan may result in a delay of claims payment. B – UHP must have accurate documentation to confirm the date of discharge and the discharge information.

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BHIF Avoidable Days

At times, potentially avoidable delays may occur in discharging members from an acute level of behavioral health care to a less restrictive treatment setting. Such delays typically occur because the less restrictive, community-based treatment and supports that are necessary for a safe and successful discharge are not yet fully arranged or available. Potentially avoidable inpatient days are periods of continued hospitalization on a BHIF level of care are authorized by the health plan when medical necessity no longer is demonstrated, but services at a lower level of care are not yet available, despite active, comprehensive, and timely discharge planning efforts by the facility or provider. Potentially avoidable inpatient days will be authorized only when discharge planning activities are documented appropriately by the facility or provider from the time of the member's initial admission, and when evidence of continued, comprehensive discharge planning efforts is submitted daily to the health plan for review, until discharge of the member occurs.

Potentially avoidable inpatient days must be preceded by at least one acute inpatient day (24 hours in duration) that meets medical necessity criteria. Authorization will not be provided for direct admission from an outpatient or residential treatment setting to a more acute level of care for which medical necessity has not been demonstrated, or for which prior authorization has not been obtained. Potentially avoidable inpatient days also will not be authorized solely for convenience, or when appropriate services in an alternative setting are available, but refused or declined by the member, the member's family, or the inpatient treatment team.

When potentially avoidable inpatient days are authorized, the facility or provider must continue to assure that appropriate BH treatment and services are provided to the member until the time of discharge to a lower level of care. Types of potentially avoidable inpatient days include: (1) lack of an available residential treatment bed in a BHRF, or TFC/ ABHTH level of care; (2) lack of available specialty services (such as those that are medically necessary for members with an autism spectrum diagnosis, sexually maladaptive behaviors, cognitive limitations, a significant history of aggression toward others, accompanying medical disorders, or other similar conditions), and (3) lack of access to other community based treatment and supports that are necessary to sustain adequate functioning in the community.

BHIF Required Reporting of Avoidable Days

To justify avoidable/administrative bed days the following must be provided during the UM Reviewer during concurrent review, failure to provide this information may result in an Administrative or Medical Necessity Denial:

- Clinical documentation must support that alternative discharge arrangements available are not adequate to safely meet the needs of the member
- If a required service is not currently available, the discharge plan must clearly state this and identify the steps to be able to access needed services. Entries such as "deferred until patient stabilizes," "to be determined," or "placement pending," are not acceptable.
- Evidence of active attempts to effectuate discharge to a specified placement/level of care or community-based service must be provided and resubmitted/updated and reviewed by staff every 24 hours. If there are insufficient discharge planning activities a denial should be issued.

B – UHP Behavioral Health UM staff will expedite services requiring prior authorization to ensure prompt placement to lower level of care. The Health Plan may assign a Behavioral Health Care Manager to assist a contracted provider in securing lower level of care and submission of out of home packet.