Medicaid Utilization Management
Statewide Inpatient Psychiatric Programs
Florida Agency for Health Care Administration

Version 3.0
August 31, 2010
Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule¹ and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration, Inc. developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule
# Revision History

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<th>Date</th>
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<th>Comments</th>
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<tr>
<td>N/A 1.0 by default</td>
<td>06/06</td>
<td>Utilization Management Procedures for Statewide Inpatient Psychiatric Programs – Florida Agency for Health Care Administration</td>
<td>Annual update (earlier versions available from Contract Management)</td>
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<tr>
<td>2.0</td>
<td>01/31/08</td>
<td>Medicaid Utilization Management Statewide Inpatient Psychiatric Programs – Florida Agency for Health Care Administration</td>
<td>Moving to annual review; updating Provider Manual</td>
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<tr>
<td>2.1</td>
<td>04/24/09</td>
<td>Medicaid Utilization Management Statewide Inpatient Psychiatric Programs – Florida Agency for Health Care Administration</td>
<td>Annual Review</td>
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<tr>
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### Florida Criteria for Statewide Inpatient Psychiatric Programs

8.0 Florida Criteria for Statewide Inpatient Psychiatric Programs

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1.0 Statewide Inpatient Psychiatric Program (SIPP)

1.1 Introduction

Historically, the Florida Medicaid program funded a wide array of community and facility-based psychiatric services for Medicaid recipients under the age of 18. There were however, significant numbers of high-risk children and adolescents who did not respond adequately to intensive community-based services and/or experienced multiple or lengthy acute psychiatric inpatient admissions. The Florida Agency for Health Care Administration (AHCA) received approval from the U.S. Centers for Medicare and Medicaid Services (CMS) for a waiver to allow the purchase of services for children in Statewide Inpatient Psychiatric Programs (SIPPs). These facilities provide intensive psychiatric services to children in a locked residential setting and are designed to serve those high-risk youths that fail to benefit from acute inpatient or traditional outpatient treatment settings.

Generally, these high-risk children and adolescents present with complex conditions that require extended treatment in a secure setting in order to more adequately treat their psychiatric and psychosocial needs. These residential programs can improve outcomes for children and adolescents both by providing a course of active psychiatric treatment and by providing or facilitating access to community-based aftercare mental health services with linkages to schools, community resources, and family/natural supports.

In order to maximize this continuity of care, each individual discharged from a SIPP is offered services by a children’s mental health targeted case manager at the earliest time allowed under state and federal guidelines. If targeted case management services are accepted, the case manager coordinates and facilitates implementation of aftercare services recommended in the discharge plan. The targeted case manager will continue to work with the individual to assess needs and to monitor the quality of and access to care. These aftercare services might include, but are not limited to, outpatient psychiatric services, assessments, clinical and in-home services, or other services available under the Medicaid Community Behavioral Services Program. The case manager will also refer the child/adolescent to his or her assigned primary care physician or health maintenance organization for assessment and/or treatment.

1.2 Program Objectives

Treatment in a SIPP is seen as a component in the continuum of a child’s care, with the goals of

- Stabilization of presenting problems and symptoms and adequate resolution to allow safe return of the child to the family and community
• Reduction of recidivism of admission into acute psychiatric or SIPP services by providing aftercare services and/or linkages with appropriate community services
• Design of aftercare treatment plans that can be effectively implemented
• For children in the state’s custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with Family Safety

1.3 Definition of Terms

The Florida Agency for Health Care Administration (AHCA) and Magellan Medicaid Administration have provided certain definitions for services and patient status that serve to provide a common reference point for consistent implementation of the program. These definitions are as follows:

1.3.1 Active Treatment

Implementation of a professionally developed and supervised individualized plan of care, as described in 42CFR 441.155 and the regulations there under.

1.3.2 Admission Review

Medical record review performed at least 24 hours prior to the patient’s admission to a SIPP to determine the medical necessity for admission.

1.3.3 Assessment

The determination of a child’s current and potential strengths, problems, and needs, by utilizing current intake, diagnosis, and evaluation information in order to identify service needs.

1.3.4 Case Management

Care coordination, or the practice of planning, directing, and coordinating the provision and utilization of mental health and substance abuse services on an individual basis, as defined in the Medicaid Targeted Case Management Handbook.

1.3.5 CFR

Code of Federal Regulations

1.3.6 Community Aftercare Services

Ongoing services received in a community-based outpatient setting following discharge from an inpatient facility.
1.3.7  Continued Stay Review

Medical review conducted while the patient is in a SIPP to determine status of medical necessity for the continuation of services.

1.3.8  Culturally Sensitive

Applying knowledge and skills that respect the recipient’s and family’s individual and societal values, beliefs, and attitudes to provide effective care and treatment for diverse populations.

1.3.9  Family

The child’s biological, adoptive or foster parent(s), guardian(s), sibling(s), grandparent(s), aunts and uncles, and other related or unrelated persons who have a significant relationship with the individual. For children placed pursuant to Chapter 39, F.S., the term family also includes the child’s guardian ad-litem.

1.3.10  FirstHCM™

The name of the Magellan Medicaid Administration online prior authorization application used to conduct the utilization management process. Registered users may access this application to submit prior authorization and continued stay requests and view determination letters, notices, and the status of submitted requests via the Internet. Additional information is available at the following web address: http://florida.fhsc.com.

1.3.11  Good Physical Health

A recipient is not suffering from chronic or acute illnesses that require immediate or ongoing medical treatment to maintain independent functioning.

1.3.12  Institution of Mental Diseases (IMD)

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related service. (A SIPP provider that has more than 16 beds is classified as an IMD.) Pursuant to federal regulations regarding IMDs, children and adolescents in IMDs are not eligible for any other Medicaid benefit while they are SIPP services recipients. A SIPP provider is expected to provide routine medical care for individuals in good physical health. If more severe medical problems arise, an admitted recipient must be discharged from the SIPP provider in order to receive other medical benefits available to Medicaid eligible individuals.
1.3.13 Medical Necessity or Medically Necessary

As defined in Section 59G.-1.010, F.A.C., “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs.
3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
4. Be reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available; statewide.
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. Be furnished in accordance with Medicaid Policy.

1.3.14 Multidisciplinary Treatment Team

Per 42CFR 441, and based on education and experience, preferably including competence in child psychiatry, a multidisciplinary team, also called an interdisciplinary team, must be capable of

1. Assessing the recipient’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities
2. Assessing the potential resources of the recipient’s family
3. Setting treatment objectives
4. Prescribing therapeutic modalities to achieve the plan’s objectives

The team must include, at a minimum, one of the following:

1. A board-eligible or board-certified psychiatrist
2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy
3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master’s degree in clinical psychology or who has been certified by the State psychological association
The team must also include one of the following:

1. A psychiatric social worker or a Florida licensed clinical social worker
2. A registered nurse with specialized training or one year of experience in treating individuals with mental illness
3. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating individuals with mental illness

1.3.15 Primary Diagnosis

The principle mental disorder that is the medically necessary reason for clinical care and the primary focus for treatment.

1.3.16 Pre-Admission Review

Review of a recipient’s medical information prior to admission to the hospital to determine the medical necessity of admission. May also be called admission or initial review.

1.3.17 Prior Authorization

Determination by Magellan Medicaid Administration that the recipient’s admission or continued-stay is appropriate and meets medical necessity criteria following the submission of a review.

1.3.18 Reconsideration

Upon request of a provider or recipient, the review of an adverse determination previously rendered by Magellan Medicaid Administration.

1.3.19 Treatment Plan

The written compilation of the recipient’s individualized treatment goals, measurable objectives, and the treatment services to be provided. The treatment plan is the goal-oriented, time-limited, individualized plan of action, which directs the treatment and services to be provided for the child and family.

1.3.20 Working Day

8:00 a.m. to 6:00 p.m. Eastern Time, Monday through Friday excluding holidays
2.0 Overview of Process

On behalf of the Florida Agency for Health Care Administration, Magellan Medicaid Administration will perform all SIPP admission and continued stay reviews of services provided to Florida Medicaid recipients under the age of 18. Admission into a SIPP is voluntary and recipients may disenroll at any time. The program is limited to recipients in the following Medicaid eligibility categories:

- TANF-related
- Supplemental Security Income (SSI)
- SSI-related under age 18

Recipients may not be admitted to a SIPP facility if any of the following applies:

- They have Medicare coverage
- They reside in a nursing facility or an intermediate care facility for individuals with developmental disabilities (ICF/DD)
- They have an eligibility period that is only retroactive
- They are eligible as medically needy

Reviews for SIPP hospitalizations consist of (a) pre-admission reviews and certification of admissions, and (b) authorizations for continued stays. These reviews also verify the facility’s compliance with applicable Medicaid regulations relating to pre-admission, admission, and utilization control.

Pre-admission and continued stay reviews must be submitted to Magellan Medicaid Administration via the web-based application (FirstHCM™). In special circumstances, requests may be submitted telephonically. Specific information and instructions on enrollment for providers to use the FirstHCM™ application is posted on the Magellan Medicaid Administration web page:

http://florida.fhsc.com

Permission to submit telephonic reviews must be approved by Magellan Medicaid Administration and the Florida Agency for Health Care Administration.

Pre-admission information is expected to be submitted to Magellan Medicaid Administration at least 24 hours prior to admission. Continued stay information is expected to be submitted to Magellan Medicaid Administration at least 24 hours prior to the expiration of the last authorized stay, but no more than 5 days prior to the expiration of the last authorized stay.
Magellan Medicaid Administration will make a decision for all pre-admission and continued stay requests within 24 hours (1 business day) of receipt of a properly submitted request. The date of receipt of a properly submitted request is the date when all information needed to make a decision has been provided to Magellan Medicaid Administration. Board-certified Magellan Medicaid Administration physician advisors will make all adverse decisions. Information on the status of the request is available to the SIPP facility within 24 hours of the properly submitted request via the FirstHCM™ application. Magellan Medicaid Administration sends notification of the decision in writing to the recipient/legal guardian and to the SIPP within one business day of a denial or within one business day of receipt of the prior authorization (PA) number from the Medicaid fiscal agent. The letter may also be viewed via the FirstHCM™ application by the designated facility staff within one business day of a denial or within one business day of receipt of the prior authorization number from the fiscal agent.

The following minimum information is required to complete a pre-admission certification review or a continued stay review:

- A DSM IV-TR or ICD-9-CM Diagnosis on Axis I through V
- A description of the initial treatment plan relating to the admitting symptoms
- Current symptoms requiring SIPP treatment
- Medication history
- Prior hospitalizations
- Documentation that the child or adolescent is mentally competent, has age appropriate cognitive ability and is sufficiently stable cognitively to benefit from treatment
- Documentation that the child or adolescent is in good physical health, as certified by a medical doctor (MD), doctor of osteopathy (DO), registered nurse, physician's assistant, or other professional who has the authority to perform physical examinations of a medical nature
- Prior alternative treatment
- Appropriate medical, social and family histories
- Proposed aftercare placement/community-based treatment
- Qualified Evaluator Network (QEN) assessment recommendation (for children and adolescents in the custody of the state)
- The Child and Family Staffing Form must be reviewed prior to admission for those children not “dependent.”

Upon conclusion of the pre-admission review, Magellan Medicaid Administration will make one of the following determinations:
• Treatment in a SIPP is medically necessary. A Certification of Need (CON) form will be completed by Magellan Medicaid Administration and a letter of approval will be sent.
• If determined by a physician advisor that the recipient’s condition does not require SIPP inpatient services, a letter of denial will be sent and will contain a description of the recipient’s rights and the provider's rights to a formal reconsideration and a description of the appeal process.

Upon completion of the review, Magellan Medicaid Administration will notify all relevant parties in the following manner:

• The status and determination of the request will be available to the SIPP facility via the FirstHCM™ application.
• The recipient’s legal guardian and the SIPP facility will be notified of the determination by mail. The notice will be mailed by Magellan Medicaid Administration within one business day of a denial or within one business day of receipt of the prior authorization number from the fiscal agent.

2.1 Admission Procedures

Children and adolescents must receive prior approval for admission into a SIPP. The provider is required to notify Magellan Medicaid Administration at least 24 hours in advance of the admission. It is recommended that the provider notify Magellan Medicaid Administration at least 72 hours in advance when possible.

There are no emergency admissions into a SIPP. The following applies to all SIPP admissions:

• Medical clearance must be given by a medical doctor or physician advisor prior to admission.
• The child or adolescent must be in good physical health (no acute medical conditions or life threatening medical problems).
• Acceptance of a child or adolescent with chronic illness will be a joint decision between Magellan Medicaid Administration and the provider.
• The child or adolescent has age appropriate cognitive ability.
• The recipient’s family or legal guardian must be contacted by the physician advisor or other designee to obtain admission approval. The family has the right to refuse the referral.
• Individuals who are in state custody may not be referred or admitted without an independent evaluation by a qualified evaluator in accordance with C 39.407, F.S., which concurs with the findings of medical necessity for this level of care.
• The Child and Family Staffing Form must be reviewed prior to admission on those children not “dependent.”
2.2 Continued Stay Procedures

Timeframes for continued stay reviews:

- **Recipients under ten years of age**: Reviews shall be conducted at least every 21 days.
- **Recipients age ten years and over**: Reviews shall be conducted at least every 30 days.

- SIPP providers shall submit review information to Magellan Medicaid Administration at least 24 hours (preferably 48 hours) prior to the recipient’s last certified day to request additional certification. Continued stay review information submitted five or more days prior to the end of an approved stay will not be reviewed unless approval for early submission is granted by both AHCA and Magellan Medicaid Administration.

2.3 Estimated Length of Stay and Discharge Planning

At each continued stay review, the facility should address the estimated length of stay for the recipient and plans for discharge. There should be a basic agreement regarding length of stay and the anticipated date of discharge.

At each continued stay review, the facility should address the anticipated placement for the child or adolescent upon discharge, the identified support services needed upon discharge and the current status of referral and/or linkage to those services.
3.0 Pre-Admission Review and Certification of Need for SIPP Admissions

Magellan Medicaid Administration will perform a pre-admission and CON review for all Medicaid SIPP admissions. To accomplish this, the facility will submit a request to Magellan Medicaid Administration at least 24 hours (preferably 48 hours) prior to admission in order to complete the pre-admission review process.

There can be neither involuntary commitment admissions nor emergency admissions into a SIPP. A child being considered for admission into a SIPP must have medical clearance from a medical doctor or physician advisor. The medical doctor or physician advisor must certify that a recipient is currently in good physical health with no acute or chronic conditions requiring extensive medical treatment, and that the need for medical care, other than routine, is not anticipated. “Good physical health” means that a recipient is not suffering from a critical illness such as cancer, which requires extensive treatment measures. A recipient with a chronic but stable illness that can be managed with medication and routine monitoring can be accepted if Magellan Medicaid Administration and the provider agree. If, however, a recipient experiences a medical crisis, he or she will be discharged from the SIPP to receive other medical services. If a recipient is discharged for medical reasons, SIPP providers may maintain a bed for a period of time to be decided in consultation with Magellan Medicaid Administration but not to exceed seven days. Acceptance of a recipient with a chronic but stable physical illness into a SIPP will be a joint decision between Magellan Medicaid Administration and the SIPP provider. If a disagreement results from this process, the provider may request a review by AHCA.

One of Magellan Medicaid Administration’s licensed clinical reviewers will review the recipient's information to include

- Demographic information
- Prior inpatient treatment
- Prior outpatient treatment
- Initial treatment plan with anticipated discharge date
- Estimated length of stay
- DSM IV-TR and/or ICD-9 diagnosis on Axis I through V
- Consent for psychotropic medications
- Psychotropic medications currently being taken or which have been tried
- Current symptoms requiring SIPP care
- Chronic behavior/symptoms
- Anticipated date of admission
• Comprehensive psychiatric, medical, psychosocial, social, and educational assessments initiated/completed
• QEN evaluations, if the child is in State custody
• Child and Family Staffing Form for those children not “dependent”

If the admission does not clearly meet medical necessity criteria for admission or the information is insufficient, the clinical reviewer will place the information in “information pending” status with specific questions for the facility representative to provide additional information.

After further researching the record or conferring with the attending physician, the facility representative must submit additional information within one business day via the FirstHCM™ application. The Magellan Medicaid Administration clinical reviewer will review any additional information and defer the admission request to the assigned physician.

If no additional information is submitted within the one-business-day timeframe, the case will automatically be deferred to a physician for review.

The Magellan Medicaid Administration licensed clinical reviewer will initiate a CON and submit it to a Magellan Medicaid Administration physician to review in conjunction with the available information. If the information supports the need for SIPP treatment, the Magellan Medicaid Administration board-certified physician advisor will sign and date the CON approving the planned admission. The completed hard copy CON is stored at Magellan Medicaid Administration.

The Magellan Medicaid Administration physician will make a determination based upon available information. Information on the final determination is available on the FirstHCM™ application as soon as the request has been reviewed by the physician.

Within 24 hours of the posting of an adverse determination, the facility attending physician may request an informal telephonic peer review with the Magellan Medicaid Administration physician to discuss why the recipient cannot be treated less restrictively. The peer review must be scheduled within 48 hours of posting of the adverse determination. The peer review must be completed within 72 hours of the posting of an adverse determination. After the peer review is completed, the Magellan Medicaid Administration physician will approve or deny the authorization request. If the attending physician fails to complete a scheduled peer review, the adverse determination will remain. However, the legal guardian or provider may request a reconsideration of the findings in writing within 40 days of the adverse determination.
**Approval**

Approved days may be authorized in blocks of up to 21 days for recipients under age 10. For recipients age 10 and older, days may be authorized in blocks of 30. In some circumstances, fewer than 21 or 30 days may be authorized.

Information on the determination status and the prior authorization number will be available to the provider on the Magellan Medicaid Administration secure website via the FirstHCM™ application. Notification letters are sent to the facility and to the recipient/legal guardian.

**Denial**

When a Magellan Medicaid Administration board-certified physician advisor denies the authorization, a letter will be generated that includes the physician’s statement of the action, the rationale for the action, and the medical necessity criteria that support the determination. A letter of denial will be sent to the SIPP facility and to the recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the SIPP facility to request reconsideration of the determination. The facility designated staff member may view the letter of adverse action via the FirstHCM™ application at any time within one business day of the determination.

The recipient/legal guardian or SIPP facility may request reconsideration within 40 days of the adverse determination. Magellan Medicaid Administration will complete the reconsideration request within seven business days after the date the reconsideration request and hardcopy of the recipient record are stamped received by Magellan Medicaid Administration.
3.1 Certificate of Need

Available at the following link: https://florida.fhsc.com/Providers/Forms.asp
4.0 Medical Necessity Review for Continued Stay Reviews

It is the responsibility of the SIPP provider to contact Magellan Medicaid Administration for continued stay reviews. This is accomplished by entering a continued stay request via the FirstHCM™ application at least 24 hours (preferably 48 hours) prior to the expiration of the current certified period of stay. Magellan Medicaid Administration conducts continued stay reviews for all SIPP admissions at least every 21 days for recipients under age 10 and at least every 30 days for recipients age 10 and older during a SIPP inpatient stay. The following information is required to complete a continued stay review:

- Current treatment plan
- Current DSM-IV-TR or ICD-9-CM diagnosis on all five Axes
- Assessment of treatment progress with regard to admitting symptoms
- Summary of treatment provided up to the point of review
- Assessment of need for further treatment
- Current discharge criteria and discharge date and plan (presence of a well-written plan and implementation efforts)
- If discharge date changes, an explanation as to rationale for change
- Current consent for any new psychotropic medications added and PRN/ETO meds

A Magellan Medicaid Administration licensed clinical reviewer will review the information to make a determination. The reviewer will determine if the recipient continues to meet criteria for continued stay or defer the request to a Magellan Medicaid Administration physician to make a determination. Once a decision is made, it will be immediately available to the provider via the FirstHCM™ application.

Approval

Days will be authorized not to exceed 21 days for recipients under age 10, or 30 days for recipients age 10 and older. The Magellan Medicaid Administration clinical reviewer will complete the continued stay review based upon the information provided by the provider representative. The information must be sufficient for the clinical reviewer to make a determination that medical necessity criteria are met. Magellan Medicaid Administration generates a letter with the continued stay certification and mails a copy to the SIPP provider and to the recipient or legal guardian. The letter is mailed within one business day of receipt of the prior authorization number assigned by the Medicaid fiscal agent. This letter may also be viewed via FirstHCM™ application by the provider’s designated staff member.
Information Pending

If the continued stay request does not provide sufficient information to determine if it meets medical necessity criteria for additional days, the Magellan Medicaid Administration clinical reviewer will place the review in “information pending” status and allow the provider to provide additional information within one business day. The provider representative may enter additional information into the Magellan Medicaid Administration review database through the FirstHCM™ application.

If no additional information is provided, the review will automatically be deferred to a Magellan Medicaid Administration physician who will make a determination based upon the available information. The determination will be available to the SIPP provider via the FirstHCM™ application.

Denial

In case of a denial, the SIPP provider may request an informal telephonic peer review with the Magellan Medicaid Administration physician to discuss why the recipient cannot be treated less restrictively. The peer review must be scheduled within one business day of the denial determination. The review must be completed within 72 hours of notification of the denial. After the peer review, the Magellan Medicaid Administration physician may approve or deny the authorization request.

When a Magellan Medicaid Administration board-certified psychiatrist denies the authorization, a letter will be generated that includes the physician statement of the action, provides the rationale for the action, and medical necessity criteria, which support the determination. A letter of denial will be sent to the SIPP provider and recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the provider to request a reconsideration of the determination. This letter may also be viewed via the FirstHCM™ application by the provider designated staff member at any time within one business day of the determination.
5.0 Peer-to-Peer Review Procedures

Notification to the SIPP provider of the decision for all pre-admission and continued stay requests is available through the FirstHCM™ application. This information is generally available within one business day of a properly submitted request. Once the intention to partially approve or deny has been determined, the provider’s physician or assigned clinician may request an informal discussion of the recipient’s case with the Magellan Medicaid Administration physician. If the option of the peer review is elected, then the provider representative must call Magellan Medicaid Administration within 72 hours of the posting of the denial determination on the FirstHCM™ application to schedule an appointment time for the peer review. The peer-to-peer review is scheduled at the request of the attending physician but must be completed within six business days of posting of the adverse action. The SIPP staff must consult with the attending physician prior to scheduling the peer-to-peer review in order to verify that the provider physician wants a peer-to-peer review and to discuss available appointment times. The attending physician’s office staff or SIPP staff may schedule the peer review appointment. Should the provider physician be unable to complete the scheduled peer review with Magellan Medicaid Administration, the peer review may be rescheduled if Magellan Medicaid Administration receives notification prior to the scheduled time. Magellan Medicaid Administration is unable to reschedule peer reviews if notification is received after the scheduled time. After the completed peer review, the Magellan Medicaid Administration physician may approve or deny the authorization request.

Magellan Medicaid Administration will provide notification of the peer review decision in writing to the recipient/legal guardian and the SIPP provider by the close of the third business day after the peer review is completed or upon receipt of the prior authorization number from the Florida Medicaid fiscal agent. The determination is also available to the provider through the FirstHCM™ application.

Approval

Following a peer-to-peer review, the Magellan Medicaid Administration physician may authorize days not to exceed 21 days for recipients under age 10 and 30 days for recipients age 10 and older. A letter is generated and sent to the provider, and the recipient/legal guardian indicating that Magellan Medicaid Administration reversed the initial adverse determination through the informal peer review. The provider designated staff member may view this determination via the FirstHCM™ application at any time within one business day of the determination.
Denial

When a Magellan Medicaid Administration board-certified psychiatrist denies further authorization following the informal peer review process, a letter will be generated that includes the physician statement of the action, the rationale for the action, and medical necessity criteria, which support the determination. A letter of denial will be sent to the SIPP provider and to the recipient/legal guardian. The denial letter will include an explanation of the rights of the recipient/legal guardian and the provider to request a reconsideration of the determination. The provider designated staff member may view this letter via the FirstHCM™ application at any time within one business day of the determination.

The peer-to-peer review process is provided as an additional step in the appeal process and does not supersede the formal reconsideration process for the recipient/legal guardian or provider.
6.0 **Appeals Process**

The appeals process generally consists of two steps:

- Reconsideration that is available to the recipient/legal guardian or facility
- Fair hearing that is available only to the recipient/legal guardian

Additional supporting information may be submitted at the time the formal written request for reconsideration or fair hearing is made.

6.1 **Reconsideration**

The recipient/legal guardian or provider may request a reconsideration of any adverse determination. The request for reconsideration must be made in writing to Magellan Medicaid Administration. A hard copy of the medical record must be submitted with the request for reconsideration.

Upon receipt of the request, a board-certified Magellan Medicaid Administration psychiatrist not involved in the initial determination will review all submitted documentation and render a determination within seven business days of receipt of the request. If the second Magellan Medicaid Administration psychiatrist agrees with the original determination, the decision is upheld and the reconsideration process is completed. Magellan Medicaid Administration will provide written notification of the reconsidered determination within three business days to the recipient/legal guardian and SIPP facility. The written notification will advise the recipient/legal guardian of the right to a fair hearing as the next level of appeal. The determination and written notification will be available to the SIPP provider through the FirstHCM™ application.

If the second Magellan Medicaid Administration psychiatrist reverses the original adverse determination, the case is overturned and the reconsideration process is complete. Written notification will be provided to the recipient/legal guardian and SIPP provider within 24 hours of receipt of the prior authorization number from the fiscal agent. The determination and written notification will be available to the SIPP provider through the FirstHCM™ application.

The written request for reconsideration must be sent to

Magellan Medicaid Administration
Florida Reconsideration Unit
4300 Cox Road
Glen Allen, VA 23060
6.2 Request for Fair Hearing

The recipient/legal guardian has the right to request a hearing for any adverse determination subsequent to the reconsideration determination, or at any time during the appeals process. Fair hearing is a process managed by the Department of Children and Families – Office of Appeals. Magellan Medicaid Administration participates by providing documentation and staff testimony of Magellan Medicaid Administration determinations in the prior authorization process.

The request for a fair hearing may be made by contacting the local Agency for Health Care Administration office or by writing:

Office of Appeals Hearings
1317 Winewood Dr. Bld. 5 Rm. 203
Tallahassee, Florida 32399-0100
Phone: 1-850-488-1429
Fax: 1-850-487-0662
7.0 Hours of Operation

Magellan Medicaid Administration’s hours of operation are from 8:00 a.m. until 6:00 p.m. Eastern Time, Monday through Friday. Magellan Medicaid Administration maintains a toll-free telephone line for questions regarding clinical issues, specific cases, and for scheduling peer reviews. Magellan Medicaid Administration staff may be reached during business hours by calling 1-800-770-3084. After business hours, callers may leave a voice mail message. Magellan Medicaid Administration staff will return the call by noon of the following business day.

Providers are required to submit data via the web-based online prior authorization (PA), FirstHCM™ system. A secure login is required to submit requests. Providers with the appropriate login may access this secure website through the Magellan Medicaid Administration web page at any time of the day or night. The web address is http://florida.fhsc.com.

Additional information on this site includes but is not limited to

- Provider manuals
- Special information bulletins
- Complaint instructions and forms
- Data Correction Request forms and other forms
- Satisfaction and other surveys

Magellan Medicaid Administration maintains a toll-free line for providers who have questions regarding accessing the FirstHCM™ application or are experiencing difficulty in accessing and using the site. The number is 1-800-241-8726

Staff are available to provide assistance in accessing the web-based application, FirstHCM™ from 8:00 a.m. until 8:00 p.m. Eastern Time.
8.0 Florida Criteria for Statewide Inpatient Psychiatric Programs

8.1 Admission Criteria

The following criteria are to be used for admission to a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients:

1. All admissions are non-emergency and voluntary.

2. Medical clearance must be given by a physician prior to admission.

3. The child or adolescent has age appropriate cognitive ability to benefit from treatment.

4. The child or adolescent has the cognitive and developmental ability to benefit from treatment and group setting.

5. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP.
   A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community.

To meet this requirement, one of the following shall be established.

1. A lower level of care will not meet the recipient’s treatment needs. Examples of lower levels of care include
   a. Family or relative placement with outpatient therapy
   b. Day or after-school treatment
   c. Foster care with outpatient therapy
   d. Therapeutic foster care
   e. Group childcare supported by outpatient therapy
   f. Therapeutic group childcare
   g. Partial hospitalization
   h. Custodial care
2. An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.

B. Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement all of the following criteria must be met:

1. An ICD-9 diagnosis is present and has been established through a documented comprehensive bio-psychosocial diagnostic assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly diagnosed psychotic disorders. A concurrent Axis I substance abuse disorder may be present.

2. The rating on DSM IV Axis V at admission is less than 70.

3. The recipient is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as a, b, c, or d:
   a. **Self-care Deficit (not Age Related)**: Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the recipient’s mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications)

   OR

   b. **Impaired Safety (Threat to Self or Others)**: Evidence of intent to harm self or others caused by the recipient’s mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:

   1) Severely depressed mood

   2) Recent loss
3) Recent suicide attempt or gesture or past history of multiple attempts or gestures

4) Concomitant substance abuse

5) Recent suicide or history of multiple suicides in family or peer group

OR

c. Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm.

Indicators:

1) Disruption of safety of self, family, peer, or community group

2) Impaired reality testing sufficient to prohibit participation in any community educational alternative

3) Not responsive to outpatient trial of medication or supportive care

4) Requires sub acute diagnostic evaluation to determine treatment needs

OR

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes, which place the recipient at risk

Indicators (one of the following):

1) Family environment is causing escalation of recipient’s symptoms or places recipient at risk.

2) The family situation is not responsive to available outpatient or community resources and intervention.

3) Instability or disruption is escalating.

4) The situation does not improve with the provision of economic or social resources.

5) Severe behavior or established pattern of behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse.
4. The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self care, etc.) as evidenced by documented presence of

- Deficits in cognition, control, or judgment due to diagnosis(es)
- Circumstances resulting from those deficits in self care, personal safety, social/family functioning, academic or occupational performance
- Prognostic indicators which predict the effectiveness of treatment

5. The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational, and substance abuse needs. Specifically:

a. Services shall be under the supervision of a physician advisor.

b. Intervention of qualified professionals shall be available 24 hours a day.

c. Multiple therapies (group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the recipient. Families or surrogates must be involved in the treatment. Family therapy with families or surrogates must be included unless clinically contraindicated, with an expectation of at least one family session per week.

C. The services can reasonably be expected to improve the recipient’s condition within a reasonable timeframe of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1. The treating facility shall provide a description of the plan for treatment illustrating the required services available at SIPP level of care.

2. The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable, and timeframed discharge criteria.

3. The benefits of SIPP care are expected to result in maintaining or improving the recipient’s level of functioning.
8.2 Exclusion Criteria for Admission

Children and adolescents meeting any one of the following criteria are not considered appropriate for care in a SIPP:

- Less intensive levels of treatment will appropriately meet the needs of the child or adolescent.
- The primary diagnosis is substance abuse, mental retardation, or autism.
- The recipient is not expected to benefit from this level of treatment.
- The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment.
- The youth has a history of long standing violations of the rights and property of others.
- A pattern of socially directed disruptive behavior (e.g., gang involvement) is the primary presenting problem or remaining problem after any psychiatric issue has stabilized.
- Recipients cannot be admitted to a SIPP if they have Medicare coverage, reside in a nursing facility or ICF/DD, or have an eligibility period that is only retroactive or are eligible as medically needy.
- Lack of medical clearance from a physician for admission.

8.3 Continued Stay Criteria

The following are criteria to be used for continued stay in a SIPP facility when reimbursement is to be made on behalf of eligible Medicaid recipients.

Requirements A, B, and C shall be met for continued stay:

A. Ambulatory care resources available in the community do not meet the treatment needs of the recipient (42 CFR 441.152(a)).

To meet this requirement, one of the following shall be established.

1. A lower level of care is unsafe and will place the recipient in imminent danger of harm.

Examples of lower levels of care include

- Family or relative placement with outpatient therapy
- Day or after-school treatment
- Foster care with outpatient therapy
- Therapeutic foster care
e. Group childcare supported by outpatient therapy
f. Therapeutic group childcare
g. Partial hospitalization
h. Custodial care

2. Clinical evidence exists that a lower level of care will not meet the recipient's treatment needs.

3. The recipient’s mental disorder could be treated with a lower level of care, but because the recipient suffers one or more complicating concurrent disorders, SIPP care is medically necessary.

Example: Major Depressive Disorder with Epilepsy

B. Proper treatment of the recipient’s psychiatric condition continues to require services on an inpatient basis under the direction of a physician (42 CFR 441.152(a)).

To meet this requirement, all of the following criteria must be met:

1. The patient continues to have a psychiatric condition or disorder that is classified as an ICD-9 diagnosis. A concurrent Axis I substance abuse disorder may be present.

2. The rating on DSM IV Axis V continues to be less than 70 for the primary diagnosis

3. The recipient continues to experience problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as (a), (b), (c), and (d):

   a. **Self-care Deficit (not Age Related):** Impairment of ability to meet physical needs which place the recipient at risk of self-harm.

      **Indicator:**

      1) Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe.

   b. **Impaired Safety (Threat to Self or Others):** Continued evidence of intent to harm self or others caused by the recipient’s mental disorder, provided that such intent does not constitute a clinically emergent situation.
**Indicators:**

1) Continued suicidal/homicidal ideation with expression of plan of intent

2) Potential for aggressive behavior requiring infrequent seclusion or restraint

c. **Impaired Thought and/or Perceptual Processes (Reality Testing):**
   Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (paranoia, hallucinations, and delusions) and it is likely that the recipient will suffer serious harm.

**Indicators:**

1) Disruption of safety of self, family, peer, or community group

2) Impaired reality testing sufficient to prohibit participation in any community educational alternative

3) Requires continued sub-acute diagnostic evaluation to determine treatment needs

d. **Severely Dysfunctional Patterns:** Family, environmental, or behavioral processes, which place the recipient at risk of serious harm

**Indicators (one of the following):**

1) Family contacts and interaction and/or family environment are causing escalation of recipient’s symptoms and place the recipient at risk of serious harm.

2) Instability or disruption is escalating.

3) Severe behavior prohibits any participation in a lower level of care; e.g., habitual runaway, prostitution, repeated substance abuse.

4. **The child or adolescent has a serious impairment of functioning compared with others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self care, etc.) as evidenced by documented presence of**

   - Deficits in cognition, control, or judgment due to diagnosis
   - Circumstances resulting from those deficits in self care, personal safety, social/family functioning, academic or occupational performance
– Prognostic indicators, which predict the effectiveness of treatment

5. The facility has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at this level of care; specifically
   a. Services shall be under the supervision of a physician advisor.
   b. Intervention of qualified professionals shall be available 24 hours a day.
   c. Multiple therapies (group counseling, individual counseling, recreational therapy, expressive therapies, family therapy, etc.) shall be actively provided to the recipient.

C. 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 (42 CFR 441.152(a)).

1. The treating SIPP facility has developed a plan for continuing treatment illustrating the required intensity of services available at a SIPP level of care.

2. The treating SIPP facility has provided a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan was initiated as soon as the initial assessment was completed and included discrete, behavioral, and timeframed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.

3. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued SIPP hospitalization would be required or would result in regression.

8.4 Transfer Criteria

Transfer of a child or adolescent from one SIPP into another SIPP may occur only under the following conditions:

• The patient/provider relationship is not mutually acceptable and this finding is confirmed by Magellan Medicaid Administration, the Agency, and the Department of Children and Families (DCF)
• The child’s condition or illness could best be treated by another provider type
• The SIPP facility determines that it is not able to provide effective treatment to a child due to the child’s noncompliant behavior, subject to a case review by Magellan Medicaid Administration in collaboration with DCF or the child’s guardian/caregiver. If Magellan
Medicaid Administration in conjunction with DCF, or the child’s guardian/caregiver, determines that the SIPP should be able to address the child’s needs, Magellan Medicaid Administration will recommend that the plan of care be revised, and the SIPP provider continue to serve the child. However, if in good faith, the SIPP provider and Magellan Medicaid Administration continue to determine that the SIPP cannot meet the child’s needs, AHCA will not force the provider to continue services and the child may be discharged to a more appropriate provider.

The SIPP provider will keep a child as a client until another SIPP facility or acute care setting for recipients under age 18 is available, if the child or adolescent continues to meet the criteria for this level of care.

When a request is made to transfer a child or transfer is being considered; the DCF circuit office child specialist or the community-based care single point of access (SPOA) and the Magellan Medicaid Administration regional care coordinator (RCC) will coordinate to ensure that all parties are aware of the request.

The RCC and the SPOA will coordinate to ensure that at a minimum, the parent/legal guardian and the current SIPP are informed and consulted regarding the request. If the SPOA is associated with a community-based care (CBC) provider, he/she needs to inform the District Children’s Mental Health staff of the transfer request.

The request to transfer should be reviewed by the treatment team of the current SIPP to determine clinical appropriateness of transferring the child; i.e., how will the child/youth benefit from transfer to another SIPP, what issues need to be addressed by the receiving SIPP and what are the clinical considerations for the receiving SIPP (if the transfer is approved).

If the parent/guardian is in agreement with the transfer request, the Magellan Medicaid Administration RCC will provide a clinical overview of the child to the RCC program manager and make recommendations regarding the clinical appropriateness of the transfer request.

The SPOA will complete the Special Consideration for SIPP Placement Request Form and submit to the Magellan Medicaid Administration RCC project manager. The RCC will complete the SIPP Transfer Request and submit to the RCC project manager. The RCC project manager will fax copies of both completed forms to AHCA and CMH for review and conference staffing of the request. The Magellan Medicaid Administration RCC project manager will maintain a file of all original requests for tracking and audit purposes.

CMH, AHCA, and the RCC program manager will review the information submitted and respond to the SPOA and RCC regarding the request. The RCC will inform the current SIPP provider of the clinical appropriateness for transfer.
If the request for transfer is approved, the RCC program manager will inform the Magellan Medicaid Administration Utilization Management supervisor of the transfer approval. Once a discharge date is established, the transferring SIPP will complete a discharge with Magellan Medicaid Administration, at that point, the receiving SIPP will submit a request for prior authorization for initial placement with Magellan Medicaid Administration via the Magellan Medicaid Administration web application.

Magellan Medicaid Administration, AHCA, and the District CMH staff will review and determine the appropriateness of the SIPP Transfer Request within two business days of the request for transfer.

Following approval by Magellan Medicaid Administration, a SIPP facility must notify a participant and parent or legal guardian in a direct and timely manner of a provider’s decision to discontinue treatment. The participant may request reconsideration of this decision according to the reconsideration and appeals process.

Data regarding requests for disenrollment or transfer to another SIPP provider under this program will be tracked by AHCA. If data indicate repeat requests for disenrollment by one provider, it will trigger a program review and evaluation.

8.5 Discharge Criteria

The following requirements shall be met prior to discharge from a SIPP facility:

- The recipient has received maximum benefit from his or her present plan of care.
  OR
- The child has failed to benefit from a reasonable course of SIPP care, and documentation supports that a suitable alternative placement is established that will meet the child’s needs, and the discharge plan includes input from family or surrogate family and DCF-Substance Abuse and Mental Health program office.
  OR
- Severe medical problems have arisen that cannot be managed by the SIPP facility. If it is determined that a child will require extensive medical attention, the SIPP may work with the Medicaid area office to disenroll the child from the SIPP, so that other Medicaid services can be accessed.

Note: In order to provide for continuity of care for the child, the SIPP request for proposal (RFP) requires that providers hold a bed for a child for up to seven days if the child is undergoing an acute medical or psychiatric admission and is expected to return to the SIPP.
The provider is required to demonstrate detailed aftercare planning services are recommended and developed by the treatment team that identify treatment needs and provide access to resources for continuing treatment upon return to the community. Aftercare planning must include liaison with the recipient’s school and other appropriate agencies and community resources such as targeted case management, DCF-Substance Abuse and Mental Health and Family Safety, Department of Juvenile Justice, and vocational rehabilitation. The goal of aftercare planning is to promote a coordinated transition into the community.

SIPP providers should be mindful of the requirements for discharge and transfers as outlined in the 2004 SIPP RFP. A SIPP provider will be disenrolled from Medicaid and the agreement terminated as a result of the provider’s failure to comply with enrollment requirements or provisions of the contract.