

This is a sample guide to utilization reviews with ValueOptions. This is intended to guide only. Review questions may include, but not be limited to, the following examples. Questions are based on each unique member and his/her presentation. This sample is based on criteria 2.201. The complete set of medical necessity criteria can be found on ValueOptions.com

2.20 INPATIENT SERVICES

2.201 Acute Inpatient Mental Health (Adult)

Description of Services: Acute inpatient mental health treatment represents the most intensive level of psychiatric care. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour secure and protected, medically staffed and psychiatrically supervised treatment environment. Twenty-four hour skilled psychiatric nursing care, daily medical evaluation and management, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize individuals who display acute psychiatric conditions associated with a relatively sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring disorder. Typically, the individual poses a significant danger to self or others, or displays severe psychosocial dysfunction. Special treatment may include physical and mechanical restraint, seclusion, and a locked unit. Active family/significant other involvement is important unless contraindicated. Estimated length of stay is based on individual needs which must be documented in the treatment plan.

Criteria

Admission Criteria

The following criterion is necessary for admission:

1. Individual has been evaluated by a licensed clinician and demonstrates symptomatology consistent with a DSM-IV-TR Axes I, and II (if applicable) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention.
ValueOptions Clinical Care Managers (CCMs) will ask for standard assessment items such as diagnosis and precipitant to decompensation (psychosocial stressor, medication noncompliance, substance abuse).

There is evidence of actual or potential danger to self or others or severe psychosocial dysfunction as evidenced by at least one of the following (2-11):

2. A suicide attempt which is serious by degree of lethality and intentionally or suicidal ideation with a plan and means. Impulsive behavior and/or concurrent intoxication increase the need for consideration of this level of care. However, 23-hour observation may be used initially to rule out presence of acute psychiatric symptomatology and/or as a result of intoxication. Assessment should include an evaluation of:
 - a. the circumstances of the suicide attempt or ideation;
 - b. the method used or contemplated;
 - c. statements made by the individual; and
 - d. the presence of continued feelings of helplessness and/or hopelessness, severely depressed mood, and/or recent significant losses.
 - e. availability of responsible support systems

CCM will ask for circumstances surrounding the attempt or ideation; if member is still currently suicidal; and what the safety plan is (or plan to develop a safety plan with specific skills and steps). A significant focus will be on the seriousness, intentionality, plan, means of any dangerousness in addition to how recent the thoughts or behavior were.
3. Current assaultive threats or behavior, resulting from an Axis I disorder, with a clear risk of escalation or future repetition (i.e., has a plan and means).

	<p><i>CCM will ask for a thorough behavioral description</i></p> <p>4. Recent history immediately prior to admission, prompting evaluation or intake of significant self-mutilation (non-chronic), significant risk-taking, or loss of impulse control resulting in danger to self or others. <i>CCM will ask for a behavioral description, the dangerousness of the behavior and how it is different from the baseline.</i></p> <p>5. Recent history immediately prior to admission, prompting evaluation or intake of violence resulting from an Axis I or Axis II (Borderline Personality) disorder. <i>CCM will ask for a thorough behavioral description.</i></p> <p>6. Command hallucinations directing harm to self or others. <i>CCM will ask for a thorough behavioral description and, if there is an identified victim and if there is a need, facility will do Duty To Warn.</i></p> <p>7. Disordered/bizarre behavior or psychomotor agitation or retardation that interferes with the activities of daily living to such a degree that the individual cannot function at a less intensive level of care. <i>CCM will ask for a thorough behavioral description to include objective findings.</i></p> <p>8. Disorientation or memory impairment which is due to an Axis I disorder and accompanied by severe agitation which endangers the welfare of the individual or others. <i>CCM will ask for a thorough behavioral description including how the behavior affects the level of dangerousness.</i></p> <p>9. The individual manifests major disability in social, interpersonal, occupational, and/or educational functioning which is leading to dangerous or life-threatening functioning and that can only be addressed in an acute inpatient setting. <i>CCM will ask for a thorough behavioral description including how the impaired functioning affects the level of dangerousness.</i></p> <p>10. Inability to maintain adequate nutrition or self-care due to a psychiatric disorder and family/community support cannot be relied upon to provide essential care. <i>CCM will ask for a thorough behavioral description including how the inability affects the individual's safety.</i></p> <p>11. The individual has experienced severe or life-threatening side effects of atypical complexity from using therapeutic psychotropic drugs. <i>CCM will ask for a thorough description including the level of medical dangerousness.</i></p> <p><i>It is expected that the following takes place:</i></p> <p>12. The multi-disciplinary discharge planning process starts from the assessment and tentative plan upon admission, and includes the patient and family/significant other as appropriate, unless contraindicated secondary to risk of harm to patient or family/support. <i>CCM will ask what the discharge plans are anticipated to be (living arrangements, step-down level of care, supports) and what needs to happen prior to day of discharge to accomplish this. This discharge planning information should be available from the first review onward.</i></p> <p>13. The treatment plan needs to clearly state the benefits individual will receive in program, and the goals of treatment cannot be based solely on need for structure and lack of supports. <i>CCM will ask what this member will specifically gain from this group, individual, and family therapy. This might include specific coping skills, safety planning, DBT skills and more. Each time a review occurs, the CCM will ask about progress toward these specifics.</i></p>
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<p>Psychosocial, Occupational, and Cultural and Linguistic Factors</p>	<p><i>These factors, as detailed in the Introduction, may change the risk assessment and should be considered when making level of care decisions.</i></p>
<p>Exclusion Criteria</p>	<p><i>Any of the following criteria is sufficient for exclusion from this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual can be safely maintained and effectively treated at a less intensive level of care. <i>If necessary care can be safely accomplished at a less intensive setting, care can not be authorized.</i> 2. Symptoms result from a medical condition which warrants a medical/surgical setting for treatment. 3. The individual exhibits serious and persistent mental illness and is not in an acute exacerbation of the illness. 4. The primary problem is social, economic (e.g., housing, family conflict, etc.), or one of physical health without a concurrent major psychiatric episode meeting criteria for this level of care, or admission is being used as an alternative to incarceration.
<p>Continued Stay Criteria</p>	<p><i>All of the following criteria are necessary for continuing treatment at this level of care:</i></p> <ol style="list-style-type: none"> 1. The individual’s condition continues to meet admission criteria for inpatient care, acute treatment interventions (including psychopharmacological) have not been exhausted, and no other less intensive level of care would be adequate. <i>ValueOptions Clinical Care Managers (CCMs) will ask for standard assessment items such as diagnosis and precipitant to decompensation (psychosocial stressor, medication noncompliance, substance abuse).</i> 2. The multi-disciplinary discharge planning process starts from the assessment and tentative plan upon admission, and includes the patient and family/significant other as appropriate unless contraindicated secondary to risk of harm to patient or family/support. <i>CCM will check in on the previously stated discharge plan to see if progress has been made toward any necessary living arrangements or placement, step-down level of care, and work with supports. Discharge planning must be aggressive and timely.</i> 3. Treatment planning is individualized and appropriate to the individual’s changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems, social, occupational and interpersonal assessment with involvement unless contraindicated. Family sessions need to occur in a timely manner. Treatment planning goals should be realistic and attainable. Expected benefits from all relevant modalities, including family and group treatment are documented. <i>CCM will ask questions to ensure the treatment plan is individualized for this member versus a set program. CCM will ask questions to ensure each treatment modality is offered as frequently as he/she needs, based on the actual acute reason the individual is requiring this specific level of care.</i> 4. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice. <i>CCM will ask questions to ensure treatment modality is offered as frequently as she/she needs, and will focus on how efficiently this is being accomplished.</i> 5. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address lack of progress and/or psychiatric/medical complications are evident.

	<p><i>CCM will ask for evidence of progress or that the treatment plan has been modified (medication adjustments, behavioral interventions, etc.) to help progress occur with particular focus on the reasons the individual requires this specific level of care.</i></p> <p>6. Care is rendered in a clinically appropriate manner and focused on the individual’s behavioral and functional outcomes as described in the discharge plan. <i>CCM will ask questions to ensure the provided treatment is targeting the symptoms that necessitated this level of care. Other issues may be appropriate for longer term outpatient care.</i></p> <p>7. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated and consistent with prescribing guidelines. <i>CCM will ask questions about medications and dosages. Any medication concerns (e.g. type of medication, augmentation, dosing, etc.) will be referred to our doctor in rounds or via peer review. The rationale why additional medication adjustments can not be accomplished at a less restrictive level of care should be discussed.</i></p> <p>8. Patient is actively participating in plan of care and treatment to the extent possible consistent with his/her condition. <i>CCM will inquire about member’s level of participation and if non-participative, what the provider is doing to encourage participation.</i></p> <p>9. Coordination with relevant outpatient providers is implemented. <i>This should happen as early in the course of treatment as necessary.</i></p>
<p>Discharge Criteria</p>	<p><i>Any of the following criteria are sufficient for discharge from this level of care:</i></p> <p>1. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged and deployed at a lower level of care. Follow-up aftercare appointment is arranged for a timeframe consistent with the member’s condition and applicable standards. <i>Failure to efficiently arrange follow-up would not be considered a rationale for continued stay.</i></p> <p>2. The individual no longer meets admission criteria or meets criteria for a less intensive level of care.</p> <p>3. The individual, family, legal guardian and/or custodian are competent but non-participatory in treatment or in following program rules and regulations.</p> <p>4. The non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.</p> <p>5. Either it has been determined that involuntary inpatient treatment is inappropriate, or a court has denied a request to issue an order for involuntary inpatient treatment</p> <p>6. Consent for treatment is withdrawn and, either it has been determined that involuntary inpatient treatment is inappropriate, or the court has denied involuntary inpatient treatment.</p> <p>7. Support systems that allow the patient to be maintained in a less restrictive treatment environment have been thoroughly explored and/or secured. <i>Failure to efficiently explore and arrange for support systems will not be considered a rationale for continued stay.</i></p> <p>8. The individual is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care due to chronicity.</p> <p>9. The individual's physical condition necessitates transfer to a medical facility.</p>