



LEVEL OF CARE SCREENING PROCEDURES FOR UNDER 21 BENEFIT

Revised 7.1.13

The policies and procedures in this document are approved and signed by Operations Director prior to posting.

Ascend is recognized nationally as a leader in providing outstanding clinical processes, information systems and superior management solutions to help our customers enhance their healthcare delivery systems.

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I. INTRODUCTION AND OVERVIEW

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I-A: Under 21 Screening Overview

This manual serves as a reference for behavioral health providers that treat individuals under age 21. In the following sections, we provide you with a description of screening requirements, screening processes, and important definitions that you will need to know in order to follow the program requirements. Acute and residential screening requirements advocate for the individual, through promoting the least restrictive and most appropriate placement at the earliest possible time.

I-B: Ascend Management Innovations

Ascend Management Innovations is a Tennessee-based utilization review firm that specializes in integrated disease management directed at both behavioral and medical health care. Our staff is well versed in Utilization Review processes, including Under 21 screening in North Dakota, as well as in a variety of states.

Screening information can be forwarded by facsimile, mail, phone, email, or web-based submission. All phone and facsimile numbers are toll free. Contact information is as follows:

Ascend Management Innovations
North Dakota Division
227 French Landing Drive, Suite 250
Nashville, Tennessee 37228
Phone: 877.431.1388 • Facsimile: 877.431.9568

Ascend conducts reviews at admission and at designated review points to determine need for continued care. Determinations for admission and continued stay reviews are provided within one business day of referral.

I-C: Hours of Operation

Ascend reviewers are available Monday through Friday, between the hours of 8:00am until 5:00pm Central Time, with the exception of North Dakota State holidays.

II. THE UNDER 21 BENEFIT

II-A: Identification and Screening Requirements Under 21

The federal government allows states the option of covering inpatient psychiatric hospital services for individuals under the age of 21 (known as the Under 21 benefit). While services may be covered only for beneficiaries age 21 and under, those under 21 at the time of admission may continue receiving care, as indicated, until age 22. This Under 21 Benefit is applicable to:

- Acute inpatient psychiatric hospitals or programs
- Accredited Psychiatric Residential Treatment Facilities (PRTF) for adolescents
- Non-Accredited PRTFs
- Reciprocal Out of State facilities

Through the Center for Medicare and Medicaid Services (CMS), the federal government requires that all agencies serving Medicaid populations and receiving Medicaid funds have a utilization control program that monitors the need for services before payment can be authorized. In the case of inpatient services, regulatory language mandates that inpatient psychiatric services are appropriate for individuals undergoing active treatment, in accordance with an individual plan of care intended to "improve the recipient's condition or prevent further regression so that the services will no longer be needed." These requirements became statutory in 1972 for Medicaid and Medicare programs.

Facilities covered by the Under 21 benefit are subject to federal guidelines in the Code of Federal Regulations (CFR), Title 42 CFR 441 Subpart D, and Subpart G of 483. These guidelines describe essential federal boundaries that the State's Utilization Review/CON agency (Ascend) will follow to enact Certification of Need oversight requirements and to perform Utilization Review for hospital and non-hospital based inpatient care. Certification of Need guidelines require that a team specified in Section 441.154 certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

II-B: Utilization Review Types and Processes

Acute inpatient services are provided in a secured psychiatric hospital or psychiatric unit to treat symptoms so severe that the absence of psychiatric intervention could potentially result in increased serious dysfunction, death, or harm to self or others. Acute inpatient admissions may be either elective or emergency.

Psychiatric Residential Treatment Facilities (PRTF) for children are defined in Century Code Section 25-03.2-01 as a facility or a distinct part of a facility that provides to children and adolescents a total, 24-hour, therapeutic environment integrating group living, educational services, and a clinical program based upon

a comprehensive, interdisciplinary clinical assessment and an individualized treatment plan that meets the needs of the child and family. PRTF admissions are elective.

Certification of Need (CON) is a regulatory review process that requires specific health care providers to obtain prior authorization for provision of services for Medicaid applicants or eligible recipients. CON applications are required for all applicants or service recipients of a psychiatric hospital or an inpatient psychiatric program in a hospital and a psychiatric facility, including PRTF, to determine the medical necessity of the proposed services. The certification of need evaluates the recipient's capacity to benefit from proposed services, the efficacy of proposed services, and consideration of the availability of less restrictive services to meet the individual's needs.

There are three types of reviews: admission, continued stay, and retrospective. CON requirements differ depending on the type of review.

II-B-01: Certificate of Need

A Certificate of Need (CON) is a federal requirement for documentation for inpatient hospitalization and residential admissions to accredited facilities for Medicaid recipients under age 21 and individuals age 21 if the individual was receiving the services immediately before reaching age 21. The referral facility is required to submit the CON form for *all emergency admissions*. If the admission to an acute or PRTF facility is *elective*, Ascend will be responsible for completing the CON.

The CON requirements certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

For an individual who is a Medicaid recipient or applicant when admitted to a facility or program, certification must be made by an independent team that:

1. Includes a physician;
2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
3. Has knowledge of the individual's situation.

North Dakota Administrative Code (NDAC) 75-02-02-10 (3) (a) (1) stipulates that: "...an independent review team must be composed of individuals who have no business or personal relationship with the inpatient psychiatric facility or program requesting a certification of need." Ascend serves as the independent team that completes the CON form for Medicaid recipients or applicants under age 21 on elective admissions (both acute and residential). This team consists of a Board-certified/eligible child

psychiatrist and a registered nurse (RN) with a minimum of two (2) years experience in children's behavioral health. For emergency admissions, the acute treatment provider must complete the CON.

Provider Certificate of Need Process

Providers are required to submit CON forms for emergency admissions and post-admission Medicaid applications for acute inpatient and accredited PRTFs if the recipient is still receiving acute or PRTF services at the time of review. The CON must certify that:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

For emergency admissions, the certification must be completed, signed, and dated by the team members responsible for the plan of care within **14 days** after admission. The team responsible for the recipient's plan of care must be employed by or provide services to individuals in the facility.

The provider team must include as a minimum of two team members, either:

1. A Board-eligible or Board-certified psychiatrist; or
2. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
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 or by the State psychological association.

The team must also include one of the following:

1. A psychiatric social worker
2. A registered nurse with specialized training or one year's experience in treating mentally ill individuals
3. An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals
4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

Note about the Provider CON

Failure to complete or submit a timely CON in emergency admissions can result in a **technical denial** for services, regardless of the individual's medical need for treatment. An admission review on an individual admitted on an emergency basis cannot be processed until the Provider CON is received.

II-B-02: Admission Reviews

Admission reviews apply to acute inpatient and PRTF admissions for individuals under age 21 or, if the individual was receiving the services immediately before s/he reached age 21, up to the date the individual reaches 22 and for those individuals who apply for Medicaid prior to admission or while receiving services.

Two types of admission reviews are performed: elective and emergency. All PRTF admissions are considered *elective*.

Acute admissions may be *elective or emergency* based on the criteria outlined below.

- **Elective:** A relatively sudden, short, and severe course of a psychiatric condition presenting significant and immediate danger to the recipient, others, or the public safety, or one resulting in marked psychosocial dysfunction or grave mental disability of the recipient. The therapeutic intervention and treatment of an acute admission is aggressive and aimed toward expeditiously moving the recipient to a less restrictive environment.
- **Emergency:** A sudden onset of symptomatology characterized by suicidal ideations/gestures, homicidal ideation/gestures, and/or psychosis to the extent that imminent hospitalization is warranted and that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part, death of the recipient, or harm to another person by the recipient.

Elective Review Process

The following process occurs for acute and PRTF elective admission reviews for Medicaid recipients and applicants under age 21.

1. The provider verifies the recipient's Medicaid eligibility or Medicaid application.
2. The provider notifies Ascend—by web system or fax—up to three (3) business days prior to or on the day of the elective admission. This notification occurs by submission of a completed North Dakota Acute or PRTF Review Form that includes:

Demographic information	Clinical information
<ul style="list-style-type: none"> • Recipient’s Medicaid ID number (MID) • Recipient’s social security number (SSN) • Recipient’s name, date of birth, gender • Recipient’s address, county of eligibility, telephone number • Responsible party’s name, address, phone number • Provider’s name, date of admission 	<ul style="list-style-type: none"> • Estimated length of stay <ul style="list-style-type: none"> • Prior inpatient treatment • Prior outpatient treatment/alternative treatment • Initial treatment plan • Admitting diagnoses, DSM-IV diagnosis on Axis I through V • Medication history • Precautions • Current symptoms requiring inpatient care • Chronic behavior/symptoms • Appropriate medical, social, and family histories

3. If additional information is required from the provider to complete the review, Ascend contacts the referral source. The request for additional information and the status of the review can be seen and submitted through the web-based system 24-hours per day.
4. Ascend conducts the review and notifies the provider of the determination by telephone or email within one (1) business day from receipt of the review request. Determinations are also available through the web-based system.
5. If medical necessity is met, Ascend completes a CON form that accompanies the written approval notification sent to the facility.

Emergency Review Process

The following occurs for acute emergency admissions for Medicaid recipients under age 21 in acute inpatient treatment facilities.

1. The provider verifies the recipient’s Medicaid eligibility or Medicaid application.
2. The provider notifies Ascend by web system or fax *on the day of admission or within two (2) business days after admission*. This notification occurs by submission of a completed North Dakota Acute Review Form that includes all information specified above (same as for elective admissions).
3. Ascend conducts the review and notifies the provider of the determination by telephone or email within one (1) business day from receipt of the review request. Determinations are also available through the web-based system.
4. The provider must submit a completed CON form within 14 days of the admission. The provider must maintain a copy of the CON form in the recipient’s or applicant’s medical record.

II-B-03: Continued Stay Reviews

Continued stay reviews (CSR) apply to Medicaid recipients and applicants who are eligible on admission and for individuals who apply for Medicaid following admission. CSRs involve continued evaluation of the individual's need for acute services. The CSR process re-applies CON criteria, comparing the individual's medical need for the level of intensity in services along with his/her continued ability to benefit from those services. For Acute Inpatient Care, each CSR may permit continued approval for the inpatient stay *up to 14 calendar days* until discharge from the facility or until medical necessity is no longer met. For PRTF care, each CSR may permit continued approval for *up to 90 calendar days* until discharge from the facility or until medical necessity is no longer met.

Acute CSR Process

The following occurs for acute CSR for individuals under age 21 who were subject to an Under 21 admission review.

1. The provider contacts Ascend by web system or fax within *one (1) business day prior to the termination of the current certification*. This notification occurs by submission of a completed North Dakota Acute Review Form that includes:
 - Demographic information as specified under admission reviews
 - Clinical information
 - Current Treatment Plan
 - Changes to current DSM-IV diagnosis on Axis I through V. Global Assessment of Functioning (GAF) is required for each authorization request
 - Assessment of treatment progress related to admitting symptoms and identified treatment goals
 - Summary of treatment provided
 - Assessment/justification for continued services at this level of care
 - Behavioral Management Interventions/Critical Incidents
 - Current list of medications or rationale for medication changes, if applicable
 - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan
2. Ascend conducts the review and notifies provider of the determination by telephone, email, or electronically within one (1) business day from receipt of the review request.
3. The determination may permit continued approval for *up to 14 calendar days* until discharge from the facility or until medical necessity is no longer met.

PRTF CSR Process

The following occurs for PRTF CSR for individuals under age 21 who were subject to an Under 21 admission review.

4. The provider contacts DDM Ascend by web system within *five (5) business day prior to the termination of the current certification*. This notification occurs by web submission of a completed North Dakota PRTF Review Form that includes:
 - Demographic information as specified under admission reviews

- Clinical information
 - Current Treatment Plan
 - Changes to current DSM-IV diagnosis on Axis I through V. Global Assessment of Functioning (GAF) is required for each authorization request
 - Assessment of treatment progress related to admitting symptoms and identified treatment goals
 - Summary of treatment provided
 - Assessment/justification for continued services at this level of care
 - Behavioral Management Interventions/Critical Incidents
 - Current list of medications or rationale for medication changes, if applicable
 - Projected discharge date and clinically appropriate discharge plan, citing evidence of progress toward completion of that plan
5. Ascend conducts the review and notifies provider of the determination by telephone, email, or electronically within one (1) business day from receipt of the review request.
 6. The determination may permit continued approval for *up to 90 calendar days* until discharge from the facility or until medical necessity is no longer met.

II-B-04: Retrospective Reviews

Retrospective reviews involve evaluating medical need for services for individuals who apply for Medicaid during or following receipt of acute inpatient or PRTF services. If an individual applies for Medicaid benefits during his/her stay, a retrospective review occurs to determine whether the admission was appropriate and, if so, whether all or portions of the stay were medically necessary. Those same considerations apply for individuals whose Medicaid application occurs after discharge.

Retrospective reviews are completed whenever an individual applies for Medicaid benefits during or following receipt of services. Submission of the retrospective review must occur by or before 6 months from the date of Medicaid approval. If medical necessity is not met for the entire length of stay, the review is deferred to Ascend's Board-certified/eligible child psychiatrist for final determination of a partial approval.

Retrospective Review Process

For individuals who apply for Medicaid during or following receipt of acute inpatient or PRTF services the following procedures apply:

1. The provider verifies the recipient's Medicaid eligibility or Medicaid application.
2. The provider completes and submits the retrospective review for reimbursement to Debbie Baier, North Dakota State Officer. The form is available at www.PASRR.com. Debbie will approve to proceed with review or issue a technical denial and return a copy of her decision to the provider and Ascend.
3. The provider has 30 days from the date of Medicaid notification to submit a retrospective review.

II-B-05: Outcomes and Notifications

The following outcomes occur as a result of the Under 21 review process.

- **Approval:** authorization of the admission and acute placement for up to 14 calendar days or PRTF placement for up to 90 days. Authorization will include the end date on which the certification period terminates.
- **Pending:** Determination that additional information is needed to complete the review. The provider must submit information within two (2) business days of the request for additional information. If additional information is not received from the provider within two (2) business days of the request, a technical denial will be issued. If additional information is received within two business days of the request and medical necessity is met, the authorization review is completed and the provider notified by telephone/e-mail of the review determination within one (1) business day from receipt of additional information.
- **Deferral:** If medical necessity is not met or if the individual is age 6 or under, the review is deferred to a Ascend Board-certified/eligible child psychiatrist for a determination. For CSRs, a deferral may also occur if there are serious discrepancies or problems with assessments and/or treatment plans for the recipient (e.g., unrealistic treatment plan, failure to provide appropriate assessments) or if there is a significant increase in the projected length of stay that occurs during the course of treatment. Ascend's psychiatrist reviews the information and makes a determination within one (1) business day of deferral or receipt of additional information. Ascend notifies the provider by telephone, email, or electronically of the review determination within one (1) business day of the determination.
- **Partial Approval:** An Ascend Board-certified/eligible child psychiatrist issues a partial approval determination when only a portion of a stay meets Medicaid medical necessity criteria. The Desk Reconsideration/Appeal processes apply to partial approvals.
- **Denial:** An Ascend Board-certified/eligible child psychiatrist issues a denial if the request for authorization does not meet Medicaid medical necessity criteria for the services requested. The Desk Reconsideration/Appeal processes apply to denial decisions.
- **Technical Denial:** A denial of Medicaid payment because of provider non-compliance with Medicaid protocol (i.e., failure to complete or submit a CON timely or appropriately, failure to submit additional information when requested, etc.). Technical denial is based on failure to submit in a timely manner and does not involve a physician review.

Notification Process

Ascend staff will call the referring individual within one (1) business day of assessment completion, followed by documentation of the assessment outcome and, as applicable, appeal rights to the legal representative. A notification letter will also be forwarded to the admitting facility.

III. ACUTE MEDICAL NECESSITY STANDARDS

Each of the following criteria A – C must be met for elective admission to acute inpatient psychiatric services when payment is to be made on behalf of eligible recipients of Title XIX Medicaid benefits (42 CFR 441.152). If

the individual is admitted through an emergency admission, in lieu of assessing the individual's status against the following criteria, a determination may be made as to whether the individual presented at admission as homicidal, suicidal, or psychotic.

III-A: Admission Criteria

Criterion A: Ambulatory resources providing less restrictive levels of care that are available in the community do not meet the treatment needs of the recipient. To meet this requirement, ONE of the following three items must be established:

- (1) A less restrictive (lower) level of care will not meet the recipient's treatment needs. Examples of less restrictive levels of care include:
 - Family or relative placement with outpatient clinical services
 - Outpatient therapy
 - Group home supported by outpatient clinical services
 - Therapeutic Group home
 - Other outpatient clinical or rehabilitation services
 - Self-help groups with outpatient day treatment
 - Residential Treatment or Day Care Treatment
- (2) An appropriate less restrictive (lower) level of care is unavailable or inaccessible. Medically necessary due to complicating co-existing mental health and physical disorders. Although the Axis III condition requires medical treatment, the co-morbid psychiatric issues on Axis I are now the predominant treatment course (e.g., major depression with epilepsy; major depression with insulin dependent diabetes; major depression with renal dialysis).

• Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement, ALL of the following four conditions must be established:

1. On or before admission, an attending or staff physician completed a medical evaluation certifying the need for hospitalization with treatment to be given under the direction of a physician.
2. The recipient has a primary diagnosis of a mental health disorder classified as a DSM IV-R Axis I diagnosis between 290-316 (excludes substance abuse disorders). Any substance abuse disorder must be secondary to a co-existing mental health disorder.
3. The severity of symptoms rating on Axis V Global Assessment of Functioning (GAF) at admission to a psychiatric hospital is 50 or below; the GAF may be higher in cases where there is acute risk of harm to self or others or in continued stay cases where the treatment has stabilized the recipient's medical condition and the recipient is awaiting placement to an appropriate lower level of care.
4. Currently the recipient is experiencing acute disturbances related to the mental health disorder with deficits in at least one of the following established:
 - **Self-care (age appropriate):** Basic impairment in ability to meet needs for nutrition, sleep, hygiene, rest, or stimulation related to the recipient's Axis I mental disorder(s) as diagnosed in number two (2). Indicators include: Self-care deficit places recipient in life-threatening physiological imbalance without skilled intervention and supervision (e.g., dehydration, starvation states, exhaustion as a result of extreme hyperactivity or insomnia, and lack of medication compliance); Sleep deprivation or significant weight loss; Self-care deficit severe and longstanding enough to prevent participation in any alternative setting in the community, including refusal to comply with treatment.
 - **Impaired Safety:** Threat to self or others caused by the mental disorder, including threats accompanied by any one of the following: depressed mood, recent loss, recent suicide attempt or gesture, concomitant substance abuse, verbalizations escalating in intensity, verbalization of intent accompanied by a gesture or plan.
 - **Impaired thought and/or perceptual processes (reality testing):** Inability to perceive and validate reality to the extent that the recipient is at risk of severe harm to self or others because of problems negotiating the basic environment (i.e., loose associations, paranoia, hallucinations, delusions, other forms of thought disorder). Indicators include: disruption of safety to self, family, peer or community group; impaired reality testing sufficient to prohibit participation in school or vocational pursuits; not responsive to outpatient trial of medication or supportive care; requires inpatient diagnostic evaluation to determine treatment needs.
 - **Severely dysfunctional patterns:** Familial, environmental, or behavioral processes that place the recipient at risk. Indicators: Family environment is causing escalation of recipient's symptoms or places him at risk; The family situation is not responsive to outpatient or community resources and intervention; Instability or disruption is escalating; The situation does not improve with the provision of economic or social resources; Severe behavior problems prohibit any participation in a less restrictive level of care (e.g., acutely sexualized behavior, risk of running away, impairing safety, repeated substance abuse, etc.)

Criterion 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. To meet this requirement, BOTH of the following conditions must be met.

1. The treatment provider describes a treatment plan showing how the recipient's condition is expected to either improve, or prevent risk of regression and possible impairment of safety, such as would be caused by discharge without immediate accessibility or availability to an appropriate placement in a lower level of care.
2. Active daily measures are diligently taken by staff to develop and implement an appropriate lower level of care. The details of these active measures are given during the Prior Authorization reviews, and are documented in the daily progress notes in the charts.

A – C must be met for discharge from acute inpatient psychiatric services.

Criterion A: Resources providing less restrictive levels of care are available and accessible and will meet the treatment needs of the recipient (examples are below).

- Family or relative placement with outpatient therapy
- Day or after-school treatment
- Therapeutic Foster care
- Group child care supported by outpatient therapy
- Other Clinical or Rehabilitative Services
- Residential Treatment

• Criteria B: Proper treatment of the recipient's psychiatric condition can be met on an outpatient basis. To meet this requirement all of the following requirements must be met:

1. The recipient is not experiencing problems related to the mental disorder in the following categories below.
 - **Self-care (age appropriate):** The recipient is able to meet basic needs for nutrition, sleep, hygiene, rest, or stimulation.
 - **Safety:** Within the past 24 hours, the recipient has not exhibited gestures of harm to self or others.
 - **Thought and/or perceptual processes (reality testing):** The recipient has demonstrated an ability to perceive and validate reality sufficient to negotiate the basic environment.
2. The treatment team has developed a plan of treatment that can be met in an outpatient level of care.

Criterion C: The outpatient services can reasonably be expected to improve the recipient's condition or prevent further regression.

III-B: Continued Stay Criteria

For continued acute inpatient stays in a psychiatric hospital or an inpatient psychiatric program in a hospital to be authorized, criteria in Sections A, B, and C must be met. If the primary need for inpatient care is substance dependency, proceed to Acute Inpatient for Substance Dependency Hospitalizations.

• Criterion A: Ambulatory care resources in the community do not meet the treatment need of the individual –and- a minimum of one of the following is established:

<p>1. A lower level of care is unsafe and will place the recipient at risk for imminent danger of harm. Examples of lower level care include:</p> <ul style="list-style-type: none"> • Family or relative placement with outpatient therapy • Day or after-school treatment • Foster care with outpatient therapy • Therapeutic foster care • Group child care supported by outpatient therapy • Therapeutic group child care • Partial hospitalization • Residential setting 	<p>2. Clinical evidence that a lower level of care will not meet the recipient's treatment needs. For example:</p> <ul style="list-style-type: none"> • Patient's behavior persists despite therapeutic interventions in a lower level of care, placing the recipient at risk of serious harm or making treatment in a lower level of care unsafe. 	<p>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, inpatient care is medically necessary at a higher level of care. Examples include:</p> <ul style="list-style-type: none"> • Major depression with epilepsy • Major depression with unstable insulin dependent diabetes • Major depression with renal dialysis
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• Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement all of the following requirements must be met:

<p>1. The patient has a psychiatric condition or disorder which is classified as a DSM-IV diagnosis (neither substance abuse nor rule-out conditions qualify under this criterion).</p>	<p>4. The treatment team has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at an inpatient psychiatric level of care; specifically</p> <ul style="list-style-type: none"> • Services shall be under the supervision of a psychiatrist • Intervention of qualified professionals shall be available 24-hours per day • Multiple therapies (group counseling, individual counseling, recreational therapy, family therapy, etc.) shall be actively provided to the recipient 	
<p>2. The rating on DSM-IV Axis V continues to be 50 or less. However, Axis V rating will be used as the basis for denial only if critical to establish the need for inpatient psychiatric hospital treatment.</p>		
<p>3. The recipient is currently experiencing problems related to the mental disorder diagnosis in number one (1) above and at least one (1) of the following categories below.</p> <p>a. Self-care deficit (not age related): Impairment of ability to meet physical needs which place the recipient at risk of serious self-harm. Indicators:</p> <ul style="list-style-type: none"> • Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe • Self-care deficit places recipient in life threatening psychological imbalance without 24-hour medical nursing intervention and supervision (examples: dehydration, starvation states, exhaustion due to extreme hyperactivity) <p>b. Impaired safety (threat to self or others): Continued evidence of serious intent to harm self or others caused by the recipient's mental disorder. Indicators:</p> <ul style="list-style-type: none"> • Continued suicidal/homicidal ideation with expression of serious plan of intent • Continued violent or aggressive behavior requiring seclusion or restraints <p>c. Impaired thought and/or perceptual processes (reality testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his basic environment, nor participate in family or school (e.g., due to paranoia, hallucinations, delusions) and it is likely that the recipient will suffer serious harm. Indicators:</p> <ul style="list-style-type: none"> • Disruption of safety of self, family, peer or community group • Impaired reality testing sufficient to prohibit participation in any community educational alternative • Not responsive to outpatient trial of medication • Requires inpatient diagnostic evaluation to determine treatment needs <p>d. Severely dysfunctional patterns: Family, environmental, or behavioral processes which place the recipient at risk of serious harm without intensive medical monitoring. Indicators (one (1) of the following):</p> <ul style="list-style-type: none"> • Family environment is causing escalation of recipient's symptoms or places recipient at risk • The family situation is not responsive to available outpatient intervention • Instability or disruption is escalating • Severe behavior prevents participation in a lower level of care 		
<p>Criterion 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.</p>		
<p>1. The treating facility shall have developed a plan for continuing treatment illustrating the required intensity of services available at an inpatient psychiatric level of care.</p>	<ul style="list-style-type: none"> • 2. The treating facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall be initiated as soon as the initial assessment is completed and shall include discrete, behavioral and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services. 	<ul style="list-style-type: none"> • 3. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued hospitalization would be required or would result in regression.
<p>4. Available clinical and research data supports the likelihood of positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.</p>		

Criteria for Acute Inpatient CSR (Primary Substance Dependency Admissions)

- Criterion A: Ambulatory care resources in the community do not meet the treatment need of the individual –and- a minimum of one of the following is established:

<p>1. A lower level of care is unsafe and will place the recipient at risk for imminent danger of harm. Examples of lower level care include:</p> <ul style="list-style-type: none"> • Family or relative placement with outpatient therapy • Day or after-school treatment • Foster care with outpatient therapy • Therapeutic foster care • Group child care supported by outpatient therapy • Therapeutic group child care • Partial hospitalization • Residential setting 	<p>2. Clinical evidence that a lower level of care will not meet the recipient's treatment needs.</p> <ul style="list-style-type: none"> •
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<ul style="list-style-type: none"> • Criteria B: Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement all of the following requirements must be met: 		
<p>1. The patient has a substance dependency disorder which is classified as a DSM-IV diagnosis (neither substance abuse nor rule-out conditions qualify under this criterion).</p>	<p>3. The treatment team has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at an inpatient psychiatric level of care; specifically:</p> <ul style="list-style-type: none"> • Services shall be under the supervision of a psychiatrist • Intervention of qualified professionals is available 24-hours per day • Multiple therapies (group counseling, individual counseling, recreational therapy, family therapy, etc.) will be actively provided to the recipient 	
<p>2. The recipient is currently experiencing problems related to the substance disorder diagnosed in number one (1) above in at least (2) two of the following categories below:</p> <ol style="list-style-type: none"> a. Evidence of signs and symptoms of withdrawal which continue to require 24-hour medical nursing intervention. b. Persistent Biomedical conditions and complications in addition to signs and symptoms of withdrawal which would place the recipient at risk of life-threatening consequences within 24-hour medical nursing care. To meet this criterion, at least one (1) of the following must be present: <ul style="list-style-type: none"> • Continued imminent danger of serious damage to physical health for concomitant biomedical conditions (e.g., pregnancy, hepatic decompensation, acute pancreatitis, gastrointestinal bleeding, cardiovascular disorders) • Continued life-threatening symptomatology related to excessive use of alcohol or other drugs (e.g., stupor, convulsions, etc.) c. Emotional/Behavioral conditions and complications - one (1) of the following: <ul style="list-style-type: none"> • Continued risk of behaviors endangering self or others (e.g., current suicidal/homicidal thoughts) • Presence of violent or disruptive behavior with imminent danger to self or others • Altered mental status with or without delirium as manifested by disorientation to self; alcohol hallucinosis, or toxic psychosis 		

<p>Criterion 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.</p>		
<p>1. The treating facility must have developed a plan for continuing treatment illustrating the required intensity of services available at an inpatient level of care.</p>	<p>2. The treating facility must provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan will be initiated as soon as the initial assessment is completed and will include discrete, behavioral and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.</p>	<p>3. Available clinical and research data supports the likelihood of positive outcome from inpatient psychiatric treatment for the patient's diagnosis and presenting symptoms.</p> <ul style="list-style-type: none"> •

Though not specifically a function of utilization criteria, determinations must consider quality of care issues in addition to medical necessity in order to arrive at a decision regarding suitability of treatment for a particular individual. These standards are further defined through operational criteria reflecting individual's

psychopathology, historical psychiatric indicators, diagnostics, and impairments resultant from current symptoms. While the basic domains are the same for both PRTF and inpatient psychiatric care, the locus of decision making for acute decisions is most heavily influenced by symptom acuity.

IV. PRTF MEDICAL NECESSITY STANDARDS

Ascend applies the Department's *Admission Criteria for PRTFs* to establish medical necessity determinations for residential treatment services. Basic admission criteria include:

- The recipient must have a DSM-IV Axis I diagnosis, excluding a primary diagnosis of chemical dependency or abuse. An individual with an Axis II diagnosis may be considered if an Axis I diagnosis indicates a need for treatment. The diagnosis should indicate the presence of a mental disorder which is moderate to severe in nature which is not a transient reactive disorder and which has had a serious impact on the individual's family, school, or social functioning.
- The rating on DSM-IV Axis V at admission must be fifty or less. The Axis IV or V rating may be used as the basis for a denial only if those ratings are critical to establishing the need for inpatient residential treatment (e.g., The individual's mental disorder rates *severe*, or the presence of two (2) or more diagnoses on Axis I and II indicate the individual's disturbance is severe and complex).

Before payment by the Department may be authorized, these following three (3) criteria (A – C) must be met for admission to or continued stay in a PRTF (see 42 CFR 441.152 for accredited PRTFs and North Dakota Administrative Code 75-02-02-10.1 for non-accredited PRTFs).

IV-A: Admission Criteria

Criterion A: Ambulatory resources available in the community do not meet the treatment needs of the recipient. To meet this requirement, ONE of A or B and Both C & D of the following:

At least one of the following (A or B):

- A) A less restrictive level of care will not meet the recipient's treatment needs or has been tried and found ineffective.
- B) An appropriate, less restrictive level of care is unavailable or inaccessible.

AND Both of the following (C & D):

- C) Family or community factors adversely impact appropriateness of less restrictive services (i.e., family persistently hampers treatment)
- D) The child's behavior disrupted placement ≥ 2 times (past 6 months if under age 12) over the past year or has persistently disrupted life at home and school over the past 9 months (over 6 months if under age 12).

AND

Family functioning or social relatedness is seriously impaired as indicated by ≥ 1 of the following (*circle as applicable*):

- a. History of severe physical, sexual, or emotional mistreatment.
- b. History of disrupted adoption or multiple foster placements.
- c. Child physically assaulted parent or adult caregiver due to the mental disorder.
- d. Child sexually assaulted others.
- e. History of fire setting (due to the mental disorder) and resulting in damage to residence.
- f. Individual less than age 14 has run away from two or more community placements.
- g. Child has impaired living situation of similar severity.

• **Criteria B:** Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. To meet this requirement ONE of the following four conditions must be established:

1. **SELF CARE DEFICIT:** Basic impairment of needs for nutrition, sleep, hygiene, rest, stimulation due to a DSM-IV diagnosis.
 - a. Self-care deficit severe and long standing enough to prevent participation in any alternative setting in the community, including refusal to comply with treatment (i.e., medications).
 - b. Self-care deficit placing the individual in a life-threatening physiological imbalance without skilled intervention and supervision, including dehydration, starvation states, exhaustion due to extreme hyperactivity.
 - c. Sleep deprivation or significant weight loss.
2. **IMPAIRED SAFETY, THREAT TO SELF OR OTHERS:** Verbalizations or gestures of intent to harm self or others, caused by the mental disorder.
 - a. Threats accompanied by one (1) of the following:
 - Depressed mood (irritable mood in children, weight loss, weight gain)
 - Recent loss
 - A recent suicide attempt or gesture (or past history of multiple attempts or gestures)
 - Concomitant substance abuse
 - Recent suicide or history of multiple suicides in family or peer group
 - Aggression toward others
 - Cruelty to animals
 - b. Verbalization escalating in intensity; or
 - c. Verbalization of intent accompanied by gesture or plan.
3. **IMPAIRED THOUGHT PROCESS:** Inability to perceive and validate reality to the extent the individual cannot negotiate basic environment or participate in family/school life (such as paranoia, hallucinations or delusions). Indicators include:
 - a. Disruption of safety to self, family, peer, or community group.
 - b. Impaired reality testing sufficient to prohibit individual's participation in any community educational alternative.
 - c. Individual is not responsive to outpatient trial of medication or supportive care.
4. **SEVERELY DYSFUNCTIONAL PATTERNS:** Family, environmental, or behavioral processes placing the individual at risk.
 - a. Documentation by mental health professional of family environment that is causing escalation of child's symptoms or places the child at risk.
 - b. A family situation not responsive to outpatient or community resources and intervention.
 - c. Escalation of instability or disruption.
 - d. A situation that does not improve with the provision of economic or social resources.
 - e. Severe behavior, such as habitual runaway, prostitution, and repeated substance abuse, prohibits participation in a lower level of care.

Criterion 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. To meet this requirement, ALL of the following conditions must be met.

1. **The provider describes an PRTF treatment plan that meets all of the following:**
 - Addresses the assessed need(s) and diagnosis(es) of the child
 - Sets out reasonable treatment goals that can be used to demonstrate improvement over the authorization period
 - Includes a comprehensive discharge plan with discrete mental, emotional, and/or behavioral criteria, expected discharge date, and identified outpatient provider for any continuing community-based treatment
2. **The psychiatric assessment delineates mental, emotional, or behavioral disorder that requires the intensity of services offered in an inpatient setting.** The psychiatric assessment identifies the recipient's requirement for additional therapeutic interventions, intensive milieu therapy, and a therapeutic environment and reflects the need for inpatient psychiatric care.
3. The individual **does not** exhibit **any** of the following **exclusion criteria of**:
 - Risk to harm to self or others (e.g., history of many suicidal gestures) and an appropriate risk management plan cannot be developed by the PRTF
 - Requires substance abuse treatment before benefit can be obtained from the PRTF

- Acutely psychotic or delirious
- Unstable medical condition

IV-A: Continued Stay Criteria

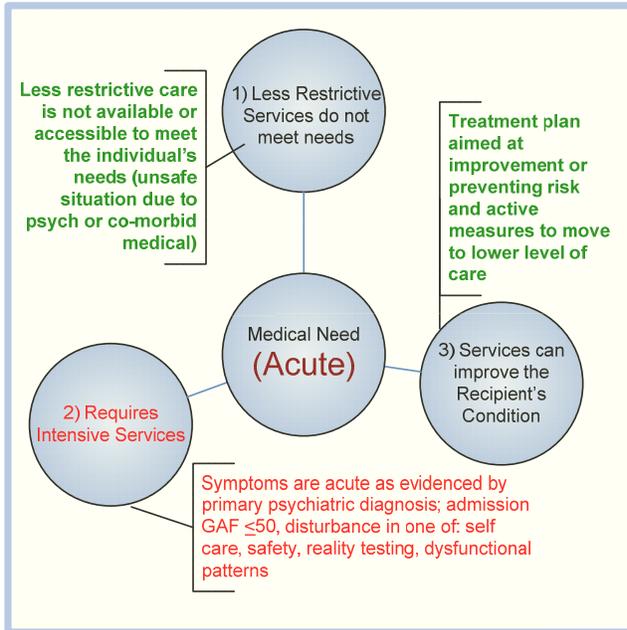
In order to be eligible for continued Medicaid payment in a PRTF, **all of the following** must be met:

<p>1. The recipient continues to meet admission criteria A, B, and C as detailed above in the Criteria for Residential Treatment Center Admissions. Examples include:</p> <ul style="list-style-type: none"> • Self-care deficit • Impaired safety, threat to self or others • Impaired thought process • Severely dysfunctional patterns • Requires 24-hour medical supervision under direction of a physician
<p>2. The ongoing treatment plan must include the patient's strengths, developmental needs, problem areas, treatment goals and objectives, which are based upon integration of the preadmission/admission assessments. For example, the recipient's treatment plan continues to describe repetitive disruptive behavior(s) in groups (<i>i.e., aggression toward others, inability to be redirected, and interruption of group process</i>).</p>
<p>3. The recipient is receiving active treatment. The recipient is responding to therapeutic services. Progress is documented in the medical record.</p>
<p>4. The recipient demonstrates reasonable likelihood of substantial benefit as a result of active continuation in the therapeutic program or a high likelihood of significant deterioration in the patient's condition without continued care in the residential settings. Benefits for this level of care are demonstrated by objective behavioral measurement of improvement; such as, but not limited to:</p> <ul style="list-style-type: none"> • Improved sleep and appetite • Improved affect and mood • Current contract for safety
<p>5. The recipient's family or surrogate family are actively involved in treatment and making progress toward goals; or, there is documentation of family's inability or unwillingness to cooperate. In this case, surrogate family or guardian must be involved (e.g., foster family, case manager).</p>
<p>6. Discharge planning is active, documented, and reflective of treatment needs and residential status.</p>

Though not specifically a function of utilization criteria, determinations must consider both quality of care and medical necessity in arriving at decisions of treatment suitability for a particular child. These standards are further defined through operational criteria reflecting the individual's psychopathology, historical psychiatric indicators, diagnostics, and impairments resultant from current symptoms. While the basic domains are the same for both PRTF and inpatient psychiatric care, the locus of decision making for acute decisions is most heavily influenced by symptom acuity. While standards do not significantly vary for PRTF placement, each of the three questions, in tandem, are more balanced in the decision making process. While judicial processes oftentimes *order* treatment as a result of criminal activity, a court order is not a sole determinant for inpatient or PRTF levels of care.

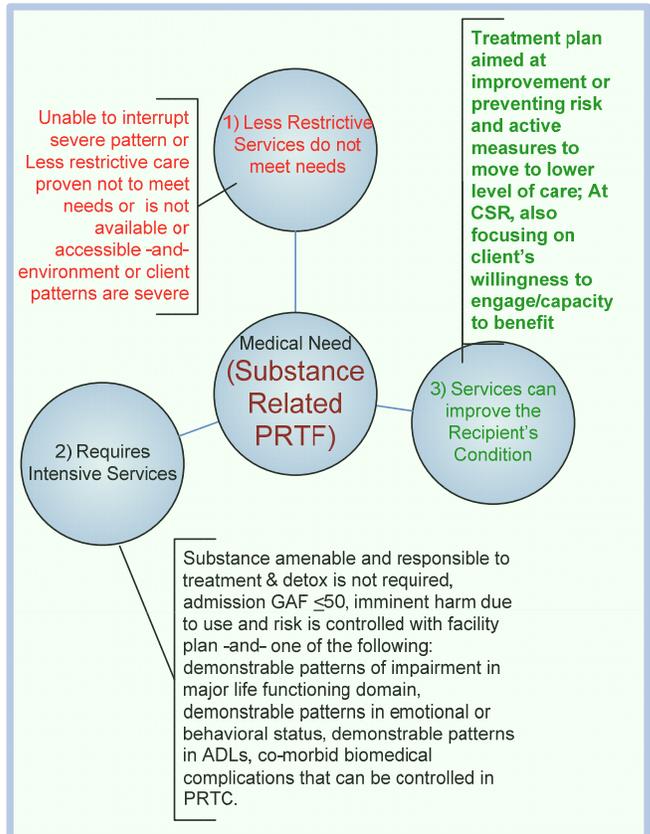
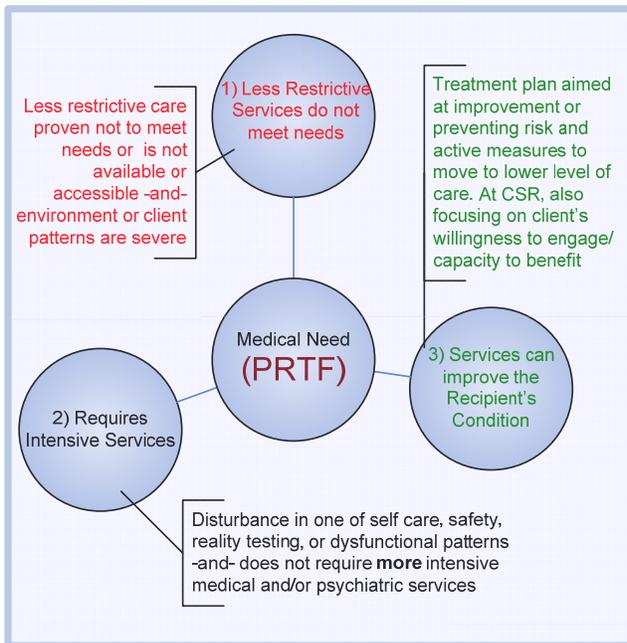
V. UTILIZATION REVIEW PARADIGM

The paradigm for emphasis differs depending upon the type of review (see picture below). For example, admission reviews focus the emphasis on the child's presenting need and its congruence with the type of requested services. While the service plan plays an important role, as well, the child's immediate needs direct the emphasis of the review. Subsequent reviews then, in turn, place an equal emphasis on the provider's quality of care and the consistency of that care with evidence-based and industry accepted practices. If the provider fails to meet the child's need, either through failure to provide appropriate service intensity or failure to deliver individualized care, that then becomes a quality issue. We work closely with providers to identify quality of care concerns and ensure need congruent and intensity congruent services meet industry benchmarks. While the basic domains are the same for both PRTF and inpatient psychiatric care, the locus of decision making for acute decisions is most heavily influenced by symptom acuity. Although federal standards do not vary for PRTF placement, the emphasis of review for each of the three questions is balanced differently in decision making process. It is also notable that, while judicial processes oftentimes *order* treatment as a result of criminal activity, a court order is not a sole determinant for inpatient or PRTF levels of care. These standards are further defined through operational criteria reflecting individual's psychopathology, historical psychiatric indicators, diagnostics, and impairments resultant from current symptoms.



441.155:
 1) ambulatory care (community) resources do not meet the treatment needs of the individual
 2) proper treatment requires IP services under the direction of a physician
 3) Services can reasonably be expected to improve the recipient's condition or prevent regression so that the services will no longer be needed

Primary Focus
Focus after stabilization
Additional Focus



VI. RECONSIDERATIONS AND APPEALS

Desk reconsideration and appeal processes are recourse opportunities for providers who disagree with adverse determinations. Desk reconsideration allows the facility to submit information not previously submitted that may justify medical necessity of the recipient's treatment. An appeal is a request from a recipient or his/her authorized representative to disagree with a denial for services and the opportunity to present his/her case to a reviewing authority

VI-A: Desk Reconsideration Process

The Desk Reconsideration Process occurs as follows:

1. The provider contacts Ascend by phone, facsimile, or email within ten (10) calendar days of the written notification of denial or partial approval.
2. Ascend will request that the provider submit any additional information disputing the basis for denial and copies of specific medical records.
3. Ascend's Board-certified/eligible child psychiatrist will complete the desk reconsideration within two (2) business days of receipt of the clinical information.
4. The physician who made the initial determination will perform the desk reconsideration whenever possible. Notification of all final determinations will include rationale for the determination based upon the applicable federal and State regulations, and include instructions as to the rights of further appeal.
5. If the desk reconsideration review upholds the adverse determination, the option to appeal remains available for the recipient and/or parent or legal guardian of the recipient as indicated in the initial determination. The Department is not responsible for payment to the provider for services provided to the recipient during desk reconsideration. If the outcome of the desk reconsideration reverses the denial, payment for services will be retroactive to the date of the disputed denial.
6. Written notification will be forwarded to the provider, recipient, and/or parent or legal guardian of the recipient related to the outcome of the desk reconsideration.

VI-B: Appeal Process

For Acute Inpatient Under 21 Providers and Accredited PRTFs receiving Title XIX funding for room and board and treatment services, the Department is not responsible for payment to the provider for services provided to the recipient during an appeal. If the outcome of the appeal reverses the denial, payment for services will be retroactive to the date of the disputed denial.

Recipients and/or parents and legal guardians of recipients may request an appeal via a written request to the North Dakota Department of Human Services within 30 calendar days of the initial denial determination notification.

Appeal Requests must be made in writing to:

Appeals Supervisor
North Dakota Department of Human Services

Department 325
600 E. Boulevard Avenue
Bismarck, ND 58505-0250

APPENDIX A: WEB SYSTEM ACCESS

How can I obtain a Login and Password Privileges?

1. **My agency needs privileges to use this application.**

- If you are required to submit Under 21 reviews, you may access the Web Based System. Your facility's supervisor can register as a provider supervisor by accessing the Supervisor Registration link on the ND Homepage. Supervisors must be designated to maintain their agency user information.
- Once the supervisor has completed the Supervisor Registration form and pressed submit, Ascend will receive it and process the request.
- Ascend will forward an email within two (2) business days to the supervisor. The email will include an approval or denial message and a link to the online system. If approved, the new user may access the link provided in the email and reset their password. Once the password has been reset, sign the electronic user agreement, which will automatically appear on the Login page. The agreement confirms that the user will use the application only for the intended purpose. The supervisor's agreement also confirms that he or she will remain responsible for periodically updating the user screen.

2. **My agency has privileges to use this application; however, we need to update our user information. (Enter new employees and remove users who are no longer employed by your agency).**

The supervisor must enter the system using their unique user name and password through the Supervisor Log In.

- On the ND Home Page, locate the link labeled "Supervisor Login."
- Click the link and enter your user name and password. The supervisor will then be able to update users through the "User Management Link" or Reset their password.
- To add a new user, click the link labeled "Add User" and complete the form. Press save once completed. The Web System will send an email to the user's email address that you provided. The email will provide instructions on how to reset their password. Once they reset their password, they will begin to submit reviews to Ascend using the Web Based system.
- To edit a user, locate the user in the table of users. Click on the link labeled "edit." The system will take you into the form for that user. Edit the information and press "Save" located at the bottom.

3. I forgot my password.

There are two ways to obtain password information.

- First, a designated supervisor from your facility maintains login information for your agency. Contact your supervisor for specific information.
- Secondly, Ascend can resend you a link to reset your password. On the ND Homepage, click the blue icon labeled “Login.” Below the user name and password, you will notice text in blue that states, “Forgot your password?” Click the blue text. The system will ask you to enter your email address. Once you have entered the information, press reset and Ascend will send an automatic email to your email account. Follow the instructions on the email.

APPENDIX B: ACUTE REVIEW FORM INSTRUCTIONS

The **Acute Screening Form** is used to identify individuals under the age of 21 who are applying for admission to, were emergently admitted to, or are currently residing in a North Dakota Medicaid funded Acute Inpatient Psychiatric Unit. The Acute screen must be completed on all individuals requiring admission to an inpatient Psychiatric Unit or Psychiatric Hospital and again before the end of the certification period, should ongoing care be needed.

- Online at www.pasrr.com
- Complete the Acute Review Form and fax to Ascend at 1.877.431.9568 if you do not have web access.

 Note: Advantages to completing the Acute Review Form online at www.pasrr.com:

- *Increased efficiency* by providing the ability to submit all information at one time (**including** the questions historically asked by Ascend reviewers when certain presenting information is present).
- *Increased accessibility* by offering the capacity to submit information 24 hours per day, 7 days per week, 365 days per year.
- *Federal compliance and reduced exposure for facilities through providing facilities with documentation* of all information reported to Ascend so that, in the event of a state or federal audit, the basis for the decision to certify is clearly provided.
- *HIPAA Compliance* through the web-based system which only allows *submission* of information, with users unable to gain access to Ascend’s database or any client data. Our web-based data is HIPAA compliant and integrates access control, authentication, and a 128-bit encryption key signed by Verisign to guarantee the security of network connections, the authenticity of local and remote users, and the privacy and integrity of data communications. As a contractor of the State of North Dakota, Ascend maintains fully compliant HIPAA practices with all communications about personally identifiable client information.
- *‘User Friendly’ access* with no IS/IT modifications or programming needs from providers to access information or submit screens. With web-based access, the provider simply accesses a specified internet address, enters a code, and begins entering information. The only changes necessary on the part of the provider may be to change settings on individual computers to print the completed screening information. Any special printing instructions will be provided on the website.

It is recommended that the referral source gather all screening information prior to initiating the electronic screen. Information is best obtained from several sources: the individual, parent/guardian, and outpatient service providers.

Facility information

Provide accurate contact information for the facility and the contact person should Ascend have additional questions.

Attending physician

The ND MD license is required for Medicaid purposes.

Type of review

Choose which type of acute review you would like to complete:

- Elective: initial review prior to or on the day of admission
- Emergency: review occurs within 2 days of admission to an inpatient unit
- CSR: continued stay review within 1 day of end date for certification period
- Retrospective: submitted within 6 months of notification of the individual's Medicaid approval

Demographics

All information is *required* in order for the review to be expedited.

- **Medicaid ID number:** should be 9 digits (include all zeroes).
- **Medicaid Applicant:** will only be "yes" if individual is currently applying for Medicaid; all individuals with a Medicaid number would be "no."
- **Medicaid Application Date:** only applies to individuals who do not currently have Medicaid but are in the process of applying.
- **Admit Date:** refers to the date of admission to the admitting facility.

Discharge plans

Complete as thoroughly as possible. Information supporting active discharge is a consideration in determining the number of days for approval.

- **Tentative or Actual Discharge Date:** refers to the anticipated date that individual will leave the current level of care. In the case of a retrospective review if the individual has left the facility, the date reflected would be the actual date of discharge.
- **Tentative Discharge Plans:** refers to any plans that are being considered for discharge location(s). Discharge plans should state where the individual is likely to go upon discharge (e.g., home with parents, PRTF placement, foster home, etc). Treatment goals are discussed elsewhere and should not be included in the discharge plans.
- **Progress:** refers to any advancement towards discharge or any changes to the plan.
 - For example: *Plan to discharge home with parents; **Progress:** Mother failed drug screening; home will need further testing before child can return. PATH added as possible discharge option.*
- **Approximate Date:** refers to the *anticipated* date that discharge will take place. Because the date is approximate, it may change from review to review as discharge plans change.

Responsible Party

Ensure this information is accurate as HIPAA protected information is mailed to this contact person.

Living Arrangements

Provide the individual's living arrangement prior to inpatient admission.

Prior Inpatient Treatment

This section must be filled out completely for the *initial* application. It is not required for CSRs unless additional information has become available since the initial admission review.

- **Admission and discharge date:** Approximations are acceptable but must be as accurate as possible based upon the judgment of the facility.
 - May be entered in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission:** Describe circumstances leading up to admission, such as suicidal statements with plan.
- **Outcome:** Describe disposition at discharge (e.g., d/c with outpatient therapy).
- **Description of Treatment:** Describe what treatment the individual received while inpatient (e.g., individual therapy, chemical dependency treatment, family therapy).

Prior Outpatient Treatment

This section must be filled out completely for the *initial* application. It is not required for CSRs unless additional information has become available since the initial admission review.

- **Admission and discharge date:** Approximations are acceptable but must be as accurate as possible.
 - May be entered in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission:** Describe why the individual required outpatient services (e.g., individual therapy after acute inpatient admission for suicidal ideation).
- **Outcome:** Describe result of treatment (e.g., no follow up by individual after initial visit, individual continued in treatment until admission to PRTF, etc).
- **Description of Treatment:** Describe intensity of treatment and what treatment was received (e.g., weekly individual therapy for 6 months).

Alcohol and Drug Use

Include all drugs that have been abused. Provide complete information for review to proceed. If no history of abuse, please write "none."

- **Substance:** Please include any drugs that are abused (e.g., nicotine, Ritalin, Tylenol PM, etc).
- **Age of regular use:** May be the same as age first used. Approximate age is permitted.
- **Date last used:** Approximate dates permitted (e.g., 2 weeks ago, 6 months ago, etc).
- **Amount:** Be specific (e.g., 2 cigarettes, 6 shots, etc).
- **Rate of Use:** Approximations are sufficient (e.g., pack of cigarettes weekly, 6 pack monthly, etc).
- **Method:** huff, drink, smoke, inject, pill, etc

Diagnosis

Complete all sections. Specify "No diagnosis" or "diagnosis deferred" if applicable.

- **Axis IV:** Mark the appropriate box(es) *and* specify the problem(s). Details help the clinician understand and obtain a comprehensive view of the individual being assessed.
- **Axis V:** If CAF and HAF aren't available, it is acceptable to insert the GAF score in both boxes.

Family Support System

Complete thoroughly, placing emphasis on level of support and treatment involvement. If individual does not have any active family supports, write "none."

- **Person:** Specify name of family member/friend
- **Relationship:** Specify relationship to individual (e.g., parent, friend, therapist, etc).

- **Description of Support:** Describe the support the person provides to the individual (e.g., makes weekly phone calls, visits monthly, etc).
- **Treatment Involvement:** Describe the person's involvement in the current treatment of the individual (e.g., participates in family therapy, helps develop treatment plan, etc).
- **Support Level:** Describe the perceived support the individual receives from the person (e.g., highly supportive, not supportive, enabling, etc).

Prescription Medications

Provide current medications first, and then list medications in the order of most recent being discontinued. If medication cannot be located on the drop down list, select "other" and write the medication in the box provided.

- **Dosage:** List the total of all dosages taken during the day (e.g., Seroquel 25 mg QAM, 50 mg QHS would be entered as *Seroquel 75mg per day* or *Seroquel 75mg QD*).
- **Diagnosis:** List individual's diagnosis that the medication is being used to treat.
- **Date started/discontinued:** Provide dates, if available; however, ranges are acceptable (e.g., started 6 months ago).

Symptoms Requiring Inpatient Care

Mark if the admission was court ordered.

- **Symptoms:** Describe a specific symptom that required inpatient/ongoing inpatient care (e.g., suicidal ideation with plan to cut wrists). Provide extensive detail about the intensity, severity, and frequency of behaviors and symptoms. Avoid use of euphemisms or jargon to describe behavior (e.g., rather than using descriptions such as 'dyscontrol', describe the behaviors, when they occur, precipitators, intensity, etc.).
- **Date started/Most recent date:** Provide the date (approximations are acceptable) that the behavior started and the most recent date the behavior presented itself.
 - For example, *suicidal ideation with plan to cut wrists; Started: 2/21/07; Most recent: 4/30/07.*
- **Intervention:** Describe any intervention provided by the family/outpatient services to address the behavior.
 - For example, *Outpatient therapy until 4/30/07. Increasing threats, acute inpatient admission required.*
- **Effectiveness:** Describe how the individual responded to the intervention.
 - For example, *OP therapy ineffective. Symptoms escalated as evidenced by increasing threats to punch mother in the face. Raised fist to mother and police were called.*

Precautions

List all precautions being used while treating the individual. Explain what behaviors warrant those precautions.

Chronic Behaviors

These are the behaviors that appear to be ongoing, with or without treatment

- **Symptom:** Describe a specific symptom that required ongoing care (e.g., physically aggressive toward mother). Avoid use of euphemisms or jargon to describe behavior (e.g., rather than using descriptions such as 'dyscontrol', describe the behaviors, when they occur, precipitators, intensity, etc.).
- **Date started/Most recent date:** Provide the date (as closely as possible) that the behavior started and the most recent date the behavior presented itself.

- For example, *Aggression towards mother. Started: 2/21/07. Most recent: 4/30/07. Aggression was evidenced by striking mother with closed fist.*
- **Intervention:** Describe any intervention provided by the family/outpatient services to address the behavior
 - For example, *Outpatient therapy until 4/30/07. Increasing threats, acute inpatient admission required.*
- **Effectiveness:** Describe how the individual responded to the intervention
 - For example, *OP therapy ineffective. Symptoms escalated as evidenced by destroying furniture in mother's home.*

Treatment Plan Goals

- **Goal:** should be attainable and should be based on criteria for successful discharge.
 - For example, *Learn appropriate coping skills to deal with feelings of loss.*
- **Start date:** should be start date for the goal. This may be the admission date or the date of a change in the treatment plan.
- **Frequency:** should be the frequency of the interventions that are being provided (e.g., daily individual therapy)
- **Effectiveness:** refers to the improvement/regression to reach the goal
 - For example, *goal changed 4/30/07 due to emergence of a new behavior.*

Service Intensity

Include the total number of interventions (i.e., group therapy, family therapy) that have taken place since the previous review. For “other,” please include items such as IQ testing, chemical dependency evaluation, etc.

APPENDIX C: PRTF REVIEW FORM INSTRUCTIONS

The ***PRTF Screening Form*** is used to identify individuals under the age of 21 who are applying for admission to, or are currently residing in a North Dakota Medicaid funded Psychiatric Residential Treatment Facility. The PRTF screen must be completed on all individuals prior to PRTF admission and again before the end of the certification period, should ongoing care be needed.

- Online at www.pasrr.com
- Complete the PASRR Level I form and fax to Ascend at 1.877.431.9568 if you do not have web access.

 Note: Advantages to completing the PRTF Review Form online at www.pasrr.com:

- *Increased efficiency* by providing the ability to submit all information at one time (**including** the questions historically asked by Ascend reviewers when certain presenting information is present).
- *Increased accessibility* by offering the capacity to submit information 24 hours per day, 7 days per week, 365 days per year.
- *Federal compliance and reduced exposure for facilities through providing facilities with documentation* of all information reported to Ascend so that, in the event of a state or federal audit, the basis for the decision to certify is clearly provided.
- *HIPAA Compliance* through the web-based system which only allows *submission* of information, with users unable to gain access to Ascend's database or any client data. Our web-based data is HIPAA compliant and integrates access control, authentication, and a 128-bit encryption key signed by

Verisign to guarantee the security of network connections, the authenticity of local and remote users, and the privacy and integrity of data communications. As a contractor of the State of North Dakota, Ascend maintains fully compliant HIPAA practices with all communications about personally identifiable client information.

- *'User Friendly' access* with no IS/IT modifications or programming needs from providers to access information or submit screens. With web-based access, the provider simply accesses a specified internet address, enters a code, and begins entering information. The only changes necessary on the part of the provider may be to change settings on individual computers to print the completed screening information. Any special printing instructions will be provided on the website.

It is recommended that the referral source gather all screening information prior to initiating the electronic screen. Information is best obtained from several sources: the individual, parent/guardian, and outpatient service providers.

Facility information

Provide accurate contact information for the facility and the contact person should Ascend have additional questions.

Attending physician

The ND MD license is required for Medicaid purposes.

Type of review

Choose which type of PRTF review you would like to complete:

- Elective: initial review prior to or on the day of admission
- CSR: continued stay review within 5 days of end date for certification period
- Retrospective: submitted within 6 months of notification of the individual's Medicaid approval

Demographics

All information is *required* in order for the review to be expedited.

- **Medicaid ID number:** should be 9 digits (include all zeroes).
- **Medicaid Applicant:** will only be "yes" if individual is currently applying for Medicaid; all individuals with a Medicaid number would be "no."
- **Medicaid Application Date:** only applies to individuals who do not currently have Medicaid but are in the process of applying.
- **Admit Date:** refers to the date of admission to the admitting facility.

Discharge plans

Complete as thoroughly as possible. Information supporting active discharge is a consideration in determining the number of days for approval.

- **Tentative or Actual Discharge Date:** refers to the anticipated date that individual will leave the current level of care. In the case of a retrospective review if the individual has left the facility, the date reflected would be the actual date of discharge.
- **Tentative Discharge Plans:** refers to any plans that are being considered for discharge location(s).
- **Progress:** refers to any advancement towards discharge or any changes to the plan.

- For example: *Plan to discharge home with parents; **Progress:** Mother failed drug screening; home will need further testing before child can return. PATH added as possible discharge option.*
- **Approximate Date:** refers to the anticipated date that this discharge plan will take place.
 - For example: **Approx date:** *changed from 5/31/07 to 6/15/07 due to need for step down placement.*

Responsible Party

Ensure this information is accurate as HIPAA protected information is mailed to this contact person.

Living Arrangements

Provide the individual's living arrangement prior to inpatient admission.

Prior Inpatient Treatment

This section must be filled out completely for the initial application. It is not required for CSRs unless additional information has become available since the initial admission review.

- **Admission and discharge date:** Approximations are acceptable but must be as accurate as possible based upon the judgment of the facility.
 - May be entered in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission:** Describe circumstances leading up to admission, such as suicidal statements with plan.
- **Outcome:** Describe disposition at discharge (e.g., d/c with outpatient therapy).
- **Description of Treatment:** Describe what treatment the individual received while inpatient (e.g., individual therapy, chemical dependency treatment, family therapy).

Prior Outpatient Treatment

This section must be filled out completely for the initial application. It is not required for CSRs unless additional information has become available since the initial admission review.

- **Admission and discharge date:** Approximations are acceptable but must be as accurate as possible.
 - May be entered in mm/dd/yyyy, mm/yyyy, or yyyy format.
- **Reason for Admission:** Describe why the individual required outpatient services (e.g., individual therapy after acute inpatient admission for suicidal ideation).
- **Outcome:** Describe result of treatment (e.g., no follow up by individual after initial visit, individual continued in treatment until admission to PRTF, etc).
- **Description of Treatment:** Describe intensity of treatment and what treatment was received (e.g., weekly individual therapy for 6 months).

Alcohol and Drug Use

Include all drugs that have been abused. Provide complete information for review to proceed. If no history of abuse, please write "none."

- **Substance:** Please include any drugs that are abused (e.g., nicotine, Ritalin, Tylenol PM, etc).
- **Age of regular use:** May be the same as age first used. Approximate age is permitted.
- **Date last used:** Approximate dates permitted (e.g., 2 weeks ago, 6 months ago, etc).
- **Amount:** Be specific (e.g., 2 cigarettes, 6 shots, etc).
- **Rate of Use:** Approximations are sufficient (e.g., pack of cigarettes weekly, 6 pack monthly, etc).
- **Method:** huff, drink, smoke, inject, pill

Diagnosis

Complete all sections. Specify “No diagnosis” or “diagnosis deferred” if applicable.

- **Axis IV:** Mark the appropriate box; as well as specify the problem
- **Axis V:** If CAF and HAF aren’t available, it is acceptable to insert the GAF score in both boxes.

Family Support System

Complete thoroughly, placing emphasis on level of support and treatment involvement. If individual does not have any active family supports, write “none.”

- **Person:** Specify name of family member/friend
- **Relationship:** Specify relationship to individual (e.g., parent, friend, therapist, etc).
- **Description of Support:** Describe the support the person provides to the individual (e.g., makes weekly phone calls, visits monthly, etc).
- **Treatment Involvement:** Describe the person’s involvement in the current treatment of the individual (e.g., participates in family therapy, helps develop treatment plan, etc).
- **Support Level:** Describe the perceived support the individual receives from the person (e.g., highly supportive, not supportive, enabling, etc).

Prescription Medications

Provide current medications first, and then list medications in the order of most recent being discontinued. If medication cannot be located on the drop down list, select “other” and write the medication in the box provided.

- **Dosage:** List the total of all dosages taken during the day (e.g., Seroquel 25 mg QAM, 50 mg QHS would be entered as *Seroquel 75mg per day* or *Seroquel 75mg QD*).
- **Diagnosis:** List individual’s diagnosis that the medication is being used to treat.
- **Date started/discontinued:** Provide dates, if available; however, ranges are acceptable (e.g., started 6 months ago).

Symptoms Requiring Current Level of Care

Mark if the admission was court ordered.

- **Symptoms:** Describe a specific symptom that required inpatient/ongoing inpatient care (e.g., suicidal ideation with plan to cut wrists). Avoid use of euphemisms or jargon to describe behavior (e.g., rather than using descriptions such as ‘dyscontrol’, describe the behaviors, when they occur, precipitators, intensity, etc.).
- **Date started/Most recent date:** Provide the date (as close as possible) that the behavior started and the most recent date the behavior presented itself.
 - For example, *suicidal ideation with plan to cut wrists; Started: 2/21/07; Most recent: 4/30/07.*
- **Intervention:** Describe any intervention provided by the family/outpatient services to address the behavior.
 - For example, *Outpatient therapy until 4/30/07. Increasing threats, acute inpatient admission required.*
- **Effectiveness:** Describe how the individual responded to the intervention.
 - For example, *OP therapy ineffective. Symptoms escalated as evidenced by increasing threats to punch mother in the face. Raised fist to mother and police were called.*

Precautions

List all precautions being used while treating the individual. Explain what behaviors warrant those precautions.

Chronic Behaviors

These are the behaviors that appear to be ongoing, with or without treatment

- **Symptom:** Describe a specific symptom that required ongoing care (e.g., physically aggressive toward mother). Avoid use of euphemisms or jargon to describe behavior (e.g., rather than using descriptions such as ‘dyscontrol’, describe the behaviors, when they occur, precipitators, intensity, etc.).
- **Date started/Most recent date:** Provide the date (as closely as possible) that the behavior started and the most recent date the behavior presented itself.
 - For example, *Aggression towards mother. Started: 2/21/07. Most recent: 4/30/07. Aggression was evidenced by striking mother with closed fist.*
- **Intervention:** Describe any intervention provided by the family/outpatient services to address the behavior
 - For example, *Outpatient therapy until 4/30/07. Increasing threats, acute inpatient admission required.*
- **Effectiveness:** Describe how the individual responded to the intervention
 - For example, *OP therapy ineffective. Symptoms escalated as evidenced by destroying furniture in mother’s home.*

Treatment Plan Goals

- **Goal:** should be attainable and should be based on criteria for successful discharge.
 - For example, *Learn appropriate coping skills to deal with feelings of loss.*
- **Start date:** should be start date for the goal. This may be the admission date or the date of a change in the treatment plan.
- **Frequency:** should be the frequency of the interventions that are being provided (e.g., daily individual therapy)
- **Effectiveness:** refers to the improvement/regression to reach the goal
 - For example, *goal changed 4/30/07 due to emergence of a new behavior.*

Motivation and Stage of Readiness

Refers to the individual’s involvement in treatment. This should include the individual’s participation in therapeutic treatments and level of willingness to make changes to address problem behaviors. For example, *individual motivated to make changes in order to return to family home. Accepts and acknowledges that acting out aggressively towards siblings is not an appropriate response when angry. Individual is working to establish positive coping skills for times when he feels angry.*

Service Intensity

Include the total number of interventions (i.e., group therapy, family therapy) that have taken place since the previous review. For “other,” please include items such as IQ testing, chemical dependency evaluation, etc.

Date of most recent evaluation by psychiatrist

This information is important to determine that the individual is under the care of a licensed physician while undergoing treatment. Key findings should indicate plans for changes to the treatment modalities in use to obtain a successful discharge.

Diagnostic Laboratory Tests

- **Lab type:** CBC, urine drug screen, etc
- **Findings:** Please describe the results of the test (e.g., UDS positive for cannabis).

APPENDIX D: FORMS

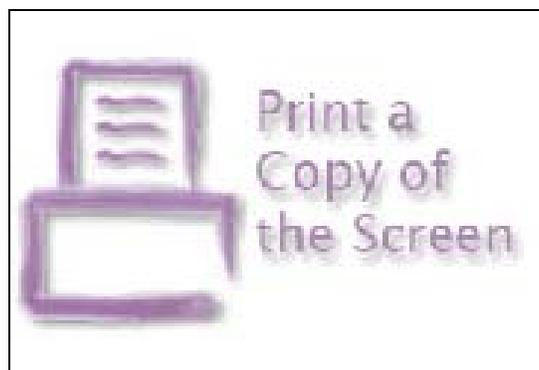
Copies of screening forms can be obtained from Ascend’s website at www.pasrr.com. You do not need a login in order to access and print forms.

To access the North Dakota Web Based Under 21 System, click the link located in Contract Sites.



Level I and Level of Care Forms

To print a copy of an Acute or PRTF Review form, click the purple printer link named “Print a Copy of the Screen.”



From that link, you should select which screen type you wish to print.

Available Screens

- Under 21 Acute Assessment
- Under 21 PRTF Assessment

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Retrospective Review Form

To print a copy of the Retrospective Review Form, click the “Retrospective Review Request for Reimbursement” link in the *Print a copy of the screen* section.

Available Screens

- Certificate of Need
- Retrospective Review Request for Reimbursement
- U21 Tracking Form
- U21 PRTF Review Form
- U21 Acute Review Form