



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

NEWSLETTER

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TO: Hospitals - Chief Executive Officer and
Independent Clinics

APPLICABLE ONLY TO: Hospitals That Provide Partial Hospitalization (PH) Services and Independent Clinics That Provide Partial Care (PC) Services

ROUTE TO: Hospital Psychiatric Clinical Department, and the Finance, Accounting and Billing Offices

SUBJECT: Prior Authorization Process for Partial Hospitalization and Partial Care Services

EFFECTIVE: Immediately

PURPOSE:

1. To inform the provider community of the clinical information needed by the Psychiatric Consultant to make determinations for the prior authorization of PC and PH services;
2. To distribute the "Guidelines for Prior Authorization Requests for Partial Hospitalization and Partial Care Services Provided to Medicaid Recipients"; and
3. To distribute the "Request for Prior Authorization Supplemental Information (FD-07A)" and instruct providers as to its use.

BACKGROUND: The purpose of the Prior Authorization process is to continue the established peer review activity that focuses on the quality, appropriateness and medical necessity of the mental health services provided through partial hospitalization and partial care programs to Medicaid recipients. Failure to obtain prior authorization, when required, will result in denial of the claim submitted for payment.

The Division of Medical Assistance and Health Services is introducing a supplemental process and form, called the Request for Prior Authorization Supplemental Information (FD-07A), to be attached to the Prior Authorization Form (FD-07) when the provider is requesting prior authorization:

1. For partial hospitalization services provided by hospital outpatient departments; or
2. For partial care services provided by mental health clinics to Medicaid recipients.

The supplemental information form is designed to provide essential and necessary information to the Psychiatric Consultant which is critical in responding to the provider's request for prior authorization. This process is designed to promote dialogue between the Psychiatric Consultant and the provider community.

ACTION: Hospitals which provide partial hospitalization services and mental health clinics which provide partial care services to Medicaid recipients, are hereby requested to follow the attached Guidelines for Prior Authorization Requests for Partial Hospitalization and Partial Care Services Provided to Medicaid Recipients.

Unisys will continue to inform providers of the outcome of the Prior Authorization (PA) process for PH and PC services. There will be no change to this PA process.

In addition, the Psychiatric Consultant will return to the provider, the Request for Prior Authorization Supplemental Information Form (FD-07A) when the prior authorization process results in one of the following:

1. A request for further information to be submitted by the provider; or
2. To inform the provider of modifications or reductions in the request for services, and the reasons for such action.

Garden State Health Plan and other managed care plans' prior authorization policies and procedures remain in effect.

For further information or questions, please contact Raymond Reinhart, M.D., Psychiatric Consultant, Office of Medical Affairs and Provider Relations, Division of Medical Assistance and Health Services, at 609-588-2749.

Attachments:

1. Guidelines for Prior Authorization Requests for Partial Hospitalization and Partial Care Services Provided to Medicaid Recipients;
2. Request for Prior Authorization for Mental Health Services (FD-07); and
3. Request for Prior Authorization Supplemental Information (FD-07A).

RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")

GUIDELINES FOR PRIOR AUTHORIZATION REQUESTS
FOR PARTIAL HOSPITALIZATION AND PARTIAL CARE SERVICES
PROVIDED TO MEDICAID RECIPIENTS

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INTRODUCTION

The New Jersey Medicaid program requires prior authorization (PA) for all partial hospitalization (PH) and partial care (PC) services provided to Medicaid recipients beyond established thresholds. Failure to obtain prior authorization from the Division of Medical Assistance and Health Services, when required, will result in denial of the claim submitted for payment. Therefore, it is very important that timely and complete prior authorization requests be submitted to the Medicaid agency.

Medicaid views PA as a peer review activity that focuses on quality, appropriateness and medical necessity of the service requested. The purpose of this document is to give providers clear guidelines concerning the information that should be included on the prior authorization request forms (FD-07) and (FD-07A). These documents were developed in consultation with representatives of the provider community and the Division of Mental Health and Hospitals. This collaboration was crucial to the development of a document that meets the intended purpose.

Use of the Guidelines in completing the request should improve the level of communication and foster a common ground for clinical dialogue between the provider of service and the Division of Medical Assistance and Health Services.

ABBREVIATED GUIDELINES

The Initial Authorization Request should establish the:

1. Major or serious mental illness (Current Diagnostic and Statistical Manual of Mental Disorders, (DSM, Axis I));
2. Failure of other treatment approaches to meet the client's needs;
3. Emergence of risk factors;
4. Severe impairment of function, which may be evidenced by the use of standard instruments (for example, a GAF Scale); and
5. Need for intense treatment by multidisciplinary team.

Subsequent Request for Continued Stay and Changes in the Level of Services should establish the:

1. Continuation of severe illness or acute exacerbation of chronic illness;
2. Length and course of illness;
3. Severity of impairment;
4. Resources and strengths, including support systems;
5. Demographics (early intervention is emphasized); and
6. Response to treatment.

GUIDELINES FOR PRIOR AUTHORIZATION

Initial Authorization Determinations:

Since prior authorization (PA) is only required beyond a certain threshold, admission to PH and PC will already have occurred by the time Medicaid receives the first request for prior authorization. Thus, the initial authorization criteria used by Medicaid for PA purposes will focus on:

1. Major mental illness (Current Diagnostic and Statistic Manual of Mental Disorders (DSM, Axis I));
 - a. presence of acute illness; or
 - b. immediate post hospital stage; or
 - c. exacerbation of chronic illness.
2. Failure of other treatment approaches to meet the needs of the client;
3. Emergence of risk factors, necessitating close surveillance;
4. Serious impairment of function. As a minimum, the request should include a narrative description of specific impairments or defects. Issues addressed should include but not be limited to the following impairments:
 - a. content of thought;
 - b. quality of thought;
 - c. orientation; and
 - d. quality of mood and affect.

Please note that the Division of Medical Assistance and Health Services does not currently require the use of a specific assessment tool. The use of standardized instruments, such as, the Global Level of Functioning (GLOF) Scale utilized by the Division of Mental Health and Hospitals, are strongly encouraged because it provides an objective measure of the client's level of functioning. An alternative to the GLOF scale is the Global Assessment of Functioning scale (GAF scale) which is Axis V of the current Diagnostic and Statistical Manual of Mental Disorders.

When utilizing the Global Assessment of Functioning (GAF) Scale, scores below 20 probably indicate a need for inpatient care; scores between 20 and 50 would be candidates for PC and PH; while scores over 50 may indicate that the client could be treated with other treatment approaches. It is recognized that absolute scores may not reflect the true need for services and, therefore, no "cutoff" for approval has been set. However, the use of the tool does provide a basis for communicating general information concerning the client's level of functioning.

5. Need for intense multidisciplinary structured treatment plan, employing multidisciplinary staff. The treatment plan must be goal/outcome oriented.

Continued Care and Level of Care:

In general, an attempt is made to tailor authorization approvals, modifications and denials according to evaluation of data supplied on FD-07 (FD-07A) requests. Consideration is given to all the items listed below. It must be stressed that the data is looked at in total and that no one item is considered in isolation.

1. Diagnosis:

An Axis I diagnosis is generally required to establish medical necessity of PC and PH services. Multiple diagnoses usually indicate a need for intensive treatment.

Axis II diagnoses, consisting of developmental disabilities and personality disorders, are dealt with by other than traditional mental health modalities. Persons dually diagnosed with developmental disabilities and mental illness may be approved for PC and PH services, if the mental illness is the primary diagnosis or there is a clearly described functional justification. Personality disorders warrant PC and PH necessary treatment only when they are severe enough to cause incapacitation or subjective suffering, and, therefore, would qualify as Axis I diagnosis. V Codes Diagnoses alone do not qualify for approval for this intensity of care.

2. Length and Course of Illness:

Recent acute illnesses and acute exacerbation of chronic illnesses generally require more intense levels of treatment than does a chronic illness that has been maintained or stabilized over a period of established treatment. Information should be provided concerning recent hospitalization, evidence of improvements and regression, the development of new problems, etc.

3. Severity of Illness/ Degree of Impairment:

Severity of illness as evidenced in severity of symptom, disturbance of behavior, impairment of reality testing and overall impairment of functional capacity will influence decisions about level of treatment. Information concerning the severity of illness helps to determine whether a less intensive level of service/treatment is precluded. The same issues discussed under the initial authorization determinations concerning degree of impairment and use of standardized instruments are applicable to continuation requests.

4. Resources:

The presence, absence and quality of support systems that impact on treatment should be incorporated into the treatment plan (for example, living arrangement, use of recreational time, "off hours" support/family life, other linkages to the community, etc.). Personal strengths including motivation, insight, intelligence, good interpersonal and vocational background should also be considered. The use and benefit of generic community agencies will be evaluated.

5. Demographics:

At times, a client's age, as well as the stage of illness, will be a factor in decisions about intensity of treatment. In general, more intensive treatments of children, youths and younger adults will be supported, in the belief that early intervention is most effective. Older individuals are more often suffering chronic illness and, therefore, may be able to be maintained with other treatment approaches in many instances.

6. Response to Treatment:

Treatment plans that enable a patient to move toward achievement of his/her goals will be supported. A major goal of the system is to provide the most effective services in the least restrictive environment.

Significant improvement, over a period of time, should eventually lead to a reduction of the level of service. In situations where stabilization of achieved improvements is the goal of treatment, the request must justify the need for continued services in order to avoid serious consequences (for example, the threatened impact of psycho-social stressors) and should affirmatively address the discharge planning activities, including a projected downward titration of services.

Conversely, there may be a need for a treatment plan that anticipates a "phase-in" of services. An increase in service may be requested in cases where movement towards a goal is significantly increasing. This plan should be documented as part of the prior authorization request.

Treatments that are not resulting in a patient's movement toward achievement of goals cannot continue to be supported. Re-evaluation of the treatment plan, including a denial or reduction in approved hours, may be recommended in those cases where goals are not being reached.

GUIDELINES FOR PREPARATION OF PRIOR AUTHORIZATION REQUESTS (FD-07 and FD-07A)

FD-07 Request Forms (Rev. 9/91):

At the current time, the FD-07 remains unchanged. However, the use of the FD-07 will be enhanced by the addition of a supplemental information page (FD-07A) and the issuance of these revised guidelines. The supplemental information page may be used by providers to present additional information. It will also be used by the Medicaid consultants to communicate comments, requests for additional information, etc. When the form is used in the latter situation, it will be returned directly to the provider from DMAHS.

Lines 1 through 8:

These lines must be accurate and complete in order to avert a systemic suspension of the prior authorization request.

Line 9 - Brief Clinical History:

An initial request should include a concise history of the duration of illness, hospitalization treatments, and length and degree of incapacitation. The place of service immediately before admission to PC or PH should be identified. For an extension request, submit a subsequent (FD-07) and (FD-07A) but do not repeat the total history but give an interval history from the preceding authorization time block including changes of clinical status, response to treatment and treatment plan changes.

Line 10 - Present Clinical Status (To Support the Request):

Lines 9 and 10 are very important to the Medicaid consultant for making disposition. Line 10 should be a concise statement of the current status including symptoms, behaviors, dysfunctions, significant changes in the plan and medication dosages. A request for an increase in level of service requires an explanation. What is being requested in Line 10 is not necessarily more information, but concise, targeted information. The new attached supplemental information page (FD-07A) offers additional space, if needed.

Line 11 - Diagnosis and Code:

For purposes of the prior authorization request, providers may use either ICD-9-CM or the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Please note that for purposes of claim submission, a ICD-9-CM diagnosis code must be used. The use of a DSM diagnosis code on the claim form may result in claim denial. The Division of Medical Assistance and Health services is exploring a change in this regard. However, until you are notified that such a change has been implemented, the ICD-9-CM coding scheme must continue to be used for claim submission purposes.

Line 12 - Treatment Request:

Choose the week, month or year, as appropriate, NOT ALL THREE. For PC or PH services, it will most often be the week column. Do not include components of PC or PH on this line.

Line 13 - Requested Date(s):

The dates of the authorization block should ideally be end to end. Example: If one ends on 5/15, the next one should begin on 5/16. Authorized dates (Line 14) will not be earlier than the date of receipt of the FD-07. Thus, it is important that prior authorization requests be submitted on a timely basis.

Line 16B - Procedure Requested:

The procedure requested should be HCPCS Z0180 (Partial Care - Full day) or Z0170 (Partial Care - Half day) for mental health clinics and Revenue Code 912 for hospitals.

Line 16D - Units Requested:

The units should be the total number of days of PC or PH expected to be attended throughout the authorization block. Example: A request for five (5) days a week for six (6) months should be indicated by a request for 130 units (26 weeks times 5 days).

Line 16H - Description of Service:

This description should read, as follows:

For mental health clinics:

PC Full day
PC Half day

For hospitals:

PH Full day
PH Half day

Line 16I - Total Fee Requested:

This total should be the total units times your usual and customary charge for the service.

Line 17 - Service Plans and Goals:

Although many clients suffer life long illnesses and will continue to need mental health services for the rest of their lives, mental health agencies are encouraged to exercise a mind set of optimism and hope, and to conceptualize an improved status for all whom they treat. Otherwise, treatments tend to slump into static, "no end-in-sight" extensions of institutional care and perpetuation of institutionalization. In this light, DMAHS feels that the request for information on the service plan and goals, including the discharge plan, is appropriate.

Discharge plans should include a summary of services, such as, medical day care, which may be available to assist the client with the phase-out from partial care/partial hospitalization program. If no such services are available, this should be so indicated.

GENERAL CONSIDERATIONS

1. Careful attention will be given to each request in an effort to make determinations (approved, modified, denied) that are compatible with clinical data that are supplied.
2. Partial hospitalization and partial care are regarded as "total" services, that is, those services should meet all mental health needs of all those enrolled. With few exceptions, services "outside" of PH and PC should not be necessary.
3. Extension requests should arrive in the Medicaid office no later than one week before, but not earlier than one month before the beginning date being requested.
4. If, in the course of an authorization period, a treatment plan is changed and/or, if treatment needs have increased, a new FD-07 and FD-07A should be submitted.
5. If a prior authorization request is modified or denied, the recipient has the right to request a fair hearing pursuant to N.J.A.C. 10:49-10.1(b) and 42 CFR 431.200.
6. If a request is modified or denied, the provider may file a request for an administrative hearing pursuant to N.J.A.C. 10:49 - 10.3(a).

However, it may be advantageous for the provider to contact the DMAHS Psychiatric Consultant at (609) 588-2749 to informally request reconsideration.

7. The information supplement page will be used as a vehicle for dialogue and exchange between the provider community and the Medicaid consultant, for request for additional information, for explanation of PA dispositions and for comments from the provider or psychiatric consultant.

COMMON ERRORS

1. Late submission;
2. Listing of PH and PC components, in addition to PH and PC codes;
3. Routine, stereotyped, repetitious narrative on line 10 that fails to indicate the need for, or anticipated benefits of continued treatment for the individual client;
4. Stating service needs instead of clinical description on line 10;
5. Poor handwriting; and
6. Failure to record medications and dosages.

REQUEST FOR PRIOR AUTHORIZATION
 FOR MENTAL HEALTH SERVICES

PA # 12

1. Recipient's Last Name		First Name		MI	2. Recipient's Street Address			Telephone Number	
3. HSP (MEDICAID) Case No.			4. Person No.	5. Date of Birth	6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		City	State	ZIP Code

7. Place of Service - Name and Address					CLINICAL INFORMATION				
8. PROVIDER OF SERVICE INFORMATION					9. Brief Clinical History				

Telephone Number		Medicaid Provider Number (Enter only when not printed below)		
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Name and Address

10. Present Clinical Status (To support request)

11. Diagnosis and Code (Must Conform With ICD-9-CM)

12. Treatment Request	Frequency Indicate Number			Length Of Session (Check)				
	Per Week	Per Month	Per Year	1 1/2 HR	1 HR	1/2 HR	1 Day	1/2 Day
A. Psychotherapy, Individual								
B. Psychotherapy, Group								
C. Family Therapy								
D. Family Therapy/Conference								
E. Partial Hospitalization								
F. Partial Care								
G. Medication Management								
H. Psychological Testing By Code Number								

13. REQUESTED DATE(S) From: _____ Thru: _____	14. AUTHORIZED DATE(S) From: _____ Thru: _____
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16. PRIOR AUTHORIZED SERVICES DETAIL (MAXIMUM OF 5 SERVICES)								GRAY SHADED AREA FOR DIVISION USE ONLY	
A	B	C	D	E	F	G	H	I	J
	PROCEDURE & MODIFIER CODE REQUESTED	ICD-9-CM CODE & SERVICE TYPE APPROVED	Units Requested	Units Approved (U.S. 21)			Description of Service	TOTAL FEE REQUESTED	



**REQUEST FOR PRIOR AUTHORIZATION
SUPPLEMENTAL INFORMATION**

Provider Information:

(Name)

(Address)

Recipient Information:

(Name)

(Medicaid #)

Contact Person:

(Name)

(Telephone #)

17. SERVICE PLAN & GOALS

ADDITIONAL CLINICAL INFORMATION (treatment goals, response to treatment, change of treatment plan, change of clinical status, psychotropic medication, etc.)

RESERVED FOR USE BY DMAHS CONSULTANT

