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Community Psychiatric Inpatient Instructions and Requirements

Purpose

The purpose of this document is to provide instruction to the Mental Health Division (MHD) designees, also referred to as the Regional Support Networks (RSNs), regarding the process by which community psychiatric inpatient care should be certified and authorized, to assure effective utilization management through prospective and concurrent review processes.

Scope

This document applies to all Regional Support Networks from August 1, 2007 to the issuance date of any succeeding documents and is, by reference, considered material to the current PIHP and SMH contracts related to the provision of community inpatient psychiatric care. The authority for this document is found in **WAC 388-550-2600**. **These instructions and processes apply only to ADMISSIONS on 08/01/07 and after. For persons admitted prior to 08/01/07, the previous contract language and hospital billing instructions apply.**

Definitions

The following definitions and abbreviations as well as those found in **WAC 388-500-0005, 388-550-1050, 388-550-2600** apply to this document:

(a) **“Authorization number”** refers to a number that is required on a claim in order for a provider to be paid for providing psychiatric inpatient services to a medical assistance consumer. (See Procedures for Assigning Authorization Numbers page 19) An authorization number:

- Is assigned when the certification process and prior authorization process has occurred;
- Identifies a specific request for the provision of psychiatric inpatient services to a medical assistance consumer;
- Verifies when prior or retrospective authorization has occurred;
- Will not be rescinded once assigned; and
- Does not guarantee payment.

(b) **“Certification”** means a clinical determination by a MHD designee that a consumer’s need for a voluntary or involuntary inpatient psychiatric admission, length of stay extension, or transfer has been reviewed and, based on the information provided, meets the requirements of medical necessity for inpatient psychiatric care. The certification process occurs concurrently with the prior authorization process.

(c) **“Concurrent utilization review”** means an evaluation performed by the MHD designee during a consumer's course of care. A continued stay review performed during the consumer's hospitalization is a form of concurrent utilization review and is used for the purposes of identifying days that are not medically necessary and therefore not reimbursable.

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- (d) **“Denial”** A denial is ONLY when the hospital believes medical necessity is met for a hospital level of inpatient care and the MHD designee disagrees and therefore does not authorize the care (see Denials page 15).
- (e) **“Diversion”** means the decision by the MHD designee to not authorize a consumer’s admission (or continue the stay if already admitted) to the requesting hospital and instead address the consumer’s need by using a less restrictive alternative to hospital level inpatient care. It may also mean using a facility with a lower level of inpatient care (e.g. an Evaluation and Treatment center.) See Diversions page 15)
- (f) **“Institution for Mental Diseases (IMD)”** means a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The MHD designates whether a facility meets the definition for an IMD.
- (g) **“Involuntary admission”** Refer to chapters 71.05 and 71.34 RCW.
- (h) **“Mental health division (MHD)”** is the unit within the department of social and health services (DSHS) authorized to contract for and monitor delivery of mental health programs. MHD is also known as the State Mental Health Authority.
- (i) **“Mental health division designee” or “MHD designee”** means a professional contact person authorized by MHD, who operates under the direction of a Regional Support Network (RSN) or a prepaid inpatient health plan (PIHP).
- (j) **“PIHP”** See “Prepaid inpatient health plan.”
- (k) **“Prepaid inpatient health plan” (PIHP)”** A mental health prepaid health plan is an entity that contracts with the mental health division to administer mental health services for people who are eligible for the Title XIX Medicaid program. (See **WAC 388-865-0300** for requirements.)
- (l) **“Principal diagnosis”** means the primary reason the person was admitted or the primary reason care is being continued.
- (m) **“Prior authorization”** means an administrative process by which hospital providers must obtain a MHD designee’s certification for a consumer’s inpatient psychiatric admission, length of stay extension, or transfer. The prior authorization process occurs concurrently with the certification process.
- (n) **“Regional Support Network (RSN)”** The mental health division contracts with certified regional support networks to administer all mental health services activities or programs within their jurisdiction using available resources. The regional support network must ensure services are responsive in an age and culturally competent manner to the mental health needs of its community. (See **WAC 388-865-0200** for requirements.)
- (o) **“Retrospective authorization”** means a process by which hospital providers and hospital unit providers must obtain a MHD designee’s certification after services have been initiated for a medical assistance consumer. Retrospective authorization can be prior to discharge or after discharge. This process is allowed only when circumstances beyond the control of the hospital or hospital unit provider prevented a prior authorization request or when the consumer has been determined to be eligible for medical assistance after discharge
- (p) **“RSN”** See Regional Support Network.”
- (q) **“Voluntary admission”** Refer to chapters 71.05 and 71.34 RCW.

Overview of Utilization Review Process:

It is expected that hospitals and MHD designees work together toward discharge beginning at admission. Detailed timelines, documentation, and procedural expectations for **Authorization Requirements** and **Authorization Procedures** pertaining to **Initial authorization and Continued Stay review for Inpatient Psychiatric Care** are given in the named sections below. However, an overview of the process is provided here for enhancement.

For Initial authorizations, MHD designees will:

- Have procedures in place for determining medical necessity and for determining the medical necessity of inpatient admissions,
- Collect and review **Clinical Data Required for Initial Certification** (see page 40) including patient's admitting diagnosis, presenting signs and symptoms, clinical objective findings, diagnostic results, clinical assessment and the treatment and discharge plans,
- Authorize initial length of stay (LOS) using the fully completed requisite **Initial Certification and Authorization form** (see page 28),
- Document and keep on file the rational for decision,
- Communicate decision to hospital and ensure the requisite **Initial Certification and Authorization form** is sent, and
- Have procedures in place to ensure due process for reconsideration if a hospital disagrees with the MHD designee's medical necessity determination.

For Extension authorizations, MHD designees will:

- Have procedures in place to for determining medical necessity of a continued stay,
- Collect and review **Clinical Data Required for Extension Certification** (see page 41) including patient's admitting diagnosis, presenting signs and symptoms, clinical objective findings, diagnostic results, clinical assessment and treatment plan results to date and discharge plan,
- Authorize extension length of stay (LOS) using the requisite **Extension Certification and Authorization form** (see page 34),
- Document and keep on file the rational for decision,
- Communicate decision to hospital and ensure the fully completed requisite **Extension Certification and Authorization form** is sent, and

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- **Have procedures in place to ensure due process for reconsideration if a hospital disagrees with the MHD designee's medical necessity determination.**

Inpatient Psychiatric Care Criteria

Inpatient psychiatric care for all Medical Assistance consumers (e.g. those on Title XIX and state programs) must be:

- **Medically necessary** (as defined in **WAC 388-500-0005**);
- **For a covered Principal diagnosis** (see Diagnosis Categories page **38**);
- **Approved (ordered)** by the professional in charge of the hospital or hospital unit; and
- **Certified** by a Mental Health Division (MHD) designee (Regional Support Network) operating under contract with MHD.

MHD designees making determinations to authorize inpatient care must meet the definition of a Mental Health Professional as per **WAC 388-865-0150**. Only a psychiatrist may deny a request for inpatient psychiatric care. A MHD designee may not delegate authorization or denial of inpatient psychiatric care to any of the Community Mental Health Agencies (CMHA) in its network.

Provider Requirements

These requirements do not apply to:

- Freestanding Evaluation and Treatment (E&T) facilities;
- Children's Long-term Inpatient Program (CLIP) facilities;
- Eastern State Hospital;
- Western State Hospital; and
- Residential treatment facilities.

DSHS only pays for hospital inpatient psychiatric care, as defined in chapters **246-320 and 246-322 WAC** when provided by one of the Department of Health (DOH) **licensed** hospitals or units listed below:

- Free-standing psychiatric hospitals determined by MHD to meet the federal definition of an Institution for Mental Diseases (IMD), which CMS defines as: "a hospital, nursing facility, or other institution of more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services;"
- Medicare-certified, distinct psychiatric units;

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- Hospitals that provide active psychiatric treatment (see **WAC 246-322-0170**) outside of a Medicare-certified or state-designated psychiatric unit, under the supervision of a physician; or
- State-designated pediatric psychiatric units.

In addition to DOH licensure, hospitals providing **involuntary** hospital inpatient psychiatric care must be **certified** by MHD in accordance with **WAC 388-865-0500** through **388-865-0504** and must meet the general conditions of payment criteria in **WAC 388-502-0100**.

Single Bed Certification

If a consumer is detained for involuntary care and a bed is not available in an MHD certified facility, the State Psychiatric Hospitals (under the authority of the Mental Health Division) may, at their discretion, issue a single bed certification which serves as temporary certification (see **WAC 388-865-0526**) allowing for inpatient admission to occur in that setting.

Requests for single bed certification are made **by the MHD designee** prior to commencement of the detention order.

The MHD designees listed below must seek single bed certification from Western State Hospital using the form on page 7.

- **Fax:** 253-756-2572 (M-F, 7:00 a.m.- 4:00 p.m.)
- **After 4:00 pm & Holidays:** 253-756-2873

MHD designee	Counties within the MHD's designee's service area
Clark	Clark
Grays Harbor	Grays Harbor
King	King
North Sound	Skagit, Snohomish, Whatcom, Island, San Juan
Pierce	Pierce
Peninsula	Clallam, Forks, Jefferson, Kitsap
South West	Cowlitz
Thurston Mason	Thurston Mason
Timberlands	Wahkiakum, Lewis, Pacific

The MHD designees listed below must seek single bed certification from Eastern State Hospital using the form on page 8.

- **Fax:** 509-299-4583
- **After Hours & Holidays:** same fax number

MHD designee	Counties within the MHD's designee's service area
Chelan Douglas	Chelan, Douglas
Greater Columbia	Kittitas, Yakima, Franklin, Benton, Whitman, Garfield, Columbia, Asotin, Walla-Walls, Klickitat, Skamania
North Central Spokane	Okanogan, Ferry, Stevens, Pend Oreille, Lincoln, Adams, Grant Spokane

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WSH SINGLE BED CERTIFICATION

Fax requests to: WSH Director of Social Work: **253-756-2572** (M-F 7a.m.- 4p.m)

After 4:00 p.m. & Holidays: WSH Director of Nursing: **253-756-2873**

Facility Requesting Certification: _____

RSN Designated Person Making Request: _____

Name/Title

FAX _____ Phone _____

Patient Name _____

DOB _____ SSN _____

Legal Status _____

Criteria for Requesting Certification: (choose one)

- (a) The consumer requires services that are not available at a facility certified under this chapter (WAC 388-865-0500) or a state psychiatric hospital.
- (b) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

If patient is an adolescent, is this request for an adult unit?

Estimated Length of Certification: _____ Days From _____ To _____

FOR USE BY WSH STAFF

Certification Approved By _____

Date: _____

Phone: 253-756-2524 or 756-2966

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ESH SINGLE BED CERTIFICATION WORKSHEET

Fax: 509-299-4583

PERSON PROVIDING INFORMATION		DATE
PHONE	FAX	
PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CURRENT LEGAL STATUS	DATE ORDERED	EXPIRATION DATE
FACILITY NAME		
FACILITY ADDRESS		
FACILITY PHONE NUMBER		
REASON FOR SINGLE BED CERTIFICATION		
ESTIMATED LENGTH OF CERTIFICATION DAYS	FROM	TO

Psychiatric Indigent Inpatient (PII) Program

Eligibility:

This program affects indigent consumers who receive voluntary hospital inpatient psychiatric care in a community hospital. Individuals must apply for this program. Individuals receive a Medical Assistance Identification (ID) Card with the identifier “**MIP-EMER No out of state care.**” Indigent consumers who are involuntarily hospitalized under chapters 71.05 and 71.34 RCW may be covered under other programs. Consumers may qualify for the PII program only after they are determined ineligible for other medical programs. The CSO must have an authorization number to process the application (see Procedures for Assigning Authorization Numbers page 19.)

Coverage:

The PII program covers voluntary emergent hospital inpatient psychiatric care in community hospitals within the state of Washington. A consumer is limited to a single three-month period of PII eligibility each 12-month period. These consumers are also subject to the \$2,000 Emergency Medical Expense Requirement (EMER) during the same 12-month period.

Non-Coverage:

This program does not cover ancillary charges for physicians, pharmacies, transportation (including ambulance), or other costs associated with a voluntary hospital inpatient psychiatric hospitalization. [Refer to WAC 388-865-0217]. The PII program covers usual and customary charges for voluntary hospital inpatient psychiatric hospitalization billed on a hospital billing form (UB-04).

Voluntary Treatment

The Mental Health Division designee may authorize and pay for Voluntary Hospital inpatient psychiatric hospitalization services provided to consumers who are eligible for medical assistance programs (e.g., Categorically Needy Program). Please see the Health and Recovery Services Administrations General Information Booklet for more information on medical assistance programs.

Involuntary Treatment

For persons who meet the age of consent (see “Age of Consent” page 10) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by **chapters 71.05 and 71.34 RCW**, the MHD designee administers an authorization number for services provided to consumers who are receiving medical assistance. When the consumer is in the process of applying for medical assistance, the funding source issued for payment is subject to the eligibility determination. If the consumer becomes eligible for Medicaid, Medicaid funds are used. If not, state funds are used.

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The MHD designee also authorizes services that are provided to consumers detained under ITA law when the consumer either refuses to apply for, or does not qualify for, any medical assistance program as described. These stays are paid for through the use of state funds.

Unlike the PII program, under ITA, DSHS *does* cover the ancillary charges for physicians, pharmacy, transportation (including ambulance) and other costs associated with an involuntary hospital inpatient psychiatric hospitalization.

Age of Consent for Inpatient Psychiatric Care

Voluntary:

12 years of age and under: May be admitted to treatment only with the permission of the minor's parent/legal guardian.

13-17 years of age: May be admitted to treatment only with the permission of:

- ✓ the minor and the minor's parent/guardian;
- ✓ the minor without parental consent; or
- ✓ the minor's parent/legal guardian without the minor's consent.

18 years of age and older: May be admitted to treatment only with the consumer's voluntary and informed written consent, a properly executed advance directive that allows for admission when the consumer is unable to consent, or the consent of the consumer's legal representative when appropriate.

Tribal Affiliation:

For children and adults who are members of a Native American Tribe, the age of consent of the associated tribe supersedes the age of consent rules above.

Involuntary:

Involuntary admissions occur in accordance with the Involuntary Treatment Act (ITA); **chapters 71.05 and 71.34 RCW**. Therefore, no consent is required. Only persons over the age of 12 may be subject to the provisions of these laws.

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Authorization Requirements

MHD designees must provide to requesting hospitals, certification and authorization or denial for *all* inpatient hospital psychiatric admissions. This includes consumers eligible for both Medicare and Medical Assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. It also includes consumers with primary commercial or private insurance and who have secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. Unless the hospital receives this authorization, DSHS will not pay for the services provided. The MHD designee may not withhold authorization pending eligibility for medical assistance.

Time Frames for Submission and Response

Time frames for submission and response of requests are as follows:

- **Initial:** Hospitals must request authorization prior to admission. This includes consumers eligible for both Medicare and Medical Assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization. This also includes consumers with primary commercial or private insurance and who have secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. If Medicare or primary benefits are exhausted during the course of hospitalization, authorization must be sought 24 hours prior to the benefit exhaustion. If the hospital chooses to admit a consumer without prior authorization due to staff shortages, the hospital must submit a request for initial authorization the same calendar day (which begins at midnight) as the admission. In these cases, the hospital assumes the risk for denial as the MHD designee may or may not authorize the care for that day. If there is disparity between the date of admission and date of authorization, the disparate days will not be covered. **MHD designees are required to respond to initial requests for authorization within two hours and make a determination within 12 hours.**
- **Length of stay extension:** Unless the MHD designee specifies otherwise on the current authorization form, hospitals must submit requests for continued stay at least 24 hours prior to the expiration of the currently authorized period. A hospital may choose to submit a request greater than 24 hours prior to the expiration of the currently authorized period. Whenever possible, hospitals are encouraged to submit extension requests during regular business hours. **MHD designees are required to provide determinations within 24 hours of receipt of the extension request.** If an MHD designee is unable to meet these timelines, the MHD designee must authorize a single day, allowing for the MHD designee's process to occur.
- **Transfer:** If the consumer is to be transferred from one hospital to another hospital (commonly referred to as admit to admit transfer) during the course of hospital inpatient

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psychiatric care, the hospital from which the consumer is being transferred must contact the MHD designee to request a new authorization for services to be provided in the new hospital at least 24 hours prior to the change in hospital of service (transfer.) **MHD designees are required make and determinations regarding transfers with in 24 hours of receiving the request.**

- **Retrospective:** Retrospective authorization may *only* occur if the consumer becomes eligible for medical assistance after admission or in the rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission. Hospitals may request authorization after the consumer is admitted, or admitted and discharged. **MHD designees have the authority to approve or deny a request for retrospective certification for a consumer's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in WAC 388-550-2600.** All retrospective certifications must be in accordance with the requirements of this document and an authorization or denial must be based upon the consumer's condition and services rendered at the time of admission and over the course of the hospital stay until the date of notification or discharge, as applicable. **Whether or not an MHD designee may have diverted a consumer to a lower level of inpatient care is not a consideration after the fact. Decisions about retrospective days are to be based upon medical necessity and services rendered. Again, hospitals may only submit requests for retroactive authorization in limited circumstances and are otherwise required to seek prior authorization.**

- ✓ For retrospective certification request *prior to discharge*, the hospital must submit a request for authorization for the current day and days forward. For the current day and days forward, the MHD designee must respond to the hospital within two hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e. admission date to the day before the MHD designee was contacted), the hospital must submit a separate request for authorization. MHD designees must provide a determination within 30 days upon receipt of the required clinical documentation for those days prior to MHD notification.
- ✓ For retrospective certification requests *after the discharge*, the hospital must submit a request for authorization as well as provide all the required clinical information to the MHD designee within 30 days of discharge. The MHD designee must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.

Medicare Dual Eligibility

For the purposes of this document, **Medicare dual eligibility** refers to cases when a consumer has healthcare coverage under both Medicare and Medical Assistance. In such cases, the following applies:

- Although hospitals are not required to seek the MHD designee's authorization for Medicare inpatient services, they *are* required to notify the MHD designee of a consumer's dual eligibility at the time of admission via phone or fax within the same calendar day as the admission. **The MHD designee is responsible for the consumer's deductible, co-insurance, or co-pay, up to the department determined allowed amount.**
- If the consumer with Medicare dual eligibility has exhausted their Medicare lifetime benefit at admission, the hospital is required to seek authorization from the MHD designee at admission. **MHD designees are required to respond to these requests within two hours and make a determination within 12 hours.**
- If the consumer with Medicare dual eligibility has exhausted their Medicare lifetime benefit during the course of hospital inpatient psychiatric care, the hospital is required to seek authorization from the MHD designee prior to the anticipated benefit exhaustion for the remaining expected days. **MHD designees are required to respond to these requests within two hours and make a determination within 12 hours.**

Commercial (Private) Insurance

As with Medicare dual eligibility, hospitals are required to notify the MHD designee at admission if a consumer has **commercial (private) insurance** that pays for hospital inpatient psychiatric care and has Medical Assistance as a secondary payor. Hospitals are required to seek the MHD designee's authorization 24 hours prior to the benefit exhaustion of the commercial or private insurance for any anticipated days past the benefit exhaustion date. The MHD designee may provide authorization retrospectively in cases where a delay has occurred in the commercial insurer's notification to the hospital that the benefit is exhausted. **MHD designees are required to respond to these requests within two hours and make a determination within 12 hours.**

Changes in Status

There may be more than one authorization needed during an episode of hospitalization. A request for authorization is required when there has been a change in a consumer's legal status, principal diagnosis, or hospital of service as indicated below. MHD designees must respond to

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hospital requests for authorization with in the timelines below when there has been a change in consumer's legal status, principal diagnosis, or hospital of service as follows:

- **Change in legal status:** If a consumer's legal status changes from involuntary to voluntary, the hospital must contact the MHD designee within 24 hours to request a new authorization reflecting the changed legal status. A subsequent authorization may be issued if the stay is authorized. If a consumer's legal status changes from voluntary to involuntary, the hospital is not required to notify the MHD designee because a DMHP is required for detention and thus the MHD designee would already be notified. The MHD designee will issue a separate authorization for the involuntary days. Any previously authorized days under the previous legal status that are past the date of the change in legal status are not covered. **MHD designees are required to respond to these requests within 2 hours and make a determination within 12 hours.**
- **Change in principal diagnosis:** The situations below outline different scenarios and corresponding expectations when a change in principle diagnosis occurs. **MHD designees must respond with in two hours and provide determinations with in 12 hours for requests related to changes in principal diagnosis:**
 - ✓ If a consumer's principal diagnosis changes from a physical health condition to a covered mental health condition, the hospital must contact the MHD designee within the calendar day to request an authorization related to the new principal covered diagnosis. An authorization may be issued if the stay is authorized.
 - ✓ If a consumer's principal diagnosis changes from a covered mental health diagnosis to a physical health diagnosis, the hospital must notify the authorizing MHD designee within 24 hours of this change. Any previously authorized days under the previous principle covered diagnosis that are past the date of the change in principle covered diagnosis are not covered.
 - ✓ If a consumer's principal diagnosis changes from a covered mental health diagnosis to another covered mental health diagnosis, a new authorization is *not* required, though this change should be communicated to the MHD designee within 24 hours of the change in diagnosis.
 - ✓ If a consumer authorized for hospital inpatient psychiatric care is discharged, admitted to a medical unit and then medically discharged and readmitted to psychiatric care during the course of their hospitalization, a new authorization (following initial timelines page 11) is required for the readmission to psychiatric care for that day forward.
- **Change in hospital of service (transfer):** If the consumer is to be transferred from one hospital to another hospital during the course of inpatient psychiatric care, (commonly referred to "admit to admit transfer") the hospital from which the consumer is being transferred must contact the MHD designee to request a new authorization for services to be

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provided in the new hospital 24 hours prior to the change in hospital of service (transfer). A subsequent authorization may be issued if the stay is approved. Hospitals will ensure that when a consumer who has been involuntarily detained is transferred from one facility to another, the consumer's current medical, psychiatric, and copies of any ITA or court papers accompany the consumer. **MHD designees are required to respond to requests within 24 hours of receipt of the request.**

Notification of Discharge:

MHD designees will be notified by hospitals within 24 hours when a consumer who has been authorized for inpatient care by the MHD designee has been discharged, or has left against medical advice, prior to the expiration of the authorized period. Authorized days which extend past the date the consumer was discharged or left the facility are not billable by hospitals and will not be paid. **The MHD designee will add the discharge date information to the current authorization form and ensure the hospital receives a copy within 3 business days of hospital notification.**

Denials:

- A denial occurs **ONLY** when the hospital believes medical necessity is met for a hospital level of inpatient care and the MHD designee disagrees and therefore does not authorize hospital level of inpatient care. Evaluation and Treatment (E&T) facilities also provide inpatient care. However, E&Ts are considered a lower level of inpatient care than the hospital due to the lack of medical services that are provided in hospitals. If the MHD designee believes an E&T is the more appropriate level of inpatient care and the hospital *agrees*, it is **NOT** a denial, it is a diversion from hospital level of care. If the MHD designee believes an E&T is the more appropriate level of inpatient care and the hospital does *not* agree, it **IS** a denial. A transfer from one community hospital to another community hospital is not a denial.
- If a denial appears indicated, the MHD designee must ensure the request is reviewed by a psychiatrist. **Only a psychiatrist may issue a denial.** A denial may be appealed. (See Clinical Appeals page 17) Concerns **NOT** pertaining to medical necessity may be disputed. (See Administrative Disputes page 17.)

Diversions:

- A diversion is any time a community hospital *agrees* to an alternative level of inpatient care (e.g. E&T) or any other alternative level of care (e.g. community-based crisis stabilization placement.) A diversion can occur prior to admission or during continued stay review if it is determined that another level of care is medically indicated. Below are some scenarios of diversions:

What is a Diversion?

- A Diversion is -If a requesting community hospital **agrees** to any alternative Level of Care, it is a *diversion*. **NOT** a denial. This can be applicable prior to admission or if during continued stay review it is determined another level of care is medically indicated.

What is a Denial?

- A Denial is- If a requesting community hospital requests an authorization for inpatient care and a reviewer makes a determination that Evaluation and Treatment (E & T) is appropriate, but the hospital **disagrees**, the mental health designee must deny the authorization in order to move to Evaluation and Treatment. E & T is considered a lower Level of Care.
- A Denial is- When the continued stay review determines that it is no longer medically necessary to keep the patient in the community hospital and the client can be discharged home and the hospital **disagrees and believes the patient should stay longer**, the mental health designee must deny the remaining LOS for the admission.
- A Denial is- When the continued stay review determines that it is no longer medically necessary to keep the patient in the Community hospital and the client can be discharged and moved to another facility (E&T) and the hospital **disagrees and believes the patient should stay longer**, the mental health designee must deny the remaining LOS for the admission if client remains in the community hospital setting.

Other scenarios for reference:

- The authorization of an Initial Length of Stay is shorter than the requested length of stay it is NOT a denial.
- Any time the RSN facilitates the transfer from one inpatient facility to another inpatient facility to assure the level of care is met or to assure the best price for the same level of care, it is NOT a denial. An inpatient level of care is being achieved.

Notice of Adverse Action:

Notice of Adverse Action is sent when a denial is issued regarding medical necessity for hospital inpatient admission or continued stay to a Medicaid enrollee.

Notice of Determination:

A Notice of Determination is sent when a denial is issued regarding medical necessity for hospital inpatient admission or continued stay to a consumer NOT enrolled in Medicaid (state only.)

Clinical Appeals:

Medical necessity determinations made by the MHD designee may be appealed. MHD designees are responsible for providing an appeal process to address the hospital's concerns regarding the MHD designee's medical necessity determination for admission or number of days authorized. Inclusive in that process is the expectation that the clinical appeal must be conducted by a different psychiatrist than the psychiatrist involved in the initial denial determination. The second psychiatrist may not be in the MHD designee's own CMHA provider network. The MHD designee is required to provide a due process for these appeals as per **WAC 284-43-322** and **CFR 42 431**.

Administrative Disputes:

Concerns regarding an MHD designee's compliance with published requirements may be addressed through an administrative dispute process. Hospitals which have administrative disputes (i.e. NOT medical necessity) with a particular MHD designee must utilize the administrative dispute resolution process established by the MHD designee involved. If not resolved at the MHD designee level, hospitals may contact the MHD for instructions regarding a second level review, The MHD review is final.

- The MHD will maintain a formal dispute process to review disputes that cannot be resolved between an MHD designee/PIHP(s) and a community hospital provider.
 - ✓ The MHD dispute process will be confined to disputes regarding authorization of care for all or a portion of an inpatient hospital stay.
 - ✓ All local and regional dispute resolution procedures must be exhausted prior to submission to the MHD.
 - ✓ When a hospital disputes an MHD designee, the MHD designee has 14 calendar days to respond. Failure to respond within the timeframe may result in a default award to the hospital.
- The MHD dispute process does not apply to disputes between MHD designee/PIHPs regarding the assignment of inpatient claims (see MHD Intranet Dispute System.)
- The MHD dispute process does not apply to disputes between an MHD designee/PIHP and hospital provider that arise pursuant to the MHD designee/PIHP's *clinical decision to approve or deny medical necessity for an inpatient admission*. Such cases shall be appealed to the MHD designee/PIHP(s). MHD designees are required to address clinical appeals in accordance with WAC 283-43-322 and CFR 42-431.
 - ✓ A consumer (or advocate on behalf of that consumer) may access the right to a Fair Hearing for denial of appropriate services.
 - ✓ A consumer (or advocate on behalf of that consumer) may contact the MHD designee Ombuds office for assistance.

PROCEDURE:

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- 1) The appellant shall submit a written notice of intent to dispute the administrative action(s) of the MHD designee.
 - a) The dispute shall be submitted to the designated MHD Chief or Mental Health Services, who will delegate review to the Inpatient Team.
 - b) The dispute shall summarize the nature of the dispute and the perspectives of both parties to the dispute. The MHD designee /PIHP that is party to the dispute shall separately submit their position regarding the dispute.
 - c) The appellant shall provide sufficient evidence to permit comprehensive MHD review. The MHD designee /PIHP may submit additional evidence to support a comprehensive MHD review within 14 days.
 - d) The MHD will not conduct independent research regarding the dispute. If the MHD requires additional information in order to make a determination, it shall be the responsibility of the parties to the dispute to obtain and submit that information.

- 2) The MHD shall review the submitted dispute and issue a written opinion within 30 days of the receipt of all necessary information.
 - a) If the MHD determines that the dispute may be resolved through clarification of rule or contract, the MHD will issue such clarification in writing.
 - i) In such cases the MHD shall take no further action to approve or deny payment of the specific claim(s) in question.
 - ii) The parties shall proceed immediately to resolve their dispute based upon the clarification of rules.

- 3) If after review of the submitted dispute the MHD finds that payment is due the hospital, the MHD shall authorize payment for the days of service in question.
 - a) The cost for those days of service shall be assigned to the responsible MHD designee /PHP in accordance with the MHD/MHD designee /PIHP contract.

- 4) If either party disagrees with the MHD opinion, they may submit a written request for a second review to the director of the MHD.
 - a) It will be incumbent upon the appellant to submit additional evidence supporting the second level dispute.
 - b) The MHD Chief of Mental Health Services shall participate in the review to assure all procedural and administrative guidelines have been followed.
 - c) The MHD shall issue an opinion regarding the second level dispute within 14 working days of receipt of all necessary information.
 - d) The MHD second review is the final level of appeal within the department and must precede any judicial action.

MHD Designee Disputes:

A request of paid claim re-assignment to another MHD designee can be initiated by utilizing the MHD Intranet Dispute System. Please refer to the MHD website for information regarding the Intranet Inpatient Dispute System.

Procedure for Assigning Authorization Numbers:

Each admission to inpatient psychiatric care must be identified by a **unique authorization number**. The authorization number must be generated by the MHD designee that authorized the admission. Hospitals will ensure the number appears in the form locator field 63 on the UB claim form in order for payment to be made. In addition, legal status will be noted in the “comments” section of the UB.

The authorization number must be comprised of 9 numerical digits. The **first two digits** of the number will always be **88**, indicating a psychiatric admission.

The **next five digits** identify a specific admission with a number from 00001 through 99999. For regional procedures, contact the appropriate MHD designee. Once the MHD designee has exhausted the above sequence, it will start over with 00001.

The **last two digits** will identify the MHD designee that authorized the admission. The two-digit code assigned to each MHD designee is as follows.

MHD Designee	Two-Digit Code
Clark County RSN	24
Chelan Douglas RSN	25
Grays Harbor County RSN	20
Greater Columbia RSN	13
King County RSN	11
North Central RSN	14
North Sound RSN	12
Peninsula RSN	16
Pierce County RSN	19
Spokane County RSN	10
South West RSN	17
Thurston Mason RSN	18
Timberlands RSN	26

Billing Recoupment

For any claims paid, if the number of days billed exceeds the number of days authorized by the MHD designee, the department will assist with the recovery unauthorized days paid as follows:

- **MHD designees must track the number of days authorized and compare that number to the total number of days that were billed by the hospital and subsequently paid by the Division.**

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- **By the 5th of each month, the MHD DESIGNEE must notify the designated fiscal staff at the Division of any discrepancies between the number of days authorized and the number of days billed/paid for the previous month's claims.**
- **The Division fiscal staff will forward the list of claims that need to be adjusted to the HRSA Dental and Institutional Resolutions and Adjustment Unit. This will occur in block fashion on a no less than quarterly basis for any admissions for date of service prior to the implementation date of the Provider One Prior-Authorization Program.**
- **The HRSA Dental and Institutional Resolutions and Adjustment Unit will then recoup the funds paid to the hospitals for the unauthorized days.**

Authorization Procedures

DOCUMENTATION:

To receive authorization for hospital inpatient psychiatric care, the hospital intending to provide the service must contact the appropriate MHD designee within the required timelines. MHD designees must abide by the required timelines for response. (See Authorization Requirements page 11).

- **Initial Certification For Admission to Inpatient Psychiatric Care (Initial Certification):** Hospitals must request authorization prior to admission. This includes consumers eligible for both Medicare and Medical Assistance who have exhausted their lifetime Medicare benefits at admission or during the course of hospitalization and for consumers with primary commercial or private insurance and secondary Medicaid coverage when their primary insurance has been exhausted at admission or during the course of hospitalization. If Medicare or primary benefits are exhausted during the course of hospitalization, authorization must be sought within the calendar day of benefit exhaustion. If the hospital chooses to admit a consumer without prior authorization due to staff shortages, the hospital must submit a request for initial authorization the same calendar day (which begins at midnight) as the admission. In these cases, the hospital assumes the risk for denial as the MHD designee may or may not authorize the care for that day. If there is disparity between the date of admission and date of authorization, the disparate days will not be covered. MHD designees are required to respond to requests for authorization within two hours and make a determination within 12 hours. The Initial Certification provides the MHD designee's authorization of:

- ✓ Authorized days (covered),
- ✓ Administrative days, if applicable (paid at the administrative day rate),
- ✓ Non-authorized days (non-covered) for the **initial** stay, and
- ✓ Date when the hospital must contact the MHD designee for an Extension Request.

These days are important for monitoring expenditures against authorized services as well as tracking data related Utilization Review Performance Measures (see page 42).

Hospitals must obtain **subsequent/new authorizations** (see Changes in Status page 13) from the MHD designee for:

- ✓ Change in legal status,
- ✓ Change in Principal diagnosis to a covered diagnosis, and
- ✓ Change in hospital of service.

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- **Application for Medical Assistance:** If an application is made for determination of a consumer's Medical Assistance eligibility, the hospital will contact the MHD designee within the calendar day. The MHD designee may not withhold an authorization number pending the outcome of Medical Assistance eligibility. **MHD designees are required to respond to requests within two hours and make a determination within 12 hours.**

Hospitals must be prepared to present to the MHD designee, the consumer information found on the **Initial Certification For Admission to Inpatient Psychiatric Care** form page 28 at the time of the request for initial certification. **MHD designees must complete these forms and ensure that the hospital has a copy for its billing needs.**

- **Extension Certification For Admission to Inpatient Psychiatric Care (Extension Certification):** Hospitals will contact the MHD designee for requests for extension at least **24 hours prior** to expiration of currently authorized period, unless otherwise indicated by MHD designee. A hospital may submit a request greater than 24 hours prior to the expiration of the currently authorized period. **The MHD designee must provide a determination within 24 hours of receipt of the extension request.** The Extension Certification provides MHD's designee's authorization of:

- ✓ Authorized days (covered),
- ✓ Administrative days if applicable (paid at the administrative day rate),
- ✓ Days not authorized (non-covered) days for the **extended** stay, and
- ✓ Date when Extension Request must be submitted.

Again, these days are important for monitoring expenditures against authorized services as well as tracking data related Utilization Performance Measures.

The MHD designee cannot deny extension requests for adults who are detained under the ITA law unless another less-restrictive alternative is available. The hospitals and MHD designees are encouraged to work together to find less-restrictive alternatives for these consumers. However, any alternative placements would need to be ITA certified (either as a facility or through the single bed certification –see page 6). Additionally, since the ITA court papers indicate the name of the facility to which the consumer is to be detained, the court would need to be approached for a change of detention location if a less-restrictive placement is found.

Hospitals must be prepared to present to the MHD designee, the consumer information found on the **Extension Certification For Continued Inpatient Psychiatric Care** form page 34 at the time of the request for extension certification. **MHD designees are required to complete these forms and ensure that the hospital has a copy for its billing process.**

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- **Retrospective certification For Admission to Inpatient Psychiatric Care (Initial Certification):** The Initial Certification form is also used for retrospective certifications and will accordingly provide the MHD designee's authorization for:

- ✓ Authorized days (covered);
- ✓ Administrative days, if applicable (paid at the administrative day rate); and
- ✓ Non-authorized days (non-covered) for the **extended** stay

Retrospective authorization may only occur if the consumer becomes eligible for medical assistance after admission or in the rare situations where circumstances beyond the control of the hospital prevented the hospital from requesting authorization prior to admission. Hospitals may request authorization after the consumer is admitted, or admitted and discharged.

All retrospective certifications must be in accordance with the requirements of this document and an authorization or denial must be based upon the consumer's condition and services rendered at the time of admission and over the course of the hospital stay until the date of notification or discharge, as applicable. Whether or not an MHD designee may have diverted a consumer is not a consideration after the fact. Decisions about retrospective days are to be based upon medical necessity.

MHD designees have the authority to approve or deny a request for retrospective certification for a consumer's voluntary inpatient psychiatric admission, length of stay extension, or transfer when hospital notification did not occur within the timeframes stipulated in WAC 388-55-2600 and this document.

- ✓ For retrospective certification request *prior to discharge*, the hospital must submit a request for authorization for the current day and days forward. For the current day and days forward, the MHD designee must respond to the hospital within two hours of the request and provide certification and authorization or denial within 12 hours of the request. For days prior to the current day (i.e. admission date to the day before the MHD designee was contacted), the hospital must submit a separate request for authorization. MHD designee must provide a determination within 30 days upon receipt of the required clinical documentation for those days prior to MHD notification.
 - ✓ For retrospective certification requests *after the discharge*, the hospital must submit a request for authorization as well as provide all the required clinical information to the MHD designee within 30 days of discharge. The MHD designee must provide a determination within 30 days of the receipt of the required clinical documentation for the entire episode of care.
- **Administrative Days:** MHD designee's are expected to use the provision of administrative days infrequently for short durations of time. Administrative days may only be issued when all of the following conditions are true:

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- ✓ The consumer has a legal status of voluntary,
 - ✓ The consumer no longer meets medical necessity,
 - ✓ The consumer no longer meets intensity of service criteria,
 - ✓ Less restrictive alternatives are not available, posing barrier to safe discharge, and
 - ✓ The hospital and MHD designee mutually agree to the appropriateness of the administrative day.
- **Out-of-state hospitals and Critical Border Hospitals:** Hospitals outside Washington State must obtain authorization from the appropriate MHD designee for all **Medicaid** consumers. Inpatient services for non Medicaid consumers, if provided outside of State of Washington, are not billable and will not be paid. An exception is for consumers who are qualified for the General Assistant – Unemployable (GAU) program. For these consumers who receive inpatient psychiatric services provided in *bordering cities and critical border hospitals*, billing may occur and be paid. All requirements set forth in his document apply to these claims. All claims for admissions to **out-of-state hospitals** are paid as **voluntary** legal status as the Involuntary Treatment Act applies only within the borders of Washington State.
 - **Extensions for youth waiting for Children’s Long-Term Inpatient Program (CLIP):** The MHD designee cannot deny an extension request for a child or youth who has been detained under ITA who is waiting for a CLIP placement unless another less-restrictive alternative is available. As noted above, use of administrative days may be considered in voluntary cases only.
 - ✓ **Voluntary:** For a child waiting for CLIP placement who is in a community psychiatric hospital on a voluntary basis, the MHD designee may authorize or deny extensions or authorize administrative days. Hospitals and MHD designees are encouraged to work together to find less-restrictive alternatives for these children.
 - ✓ **Involuntary:** For a youth waiting for CLIP placement who is in a community psychiatric hospital on an involuntary basis, extensions may *not* be denied and administrative days may *not* be authorized by MHD designee. The hospitals and MHD designees are encouraged to work together to find less-restrictive alternatives for these youths. However, any less-restrictive placements would need to be ITA certified (either as a facility or through the single bed certification –see page 6). Additionally, since the ITA court papers indicate the name of the facility to which the youth is to be detained, the court would need to be approached for a change of detention location if a less-restrictive placement is found.

ADDITIONAL REQUIREMENTS:

In addition to timely requests for authorization and provision of required consumer information as indicated, admission must be determined to be **medically necessary** for treatment of a **covered principal diagnosis code**. (See Diagnostic Categories on page 38).

- **Medically necessary** includes the following:

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- ✓ Ambulatory care resources available in the community do not meet the treatment needs of the consumer, AND
 - ✓ Proper treatment of the consumer's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to **WAC 246-322-170**), AND
 - ✓ The services can reasonably be expected to improve the consumer's level of functioning or prevent further regression of functioning, AND
 - ✓ The consumer has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a Principal covered diagnosis (see Diagnostic Categories page 38) and warrants extended care in the most intensive and restrictive setting; OR
 - ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (**Chapter 71.05 or 71.34 RCW**); OR
 - ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (**Chapter 71.05 or 71.34 RCW**) but agreed to inpatient care.
- **Provision of required Clinical Data:** In order for the MHD designee to make the above medical necessity determination, hospitals will provide and the MHD designee must collect the requisite **MHD required Clinical Data** for initial and extended authorizations (see Clinical Data page 40). While MHD designees may use different formats for collection of this clinical data, the data set that is required is the same regardless of which MHD designee is certifying need for inpatient psychiatric care.

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Admission to Inpatient Psychiatric Care Forms

Initial Certification Authorization for Admission to Inpatient Psychiatric Care [DSHS 13-821] Form

Where to Get the Form

To **view and download** the Initial Certification Authorization for Admission to Inpatient Psychiatric Care [DSHS 13-821] form, visit DSHS Forms and Records Management Service on the web: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:

- Phone: 360.664.6047
- Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity needed;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

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How to Use the Form

- **Purpose:** The initial certification is the MHD designee's approval for payment for inpatient psychiatric admission. The MHD designee certifies the professional's decision regarding the medical necessity for inpatient psychiatric care for a consumer. The MHD designee must complete the form, make a determination, and share that determination within the timelines identified in this document. The completed form must be provided to the hospital by the MHD designee and will be kept in the consumer's hospital file. The hospital must have the form for billing purposes. Accordingly, the MHD designee must ensure the hospital is provided the form. Unless the hospital requires immediate reception of the form prior to admission, the MHD designee will ensure the form is provided to the hospital within 3 business days of the authorization unless another agreement has been arranged between the MHD designee and the hospital. The MHD designee must also keep a copy. In order to meet federal, state, and MHD designee requirements, the form must be completed in its entirety.

The initial certification form is to be utilized statewide. The hospital must be prepared to provide the consumer information on the initial certification form as well as the clinical data identified in "Clinical Data Required for Initial Certification" farther along in this document. At its discretion, an MHD designee may require additional information from the hospital in order to make determinations.

- **Form distribution:** The hospital contacts the MHD designee, providing the designee with all of the required consumer information and clinical data. The MHD designee completes the form and sends it to the hospital, retaining necessary copies for designee use. All completed Initial Certification Authorization for Inpatient Psychiatric Care [DSHS 13-821] forms must accompany the claims related to the dates authorized for payment to be made.

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**INITIAL CERTIFICATION AUTHORIZATION FOR ADMISSION TO
INPATIENT PSYCHIATRIC CARE**

Last Name:		First Name:		Medicaid ID (PIC):	
Address:			Resided at address >60 days: <input type="checkbox"/> Yes <input type="checkbox"/> No		
City:		State:	Zip Code:	County Of Residence:	CSO if Known:
DOB:		SSN:		Hospital:	
Date of Admission:		Legal Status: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary			
Eligibility Status REQUIRED FOR ITA CLAIMS:					
<input type="checkbox"/> Currently receiving medical assistance <input type="checkbox"/> Applied for public assistance eligibility on _____ date. <input type="checkbox"/> Mental state and condition prevents efforts to determine eligibility (72 hours allowed) <input type="checkbox"/> Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed) <input type="checkbox"/> Client or responsible party refuses to apply for resources					
Diagnosis Code(s)					
Requested Days (Covered):		From _____ To _____ <small>(mm/dd/ccyy) (mm/dd/ccyy)</small>		#DAYS _____	
AUTHORIZATION #: _____					
On this date, an assessment to determine the need for psychiatric inpatient care was completed. All required clinical information was reviewed by the MHD Designee. Based upon this information, the above named individual: <input type="checkbox"/> DOES or <input type="checkbox"/> DOES NOT MEET MEDICAL NECESSITY					
DAYS AUTHORIZED (Covered):		From _____ To _____ <small>(mm/dd/ccyy) (mm/dd/ccyy)</small>		#DAYS _____	
ADMINISTRATIVE DAYS AUTHORIZED (Covered):		From _____ To _____ <small>(mm/dd/ccyy) (mm/dd/ccyy)</small>		#DAYS _____	
DAYS NOT AUTHORIZED (Non-Covered):		From _____ To _____ <small>(mm/dd/ccyy) (mm/dd/ccyy)</small>		#DAYS _____	
Discharge Date:		<input type="checkbox"/> Early Discharge <input type="checkbox"/> Left Against Medical Advice			
Signature of MHD Designee		Print/Type Name		Title	
MHD Designee Organization Name (RSN)		Telephone		Date	
Extension Request due date:					

August 1, 2007

**FORM INSTRUCTIONS
INITIAL CERTIFICATION AUTHORIZATION
FOR ADMISSION TO INPATIENT PSYCHIATRIC CARE**

Purpose: The Initial Certification is the MHD designee's approval for payment for inpatient psychiatric admission. The MHD designee certifies the professional's decision regarding the medical necessity for inpatient psychiatric care for a consumer. Copies of a completed Initial Certification form should be kept in the consumer's hospital file. The MHD designee will also keep a copy. In order to meet federal, state and MHD Designee requirements, the form must be completed in its entirety.

The Initial Certification form in this document is to be utilized statewide. The following information must be completed on each form and submitted with the associated claim or a claim cannot be processed and will be denied. The hospital must be prepared to provide the consumer information on the Initial Certification form as well as the Clinical Data identified on page 23 of the Inpatient Psychiatric Billing Instructions. At its discretion, an MHD designee may require additional information from the hospital in order to make determinations.

Form distribution: The hospital contacts the MHD designee, providing the designee with all of the required consumer information and clinical data. The MHD designee sends the completed form to the hospital, retaining necessary copies for designee use. All completed Initial Certification Authorization for Inpatient Psychiatric Care forms must accompany the claims related to the dates authorized for payment to be rendered.

INFORMATION TO BE PRESENTED TO MHD DESIGNEE BY HOSPITAL:

Last Name: The consumer's Last name.

First Name: The consumer's First name.

Medicaid ID (PIC): This is the Patient Identification Code which is obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".

Address: The consumer's address at time of hospitalization.

Resided at Address > 60 days: If consumer has resided at given address more than 60 days, check Yes. If not, check No.

Zip Code: The consumer's zip code at time of hospitalization.

County of Residence: The County from which the consumer's medical card was issued.

CSO (if known): The DSHS Community Service Office from which the consumer's medical card was issued.

DOB: The consumer's date of birth.

SSN: The consumer's Social Security Number.

Hospital Name: The name of the hospital where services are to be provided.

Date of Admission: The date upon which the consumer was admitted to inpatient psychiatric care.

Legal Status: The consumer's current legal status which is either voluntary or involuntary. Involuntary legal status applies to only those consumers who are over the age of twelve (12) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW.

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Eligibility Status REQUIRED FOR ITA CLAIMS: This section *replaces* the Involuntary Treatment Act Patient Claim Form DSHS 13-628. One of the following boxes must be checked for ITA claim payment.

- Currently receiving Medical Assistance
- Applied for public assistance eligibility on _____ date
- Mental state and condition prevents efforts to determine eligibility (72 hours allowed)
- Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed)
- Client or responsible party refuses to apply for resources

Diagnosis: Diagnosis used to reflect the consumer's Principal diagnosis and reason for admission.

Requested Length of Stay: The maximum number of days requested, followed by the start and end dates which reflect the number of days requested.

TO BE COMPLETED BY MHD DESIGNEE:

Authorization Number: The number issued by the MHD designee (RSN of residence) referencing the current episode of inpatient care.

Certification Statement: The proclamation by MHD Designee that the consumer does or does not meet Medical Necessity. For a consumer to be found to meet medical necessity, the following must be true:

- ✓ Ambulatory care resources available in the community do not meet the treatment needs of the consumer, AND
- ✓ Proper treatment of the consumer's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170), AND
- ✓ The services can reasonably be expected to improve the consumer's level of functioning or prevent further regression of functioning, AND
- ✓ The consumer has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a Principal covered diagnosis (see Diagnostic Categories page 23) and warrants extended care in the most intensive and restrictive setting; OR
- ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); OR
- ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care

Days Authorized: The maximum number of the requested days that are authorized by the MHD designee for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of days authorized.

Administrative Days Authorized: If applicable, the maximum number of the requested days that are authorized by the MHD designee at the administrative bed day rate (Revenue Code 0169) for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of administrative days authorized.

Days Not Authorized: The number of the requested days that are not authorized by the MHD designee for the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the number of days not authorized.

Discharge Date: The date the consumer was discharged, specifying if discharge was early or against medical advise.

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MHD Designee Signature: The MHD designee must sign and print/type their name and title, and date the form on the same date they sign it. A Psychiatrist's signature is required for any denials (consumers determined to *not* meet medical necessity).

Print/Type Name: The printed or typed name of the person who signed as the MHD designee.

MHD Designee Organization Name: The name of the Regional Support Network serving through contract as the MHD designee.

Telephone: Telephone number of person who signed as MHD designee.

Date: The date the form was signed.

Extension Request due date: The date a request for an extension must be submitted to the MHD designee.

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Extension Certification Authorization for Continued Inpatient Psychiatric Care [DSHS 13-822] Form

Where to Get the Form

To **view and download** the Extension Certification Authorization for Admission to Inpatient Psychiatric Care [DSHS 13-822] form, visit DSHS Forms and Records Management Service on the web: <http://www1.dshs.wa.gov/msa/forms/eforms.html>

To **have a paper copy sent** to you, contact DSHS Forms and Records Management Service:

- Phone: 360.664.6047
- Fax: 360.664.6186

Include in your request:

- Form number and name;
- Quantity needed;
- Your name;
- Your office/organization name; and
- Your complete mailing address.

August 1, 2007

How to Use the Form

- **Purpose:** The extension certification is the MHD designee's approval for payment for inpatient psychiatric admission. The MHD designee certifies the professional's decision regarding the medical necessity for inpatient psychiatric care for a consumer and authorizes care. The MHD designee must complete the form, make a determination, and share that determination within the timelines identified in this document. The completed form must be provided to the hospital by the MHD designee and will be kept in the consumer's hospital file. The hospital must have the form for billing purposes. Accordingly, the MHD designee must ensure the hospital is provided the form. Unless the hospital requires immediate reception of the form prior to admission, the MHD designee will ensure the form is provided to the hospital within 3 business days of the authorization unless another agreement has been made between the MHD designee and the hospital. The MHD designee must also keep a copy. In order to meet federal, state, and MHD designee requirements, the form must be completed in its entirety.

The extension certification form is to be utilized statewide. The hospital must be prepared to provide the consumer information on the initial certification form as well as the clinical data identified in "Clinical Data Required for Initial Certification" farther along in this document. At its discretion, an MHD designee may require additional information from the hospital in order to make determinations.

- **Form distribution:** The hospital contacts the MHD designee, providing the designee with all of the required consumer information and clinical data. The MHD designee completes the form and sends it to the hospital, retaining necessary copies for designee use. All completed Extension Certification Authorization for Continued Psychiatric Care [DSHS 13-822] forms must accompany the claims related to the dates authorized for payment to be made.

August 1, 2007

**EXTENSION CERTIFICATION
AUTHORIZATION FOR CONTINUED
INPATIENT PSYCHIATRIC CARE**

Last Name:		First Name:		Medicaid ID (PIC):	
Address:			Resided at address >60 days: <input type="checkbox"/> Yes <input type="checkbox"/> No		
City:	State:	Zip Code:	County of Residence:	CSO if known:	
DOB:	SSN:		Hospital:		
Date of Admission:	Legal Status: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary				
Eligibility Status REQUIRED FOR ITA CLAIMS: <input type="checkbox"/> Eligible for Medical Assistance <input type="checkbox"/> Applied for public assistance eligibility on _____ date <input type="checkbox"/> Mental state and condition prevents efforts to determine eligibility (72 hours allowed) <input type="checkbox"/> Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed) <input type="checkbox"/> Client or responsible party refuses to apply for resources					
Diagnosis Code(s)					
Requested Days (Covered):	From _____ <small>(mm/dd/ccyy)</small>	To _____ <small>(mm/dd/ccyy)</small>	#DAYS _____		
AUTHORIZATION #: _____					
<p>On this date, a utilization review to assess the need for continuation of psychiatric inpatient care was completed. All required Extension clinical information was reviewed by the MHD Designee. Based upon this information, the above named individual:</p> <p align="center"><input type="checkbox"/> CONTINUES TO or <input type="checkbox"/> NO LONGER MEETS MEDICAL NECESSITY</p>					
EXTENSION DAYS AUTHORIZED (Covered):	From _____ <small>(mm/dd/ccyy)</small>	To _____ <small>(mm/dd/ccyy)</small>	#DAYS _____		
ADMINISTRATIVE EXTENSION DAYS AUTHORIZED (Covered):	From _____ <small>(mm/dd/ccyy)</small>	To _____ <small>(mm/dd/ccyy)</small>	#DAYS _____		
EXTENSION DAYS NOT AUTHORIZED (Non-Covered):	From _____ <small>(mm/dd/ccyy)</small>	To _____ <small>(mm/dd/ccyy)</small>	#DAYS _____		
Discharge Date: <input type="checkbox"/> Early Discharge <input type="checkbox"/> Left Against Medical Advice					
Signature of MHD Designee		Print/Type Name		Title	
MHD Designee Organization Name (RSN)		Telephone		Date	
Extension Request due date:					

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FORM INSTRUCTIONS
EXTENSION CERTIFICATION AUTHORIZATION
FOR CONTINUATION OF INPATIENT PSYCHIATRIC CARE

Purpose: The Extension Certification is the MHD designee's approval for payment for continued inpatient psychiatric admission. The MHD designee certifies the professional's decision regarding the medical necessity for continued inpatient psychiatric care for a consumer. Copies of a completed Extension Certification form should be kept in the consumer's hospital file. The MHD designee will also keep a copy. In order to meet federal, state and MHD Designee requirements, the form must be completed in its entirety.

The Extension Certification form is to be utilized statewide. The following information must be completed on each form and submitted with the associated claim or a claim cannot be processed and will be denied. The hospital must be prepared to provide consumer information on the Extension Certification form as well as the Clinical Data identified in the Inpatient Psychiatric Billing Instructions. At its discretion, an MHD designee may require additional information from the hospital in order to make determinations.

Form distribution: The hospital contacts the MHD designee, providing the designee with all of the required consumer information and clinical data. The MHD designee sends the completed form to the hospital, retaining necessary copies for designee use. All completed Extension Certification Authorization for Inpatient Psychiatric Care forms must accompany the claims related to the dates authorized for payment to be rendered.

INFORMATION TO BE PRESENTED TO MHD DESIGNEE BY HOSPITAL:

Last Name: The consumer's Last name.

First Name: The consumer's First name.

Medicaid ID (PIC): This is the Patient Identification Code which is obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".

Address: The consumer's address at time of hospitalization.

Resided at Address > 60 days: If consumer has resided at given address more than 60 days, check Yes. If not, check No.

Zip Code: The consumer's zip code at time of hospitalization.

County of Residence: The County from which the consumer's medical card was issued.

CSO (if known): The DSHS Community Service Office from which the consumer's medical card was issued.

DOB: The consumer's date of birth.

SSN: The consumer's Social Security Number.

Hospital Name: The name of the hospital where services are to be provided.

Date of Admission: The date upon which the consumer was admitted to inpatient psychiatric care

Legal Status: The consumer's current legal status which is either voluntary or involuntary. Involuntary legal status applies to only those consumers who are over the age of twelve (12) who are detained under the provisions of the Involuntary Treatment Act (ITA) as defined by chapters 71.05 and 71.34 RCW.

August 1, 2007

Eligibility Status REQUIRED FOR ITA CLAIMS: This section *replaces* the Involuntary Treatment Act Patient Claim Form DSHS 13-628. One of the following boxes must be checked for ITA claim payment.

- Currently receiving Medical Assistance
- Applied for public assistance eligibility on _____ date
- Mental state and condition prevents efforts to determine eligibility (72 hours allowed)
- Left facility prior to probable cause hearing and cannot be located to complete eligibility application (72 hours allowed)
- Client or responsible party refuses to apply for resources

Diagnosis: Diagnosis used to reflect the consumer's Principal diagnosis and reason for continued stay.

Requested Length of Stay: The maximum number of days requested, followed by the start and end dates which reflect the number of days requested.

TO BE COMPLETED BY MHD DESIGNEE:

Authorization Number: The number issued by the MHD designee (RSN of residence) referencing the current episode of inpatient care.

Certification Statement: The proclamation by MHD Designee that the consumer does or does not meet Medical Necessity. For a consumer to be found to meet medical necessity, the following must be true:

- ✓ Ambulatory care resources available in the community do not meet the treatment needs of the consumer, AND
- ✓ Proper treatment of the consumer's psychiatric condition requires services on an inpatient basis under the direction of a physician (according to WAC 246-322-170), AND
- ✓ The services can reasonably be expected to improve the consumer's level of functioning or prevent further regression of functioning, AND
- ✓ The consumer has been diagnosed as having an emotional/behavioral disorder or a severe psychiatric disorder (as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association) which is considered a Principal covered diagnosis (see Diagnostic Categories page 23) and warrants extended care in the most intensive and restrictive setting; OR
- ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW); OR
- ✓ The consumer was evaluated and met the criteria for emergency involuntary detention (Chapter 71.05 or 71.34 RCW) but agreed to inpatient care

Days Authorized: The maximum number of the requested days that are authorized by the MHD designee for the extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of days authorized.

Administrative Days Authorized: If applicable, the maximum number of the requested days that are authorized by the MHD designee at the administrative bed day rate (Revenue Code 0169) for the extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the maximum number of administrative days authorized.

Days Not Authorized: The number of the requested days that are not authorized by the MHD designee for extension of the episode of inpatient psychiatric care. This is followed by the start and end dates which reflect the number of days not authorized.

Discharge Date: The date the consumer was discharged, specifying if discharge was early or against medical advise.

MHD Designee Signature: The signature of the MHD designee approving the number of extension days allowed. A psychiatrist's signature is required for any denials (consumers determined to *not* meet medical necessity).

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Print/Type Name: The printed or typed name of the person who signed as the MHD designee.

MHD Designee Organization Name: The name of the Regional Support Network serving through contract as the MHD designee.

Telephone: Telephone number of person who signed as MHD designee.

Date: The date the form was signed.

Extension Request Date: The date a request for an extension must be submitted to the MHD designee.

Diagnostic Categories

PSYCHIATRIC DIAGNOSTIC CATEGORIES WHICH MAY BE APPROVED FOR INPATIENT PSYCHIATRIC CARE

Organic Psychotic Conditions (290-294)

- 290- Senile and pre-senile organic psychotic conditions
- 291- Alcoholic psychoses
- 292- Drug Psychoses
- 293- Transient organic psychotic conditions
- 294- Other organic psychotic conditions (chronic)

Other Psychoses (295-299)

- 295- Schizophrenic Psychoses
- 296- Affective Psychoses
- 297- Paranoid Psychoses
- 298- Other non organic psychoses
- 299- Psychoses with origin specific to childhood

Neurotic Disorders, personality disorders and other non psychotic mental disorders (300-314)

- 300- Neurotic disorders
- 301- Personality Disorders
- 306- Physiological malfunction arising from mental factors
- 307- Special symptoms or syndromes not elsewhere classified
- 308- Acute reaction to stress
- 309- Adjustment reaction
- 310- Specific non psychotic mental disorders due to organic brain damage
- 311- Depressive disorder, not elsewhere classified
- 312- Disturbance of conduct not elsewhere classified
- 313- Disturbance of emotions specific to childhood and adolescence
- 314- Hyperkinetic syndrome of childhood

PSYCHIATRIC DIAGNOSTIC CATEGORIES WHICH *CANNOT* BE APPROVED FOR VOLUNTARY INPATIENT PSYCHIATRIC CARE

Non-psychotic Mental Disorders (302-316)

- 302- Sexual deviations/disorders
- 303- Alcohol dependence syndrome (1)
- 304- Drug Dependence (1)
- 305- Non dependent abuse of drugs (1)
- 315- Specific delays in development
- 316- Psychiatric factors associated with diseases classified elsewhere

Mental Retardation (317-319)

- 317- Mild Retardation
- 318- Other specified mental retardation
- 319- Unspecified mental retardation

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Noted Exceptions:

- The requirements in this memorandum do not apply to 3 and 5 day detoxification program admissions associated with the Division of Alcohol and Substance Abuse. Please reference HRSA *Billing Instructions for Hospital-Based Inpatient Detoxification*.
- For persons admitted involuntarily in under chapters 71.05 or 71.34 RCW, the exclusion of diagnoses codes 302-319 does not apply.
- For persons with dual eligibility the exclusion of diagnoses codes 302-319 does not apply until the lifetime Medicare benefit has been exhausted.

Diagnosis Related Group (DRG)

The DRGs given below are intended to be used as a benchmarking tool in determining the length of stay that may be indicated based for a psychiatric inpatient stay upon the consumer's diagnosis, services rendered, response to treatment and overall clinical presentation. A comparison is offered between the historical average length of stay per DRG versus the PAS 1995 length of stay that has been used as the benchmark prior to 08-01-07.

DRG	DESCRIPTION	AVE LOS	PAS LOS
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSIS OF MENTAL HEALTH	7	14
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	4	4-15
426	DEPRESSIVE NEUROSES	4	4-19
427	NEUROSES EXCEPT DEPRESSIVE	5	5-27
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL	2	2-21
429	ORGANIC DISTURBANCES & MENTAL RETARDATION	6	6-19
430	PSYCHOSES	5	5-21
431	CHILDHOOD MENTAL DISORDERS	4	4-21
432	OTHER MENTAL DISORDER DIAGNOSES	2	1-27

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Clinical Data Required For *Initial* Certification

In addition to the information required on the **Initial Certification for Inpatient Psychiatric Care form** the following data elements must also be provided by the hospital when seeking Initial Certification and Authorization. While MHD designees may use different formats for collection of this clinical data, the elements that are required are the same regardless of which MHD designee is certifying and authorizing the need for inpatient psychiatric care. MHD designees are to use this information to determine medical necessity using established medical necessity criteria.

History	
Risk Factors by HX	Prior hospitalizations, CLIP, foster care, suicide attempts, ER use, legal system involvement, homelessness, substance abuse TX, and enrollment in MH system.
Presenting Problems	
Mental Status	Diagnosis, thought content, risk of harm to self or others, behavioral presentation.
Co-Morbidity Issues	Substance abuse HX/current, toxicity screen results, developmental disability, medical issues.
Other System Issues	Jail hold, other legal issues, DDD/MH Cross System Crisis Plan.
Actions Taken to Prevent Hospitalization	
Less Restrictives	Involvement of natural supports, outpatient services including medication management, CM, PACT team, WRAP-Around, etc. Consultation with Crisis Plan, DD/MH Cross-System Crisis Plan, or Advanced Directive.
Rule Outs	Malingering, medical causes, toxicity, hospitalization in lieu of homelessness or inability to access outpatient services.
Anticipated Outcomes for Initial Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of hospitalization.
Discharge Plan	Anticipated length of stay, involvement of consumer, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

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Clinical Data Required For *Extension Certification*

In addition to the information required on the **Extension Certification for Continued Inpatient Psychiatric Care form** the following data elements must also be provided by the hospital when seeking an Extension Certification and Authorization. While MHD designees may use different formats for collection of this clinical data, the elements that are required are the same regardless of which MHD designee is certifying and authorizing the need for inpatient psychiatric care. MHD designees are to use this information to determine medical necessity using established medical necessity criteria and (if authorized) the number of days authorized.

Course of Care	
Treatment Rendered	All inpatient services rendered since admission (medical and psychiatric tests, therapies, and interventions performed including type and frequency) and consumer response to treatment thus far.
Changes	Changes in diagnoses, legal status, TX plan, or discharge plan.
Current Status	
Mental Status	Diagnoses Axis I-V, thought content, risk of harm to self or others, behavioral presentation.
Medical Status	Diagnoses, labs, behavioral presentation, withdrawal.
Anticipated Outcomes for Continued Stay	
Proposed TX Plan	Medical interventions or tests planned, psychiatric interventions planned (individual, group, medications), goal of continued stay and justification of why a less restrictive alternative is not appropriate at this time.
Discharge Plan	Anticipated length of continued stay, involvement of consumer, CM, formal and natural supports in d/c planning including identification of barriers to discharge and plans to address these.

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Utilization Review

Performance Measures

MHD designees will be monitored for:

- ✓ Number of hospital requests for admission to hospital inpatient psychiatric care
- ✓ Number of approvals for hospital inpatient psychiatric care
- ✓ Number of denials to hospitals for admission to hospital inpatient psychiatric care
- ✓ Number of diversions of hospital requests for admission to hospital inpatient psychiatric care to a lower level of inpatient care or a different level of less restrictive care

Collection of this data will occur through existing data streams. The department will generate a report reflecting these factors, identified by MHD designee. This data will be used for review of resource management, quality improvement, and data-driven decision making.

The purpose of this program is to manage the community hospital admissions ONLY. Anytime an MHD designee does not authorize an admission at a hospital, it is either a diversion or a denial (see Diversions and Denials page 15). For this program, an E&T is not considered the same level of inpatient care as hospital-based inpatient care. An E&T is a lower level of inpatient care because of the lack of medical care that is otherwise available in a hospital setting. If the hospital requesting authorization for inpatient care agrees to admit the consumer to an E&T instead of the hospital, the E&T placement is considered a diversion. If the requesting hospital disagrees with the recommendation of E&T level of care and the MHD designee admits the consumer to the E&T regardless, the action it is a denial.

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Children's Long-Term Inpatient Program Requirements

The Children's Long-Term Inpatient Program (CLIP) is provided under contract with the MHD. For more information, go to <http://www.clipadministration.org/>

The following requirements apply to hospitals and Evaluation and Treatment (E&T) facilities:

- **Referral to CLIP:** When the court determines that a 180-day commitment to inpatient care in a state-funded facility is necessary for a juvenile, the committing hospital or E&T facility must notify CLIP Administration of the court's decision *by the end of the next working day following the court hearing*. (RCW 71.34.) Once the Committee is notified, authorization for additional care can be issued by the appropriate MHD designee (see MHD designee flow chart at the end of this document.)

When a hospital or E&T receives a consumer for CLIP, they are expected to supply information as specified in the information requirements in the children's long-term inpatient care referral packet.

HRSA will not reimburse for services provided in a juvenile detention facility.

- ✓ **Initial Notification:** The committing hospital or E&T must notify the CLIP Administration by the end of the next working day of the 180-day court commitment to state-funded long-term inpatient care.

The following information is expected:

- Referring staff, organization and telephone number.
 - Consumer's first name and date of birth.
 - Beginning date of 180-day commitment and initial detention date.
 - Consumer's county of residence.
- ✓ **Discharge Summary and Review of Admissions:** Within two weeks of transfer from the hospital or E&T to a CLIP facility, a copy of the completed discharge summary must be submitted to the CLIP Administration and to the facility where the child is receiving treatment. *All referral materials* should be sent to the CLIP Administration at the following address:

CHILDREN'S LONG-TERM INPATIENT PROGRAM (CLIP)
2142 10TH AVENUE W
SEATTLE WA 98119
(206) 298-9654

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Under the conditions of the At Risk/Runaway Youth Act, as defined in chapter 71.34 RCW, hospitals must provide the MHD designee access to review the care of any minor (regardless of source of payment) who has been admitted upon application of his/her parent or legal guardian. For the purposes of the Review of Admissions, all information requested must be made available to the MHD designee. The MHD designee must document in writing any subsequent determination of continued need for care. A copy of the determination must be in the minor's hospital record.

- ✓ **Referral Packet:** A referral packet concerning the ITA committed youth must be submitted to the CLIP Administration within five (5) working days of telephone notification for the 180-day commitment. If the child is transferred to another facility for an interim placement until CLIP care is available, the referral packet must accompany the child. The following items are required components of the referral packet:
 - A certified copy of the court order: 180-day commitment petition with supporting affidavits from a physician and the psychiatrist or a children's mental health specialist.
 - A diagnosis by a Psychiatrist including Axis I-V related to the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
 - An admission evaluation including:
 - ✓ Medical evaluation
 - ✓ Psychosocial evaluation
 - The hospital or E&T record face sheet
 - Other information about medical status including:
 - ✓ Laboratory work
 - ✓ Medication records
 - ✓ Consultation reports
 - Outline of entire treatment history
 - All transfer summaries from other hospitals or E&Ts where the child has been admitted during current commitment as well as all discharge summaries from any prior hospitalization or E&T.
 - A brief summary of youth's progress in treatment to date including inpatient course, family involvement, special treatment needs, and recommendations for long-term treatment/assignment.
- ✓ **Submitting Other Background Information for CLIP referrals:**

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During the 20 days following the 180-day commitment hearing, the committing hospital or E&T must arrange to have the following background information submitted to the CLIP Administration. This information should be submitted prior to admission to the CLIP program.

- Written formulation/recommendation of the local intersystem team responsible for the adolescent's long-term treatment plan should include family's involvement, and detail of treatment history, as well as less restrictive options being considered.
 - DSHS case records, including placement history form, ISPs, court orders, etc. Include legal history regarding juvenile arrests, convictions, probation/parole status
 - Complete records from all hospitalizations or other inpatient care, including admission and discharge summaries, treatment plans, social history evaluations, consultations, and all other assessments (do not include daily progress notes.)
 - Treatment summaries and evaluations from all foster or residential placements and all day treatment and outpatient treatment summaries.
 - If not contained in other documents, a comprehensive social history, including developmental and family history.
 - School records, including special services assessments, transcripts, psychological evaluations, current IEP, current level of functioning.
 - Immunization record, copy of social security card and birth certificate.
- ✓ **Inter-facility Transfer Reports**

When an youth who has been involuntarily detained is transferred from one facility to another, an inter-facility or hospital transfer report detailing the adolescent's current medical, psychiatric, and legal status (in terms of both ITA commitment and custody) must accompany that child as well as a certified copy of the court order.

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MHD Designee Flow Chart –

