

Inpatient Care Guidelines

Pre-Authorization/Authorization

All referrals are based on PBH's Medical Necessity criteria and require Pre-Authorization. If the admission to treatment involves an emergency, the authorization needs to be concomitant with the admission.

Referrals for assessment for level of care may be made to a facility in any of the following ways:

- ◆ Direct referral for admission from PBH Clinical Services
- ◆ Referral from PBH Clinical Services for assessment
- ◆ Referral from a PBH-contracted practitioner
- ◆ Referral from a primary care physician
- ◆ Member self-referral
- ◆ Involuntary admission

Providers can call PBH for authorization 24 hours a day/seven days a week by either using the Provider Helpline at (800) 716-1166 or the Clinical Care Management Line available in the Quick Reference Guide in the Region Specific Information section of this manual. Members may also use the Clinical Care Management Line or the number indicated on their benefit card.

PBH Care Managers require clinical information that supports the level of care which is being requested. All assessments for the inpatient level of care conducted at a facility must be by a licensed mental health professional. If the information given by the facility does not appear to satisfy the criteria for the requested level of care, the Care Manager may request a physician-to-physician review.

All PBH members are to be assigned to an attending physician from the PBH provider network.

If weekend or after-hours coverage is arranged during a member's hospitalization, it must be with a contracted PBH provider.

Inpatient Eligibility and Accessibility

PBH is available for eligibility verification 24 hours a day/seven days a week.

It is our expectation that referrals will be addressed in a timely manner and the results of an assessment request will be phoned to a PBH Care Manager promptly.

Treatment is authorized according to the available benefits from the member's health care plan. PBH cannot authorize care that is not covered in a member's benefit plan.

Utilization Management

For effective management of treatment planning, it is imperative that the facility establish the following parameters:

- 1) All Utilization Review staff must be licensed clinicians. One or more designated persons should act as a liaison for PBH Care Managers to contact regarding utilization review.
- 2) PBH should be notified promptly whenever any of the following occur:
 - ◆ the patient's level of care changes
 - ◆ the patient's diagnosis changes (i.e., mental health to chemical dependency)
- 3) Utilization review staff should contact PBH within 24 hours of a patient's admission with complete admission information and furnish telephonic progress reports as required by PBH.
- 4) Utilization review staff should facilitate a MD to MD review with the attending psychiatrist and a PBH psychiatrist when requested.

Admission notes must have the following:

- ◆ Name of licensed facility reviewer (should be one consistent person)
- ◆ Admit date
- ◆ Attending psychiatrist
- ◆ Precipitating event
- ◆ DSM-IV Five Axis diagnosis

- ◆ Report on ADLs / functional impairments
- ◆ Report on current symptoms
- ◆ Report on medications: (current and historically)
- ◆ Report on PCP involvement (if indicated)
- ◆ Report on mental status
- ◆ Previous treatment history
- ◆ Chemical dependency history
- ◆ Family history
- ◆ Social support network
- ◆ Treatment plan with specific goals and objectives
- ◆ Discharge plan

Follow-up notes must have the following:

- ◆ Current symptoms
- ◆ Any changes in diagnosis or level of care
- ◆ Current report on mental status
- ◆ Treatment provided
- ◆ Revisions to the treatment plan
- ◆ Changes to the discharge plan
- ◆ Estimated length of stay
- ◆ Number of days authorized
- ◆ Discharge plan with follow-up appointment, name of provider and licensure, discharge medications, and placement resources.

Patients with the following may require review between a PBH MD and the attending MD:

- ◆ Significant medical complications
- ◆ Eating Disorders
- ◆ Autism
- ◆ Dementia
- ◆ Neurological involvement
- ◆ Difficult to manage symptoms/problems

A PBH Care Manager may request a review with the attending psychiatrist rather than hospital UR staff when the following occurs:

- ◆ Facility UR staff give an admission rationale but Medical Necessity is lacking
- ◆ UR staff cannot answer the PBH Care Manager's questions
- ◆ UR staff changes each day and there is no consistency the in information provided
- ◆ UR staff is not available
- ◆ UR staff lack current, adequate information
- ◆ UR staff indicate the attending physician's daily visit won't be until after five PM
- ◆ UR staff can justify continued stay, but cannot offer a clear treatment plan
- ◆ UR staff can offer a treatment plan, but it does not appear that treatment is consistent with the plan
- ◆ UR staff offer a treatment plan that PBH cannot support
- ◆ UR staff lacks appropriate credentials (RN, MFCC, LCSW)

Inpatient Care Management

- ◆ Discharge planning should begin at the time of admission.
- ◆ PBH Care Managers should be informed of all changes in the patient's progress.
- ◆ The PBH Care Manager is a valuable resource in planning care.
- ◆ Any referral for continuing care must be pre-authorized.
- ◆ PBH Care Managers should be notified if another physician is providing weekend or vacation coverage.
- ◆ PBH should be notified within 24 hours of any serious injury or death of a member; PBH must also be notified of any patient's elopement or discharge against medical advice.
- ◆ If a PBH member requires medical-surgical consultation and/or care, this must be coordinated and authorized by the primary medical group or medical plan.
- ◆ It is expected that the treating facility will be responsible for establishing an outpatient follow-up appointment for the patient prior to discharge. A PBH Care Manager can assist with referral options from the PBH provider network.

Facility Credentialing/Recredentialing

- ◆ Facility credentialing occurs prior to contracting; recredentialing occurs every three years.
- ◆ Copies of all licenses, accreditations, and liability insurance are to be mailed/faxed to the PBH Provider Network Management Department at time of renewal. An update MD affiliation list should be sent at the time of recredentialing.
- ◆ Any program administration changes are to be communicated in writing to the PBH Network Management Department.
- ◆ A site visit may be required for any of the following occurrences:
 - Pre-contracting, credentialing or recredentialing
 - Greater than 40 percent turnover in staff

- Change of ownership, with or without contract assignment
- Significant change in treatment modalities or programming
- Loss or change in licensing or accreditation/certification status
- Any significant quality management occurrence
- PBH Peer Review Committee directs audit to be conducted due to quality of care concerns
- Program does not qualify for accreditation but is state licensed or certified.

Medical Staff

- 1) At non-inclusive contracted facilities, only those doctors credentialed and contracted with PBH can be utilized. Each facility should have at least 6 doctors paneled with PBH.
- 2) At all-inclusive contracted facilities, it is strongly recommended that doctors utilized in PBH cases also be credentialed and contracted to facilitate continuity of care to outpatient treatment once the patient is discharged.

Billing and Reimbursement

- ◆ Complete a Universal Claim form UB 92 (HCFA 1450) and submit bills within 90 days of the discharge date.
- ◆ Make sure dates and levels of care match authorized dates and levels of care, and attach a copy of the appropriate PBH authorization form.
- ◆ The use of diagnostic codes from the DSM-IV is preferred over ICD-9 codes; the DSM-IV code 799.90 should not be used.
- ◆ Include the member's name, address, date of birth and Social Security number.
- ◆ Follow the appeals and grievance process if you wish to appeal a denial.
- ◆ Do not balance bill the PBH member.
- ◆ Mail claims to:
PacifiCare Behavioral Health, Inc.

P.O. Box 31053
Laguna Hills, CA 92654-1053

Non E.R. Admits Through Emergency Departments

Facilities are discouraged from routinely referring admissions through their Emergency Departments. Contractual arrangements prohibit such action since this usually results in unnecessary services and charges. This process may result in the patient being balance billed for the unnecessary service. Balance billing is a violation of the facility contract.

In situations where facility by-laws or internal structures require that all admissions go through the Emergency Department, PBH requires that the Emergency Department physicians send their bills directly to the facility for payment and not to PBH nor to the patient.

Emergency Referrals

If a member is in imminent danger of harm to self or others or appears to be gravely disabled, the primary care physician (PCP) should call either PBH's Physician Consultation Service at (800) 292-2922 or the toll free number on the patient's insurance card and speak to our clinical staff regarding hospital admission.

If it is not possible to contact PBH prior to admission to a psychiatric hospital, the PCP should take the necessary and appropriate actions to stabilize the emergency and call PBH within 24 hours of the admission. Examples of signs/symptoms/behaviors that may require emergency treatment include:

- ◆ Suicidal/homicidal ideation with a plan
- ◆ Suicide/homicide attempt (patient must be medically stable)
- ◆ Gravely disabled
- ◆ Self-mutilating behavior
- ◆ Hallucinations
- ◆ Total body rigidity or immobility
- ◆ Bizarre behavior

- ◆ Delusions
- ◆ Severe depression
- ◆ Severe medication reactions