**Section 139.500 Medical Necessity and Utilization Review of Services**

a) Utilization Review. The Department shall utilize its designated PRO/QIO to review clinical services provided in a residential setting. For services requiring prior authorization and ongoing continued stay authorization, payments to providers will only be made upon authorization of services.

1) Utilization review denials for clinical reasons shall be based upon physician review and determination.

2) Utilization review may consist of, but shall not be limited to, certification of need, prior authorization, continued stay, pre-payment, post-payment, and all other clinical review activities required.

3) Utilization review activities shall determine:

A) Whether the services being requested are reasonable and medically necessary for the diagnosis and treatment of illness;

B) The medical necessity, reasonableness and appropriateness of residential treatment requests for the individual seeking services that have demonstrated that community services are unable to meet his or her clinical needs;

C) The completeness, adequacy and quality of residential treatment, when provided;

D) Whether the quality of the services meets professionally recognized standards of health care; or

E) Whether those services furnished or proposed to be furnished are:

i) Consistent with the provisions of appropriate medical care; and

ii) Being delivered in the most clinically appropriate and cost efficient manner as determined by the PRO/QIO.

b) Certification of Need. The Department shall require a Certification of Need prior to admission to designated residential treatment facilities. A Certification of Need shall include:

1) A screening by the Department's designated provider of mobile crisis response services for children to determine that community supports and treatment cannot meet the individual's needs in the community;

2) A psychiatric evaluation and signed attestation from the individual's treating physician indicating the clinical justification for residential treatment.

A) The psychiatric evaluation shall include: mental status examination and diagnosis; overview of illness and presentation, including functional impact; history of treatment, including medications, for at least the most recent 12 months; treatment goals for residential treatment and timespan for achieving those goals; and

B) The signed attestation from the physician shall indicate that admission to a residential setting is required to meet the treatment needs of the individual seeking services; and

3) The Department's agent shall have a physician concur, through the issuance of prior authorization, that the residential treatment at the facility being requested shall be sufficient to meet the clinical needs of the individual seeking services.

c) Prior Authorization for Residential Treatment. A prior authorization review shall be conducted prior to admission to a residential facility to determine if the request for residential treatment is clinically appropriate for the individual seeking residential care, given the individual's overall clinical presentation.

1) Approved requests for residential treatment shall be issued an initial authorization of 60 days of treatment.

2) Determinations resulting from the prior authorization review that residential treatment is not clinically appropriate may be resubmitted for a prior authorization reconsideration review or completed by a physician unfamiliar with the original review.

3) Final determinations that residential treatment is not clinically appropriate for the individual seeking residential services shall be based upon physician review and clinical determination. Written notice of the determination shall be issued in writing to the individual seeking services, and parent or legal guardian, including notice of the right to appeal and how to pursue an appeal under Section 139.600.

d) Continued Stay Review. Continued stay review may be conducted during the last 10 days of any authorized treatment period to determine the ongoing clinical appropriateness for residential services.

1) Continued stay reviews shall assess the ongoing needs of an individual seeking care, provision of active treatment by the provider, and the individual's active participation in treatment services.

2) If approved pursuant to continued stay review, residential treatment shall be authorized for a continued treatment period of 30 days.

3) Determinations resulting from the review that residential treatment is no longer clinically appropriate may be resubmitted for a continued stay reconsideration review completed by a physician unfamiliar with the original review.

4) Final determinations that residential treatment is no longer clinically appropriate for the individual seeking residential services shall be based upon physician review and clinical determination. Written notice of the determination shall be issued in writing to the individual seeking services and the parent or legal guardian as appropriate, including notice of the right to appeal and how to pursue an appeal under Section 139.600.

e) FSP Bed Holds

1) Prior approval of planned bed hold requests that exceed 3 days in length shall be performed prior to the FSP youth's departure from the facility.

2) Concurrent review of unplanned bed hold requests shall be performed on the first day of the FSP youth's absence from the facility.

3) Bed hold requests shall be performed consistent with the criteria established in Section 139.305(e).

f) SFSP Transition Beds

1) Prior approval for SFSP transition beds shall be performed prior to admission. Approved requests for SFSP transition beds shall be issued an initial authorization of 7 days.

2) Continued stay review for SFSP transition beds may be performed within the last 3 days of an SFSP youth's treatment in an SFSP transition bed to seek continued crisis stabilization services. An approved request for continued stay for SFSP transition beds shall be authorized for subsequent periods up to 7 days, not to exceed a total authorization of 30 consecutive days.

g) Pre-payment Review. The Department may require residential facilities to submit claims to the Department for pre-payment review and approval prior to rendering payment for services provided.

h) Utilization Control. Residential treatment facilities funded by the Department are subject to the utilization control requirements established in 42 CFR 456. The Department or its designee shall provide 30 days written notice to residential providers of the establishment of all necessary utilization control efforts. Written notice may include the publication of agency handbooks or other policy documents.

1) Denial of Payment as a Result of Utilization Review

A) If the Department determines, as a result of utilization review, that a residential treatment facility has misrepresented admissions, length of stay, discharges or billing information, or has taken an action that results in the unnecessary admission or inappropriate discharge of a program participant, unnecessary multiple admissions of a program participant, unnecessary transfer of a program participant, or other inappropriate medical or other practices with respect to program participants or billing for services furnished to program participants, the Department may, as appropriate:

i) Deny payment (in whole or in part) with respect to residential services provided; and

ii) Require the residential facility to take action necessary to prevent or correct the inappropriate practice.

B) When payment is denied by the Department under subsection (h)(1)(A)(i) as a result of prepayment review, an appeal of the review activity may be made to the PRO/QIO. The PRO/QIO shall provide the final reconsideration within 30 days after the request of the provider, if that request is:

i) The result of a medical necessity or appropriateness of care denial determination; and

ii) Received within 60 days after receipt of the notice of denial. The date of the notice of denial is counted as day one.

C) When payment is denied by the Department under subsection (h)(1)(A)(i) as a result of a certification of need, prior authorization, concurrent or continued stay review, an expedited appeal of the review activity may be requested.

i) The PRO/QIO shall provide a final expedited review within one business day after the request of the provider, if the request includes:

• All necessary information to process the appeal of the review;

• All relevant medical documents; and

• The basis for seeking the appeal.

ii) Failure of the provider to submit all needed information shall toll the time in which the final review shall be completed. The results of the final review shall be communicated to the provider by telephone within one business day, and in writing within 3 business days, after the determination.

D) A determination under subsection (h)(1), if it is related to a pattern of inappropriate admissions, length of stay and billing practices, may result in a referral to the HFS Office of Inspector General.