Amerigroup RealSolutions in healthcare

Provider update

Behavioral health clinical submission

Summary: Implementing adequate clinical submissions for every treatment plan enables Amerigroup Community Care to make informed decisions on medical necessity when conducting initial and concurrent reviews. Clinical submission notes are reviewed along with documented treatment to help determine the most appropriate level of care for each member.

Facilities and providers must supply adequate clinical submission notes to determine if proposed treatment is medically necessary and to provide the most appropriate level of care based on the following listed provisions for each entity of service.

Precertification for inpatient admission

General information

- Obtain pertinent contact information and release of information requests.
- If transferring from an ER or medical facility, include the urinary drug screen (UDS) and lab results.

Risk assessment

- What are specific acute symptoms the member is presenting with that require admission:
    - Suicidal ideations (SIs) — Plan, intent, what is the risk?
    - Homicidal ideation (HI) — Plan, intent, what is the risk (specific person/people targeted)?
    - Hallucinations — What type (what are they seeing, hearing, feeling)?
    - Paranoia/delusions — What are they experiencing?
    - Responding to internal stimuli — What is being observed?
- Why now? What happened in the last 24-48 hours that may have triggered the member's current symptoms/behaviors?
- What specifically did the member say or describe?
- If member required medical intervention, please specify the reason (for example, charcoal, sutures, ICU admission, etc.).

Lab work

- UDS completed on all admissions or obtained from ER or medical facility
- Medical lab work as appropriate

Eating disorder admission

- Height & Weight (BMI)
- Abnormal lab work
- Vital signs — blood pressure (BP), pulse (standing, sitting, lying down)
- Medical conditions
- Document if the member is medically compromised/in need of medical monitoring

For detox admission

- Include **all** drugs/alcohol used and specify:
    - Amount.
    - Frequency.
    - Last time of use.
- Vitals to take upon admission include:
    - BP, pulse, respiration and temperature.
- Clinical Opiate Withdrawals Scale (COWS) and/or Clinical Institute Withdrawal Assessment for Alcohol (CIWA)
- Current withdrawal symptoms
- Medical conditions that might complicate withdrawal
- Any legal charges related to drug/alcohol use

Readmission (rapid or frequent)

- Gather information about what member did after discharge from recent hospitalizations.
- List medication(s) member was on or changed (any barriers to getting medication).
- Was a safety/crisis plan created at last discharge?
    - Were there barriers to implementing this?

Discharge planning (starts at admission)

- A preliminary discharge plan should be completed at intake including:
    - Where will the member be discharged?
    - What aftercare services will be scheduled?

Concurrent stay reviews

Diagnosis

- Include any changes and what date the changes occur.
- Provide the full ICD-10 diagnosis and/or include the ICD-10 code(s).

Risk assessment

- Provide the bulleted information below if any of these behaviors are present: suicidal or homicidal thoughts or plans, physical aggression to self or others, command auditory hallucinations on close observation, drug and/or alcohol withdrawal symptoms, or comorbid health concerns:
    - Dates of current symptoms
    - To whom the member is reporting these symptoms
    - Specific information about these including what member states they're experiencing
    - What the staff is seeing with regard to these symptoms
    - If the member is contracting for safety, and if not, what member is saying they will do

- If not contracting for safety, the member-specific precautions in place to maintain the member's safety, and what needs to happen for the member to contract for safety

Lab results

- Include lab results concerning any medical issues
- UDS should be completed on all admissions
- Medication that requires blood levels be drawn should have results posted (and not just within normal limits)

Medication

- Name, dose, frequency, what it is being used for and date of any changes
- If consent is pending, indicate that medication on a different line and put the date it was requested and who was contacted; document if consent not received
- PRN (as needed) medicines — list date and time administered, name, dose and route

Family therapy

- First family therapy session should be held within the initial 72 hours of admission or sooner. (If not held, please provide the reason.)
  - Even if the member is in Department of Family and Children Services (DFCS) custody, there should be therapy sessions with the caseworker.
- If member is there longer than 72 hours, a session should be held a minimum of once every week.
- Include date, who participated, what was discussed, and if by phone or face to face (this helps to know the type of contact a member is having while hospitalized).
- Discharge and safety planning should be discussed and noted.
- Session discussions should be relevant to current treatment and the admitting symptoms/behaviors.

Nursing note

- Include date of session and details:
  - SI/HI (plan, intent, risk, if specific person is identified for HI)
  - Psychosis (How is it impacting functioning level, what is being reported by the member and what is staff seeing currently?)
  - Sleep, appetite, hygiene and activities of daily living (ADLs)
  - Mental status
  - If the member is attending and participating in treatment groups or not
  - Any other pertinent information

MD note

- Include date of session and details:
  - SI (plan, intent, risk; if no plan/intent, why facility believes member is still at risk)
  - HI (plan, intent, risk, if specific person is identified for HI)
  - Psychosis (How is it impacting functioning level, what is being reported by the member and what is staff seeing currently?)
  - Sleep, appetite, hygiene and ADLs

    - Mental status
    - Member-specific precautions and/or special precautions
    - Any other pertinent information
- What is the plan for medication changes?
- If member is denying any acute symptoms, what specifically is being addressed to warrant remaining at this level of care (LOC)?
- What is the MD's rationale for continued stay status?
- What is the plan of action if the member is not progressing and has barriers to care?

Other treatment plan changes or assessments

- Include what will be done differently if member is a rapid readmission

Response to treatment

- If member is receiving individual therapy, include dates, what is being addressed, how member is participating, if they are grasping concepts and if they are putting them to use while inpatient.
- If a member is not progressing, then treatment plan changes must be included to document what is being done to make progress more likely
- Include answers from the *Focus on Next Review* questions asked from prior review.

Involvement in treatment

- Include who was contacted and what was discussed with each contact
- Results/follow-up needed

For detox

- Vitals updated including how often they are taken (if abnormal)
- Start and end of the detox protocol — what is being used
- Medical issues
- CIWA and/or COWS
- Any PRNs being used due to withdrawal symptoms
- Issues with eating/drinking, dehydration
- Specific withdrawal symptoms
- Member participation in treatment

Discharge planning

- Facility should indicate recommendations for discharge on every review and for each section as appropriate.
- Barriers for discharge plan are documented, including if placement is not currently known.

Why is this change necessary?

- To ensure that Amerigroup has the most pertinent clinical information to make an informed decision regarding treatment and level of care for the member
- To ensure members are receiving the most appropriate treatment in a timely manner and without delay

- To enable Amerigroup to continuously adhere to mandated timelines governed by the state for determining proper medical decisions, and whether or not necessary clinical data are being received with each review

What is the impact of this change?

- Increase appropriate continuity of care
- Allow the medical facility, in conjunction with Amerigroup, to facilitate safe and accurate discharge planning with appropriate referrals (when applicable)
- Decrease prolonged determinations of medical necessity
- Minimize possibility of readmissions
- Reduce the need for peer-to-peer requests due to the possibility of more favorable outcomes on medical decisions rendered

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.