Purpose:
To assist in the maintenance of quality care for DBI-CA Medicaid funded residents and to evaluate each of these resident’s need for continued stay at the PRFT level of care versus discharge to a lower level of care.

Objectives:
The objectives of the Utilization Review Program are:

A. To monitor the need for continued stays and discharge criteria
B. To assist the PRFT professional staff in meeting or excelling in minimum standards of services / care as set by the board of managers, accreditation agencies and payers.
C. To identify and evaluate resident care issues for improvement in the quality of care and services provided.
D. To respond to denials by external reviewers and involve the treatment team, PRFT Medical Director, resident and family/guardian (as deemed necessary) to deliberate the denial of care.
E. To analyze continued stay reviews with an emphasis placed on evaluating the progress made in the active clinical treatment plan provided and appropriate discharge plans; to evaluate whether documentation demonstrates that the resident meets criteria for continued stay in a PRFT.

Authority:
The Board of Managers has authorized this plan for ongoing and retrospective review of the over and underutilization of resident services and has delegated the responsibility for its implementation and maintenance to the clinical team and Utilization review committee to collect, analyze and interpret data.

Utilization Review Committee:
Members of the Utilization Review Committee shall include two physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases, the Chief Operating Officer, the Director of Quality, and when not a conflict of interest, the DBI Program Director and two therapy staff who are not directly responsible for the care or treatment of the residents to be reviewed. The UR Committee shall review and document decisions utilizing the UM Committee Utilization Review form. Completed review Forms will be distributed electronically to all necessary program team members upon completion including the Program Director, Medical Director, Clinical Coordinator, Nurse Manager, Program Coordinator, and Primary Therapist. The identities and of residents in al UR records and UM Committee reports shall be kept confidential, utilizing initials and state of residence as identifiers.

Function of Utilization Review Process:
The Utilization Review Program (UR) is the mechanism for reviewing the appropriateness of continued stay, discharge, and treatment of PRTF residents at DBI-CA. The goal of the UR process (as an advocate for the resident) is to review and facilitate possible resolutions, in a positive manner, for ensuring the proper medically necessary care for all residents.
The methods of identifying, monitoring and evaluating utilization review problems include, but are not limited to:

A. Review of PRTF medical records with particular emphasis on: length of stay, physician orders, medication management, psychiatry notes, individual therapy, group therapy, family therapy, recreation and activities, skill building, educational goal attainment, lab work and the treatment plan.

B. Reviews of resident symptoms/behaviors/progress are done at a minimum of once every 30 days depending on the length of stay, in regards to meeting continued stay and discharge criteria.

C. Communicating with the treatment team as needed by the therapist in treatment team meetings and via email, phone and face to face conversation.

D. Recommendations received from any/all treatment personnel.

E. Report identified problems, if any, of concurrent or retrospective level of care reviews.

F. Incorporate accreditation/licensure inspection survey recommendations.

Utilization Review Process:

A. To monitor each medical record for indications of medical necessity with regard to the follow service areas.

   a. Medication Management (i.e. timely and relevant to current symptoms and at effective levels and/or noted symptoms).

   b. Psychiatry – review documentation, ensuring compliance with regulations and frequency of contact needed.

   c. Milieu Treatment – special procedures / special precautions, staffing increases as indicated, resident participation in and compliance with program expectations.

   d. Individual Therapy – minimum quantity of one weekly session documented and submitted within 1 business day.

   e. Group Therapy – minimum quantity of 3 sessions per week documented and submitted within 1 business day.

   f. Family Therapy – minimum quantity equals 2 times per month documented and submitted within 1 business day.
g. **Medical Services** – illnesses or injuries documented with appropriate follow up, lab levels current and up to date, pain related issues with documented interventions and plan to eliminate.

h. **Educational Services** – progress being achieved toward academic goals and school attendance.

i. **Treatment Plan** – initial treatment plan implemented upon admission; master treatment plan implemented by 14th day after admission. Treatment plan is monitored accordingly for relevance to primary diagnosis, measurability of objectives, progress noted, current and updated objectives, discharge plan and criteria for discharge current.

B. To evaluate continued stay criteria

**Concurrent Level of Care Review:**

The Utilization review function will utilize criteria approved by the applicable governing bodies to develop and implement concurrent level of care reviews to determine appropriateness for continued stay and discharge.

All concurrent level of care reviews are the responsibility of the Utilization Review Committee and/or assigned Utilization Reviewer and individual members of the treatment team as assigned. Each staff assigned will be responsible for conducting assigned documentation audits on a timely basis to submit to the assigned Utilization reviewer who will complete the review and submit to the UR Committee for final approval or determination.

A. Concurrent level of care reviews will begin following admission through initial assessment and evaluation of the resident, treatment planning and clinical case review.

B. Concurrent review will be ongoing throughout the residents stay.

C. Clinical / Medical necessity for continued stay shall be clearly justified in the progress notes, treatment plans and assessments.

**Medical Care Evaluation Studies:**

A. Medical care evaluation studies shall be initiated by the UR Committee. Studies shall be selected through identification of risk issues and concerns as identified in incident reporting data, grievance and complaint data, review of clinical and medical chart audit review findings,
recommendations from results of accreditation, state or referral source auditing activities or other sources of data supporting the need for improved care.

B. Studies will be conducted utilizing the a Quality Improvement Activity (QIA) model to establish baseline data, rationale for the need of the study, targets for improvement, documentation of follow up interventions and results, analysis and additional recommendations. (See QIA Form)

C. Each Medical Care Evaluation Study shall identify and analyze medical or administrative factors related to resident care and include analysis of at least one of the following: Admissions, duration of stay, ancillary services furnished including medications and biologicals, or professional services performed in the facility.

D. Data utilized to perform each study shall be obtained from one or more of the following sources.

E. Medical or clinical records or other appropriate facility data, eternal organizations that compile statistics, design profiles and produce comparative data or cooperative endeavors with QIO’s, fiscal agents, other service providers or other appropriate agencies.

F. The UR Committee shall at least, have one study in progress at any time and complete one study each calendar year.
LEVEL OF CARE DEFINITIONS AND CRITERIA

Residential Treatment Services (PRTF):

A. Definition
   A PRTF provides psychiatric care when an individual does not require acute psychiatric care, but does require supervision and active treatment on a 24-hour inpatient basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. Admission to a PRTF is considered elective and not of an emergency nature. For admission to the PRTF, the medical director shall accept and approve the admission recommendation. The multi-disciplinary team is under the direction of the physician (psychiatrist).

B. Admission Criteria (Pre-certification)
   All admissions will be approved by the Program Director and Psychiatrist for Clinical medical necessity for admission as indicated below and shall be clearly justified in the admission record and in the findings recorded in the psychiatric evaluation. To meet admission criteria for this level of care, a resident must meet the criteria as defined in the Acadia Healthcare Compliance policy and as follows below:

   The need for PRTF admission must be supported by documentation that:

   1. The child has a diagnosable psychiatric disorder. Admission for a primary diagnosis of Substance Abuse is not authorized.
   2. The child has a full scale IQ of 50 or above, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.
   3. The child’s psychiatric symptoms (disturbance of thought and/or mood, disruptive behavior, disturbances in social/family relationships) are severe enough to warrant residential treatment under the direction of a psychiatrist.
   4. The referral source advises that residential treatment is needed.
   5. At least one of the following is true:
      a. The child has failed to respond to less restrictive treatment in the last 3 months; OR
      b. Adequate less restrictive options are not available in the child’s community;
c. The child is currently in an acute care facility whose professional staff advises that residential treatment is needed.

6. The Admissions Review Team has certified the admission to be medically and psychologically necessary based on these criteria and review of documentation with subsequent approval by the Medical Director.

C. Continued Stay Criteria

The Utilization Review Committee will meet a minimum of monthly and more frequently if indicated, to review and evaluate resident behaviors and to determine the need for continued stay. The UR Committee will review the Monthly Report, Medical, Clinical and Documentation review audits complete and additional medical and clinical records and documentation as needed to make a determination.

The monthly Clinical Treatment Report will include a continued stay update that addresses clinical justification for continued inpatient services. For concurrent stay reviews, emphasis is placed on evaluating the progress made in the active individualized clinical treatment provided and on appropriate discharge plans.

Documentation must demonstrate the following:

1. Severity of Illness

2. Ongoing active intensity of treatment as defined in the active individualized clinical treatment plan including:
   a. measurable goals and objectives relevant to each of the identified problems,
   b. interventions by qualified mental health professionals, and
   c. Specific time frames for achieving outcomes.

3. Evaluation of Treatment Progress to include timely reviews and updates of as appropriate to the resident’s treatment plan.

4. In cases of failure to improve, reassessment and revision of the treatment plan that reflects alternatives in the treatment regimen, the measurable goals and objectives, and the level of care required for each of the patient’s problems accompanied by explanations of any failure to achieve the treatment goals/objectives.

5. Unless therapeutically contraindicated and justified as such in the clinical record, the family and/or guardian must actively participate in the continuing care of the resident through direct involvement at the facility and/or therapeutic conferences directed by the resident’s therapist.
The Utilization Reviewer shall review the recommendations and summaries for each case to confirm the need for continued stay. If the reviewer supports the determination for continuing stay, the recommendation and supporting documentation shall be reviewed and confirmed by the UM committee at the monthly UM committee meeting.

If the reviewer finds that the continued stay is not supported, he or she will notify the resident’s attending physician and give him or her an opportunity to present his or her views to support the need for continued stay and schedule a meeting of the UM Committee live or via conference call within 3 business days. If the attending physician presents additional information or clarification, the committee (with at least 2 physician members, one of whom is knowledgeable in the treatment of mental diseases) shall review the need for continued stay. If they find that the resident no longer needs inpatient psychiatric services, their decision is final.

Upon final determination of an adverse decision, the following individuals will be notified immediately: Program Director, attending physician, Medicaid agency / referral source, resident, and parent / legal guardian.

D. Discharge Criteria

Discharge Planning is viewed as an integral part of the resident’s treatment plan. Discharge planning begins on admission and is formalized at Treatment Team Conferences. As a resident is reviewed in formal and less formal meetings, discharge planning is under constant assessment and revision. In the discharge planning, the facility recognizes both family participation and any referral source involvement as significant factors in relationship to the needs of both the resident, the family and to the continuing treatment. The coordination of discharge plans is the responsibility of the Therapist in conjunction with the Physician and other members of the treatment team, resident, referral source and family.

Criteria for Discharge: Discharge criteria from the PRTF includes:

a. The resident displays behaviors which demonstrate that he or she meets:

   i. Is medically stable; and has met the specific criteria developed in the residents treatment plan AND:

   ii. Resident has reached maximum benefit from Psychiatric Residential Treatment as evidenced by successful completion or progress in therapeutic and programing level advancement; OR

   iii. Has regressed during treatment or new issues/symptoms arise that warrant transfer to an acute psychiatric hospital.

b. A plan for continued care has been established; OR
c. A documented assessment supports that the resident does not meet diagnostic criteria as assessed.

d. Administrative Discharge and / or transfer to another facility can be instituted in the following cases:

   i. Evidence of violent or other behavior or medical conditions that cannot be managed with the services;
   ii. Elopement from the facility or failure to return from a therapeutic leave of absence.

e. Discharge against medical advice (AMA) includes but is not limited to the following circumstances:

   i. Parent/guardian discharges a resident that the attending psychiatrist feels could continue to benefit from treatment and is not stable enough to function in a less restrictive environment.

   ii. A parent/guardian refuses to return a patient from pass that the attending psychiatrist feels should continue psychiatric residential treatment due to psychiatric instability.