

VERMONT MEDICAID
STANDARD OPERATING PROCEDURES MANUAL
FOR
CHILD, ADOLESCENT AND ADULT
PSYCHIATRIC INPATIENT SERVICES
CONCURRENT REVIEW

Office of Vermont Health Access
Vermont Agency of Human Services
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I. Introduction

Acute inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition.

This manual describes processes to be followed by the Community Mental Health Centers (CMHC) and the Office of Vermont Health Access (OVHA) when the following Medicaid primary populations are hospitalized for acute psychiatric illness:

- Children and adolescents to age 18*
- Adults ages 18 – 22 at the Brattleboro Retreat
- Adults in facilities outside the State of Vermont

II. Criteria for Inpatient Hospitalization:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources the OVHA has adopted the LOCUS (adults) and CALOCUS (children & adolescents) instruments for determining authorization for inpatient level of care (www.comm.psych.pitt.edu/find.html).

LOCUS and CALOCUS guidelines represent a resource efficient evidenced based approach to the management of inpatient admissions and continued length of stay. The CALOCUS provides a framework for defining the appropriate intensity of services and resources to meet the needs of children and adolescents. The instrument is a method of quantifying the clinical severity and service needs of three quite different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders.

The LOCUS is an instrument that is sufficiently sensitive to distinguish appropriate needs and services. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

For the specific cases of eating disorders, the OVHA will also utilize the APA Level of Care Guidelines for Patients with Eating Disorders

(<http://www.psychiatryonline.com/content.aspx?aID=138866#139460>)

III. Admission Process:

*Children and Adolescents to age 18**

Youth whose primary insurance is Vermont Medicaid are screened by designated staff from the local CMHC prior to being admitted to a psychiatric inpatient facility (*Attachment 1*). The purpose of screening prior to an inpatient admission is for continuity of care, identification of

*Also includes children and adolescents to age 21 who are on an Individualized Education Plan.

intervention strategies, and appropriate determination for involuntary hospitalization. This would include assessment for less restrictive alternatives and review of any existing crisis plan for the youth (**Attachment 2**). An inpatient psychiatric admission may be recommended or supported by the CMHC screener when:

- The youth is in need of hospitalization based on admission criteria, and
- Community and support system resources are exhausted, and
- A less restrictive alternative is not available

CMHC screeners are provided with an initial screening form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care and treatment options (**Attachment 3**). This admission data form must be faxed to the Office of Vermont Health Access (OVHA) by the next business day following an admission and reflects inpatient criteria met, as well as alternatives considered and reasons for ruling them out. The CMHC screener also arranges for transportation and admission to a psychiatric inpatient facility.

Children and adolescents who are out-of-state at the time of the admission will be screened by the admitting facility. All emergent and urgent admissions will require notification to the OVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the OVHA the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services* (**Attachment 5**) (<http://ovha.vermont.gov/for-providers/forms-1>).

*Adults Ages 18 – 22 to the Brattleboro Retreat***

Adults ages 18 – 22 whose primary insurance is Vermont Medicaid must be screened by designated staff from the local CMHC prior to being admitted to the Brattleboro Retreat. The purpose of screening prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This would include assessment for less restrictive alternatives and review of any existing crisis plan. An inpatient psychiatric admission may be recommended or supported by the CMHC screener when:

- The individual is in need of hospitalization based on admission criteria, and
- Community and support system resources are exhausted, and
- A less restrictive alternative is not available

CMHC screeners are provided with an initial screening form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care and treatment options (**Attachment 4**). This admission data form must be faxed to the Office of Vermont Health Access (OVHA) following an admission and reflects inpatient criteria met, as well as alternatives considered and reasons for ruling them out. The CMHC screener also arranges for transportation and admission to the Brattleboro Retreat.

Adults ages 18 and over to an Out-of-State Facility**

Adults whose primary insurance is Vermont Medicaid admitted to an out-of-state facility for psychiatric inpatient services will be screened by the admitting facility. All emergent and urgent admissions will require notification to the OVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the OVHA the *Vermont Medicaid Admission Notification Form for Out-of-State Hospital Psychiatric Inpatient Services (Attachment 5)* (<http://ovha.vermont.gov/providers/forms-1>).

Involuntary Admissions

All involuntary admissions and court evaluations, regardless of provider or pay source, must be done by a Department of Mental Health Qualified Mental Health Professional (QMHP) (*Attachments 6 & 7*).

IV. Concurrent Review

Procedure

The OVHA Utilization Reviewer will contact the admitting inpatient facility within 24 hours or the next business day after receipt of the admission notification form to begin the concurrent review process. All reviews will be performed over the phone with additional documentation faxed to the OVHA upon request. Based on information provided, the OVHA Utilization Reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The OVHA Utilization Reviewer will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information. Upon determination that clinical criteria for inpatient level of care are no longer met, the OVHA Utilization Reviewer will inform the inpatient facility of the last covered day. If the inpatient facility disagrees with this decision they may request a Secondary Review (see page 6). The OVHA will generate a payment authorization in the MMIS.

The OVHA Utilization Reviewer and OVHA Q.I. & Behavioral Health Coordinator are available Monday – Friday, 7:45am – 4:30pm (excluding holidays). All decisions regarding payment authorization for nights, weekends and holidays will be made during regular business hours. Should the situation arise outside of the regular business hours in which the clinical presentation of a patient changes and additional days are needed, the inpatient facility will notify the OVHA Utilization Reviewer on the next business day and provide the clinical justification for the additional days needed. Every effort will be made to render an authorization decision at that time, but no later than the end of the business day.

The CALOCUS and LOCUS instruments will be utilized in performing concurrent review and for assigning authorization to cases meeting criteria. Any cases that do not meet criteria; or where there is a potential to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be referred to a health care

professional who has appropriate clinical expertise in treating the member's condition or disease for determination. This would include currently licensed mental health professionals such as a LCSW, Licensed Psychologist or LCMHC. The OVHA will have in effect Inter-rater reliability mechanisms to ensure consistent application of review criteria for concurrent review decisions (see page 7).

Secondary Review

In the event an inpatient facility requests payment authorization from the OVHA for a particular beneficiary and the OVHA denies payment authorization, the inpatient facility may request a secondary review by contacting the OVHA Q.I. & Behavioral Health Coordinator. This process is not an appeals process; however, it does allow the providers to supply the OVHA with additional information. It is not a process for a review of the OVHA policy or for review of any decision other than a decision by the OVHA not to authorize payment for a particular beneficiary. Requests for a secondary review must be made no later than 14 days after the OVHA first gives notice, either written or verbal, to the inpatient facility that payment for that particular beneficiary will not be authorized beyond a certain date. The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe the OVHA should authorize payment in that particular case. All clinical data must be submitted within the 14-day notice period (**Attachment 8**).

Upon receipt of the request and all relevant, timely-submitted clinical information, the OVHA will undertake a good-faith review of the records in its possession, and the reasons supporting the provider's request for a secondary review. The inpatient facility may request a verbal discussion between clinicians involved in the care of the beneficiary and the OVHA clinical staff in order to further clarify the clinical information. The OVHA Q.I. & Behavioral Health Coordinator, or their designee, will review the records, consider the discussion and undertake the reconsideration. This review may also include the OVHA Medical Director. The inpatient facility's physician and/or Medical Director may also request to speak with the OVHA Medical Director. This will be organized by the OVHA Q.I. & Behavioral Health Coordinator and the conversation will include the inpatient facility physician and/or Medicaid Director, inpatient facility discharge planner, the OVHA Medical Director or his/her designee and the OVHA Q.I. & Behavioral Health Coordinator. The OVHA will make its best efforts to notify the provider of its secondary review decision within 30 days of receipt of notice of the request. There is no additional review after the OVHA Q.I. & Behavioral Health Coordinator or his/her designee has made a decision on reconsideration, except in the sole discretion of the Administrator.

All requests for a secondary review must be addressed to:

OVHA Q.I. & Behavioral Health Coordinator
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Awaiting Placement Days

Awaiting Placement days are those days approved at an acute inpatient facility when beneficiaries are awaiting placement to a lower level of care.

Procedure:

1. The OVHA Utilization Review (UR) Nurse will consult with the OVHA Behavioral Health Coordinator (BHC) when there is a potential delay in discharge due to the complicating factors of the case.
2. The OVHA BHC will notify DMH/DCF of the potential delay and request their assistance in the discharge planning, if deemed appropriate.
3. If necessary, the OVHA UR Nurse or OVHA BHC will request of the inpatient facility social worker that a phone conference be scheduled. Phone conferences are to include the OVHA UR Nurse, OVHA BHC, inpatient facility treatment team representatives, local treatment team representatives, DCF or DMH as appropriate, and others as deemed necessary.
4. If a resolution to the discharge problem is not obtained after the phone conference, or a meeting was already held with no resolution that did not include OVHA, a follow-up phone conference will be scheduled to include the OVHA Medical Director (or his designee), the OVHA UR Nurse, OVHA BHC, the inpatient facility treatment team representatives including the Attending Physician, the local treatment team representatives, DCF or DMH as appropriate, and others as deemed necessary.
5. Subsequent team phone conferences will be scheduled as determined by the phone conference team.
6. The decision to change a beneficiary's level of care to awaiting placement status will be made when the patient no longer meets criteria for acute inpatient level of care based on the utilization of the CALOCUS instrument for determining authorization. Awaiting placement status will be utilized only after the OVHA Medical Director (or his designee) has participated in a phone conference and the decision will be made jointly with the OVHA BHC.
 - a. If the inpatient facility does not agree with the determination, the OVHA Medical Director (or his designee) will coordinate a consultation with an appropriate specialist. The inpatient facility may request a three-way conversation with the OVHA Medical Director and the consultant.
7. The OVHA UR Nurse or OVHA BHC will notify the inpatient facility utilization reviewer no later than 24 hours or one business day prior to the change to awaiting placement status. Awaiting placement designation will not be assigned until such time.

The inpatient facility must initiate placement efforts prior to the termination of acute care coverage and shall document such efforts and contacts. The inpatient facility must continue placement efforts until placement occurs. The facility may be required to submit their documentation to the OVHA Utilization Reviewer.

Retrospective Review

The OVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud. Retrospective reviews will be performed in the case of a lack of notification to the OVHA of an admission.

V. Appeal of Payment Denial

Vermont Medicaid beneficiaries may request an internal MCO appeal for any level-of-care OVHA Medicaid payment authorization decision that results in a denial or reduction of services. Appeals are made by telephone or in writing to OVHA (*Attachment 9*). An expedited appeal can be requested if a delay would adversely affect the client's health. An appeal occurs only after all means to come to agreement about the most appropriate course of treatment are exhausted. Appeal responses are issued in writing and state the reviewer's understanding of the issues under review, reference to the information used to make the determination and the clinical criteria used to render the decision. If you disagree with the decision from the appeal, you may ask the department that made the decision for a fair hearing. You have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision, to ask for a fair hearing. You may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. You can also call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

VI. Inter-Rater Reliability

The OVHA will have in place inter-rater reliability mechanisms to ensure consistent application of review criteria for inpatient review decisions. All Utilization Reviewers, program administrators, Vermont Medicaid physicians or any designated staff responsible for authorization of psychiatric inpatient services will complete the manual and the Criteria Competency Training for use of the LOCUS and CALOCUS instruments prior to reviewing cases. The inter-rater reliability tool will be utilized to review staff on a quarterly basis for the first year of implementation of the concurrent review system. After the first year, yearly ratings will be completed except when an outlier is identified. If an outlier is identified, all staff as noted above will be reviewed quarterly until consistency is achieved. A minimum standard rating of 80% is expected. If after three quarters consistency is not achieved additional training will be provided to staff with a corrective action plan if deemed necessary. Any new hires will be reviewed quarterly for the first year.

For the review three sample cases will be given to each staff to rate using the LOCUS and CALOCUS instruments.

VII. Roles and Responsibilities

- ◆ **CMHC Screener** is responsible for initial assessment, level of care recommendation, arrangement for appropriate placement/services, and providing a brief written assessment to the admitting facility and the OVHA Clinical Unit within one business day. For involuntary admissions, the screener must be a QMHP.
- ◆ **Local Service Providers** are responsible for discharge planning and follow-up including making necessary referrals, accessing and coordinating supports and resources, making recommendations on continued care and treatment, insuring services and plans are implemented following discharge, and establishing a lead based on Act 264 responsibilities and referral. Members of this provider group would include the family and representatives of systems in which the child or youth is involved such as DCF, Department of Education, therapists, CMHC case managers and screeners, primary care physicians, developmental services, juvenile justice and substance abuse services.
- ◆ **Inpatient Facility Designated Reviewer** is responsible for providing the OVHA Utilization Reviewer with current clinical information and discharge plans at the time of each continued stay review. This information should be timely, obtained through regular communication with the inpatient facility treatment team and local service providers, and be able to be substantiated by inpatient records.
- ◆ **OVHA Utilization Reviewer** is responsible for concurrent reviews that include determining if clinical criteria for continued stay is met and insuring coordination of discharge planning between inpatient facility treating teams and local service providers.
- ◆ **OVHA Medical Director** is responsible for peer consultation when requested from the treating inpatient facility, hearing appeals if not involved in the original utilization review decision, and performing the secondary reviews as needed.
- ◆ **OVHA Q.I. & Behavioral Health Coordinator** is responsible for performing the concurrent reviews in the Utilization Reviewer's absence, coordinating the medical peer-to-peer consultations, coordinating and performing secondary reviews, and denials of service authorization requests.

VIII. ATTACHMENTS

MENTAL HEALTH 24 HOUR EMERGENCY SERVICES

Clara Martin Center <i>(Orange County)</i>	(800) 639-6360
Counseling Service of Addison County <i>(Addison County)</i>	(802) 388-7641
Health Care and Rehabilitation Services of Southeastern VT <i>(Windham and Windsor Counties)</i>	(800) 622-4235
HowardCenter – First Call <i>(Chittenden County)</i>	(802) 488-7777
Lamoille County Mental Health Services <i>(Lamoille County)</i>	(802) 888-4635 <i>After Hours-</i> (802) 888-4231
Northeast Kingdom Human Services, Inc. <i>(Essex, Caledonia and Orleans Counties)</i>	<i>St. Johnsbury -</i> (802) 748-3181 <i>Newport-</i> (802) 334-6744
Northwestern Counseling and Support Services <i>(Franklin and Grand Isle Counties)</i>	(802) 524-6554
Rutland Mental Health Services <i>(Rutland County)</i>	(802) 775-1000
United Counseling Service <i>(Bennington County)</i>	<i>Manchester -</i> (802) 362-3950 <i>Bennington -</i> (802) 442-5491
Washington County Mental Health Services <i>(Washington County)</i>	(802) 229-0591

CHILD AND ADOLESCENT RESOURCE GUIDE

Emergency Beds

Baird Center for Children and Families
1138 Pine Street
Burlington, VT 05401
(802)488-6600
(Accepts ages 6-14)

Northeastern Family Institute
486 Main Street
Winooski, VT 05495
(802)655-8833
(accepts ages 12-17)

WCMH
Home Intervention
13 Kynoch
Barre, VT 05641
(802)479-1339

Acute Hospitalization

Brattleboro Retreat
75 Linden Street
Brattleboro, VT 05302
(802)873-7328
(accepts involuntary)

Champlain Valley Physician's Hospital
Child & Adolescent Mental Health Unit
75 Beekman Street
Plattsburgh, NY 12901
(518)562-7536
(accepts ages 6-17, 18 if in school)

Cheshire Medical Center
580 Court Street
Keene, NH 03431
(603)352-4111
(accepts ages 13-17, 18 if in school)

North Adams Regional Hospital
2500 Hospital Ave.
North Adams, MA 01247
(413)664-5369
(accepts ages 16-18)

Note: Only Brattleboro Retreat can accept involuntary admission under age 18. If assistance is needed, contact VSH Admissions Office at: (802)241-1000.

OVHA Non-CRT Adults Age 18 - 21
Admission to Brattleboro Retreat Notification Form

The following information and justification must be provided to the **Office of Vermont Health Access (fax #802-879-5963)** at the time of a hospital admission to **Brattleboro Retreat for non-CRT adults, ages 18 through 21:**

- 13.) Date of admission: _____
- 14.) Client name: _____
- 15.) Address: _____
- 16.) SS/Medicaid #: _____ Date of Birth _____
- 17.) CMHC active client? ___yes ___no
- 18.) Status: ___voluntary ___involuntary
- 19.) Referral source: _____
- 20.) Screener name: _____ CMHC: _____

- | | |
|------------------------------------|--|
| 21.) Alternatives considered: | Name of person who refused admission and reason for refusal: |
| _____ In-home support | _____ |
| _____ Assist (488-6411) | _____ |
| _____ Alternatives (463-1987) | _____ |
| _____ Battelle House (442-5491) | _____ |
| _____ Home Intervention (479-1339) | _____ |
| _____ Other | _____ |

(If no alternatives were considered, the reason must be clearly explained in #10.)

If hospitals that are closer to the patient's residence refused admission, complete the following as above:

- | | |
|----------------------|-------|
| _____ CVMC | _____ |
| _____ FAHC | _____ |
| _____ RRMC | _____ |
| _____ Windham Center | _____ |

- 22.) Assessment narrative to include clinical justification that satisfies criteria for inpatient hospitalization:

- Evidence of mental illness (previous diagnosis or need for diagnostic clarity)
- Description of current and recent behavior(s) and level of dangerousness to self or others (i.e., violence, suicidal plan and means, disorganized thinking and/or functioning)
- Medical information (physical health, medications and compliance, complicating medical factors or medication issues)

**VERMONT COMMISSIONER-DESIGNATED
QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)**

Definition

The definition of mental health professional from Title 18 of the Vermont Statutes Annotated, Section 7101(13):

"Mental health professional" means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse or other **qualified person designated by the commissioner**.

By agreement with Vermont State Hospital (VSH) and designated community hospitals, only QMHP's who are designated by the DMH Commissioner can screen and serve as the applicant for involuntary psychiatric admissions.

Qualifications

◆ **Education and Experience:**

1. **Master's degree in human services field (licensure preferred) and:**
 - a. Clinical exposure to populations with major mental illness, **and**
 - b. Experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
 - c. Three months (full time equivalent) experience and training in crisis evaluation and intervention in a community setting.

or
2. **Bachelor's degree in related human services field and:**
 - a. Clinical exposure to populations with major mental illness, **and**
 - b. Experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
 - c. Six months experience (full time equivalent) and training in crisis evaluation and intervention in a community setting.

or
3. **Bachelor's degree in a field unrelated to human services and:**
 - a. Clinical exposure to populations with major mental illness, **and**
 - b. Experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
 - c. One year experience (full time equivalent) and training in crisis evaluation and intervention in a community setting.

(If an applicant does not meet the educational guidelines but meets other criteria and has extensive experience in providing crisis services in the community to severely mentally ill individuals, an application may be submitted for designation consideration.)

◆ **Demonstrated Knowledge and Training:**

1. Vermont Mental Health Statutes
2. Emergency exam, warrant, non-emergency exam (process and documentation)
3. VSH and emergency exam admission criteria and procedures
4. Conditional release, Order of Non-hospitalization, Preplacement Visit
5. Familiarity with community resources (i.e., crisis beds, respite options, general hospitals, or other options for voluntary treatment)
6. Screenings for involuntary treatment (observation preferred)
7. Special needs and services of populations being served

Documentation of Eligibility

1. Completed and signed application
2. Letter of endorsement from the CMHC's Executive Director
3. Current resume (include current work experience with the CMHC that is related to the QMHP designation criteria)
4. A copy of a contract describing the relationship and responsibilities of the applicant to the CMHC must be submitted **if** the applicant is not an employee of the requesting CMHC. In addition, evidence must be provided that the individual will be available to the DMH legal division and to appear in court as needed. If the QMHP is a hospital employee, there must be either an independent review conducted by a CMHC QMHP prior to carrying out an emergency exam to that hospital, or the hospital employee must not be working in that capacity at the same time he/she is in the role of QMHP.

Process for Designation

Step One:

The CMHC will submit a completed Application For Designation as a Qualified Mental Health Professional form to the DMH Acute Care Program Chief. The application must include a statement of endorsement authored and signed by the agency's Executive Director, and a current up-to-date copy of the applicant's resume.

Step Two:

DMH Acute Care Team reviews the form and supporting documentation.

- If additional information is needed, a request will be sent to the CMHC Emergency Services Director.
- If the request is approved, a letter of recommendation for QMHP status along with applicable DMH statutes and a QMHP Certification Form will be mailed to the applicant to sign and return. A copy of the letter also will be mailed to the CMHC Emergency Services Director.

- If a request is denied, the applicant and CMHC Emergency Services Director will be notified in writing. This letter will include the reason(s) for denial and the criteria the applicant must meet to be re-considered for QMHP designation.

Step Three:

Upon receipt of the QMHP Certification Form, the applicant returns the signed form to the DMH Acute Care Chief.

Step Four:

Copies of the designation as a QMHP, signed by the DMH Commissioner, are sent to the applicant and the CMHC Emergency Services Director.

Those individuals deemed appropriate for qualified mental health status are designated as QMHPs pursuant to 18 V.S.A. § 7101(13) and their designation remains in effect as long as they are employees in good standing at the CMHC.

- As of July 1, 2008 continuation of QMHP designation will be approved by the DMH Acute Care Chief every two years.

DMH Forensic Screening Protocol

- ❖ All QMHPs appearing at court will evaluate the defendant/client and make recommendations to the court as to whether the defendant/client should be ordered to undergo a forensic evaluation for competency and sanity and if so, whether such evaluation should be done in an outpatient or an inpatient setting.

The screener needs to keep in mind the following (in accordance with 13 V.S.A. §4815):

- ❖ The court and the parties review the screener's recommendation and consider the facts and circumstances surrounding the charge and observations of the defendant in court.
- ❖ If the court finds sufficient facts to order an examination, the defendant should be examined in the least restrictive environment deemed sufficient to complete the examination and prevent any unnecessary pre-trial detention and substantial threat of physical violence to any person, including the defendant.
- ❖ If inpatient is recommended, the defendant may be placed in the care and custody of the Commissioner of Mental Health at the Vermont State Hospital for no more than 30 days or until the examination is completed. If the defendant is ordered into the custody of the Commissioner of Corrections, the outpatient evaluation may take place at the correctional facility.
- ❖ Possible recommendations the screener may make to the court are as follows:
 1. Inpatient examination at VSH; or
 2. Outpatient examination at Correctional Facility (if defendant is in custody of DOC); or if not in custody of DOC outpatient examination at a later date and place to be determined by DDMHS (within 60 miles of defendant's residence); or
 3. Voluntary admittance to a community hospital and an outpatient examination or;
 4. No forensic examination necessary.
- ❖ The criteria for admission to VSH (or recommendation for an inpatient admission) for the purpose of a forensic evaluation is
 - A) defendant meets EE criteria; and
 - B) VSH is the least restrictive setting in which the examination may appropriately be conducted.
- ❖ VSH is currently the only inpatient facility accepting court-ordered inpatient forensic evaluations of defendants who are in the care and custody of the Commissioner of the Dept. of Corrections. This may change in the future.
- ❖ A defendant who is not in the custody of the Commissioner of the Dept. of Corrections may be admitted as a voluntary patient to a community hospital and be examined by a forensic psychiatrist on an outpatient basis.

REQUEST FOR SECONDARY REVIEW OF INPATIENT PSYCHIATRIC SERVICES
OFFICE OF VERMONT HEALTH ACCESS

This request must be submitted by the provider no later than 14 days after OVHA first gives notice, either written or verbal, to the inpatient facility that payment for that particular patient will not be authorized.

Date of Request:

Name of Provider:

Name of Patient:

Patient Medicaid ID Number:

Date of Admission:

Documented evidence that substantiates continued stay criteria must include:

1. A narrative signed by a clinical staff that provides a brief background of the case and the reasons why the provider believes OVHA should authorize payment.
2. Clinical data that supports the request for a secondary review. **Do not send the entire chart.**

The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe OVHA should authorize payment in that particular case. The inpatient facility may request a verbal discussion between clinicians involved in the care of the patient and OVHA clinical staff in order to further clarify the clinical information.

OVHA APPEALS PROCESS FOR PATIENTS AND FAMILIES

(Excerpt from the OVHA Health Care Programs Handbook)

If you don't agree with a decision made by the state to deny, limit, reduce or stop a benefit, you may ask for that decision to be reviewed. You may also ask for a review if we do not act within the time frames we said we would. If the Office of Vermont Health Access made the decision, you can ask Member Services for your reconsideration, appeal, or fair hearing (described below) by calling 1-800-250-8427, or writing to the address below. Call the customer service number on the back of your employer-sponsored insurance plan ID card for information about how to appeal a decision made by that plan.

Health Access Member Services
Office of Vermont Health Access
101 Cherry Street, Suite 320
Burlington, VT 05401

Request for Reconsideration

The request for reconsideration may help you solve your problem quickly before you start a more formal process. You or your provider may ask the department that made the decision to reconsider it. You may provide more information or explain the information that you have already provided. The person who made the decision will review your case and look at any new information. However, this step is optional and you can choose to go directly to an internal appeal or fair hearing instead.

Appeal

Appeals are heard by a qualified person who did not make the original decision. You have 90 days from the decision date to ask the department that made the decision for an appeal. Your provider may ask for the appeal if you wish. In most cases we try to make a decision in 30 days, however it can take up to 45 days. You and the state can also request up to 14 more days but only if it might help you (for example, your provider needs more time to send information or you can't get to a meeting or appointment in the original time frame). The longest it will ever take is 59 days for a decision to be made. If your need for the denied benefit is an emergency, you may ask for an **expedited appeal**. If it is decided that your appeal is an emergency, you will get a decision within three working days. If you are told your benefit is changed because of a change in a federal or state law, you may not ask for an appeal but may ask for a fair hearing.

Fair Hearing

If you disagree with the decision from the appeal, you may ask the department that made the decision for a fair hearing. You have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision, to ask for a fair hearing.

Your Choice: You may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. You can also call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

Continuation of Benefits

If a benefit has been ended or reduced based on your individual situation and you have asked for an appeal or a fair hearing: depending on when you requested an appeal or fair hearing, you may ask for the benefit to continue until your appeal or hearing is decided. If you paid for your benefits, you will be paid back the amount you paid if the appeal or hearing is decided in your favor. If the State paid for the continuing benefits and the denial is upheld, you may have to pay the cost of any benefits you get while the appeal was pending. The service cannot continue if your appeal or hearing is about a benefit that has ended or been reduced because of a change in federal or state law. If your fair hearing is about your premium, you must pay your premium by the premium due date or your coverage will end. You will be paid back the amount you over paid if the appeal or hearing is decided in your favor.