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Applied Behavior Analysis, Mental Health and Substance Abuse Services Supplement

Department of Vermont Health Access
Department of Mental Health

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS
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Introduction

This manual is designed as a supplement to and does not replace the *Green Mountain Care Provider Manual* which can be found at: https://www.vtmedicaid.com/#/manuals.

This supplement describes processes to be followed by admitting facilities, Vermont Medicaid enrolled providers of Applied Behavioral Analysis services, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) when Medicaid primary beneficiaries (or uninsured Vermonters accessing substance abuse residential treatment) are hospitalized for mental health or substance abuse treatment, admitted to a substance abuse residential facility, or are receiving Applied Behavior Analysis (ABA) services.

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule, 7103, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition and must conform to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition.

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 in order to transfer the person to a less restrictive level of care.

"Detoxification" means the planned withdrawal of an individual from a state of acute or chronic intoxication, under qualified supervision and with or without the use of medication. Detoxification is monitoring and management of the physical and psychological effects of withdrawal, for the purpose of assuring safe and rapid return of the individual to normal bodily and mental function. (Vermont Statutes, Title 33 §702). Inpatient detoxification refers to the medically managed treatment regimen requiring the full services of an acute care hospital to support the withdrawal of the addictive substance.

Substance Abuse Residential Treatment facilities are staffed 24 hours per day by designated addiction treatment, mental health, and/or general medical personnel. Services are provided in a 24 hour treatment setting where patients reside in a safe and stable living environment. These facilities provide necessary clinical services to stabilize an individual's level of functioning and assist in the development of recovery skills in order for transition to less restrictive levels of care.

As defined in Act 158, "applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA includes a wide variety of evidence-based strategies to impact behavior.

Utilization Management

The DVHA conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally-recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. DVHA and DMH staff utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. Approved criteria for the services included in this supplement include the following:

- McKesson Health Solutions InterQual® Criteria
- DVHA Clinical Guidelines http://dvha.vermont.gov/for-providers/initiatives

- Vermont State Medicaid Rules http://humanservices.vermont.gov/on-line-rules/dvha

McKesson Health Solutions InterQual® Guidelines are available to providers on the Vermont Medicaid website by navigating to the Transactions Menu and choosing the appropriate Login option. After log-in, look for the link McKesson Smart Sheets on the left window. InterQual® Guidelines are updated annually.

Prior Authorization

Prior authorization (PA) is a process used to ensure the appropriate use of health care services. The goal of PA is to ensure that the proposed health service, item or procedure meets the medical necessity criteria; that all appropriate, less-expensive and/or less restrictive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition (Please refer to section 7 of *Green Mountain Care Provider Manual* for more information https://www.vtmedicaid.com/#/manuals.

Mental Health Inpatient and Substance Abuse Residential Services

In 2012 the Department of Mental Health (DMH) and the Department of Vermont Health Access (DVHA) collaborated to create a unified, consistent utilization management system for all Medicaid funded inpatient psychiatric and detoxification services. In addition to the joint DMH/DVHA Utilization Review Team, after the closing of Vermont's State Hospital due to the effects of Tropical Storm Irene, the DMH formed an expanded Care Management Unit to actively support the system of care in Vermont and facilitate flow throughout the highest levels of care.

In 2013 the Vermont Department of Health (VDH) created a utilization management system for all Medicaid primary and uninsured/underinsured Vermonters admitted for residential treatment at Standard ADAP Residential Treatment Providers (Maple Leaf Treatment Center, Serenity House, and Valley Vista). In 2015, in collaboration with the VDH, the DVHA assumed the utilization management responsibilities for the substance abuse residential providers.

The goals for the utilization management system are as follows:

- Inpatient or residential care is provided only as long as necessary for safety and/or other acute needs.
- There are standardized criteria for admission, continued stay, and discharge throughout the system of care.
- Care is continuous between the ongoing community treatment teams and episodes of inpatient or residential care. The hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and his/her family, beginning within 24 hours of admission.
- Resources of the public system are effectively and efficiently used.
- The care management system will ensure access to effective, appropriate, recovery-based services that promote an individual's health, wellness, resiliency, and successful integration into the community.

Applied Behavior Analysis Services

Vermont Act 158 (8 V.S.A. § 4088i.), an act relating to health insurance coverage for early childhood developmental disorders, including autism spectrum disorders (ASD), was passed May 16, 2012. Act 158 requires private and Medicaid insurance plans to cover medically necessary, evidence-based diagnosis and treatment of autism spectrum disorders, including applied behavioral analysis supervised by nationally board-certified behavior analysts, for children birth until the age of 21 years.

Vermont Medicaid began enrolling Board Certified Behavior Analysts (BCBA) and Board Certified assistant Behavior Analysts (BCaBA) in June of 2015 and the ABA benefit became effective July 1, 2015.

ABA services require prior authorization to determine medical necessity through the Department of Vermont Health Access (DVHA). If prior authorization is not requested or is denied, ABA services will not be considered for reimbursement by the DVHA. The ABA benefit information and applicable prior authorization forms are available at: http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/

Court Ordered Services

Per the Vermont Medicaid Provider Manual Section 4.7: If a member is mandated to seek a service, the service **may** be covered if it meets the medical necessity and Vermont Medicaid guidelines.

Retrospective Review

The DVHA and the DMH 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 Authorization Requests

It is the responsibility of the provider to notify the DVHA or the DMH of an inpatient or residential admission and to **initiate and complete** the concurrent review process. As such, the DVHA and the DMH are under no obligation to perform retrospective authorization reviews due to lack of notification of admission or failure to request additional authorized days and provide the required clinical documentation via fax prior to the end of the previous authorization period (last covered day). **Requests for retrospective authorizations due to lack of notification or failure to request additional authorized days by the provider are considered solely at the discretion of the DVHA and the DMH**. In the instance of a member whose Medicaid eligibility becomes retroactive to the time of the inpatient hospitalization or residential stay, but who at the time of admission was not eligible for Medicaid, the provider may request that the DVHA or the DMH complete a retrospective review for authorization. The request for consideration of a retrospective authorization decision is made in writing to the DVHA or the DMH. The supporting clinical documentation demonstrating that the inpatient or residential level of care criteria were met for the days requested must be submitted for review via fax or mail. The DVHA or the DMH UR staff will make every effort to render an authorization determination within 14 days of receipt of the necessary clinical documentation.

Requests for a retrospective authorization may be made to the DVHA Manager, Quality Improvement & Clinical Integrity by Toll-free fax at 1-855-275-1212 or in writing to:

The Department of Vermont Health Access
ATT: Quality Improvement and Clinical Integrity Unit
312 Hurricane Lane Suite 201
Williston, VT 05495

Contact Information

Admission Notifications	(855) 275-1212 (Toll-free Fax)
Department of Vermont Health Access (DVHA)	(802) 879-5900 (Phone)
Department of Mental Health (DMH)	(802) 828-3824 (Phone)

DVHA and DMH Utilization Review staff are available from 8 am to 4 pm Monday through Friday (excluding State holidays)

Questions regarding claims and billing issues should be directed to the Provider Services Unit of DXC Technology (DXC) at 1-800-925-1706 (in State) or 802-878-7871 (outside Vermont).

Children and Adolescent Psychiatric Admissions

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 Department of Vermont Health Access (DVHA) has adopted the McKesson InterQual ® Criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care.

Admission Process:

Youth located in the State of Vermont whose primary insurance is Vermont Medicaid are expected to be assessed in person by designated Emergency Services (ES) staff from one of the Vermont Designated Agencies (DA) prior to being referred for admission to a psychiatric inpatient facility. The ES assessment, prior to an inpatient admission, allows for determination of whether a less intensive level of care is available that can meet the youth's clinical needs. It also assists in continuity of care with outpatient providers, the identification of emergency intervention strategies (including utilization of existing crisis plans), and if necessary, make a determination if the youth's clinical presentation meets the emergency examination criteria for involuntary hospitalization.

An inpatient psychiatric admission may be recommended or supported by the ES staff when:

1. The youth is in need of hospitalization based on clinical level of care criteria; and
2. Community and support system resources are not available; and
3. A less restrictive alternative is not available and/or is not able to meet the youth's clinical needs.

ES staff is provided with an admission notification form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care recommendations and treatment options (*Attachment 1*). This admission notification form and supporting clinical documentation must be faxed to the Department of Vermont Health Access (DVHA) by the next business day following an admission. The documentation must reflect the clinical justification for the recommendation for; or support of inpatient admission. The documentation must specify the alternatives to inpatient admission that were considered and reasoning for ruling out the alternatives. The ES staff also arranges for transportation and makes the referral to a psychiatric inpatient facility.

Admitting facilities are expected to utilize clinical level of care criteria in determining whether or not a referred youth's clinical presentation meets medical necessity for inpatient admission. **Referrals for inpatient level of care based on assessments by designated ES staff are not meant to supersede a facility's use of the facility's admissions criteria when determining the medical necessity of an urgent/emergent admission**.

Children and adolescents who are primary Vermont Medicaid members and are physically located outside the State of Vermont but are referred or seeking admission to an in-state (located in Vermont) inpatient facility are not expected to be assessed by ES staff prior to admission if the assessment cannot be completed in-person. Admitting facilities are expected to utilize clinical level of care criteria in determining whether or not a youth's clinical presentation meets medical necessity criteria for inpatient admission. In lieu of the in-person

assessment by an ES staff, the admitting facility is expected to make contact with and notify the youth's home DA of the admission and to begin coordination of care within 24 hours of the admission.

All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Behavioral Health Services* (*Attachment 2*). This form is also available electronically at http://dvha.vermont.gov/for-providers/forms-1

All elective (planned) admissions require prior authorization. The provider will fax the *Uniform Medical Prior Authorization Form (Attachment 6)* with the supporting clinical information. These forms are also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

Concurrent Review

Notification to the DVHA utilization reviewer (UR) (within 24 hours or the next business day of the admission) begins the concurrent review process. The provider is responsible for faxing the clinical documentation from the medical record to demonstrate the need for inpatient level of care to the DVHA for review. The UR will use the documentation provided to assess the member's acuity level using the InterQual ® tool. The UR will assign authorization in increments of 24 hours up to 7 days. If extenuating circumstances exist the UR staff and the provider may agree to an exception and authorize increments beyond 7 days. Notification of the authorization decision will be provided within 24 hours or 1 business day of receipt of the necessary clinical information required to complete a review.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for **a specific number of** additional inpatient days. Notification via fax must include additional clinical documentation to support the need for continued inpatient level of care. Failure to notify the UR (and fax the supporting documentation supporting additional inpatient days) results in the end of authorization. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation via fax no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that clinical criteria for inpatient level of care are no longer met, the UR will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with this decision they may request a Reconsideration Review (please see Reconsideration Process).

The DVHA expects that members will discharge with scheduled follow-up appointments with mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointments or if applicable documentation of the member's refusal of appointments. The discharge plan will be faxed to the UR and upon receipt a final payment authorization will be entered into the MMIS.

In order for the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers,

and if required the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living, the Department for Children and Families, the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), and/or the Local Educational Agency (LEA). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.

- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the DVHA UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DCF, DMH, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.**

Voluntary Adults (Non-CRT) Psychiatric Admissions

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 Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) have adopted the McKesson InterQual ® criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care

Admission Process:

Adults whose primary insurance is Vermont Medicaid admitted to a facility for psychiatric inpatient services will be assessed prior to admission by the admitting facility (provider) to determine medical necessity for inpatient level of care. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Behavioral Health Services (Attachment 2).* This form is available electronically at: http://dvha.vermont.gov/for-providers/forms-1

All elective (planned) admissions require prior authorization. The provider will fax the *Uniform Medical Prior Authorization Form (Attachment 6)* with the supporting clinical information. These forms are also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

Concurrent Review:

Notification to the DVHA utilization reviewer (UR) (within 24 hours or the next business day of the admission) begins the concurrent review process. The provider is responsible for faxing the clinical documentation from the medical record to demonstrate the need for inpatient level of care to the DVHA for review. The UR will use the documentation provided to assess the member's acuity level using the InterQual ® tool. The UR will assign authorization in increments of 24 hours up to 7 days. If extenuating circumstances exist the UR staff and the provider may agree to an exception and authorize increments beyond 7 days. Notification of the authorization

decision will be provided within 24 hours or 1 business day of receipt of the necessary clinical information required to complete a review.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for **a specific number of** additional inpatient days. Notification via fax must include additional clinical documentation to support the need for continued inpatient level of care. Failure to notify the UR (and fax the supporting documentation supporting additional inpatient days) results in the end of authorization. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation via fax no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with this decision they may request a Reconsideration Review (please see Reconsideration Process).

The DVHA expects that members will discharge with scheduled follow-up appointments with mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointments or documentation of the member's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living, and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the DVHA UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.**

Medically Managed Detoxification

Criteria for Inpatient Hospitalization:

To ensure that the medically managed detoxification services are provided at an appropriate level of care and with the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) has adopted the McKesson InterQual ® Criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care

Admission Process:

All adults (ages 18 and over) whose primary insurance is Vermont Medicaid admitted to an inpatient facility for medically managed detoxification services will be assessed by staff at the admitting facility (provider) to determine the medical necessity for inpatient level of care, prior to admission. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA all necessary clinical documentation from the medical record, including nationally-recognized, standardized tools used to assess withdrawal symptoms (ie COWS ®, CIWA ®, CIWA-Ar®) as well as the *Vermont Medicaid Admission Notification Form for Behavioral Health Services (Attachment 2).* This form is also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

All elective (planned) admissions will require prior authorization. The provider will fax the *Uniform Medical Prior Authorization Form (Attachment 6)* with the supporting clinical information. These forms are also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

Concurrent Review:

Notification to the DVHA utilization reviewer (UR) (within 24 hours or the next business day of the admission) begins the concurrent review process. The provider is responsible for faxing the clinical documentation from the medical record to demonstrate the need for inpatient level of care to the DVHA for review. The UR will use the documentation provided to assess the member's acuity level using the InterQual ® tool. The UR will assign authorization in increments of 24 hours up to 7 days. If extenuating circumstances exist the UR staff and the provider may agree to an exception and authorize increments beyond 7 days. Notification of the authorization decision will be provided within 24 hours or 1 business day of receipt of the necessary clinical information required to complete a review.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for **a specific number of** additional inpatient days. Notification via fax must include additional clinical documentation to support the need for continued inpatient level of care. Failure to notify the UR (and fax the supporting documentation supporting additional inpatient days) results in the end of authorization. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation via fax no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the inpatient facility disagrees with this decision they may request a Reconsideration Review (please see Reconsideration Process).

The DVHA expects that members will discharge with scheduled follow-up appointments with substance abuse and, if appropriate, mental health treatment providers within 7 days of the discharge date. The discharge plan

will contain documentation of these appointments or documentation of the member's refusal of appointments. The discharge plan will be sent via fax to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the utilization reviewer to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living, and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the DVHA UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting condition that led to inpatient hospitalization.**

Community Rehabilitation & Treatment (CRT)

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 Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) have adopted the McKesson InterQual ® Behavioral Health criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care

Admission Process:

Initial interview and evaluation by Designated Agency screener

Staff from the Designated Agencies (DA) evaluate all proposed CRT psychiatric inpatient admissions. These staff are referred to as screeners.

The screener interviews and evaluates all individuals identified in need of psychiatric hospitalization for purposes of:

- Continuity of care
- Recommendation of immediate intervention strategies
- Determination of appropriateness for hospitalization

- Determination of appropriateness for involuntary hospitalization

This encounter includes assessment for less restrictive alternatives and review of any existing crisis plan for the individual. This screener records this information on the *CRT Crisis Intake Worksheet* (*Attachment 3*).

If an involuntary hospitalization is sought, an *Application for Emergency Examination* must be completed (*Attachment 11*).

If the admitting facility (provider) determines (through an emergency department or 'transfer' from a medical unit or another hospital) that an individual presenting for admission is a CRT enrollee, the individual's DA emergency services program must be contacted to begin the assessment process. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The provider will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Behavioral Health Services (Attachment 2).* This form is also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

All elective (planned) admissions will require prior authorization. The provider will fax the *Uniform Medical Prior Authorization Form (Attachment 6)* with the supporting clinical information. These forms are also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

For CRT inpatient hospitalization, the payer source upon admission remains the same payer throughout the episode of care regardless of any changes that occur during the course of treatment. For example, if an individual is enrolled in a CRT program after being admitted to an inpatient facility for psychiatric services, the payer that covered the stay at the time of admission remains the payer for the entire episode of care. Conversely, if an individual is enrolled in a CRT program at the time of admission and is dis-enrolled prior to discharge from the inpatient facility, the original payer remains for the entire episode of care.

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer (UR) will be assigned to begin the authorization process. All clinical information necessary to determine that inpatient criteria are met will be provided via fax with the admission notification form. The utilization reviewer will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review, based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the member's acuity level, unless extenuating circumstances exist and the UR staff and provider agree to an exception. The utilization reviewer will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information during the concurrent review.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days and to provide supporting clinical documentation from the medical record. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days or fails to provide the supporting clinical documentation, the authorization will end. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that the clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day for payment or the change in authorization status. If the inpatient facility disagrees with this decision it may request a Reconsideration Review (please see Reconsideration Process).

The DMH expects that members will discharge with scheduled follow-up appointments with mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointment dates and times **or** documentation of the member's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the DMH to make authorization determinations, the provider is responsible for

- Notifying the DMH of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DMH expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.**

Involuntary Admissions/Emergency Examinations

Admission Process:

A Qualified Mental Health Professional (QMHP) must evaluate all individuals regardless of treatment provider, program or payer source to determine the necessity for an involuntary hospitalization. A QMHP who is also employed by a hospital psychiatric unit must not be working in that capacity at the same time he/she is acting in the role of a QMHP. By agreement with the Department of Mental Health (DMH) and designated general hospitals, only QMHPs who are designated by the DMH Commissioner or designee and employed by a Designated Agency (DA) can screen and serve as the applicant for involuntary psychiatric admissions. (See *Attachment 4* for a detailed description of requirements and responsibilities.) The QMHP reports all admissions to the DMH Admission's Office and completes the *Application for Emergency Examination* (*Attachment 11*).

Authorization Criteria for Continued Stay:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) and the Department of Mental

Health (DMH) have adopted the McKesson InterQual ® criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer (UR) will be assigned to begin the authorization process. All clinical information necessary to determine that inpatient criteria are met will be provided via fax with the admission notification form. The utilization reviewer will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review, based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the member's acuity level, unless extenuating circumstances exist and the UR staff and provider agree to an exception. The utilization reviewer will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information during the concurrent review.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days and to provide supporting clinical documentation from the medical record. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days or fails to provide the supporting clinical documentation, the authorization will end. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that the clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day for payment or the change in authorization status. If the inpatient facility disagrees with this decision it may request a Reconsideration Review (please see Reconsideration Process).

The DMH expects that members will discharge with scheduled follow-up appointments with mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointment dates and times **or** documentation of the member's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the DMH to make authorization determinations, the provider is responsible for

- Notifying the DMH of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify

appropriate post-hospitalization treatment and recovery resources.

- Prompt notification to the UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DMH expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.

Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.**

Substance Abuse Residential Treatment

Criteria for Admission:

To ensure that substance abuse residential treatment services are provided at an appropriate level of care and with the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) has adopted the McKesson InterQual ® criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care

Admission Process:

All adults and adolescents (ages 13 and over) whose primary insurance is Vermont Medicaid or uninsured adults (ages 18 and over) admitted to a substance abuse residential treatment facility will be assessed prior to admission by the admitting facility staff (provider) to determine the medical necessity for residential level of care. All admissions will require notification to the DVHA within 24 hours or the next business day of admission. The provider will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Behavioral Health Services. (Attachment 2)*. This form is also available electronically at: http://dvha.vermont.gov/for-providers/forms-1

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer (UR) will be assigned to begin the authorization process. All clinical information necessary to complete a review utilizing the InterQual ® criteria must be provided by the facility to the DVHA via fax within 3 days of the admission. The UR will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review, based on the clinical information provided, the UR will assign authorization in units of days based upon the member's acuity level. The UR will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the necessary clinical information required in order to complete a review utilizing the InterQual ® tool.

It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization **for a specified number** of additional days and provide supporting clinical documentation from the medical record. If the provider does not contact the utilization reviewer to request authorization of additional residential days, or fails to provide the supporting clinical documentation, the authorization will end. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the facility feels additional authorized days are required, the facility must make the request for authorization and provide the clinical documentation no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision at that time but no later than the end of the business day.

Upon determination that clinical criteria for residential level of care are no longer met, the UR will inform the provider of the last covered day or the change in authorization status. If the residential facility disagrees with this decision they may request a Reconsideration Review (please see Reconsideration Process).

The DVHA expects that members will discharge from residential treatment with scheduled follow-up appointments with substance abuse and, if appropriate, mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointments or documentation of the member's refusal of appointments and will be provider to the UR.

In order for the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing via fax the clinical documentation from the medical record justifying the inpatient admission. And, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required the appropriate state liaison from the Department of Mental Health, the Department for Children and Families (DCF), the Department of Disability, Aging and Independent Living and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-discharge treatment and recovery resources.
- Prompt notification to the UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DMH, DCF, DAIL and/or VDH-ADAP) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; **including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting symptoms/condition that led to admission.**

Applied Behavior Analysis Services

Prior Authorization

Providers must submit the following documentation to the DVHA to request prior authorization in order for Applied Behavior Analysis (ABA) services to be considered for reimbursement by Vermont Medicaid. All required forms and additional information regard the ABA benefit is available at:

http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/

- *State of Vermont Uniform Medical Prior Authorization* form; **and**
- *Applied Behavior Analysis Services Supplemental Authorization* form; **and**
- Prescription for ABA services; **and**
- A current diagnostic assessment (the DVHA may request a reassessment be provided if medically necessary and additional services are being requested). The diagnostic assessment should utilize

autism diagnostic tool(s) and must be conducted by a qualified professional including; a board certified or board eligible psychiatrist, doctorate-level licensed psychologist, a board certified or board eligible neurologist, a developmental-behavioral or neurodevelopmental disabilities pediatrician, or a masters-level licensed clinician who is experienced in the diagnosis and treatment of autism. Additionally, it is recommended that a diagnostic evaluation is best conducted by an interdisciplinary team of child specialists with expertise in ASD; **and**

- An assessment by a Board Certified Behavioral Analyst (BCBA) recommending ABA specific treatment. This assessment should include: direct observation of the member; interview with the member, parent(s)/guardian(s), caregiver(s), teacher(s) and other professionals involved in the member's care such as a speech and language pathologist, therapist, occupational therapist etc., *to the extent possible*; file review; administration of behavior scales or other assessment tools; and integration of existing information to establish current functioning across domains including language/communication, motor, cognitive, social/emotional and adaptive behavior; **and**
- Documentation of treatment goals and, if applicable, progress towards goals; **and**
- Completion of the ABA Provider Services Report Form which can be located at: http://dvha.vermont.gov/for-providers/initiatives **and**
- ABA treatment plan specific to member; and a list of staff members, including BCBA, BCaBAs and BTs, who will be working directly with the member. This list should include providers' names and qualifications. If additional team members are being added to the team of providers, the BCBA should notify the DVHA as soon as possible.

The DVHA will issue a notice of decision within three business days of receiving the prior authorization request. If all necessary information is not included in the PA request, the DVHA utilization review staff will contact the provider and will request missing information. The provider then has 10 business days to submit the missing information. If a PA is denied or authorized at an amount or intensity less than the original request, the provider may submit a request to the DVHA for a Reconsideration Review (please see Reconsideration Process).

Continued Authorization of ABA Services

Prior Authorizations will be required to be submitted every six months (unless greater frequency is clinically indicated) to the DVHA. The following documentation is required for consideration of continued authorization of ABA services:

- An updated treatment plan which includes a brief summary of how the member has responded to ABA treatment since the last review date; **and**
- An ABA Provider Service Report form; **and**
- In addition to meeting clinical criteria, the following must be demonstrated for consideration of continued authorization of ABA services:
    - ABA treatment plans should be reviewed and signed off by a BCBA quarterly and any time there is significant change in the treatment plan; **and**
    - Member continues to meet criteria defined in the 'Eligibility of Services' section of the Vermont Medicaid ABA benefit, available at:

      http://dvha.vermont.gov/for-providers/applied-behavior-analysis-aba/

      ; **and**
    - Treatment is not making the member's symptoms worse over the course of the most recent authorization period; **and**
    - Transition and discharge planning should include a written plan with specific details for monitoring and follow-up.

Reconsideration Process

The DVHA and the DMH will conduct an internal review of the following types of decisions directly affecting providers in response to requests by providers:

- PA disapproval by the DVHA or its agents (other than medical necessity determinations);
- PA disapproval because documentation was inadequate;
- Error in manual pricing;

The DVHA and the DMH will not review any decision other than those listed above.

Although this process is not an appeals process, it is the DVHA's and the DMH's position that providing a "second look" for certain decisions may help improve accuracy. Any affected provider may ask that the DVHA or the DMH reconsider its decision.

Requests must be made no later than 14 days after the DVHA or DMH utilization review clinician (reviewer) first gives notice, either written or oral, to the ABA provider, inpatient or residential facility of the authorization decision.

The DVHA or the DMH will base the reconsideration of authorization decision on the clinical documentation from the medical record and written documentation from the attending physician demonstrating why the provider believes the DVHA or the DMH should have found differently (based on the clinical presentation of the member). The fully completed REQUEST FOR RECONSIDERATION OF AUTHORIZATION FOR MENTAL HEALTH, SUBSTANCE ABUSE RESIDENTIAL AND APPLIED BEHAVIOR ANALYSIS SERVICES form (Attachment 5) and all clinical documentation must be submitted via fax or mail to the reviewer.

It is expected that the request will contain all supporting documents. Supplemental information submitted after the request for reconsideration of authorization is submitted, even if before the decision has been made, will not be considered by the DVHA or the DMH except when the DVHA or the DMH determines that extraordinary circumstances exist. Upon receipt of the request and supporting information, the DVHA or the DMH will review all information received.

The DVHA or the DMH will notify the inpatient or residential facility of its reconsideration of authorization decision within 14 days of receipt of notice of the request and the supporting clinical documentation from the medical record with a possible extension of up to 14 additional calendar days if the enrollee, ABA provider, substance abuse residential or inpatient facility requests extension or the DVHA and/or the DMH justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

In the event that an ABA provider, inpatient or residential facility disagrees with the DVHA or the DMH regarding the reconsideration of authorization decision, the ABA provider or inpatient or residential facility's physician and/or Medical Director may request to speak with the DVHA or the DMH designated physician for a final review of the authorization decision (aka doc to doc review).

Such requests must be made in writing to the DVHA or the DMH utilization review clinician within 5 business days of the notification of the reconsideration of authorization decision. The request must include service and or rate the provider is requesting be reviewed, the name and contact information for the provider who is requesting the review and the name and contact information for scheduling purposes.

- The provider is responsible for responding to the DVHA or the DMH proposed review times within 3 business days. Failure to respond to proposed times within 3 business days will result in the reconsideration of authorization decision being upheld.
- If a provider is unable to attend a scheduled doc to doc review, it is the provider's responsibility to contact the DVHA or the DMH utilization review clinician to request a rescheduled appointment within 3

business days. Failure of the provider to request a rescheduled appointment within 3 business days will result in the reconsideration of authorization decision being upheld.

- If a provider fails to attend three scheduled doc to doc reviews for a particular member and service, this will result in the reconsideration of authorization decision being upheld and no additional opportunities to schedule a doc to doc review for the service in question will be afforded.

There is no additional review or reconsideration after the DVHA or the DMH Medical Director or the designee has made a decision on the reconsideration of authorization request.

Expedited Decisions

For cases in which the provider indicates or the DVHA and/or DMH determines that following the standard timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the DVHA and/or DMH must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 working days after receipt of the request for this service.

Interrupted Psychiatric Stays and Rapid Readmission

Psychiatric inpatient admissions are considered "interrupted" when a patient is admitted to a psychiatric floor in a general hospital, transferred to a medical floor within the same facility and transferred back to the psychiatric floor. These stays are considered continuous for the purpose of applying the variable per diem adjustment and is considered one continuous stay for payment.

There are four types of rapid re-admissions described in this document. Rapid-re-admissions are authorized and billed in different ways to account for the days a member may be on a medical floor during a stay, days spent out of the hospital, or if a member discharges and then re-admits on the same day. When a member re-admits to a psychiatric floor of a different hospital within 3 midnights, DVHA Utilization Review (UR) clinicians review documentation to determine if the second admission should start at day 1 (new episode) or should continue as an extension of the first admission. This affects the rate of reimbursement for the second admission.

Scenario 1: Rapid re-admission - interrupted psychiatric stay

For instances where a member is on a psychiatric floor, then is transferred to a medical floor, and then is transferred back to the psychiatric floor within the same hospital.

- Member is admitted to psychiatric floor on 02/05/18 and is transferred to medical floor on 02/07/18.
- Member is on medical floor from 02/07/18 - 02/09/18 and is transferred back to the psychiatric floor on 02/10/18.
- Member is discharged on 02/15/18.

Claim:

- Submit one claim using one detail line with a date span that encompasses the entire stay with an occurrence code 74 for the dates of the stay on the medical floor.
- Submit a separate claim for the stay on the medical floor using only the dates of service the member was on the medical floor.

Claim Example:

- Psychiatric Claim #1: 02/05/18 - 02/15/18 for 10 units of revenue code 124 with occurrence code 74 for 02/07/18-02/09/18.
- Medical Claim (submitted separately): 02/07/18 - 2/10/18 for 3 units of revenue code 120 (or other inpatient medical code as appropriate).

Scenario 2: Rapid re-admission to a different hospital within 3 midnights

For instances where a member is discharged from a psychiatric floor in one hospital and readmitted to a psychiatric floor in a different hospital within 3 midnights.

- Member is admitted on 02/01/18 and discharged on 02/05/18.
- Member is out of the hospital 02/06/18.
- Member is readmitted on 02/07/18 and discharged on 02/12/18.

Claim:

- The first hospital submits a claim using the first admission and first discharge date.
- The second hospital submits a claim using the second admission date and second discharge date AND consults the final faxback to see if value code 75 & the number of units need to be entered for the first admission.

Claim Example:

- Psychiatric claim #1: 02/01/18 - 02/05/18 for 4 units of revenue code 124 by hospital 1.
- Psychiatric claim #2: 02/07/18 - 02/12/18 for 5 units of revenue code 124 AND 4 units of value code 75 by hospital 2.

Scenario 3: Rapid re-admission to the same hospital within 3 midnights

For instances where a member is discharged from a psychiatric floor in a hospital and readmitted to a psychiatric floor in the same hospital within 3 midnights.

Example:

- Member is admitted on 02/05/18 and discharged on 02/07/18.
- Member is out of the hospital on 02/08/18.
- Member is readmitted on 02/09/18 and discharged on 02/14/18.

Claim:

- The hospital submits a claim using the first admission and first discharge date.
- The hospital submits a claim using the second admission date and second discharge date **AND** consults final faxback to see if value code 75 should be used.

Claim Example:

- Psychiatric claim #1: 02/05/18 - 02/07/18 for 2 units of revenue code 124.
- Psychiatric claim #2: 02/09/18 - 02/14/18 for 5 units of revenue code 124 **AND** 2 units of value code 75.

Scenario 4: Rapid re-admission to the same hospital on the day of discharge

For instances where a member is discharged from a psychiatric floor in a hospital and readmitted to the same hospital's psychiatric floor on the same day.

Example:

- Member is admitted on 03/15/18 and discharged on 03/18/18.
- Member is readmitted on 03/18/18 and discharged on 03/22/18.

Claim:

- The hospital submits a claim using the first admission and second discharge date.

Claim Example:

- Psychiatric claim #1: 03/15/18 – 03/22/18 for 7 units of revenue code 124.

Sub-Acute and Awaiting Placement Reimbursement Rates

Sub-Acute

In order to determine if an inpatient continued stay is eligible for authorization at the sub-acute inpatient rate the following criteria will be utilized:

- The clinical documentation provided by the facility demonstrates that criteria for inpatient level of care per the McKesson InterQual ® criteria is not met and;
- The member no longer requires the intensity of services that can only be provided at the inpatient level of care and;
- The member requires a residential level of care and no discharge placement has been identified or a discharge placement has been identified but is not available, and;
- Active and appropriate aftercare planning has been ongoing from the time of admission and appropriate Agency of Human Services Department partners have been engaged by the facility if barriers to aftercare planning and/or discharge were identified (i.e. DCF central office, DMH Children's Unit, DAIL).

Awaiting Placement

Awaiting Placement days are those days authorized for the awaiting placement reimbursement rate at an inpatient facility when a member is awaiting discharge to a lower level of care.

The utilization reviewer will notify the inpatient facility utilization reviewer no later than 24 hours or one business day prior to the change to authorization at the awaiting placement rate.

Inter-Rater Reliability

The DVHA will have in effect inter-rater reliability mechanisms to ensure consistent application of review criteria for authorization decisions. Those cases not meeting criteria, potential denials, or partial approvals of service authorization for amount, duration, or scope are referred to a health care professional with appropriate clinical expertise in treating the member's condition or disease for determination. Health care professionals include currently licensed health professionals such as: Licensed Clinical Social Worker (LCSW), Licensed Psychologist, Licensed Clinical Mental Health Counselor (LCMHC), Licensed Alcohol and Drug Counselor (LADC), licensed physician's assistant (PA) or a physician.

The following procedures are in place to ensure consistent application of the review criteria. All utilization reviewers or any designated staff responsible for authorization of behavioral health services will complete these procedures.

All staff will be required to complete training on the McKesson InterQual ® Behavioral Health Clinical Decision Support Criteria tool. Training will consist of a combination of web-based, in person and text-based learning. In addition, all staff will be required to complete an annual test utilizing the InterQual ® Interrater Reliability Suite (IRR). The IRR is a Web-based testing application which is updated annually and measures how well and consistently reviewers apply InterQual ® criteria.

Reviewers must achieve a score of 80%. Should a reviewer receive a score of less than 80%, additional training will be provided until the reviewer receives a score of at least 80%.

Program Integrity

Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code should be chosen that most accurately describes the service that was provided, claims should be submitted for only those days that were authorized, and claims should accurately reflect the reimbursement rate authorized as well as the appropriate discharge status (i.e. against medical advice, acute, sub-acute or awaiting placement). It is a felony under Vermont law knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- File a claim for services that were not rendered
- File a false claim
- File a claim for unauthorized items or services
- Bill the member or the member's family for an amount in excess of that allowed by law or regulation
- Fail to credit the state or its agent for payments received from social security, insurance or other sources
- Receive unauthorized payment

Attachment 1

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

VERMONT MEDICAID CHILD & ADOLESCENT INPATIENT ADMISSION NOTIFICATION FORM

The following information and justification must be provided **in full** to the **Department of Vermont Health Access, (Toll-free fax #855-275-1212)** at the time of the inpatient admission:

Admission date: _____ Admit facility _____

Child/adolescent name: _____

Address: _____

Medicaid Unique ID: _____Date of Birth _____

Parent/guardian name: _____

Parent/guardian consent on file? ____yes ____no

DCF custody? _____yes _____no

If in DCF custody, name of social worker assigned to case, district and telephone number

_____

CMHC active client? ____yes ____no

Status: ____voluntary ____involuntary

Referral source: _____

Screener name: _____ CMHC: _____

Alternatives considered:	Name of person who refused admission and reason for refusal:
____The Baird Center 802-488-6600	_____
____Home Intervention 802-479-1339	_____
____Northeastern Family Institute 802-658-2004	_____
____Crisis Respite Beds	_____
____Kinship care	_____
____In-home support	_____
____Other (please specify)	_____

(If no alternatives were considered, the reason must be clearly explained in narrative)

Assessment narrative to include clinical justification that satisfies criteria for hospitalization:

1. Evidence of mental illness (previous diagnosis or need for diagnostic clarity)
2. 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)
3. Medical information (physical health, medications and compliance, complicating medical factors or medication issues)
4. Evidence of failure or unmanageability at less intensive levels of care (family functioning, strengths and availability of support systems such as school and community, previous and current mental health treatment)

(State the facts which you have gathered from your own personal observations and/or as reliably reported to you by another person which lead you to believe that the proposed patient is in need of inpatient hospitalization for treatment of a mental illness. If this information is contained in another document which has been completed at the time of this admission, that document can be faxed with this form with “see attached” written in this space.)

_____

_____

_____

_____

_____

Local contact for discharge planning (case manager, therapist, etc.):

Name _____ Agency_____

Phone _____

Attachment 2

VERMONT MEDICAID ADMISSION NOTIFICATION FORM

Behavioral Health Services

inpatient psychiatric & detoxification services and substance abuse residential treatment

The following information and justification must be provided to the Department of Vermont Health Access (DVHA) (**toll-free fax: 855-275-1212**) within 24 hours or next business day of an urgent or emergent **hospital admission *or*** no later than the 3rd calendar day after a **substance abuse residential admission**. **All elective (planned) inpatient hospital admissions will require notification prior to admission for authorization.** The Utilization Reviewer will contact the facility after notification is received by the DVHA to begin the authorization process.

The following information must be provided in full to the DVHA in order to make an authorization determination.

Date of Admission: _____ Admission Diagnosis:_____

Patient Last Name: _____First Name: _____

Medicaid ID Number: _____Date of Birth: _____

Physical Address_____

Is the patient being admitted involuntarily? (**inpatient only**) Yes No (circle one)

Does the patient have a guardian (DCF, or Public Guardian)? Yes No (circle one)
If yes, guardian's name: _____

Is patient receiving mental health services in Vermont from a Community Mental Health Center (CMHC)? Y N (circle one) If yes, name of agency_____

If the answer to the previous question is "No", is the patient receiving other mental health services in Vermont? Y N (circle one) If yes, name of provider_____

Referral Source (if applicable) _____

Facility Name_____ VT Medicaid Provider Number_____

Contact Person for Authorizations _____ Phone #_____

Anticipated Length of Stay upon Admission _____

Admitting or referring providers are responsible for attaching clinical documentation to demonstrate medical necessity for psychiatric or detoxification inpatient or substance abuse residential admission.

Attachment 3

CRT Crisis Intake Worksheet

For a **voluntary CRT** admission to a community hospital psychiatric unit, screeners are to provide the following information to DMH Admissions' staff. Additional information and a faxed copy of the EE paperwork are necessary for all **involuntary** admissions:

Individual's Name	
SSN	
Address	
Screening Agency	
Screener Name	
Does screener agree with admission?	
Primary Agency	
Admit Date	
Date Reported	
Time Reported	
Admit Facility	
Legal Status	
Reason for Admission:	
Danger to self	
Danger to others	
Non-adherent with recommended treatment	
Self Abusive	
Assaultive/Destructive	
Exhausted Program	
Medical Cofactor	
Personal Conflict	
Transitional	
Refused Options	
Other	

Alternatives Considered Referring Physician	
Estimated Length of stay	

Attachment 4

VERMONT DEPARTMENT OF MENTAL HEALTH 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 DMH and designated general hospitals (DH), only QMHP's who are designated by the Department of Mental Health (DMH) Commissioner or designee, and employed by a Designated Agency (DA), 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. 1-2 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
    c. Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

OR

2. **Bachelor's degree in related human services field and:**
    a. Clinical exposure to populations with major mental illness, **and**
    b. 2-3 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
    c. Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

OR

3. **Bachelor's degree in a field unrelated to human services and:**
    a. Clinical exposure to populations with major mental illness, **and**
    b. 3-5 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
    c. Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

OR

4. If an applicant does not meet the qualifications but meets other criteria and has experience in providing crisis services in the community to severely mentally ill individuals, an application may be submitted for

designation consideration. The application should include information that explains the reason(s) for the exception.

Demonstrated Knowledge of and Training in:

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

Attachment 5

REQUEST FOR RECONSIDERATION: FOR MENTAL HEALTH, SUBSTANCE ABUSE RESIDENTIAL AND APPLIED BEHAVIOR ANALYSIS SERVICES

This request form must be completed **in its entirety** and submitted to the utilization reviewer no later than 14 days after the DVHA or DMH Utilization Reviewer first gives notice, either written or oral, to the provider, inpatient or residential facility that authorization for a particular member will end or authorization will be continued at a lower reimbursement rate or that ABA services will not be authorized or will be authorized at a lesser duration or amount than the original request.

Date of Request:

Dates Provider is Requesting be Reviewed (must list both begin and end date for review): *an end date must be provided as reviews cannot be open-ended

Begin: **End:**

Reimbursement Rate Requested by Provider:

Name of Provider:

Name of Member:

Member Medicaid ID Number:

The Following Section Must Be Completed by Attending Physician or Licensed Treating Provider (for ABA or Substance Abuse Residential Services)

1. For the days being reviewed, please describe the severity of symptoms that required the requested level of care:

2. For the days being reviewed, please describe the services provided to address the above described symptoms that required the requested level of care:

Name of Attending Physician or Licensed Provider Completing Form:

Attachment 6

UNIFORM MEDICAL PRIOR AUTHORIZATION FORM

State of Vermont

Uniform Medical Prior Authorization Form

Urgent Request ☐

Non-Urgent Request ☐

Instructions: Please complete all fields and submit all additional treatment information and/or medical notes that support your request for benefits. If you need more room, you may attach additional pages or forms. Send or fax this information to the member's health plan in advance of the proposed services. Please refer to information provided on the health plans' website for submission instructions and contact information.

Patient/Member Information (* Required Field)		
***First Name:** **Middle Initial:** ***Last Name:**		
***Health Insurance ID#:**	***DOB** *(MM/DD/YYYY)*: / /	***Gender:** Male ☐ Female ☐ Unknown ☐
***Address:** **Apt.#:**		
***City:** ***State:** ***Zip:** **Telephone #:**		

Referring/Requesting Provider Information	**Rendering/Attending Provider Information**
First Name: **Last Name:**	**First Name:** **Last Name:**
NPI/TIN #: **Specialty:**	**NPI/TIN #:** **Specialty:**
Group/Practice Name:	**Group/Practice Name:**
NPI/TIN #:	**NPI/TIN #:**
Address: **Suite #:**	**Address:** **Suite #:**
City: **State:** **Zip:**	**City:** **State:** **Zip:**
Office Contact/ Person Completing Form:	
Telephone #: **FAX #:**	

Required Clinical Information (* Required Field)	
***Date of Request:**	**Is this request for Out-of-Network services?** Yes ☐ No ☐

***Type of Service Requested**		
Inpatient Care:	**Outpatient/Office Care:**	**Therapies:**
Medical Admit ☐	Acupuncture ☐	Occupational Therapy ☐
Mental Health/Substance Abuse Admit ☐	Chiropractic ☐	Physical Therapy ☐
OB ☐	Infusion/Oncology Drugs ☐	Speech Therapy ☐
Surgery ☐ Oral Surgery ☐	Mental Health/Substance Abuse ☐	Cardiac Rehab ☐

Testing: Diagnostic Imaging ☐ Diagnostic Medical Test ☐	**Other:** DME ☐ SNF ☐ Home Health ☐ Vision/Glasses ☐ Other ☐ - please specify:
***Date Diagnosed:**	***Place of Service:** Inpatient ☐ Outpatient ☐ Office ☐ Other ☐ - specify:
***Proposed Date(s) of Service: From:** **To:**	***Facility Where Service Will be Performed:**
***Proposed Number of Inpatient Treatment Days:**	***Proposed Number of Outpatient Treatment Visits:**
***Primary Diagnosis:**	***Primary Diagnosis Code:**
***Secondary Diagnosis:**	***Secondary Diagnosis Code:**
***Name of Proposed Procedure or Test:**	***CPT/HCPCS or Revenue Code:**
***Requested DME:**	
***DME CPT/HCPCS Code:**	***Requested DME Duration (Date(s) of Service):**
***DME Purchase Price: $**	***DME Monthly Rental Price: $**

Additional Clinical Information Attached: ☐ (No. of pages)

Attachment 7

MENTAL HEALTH 24 HOUR EMERGENCY SERVICES

Clara Martin Center *(**Orange** County)*	(800) 639-6360
Counseling Service of Addison County *(**Addison** County)*	(802) 388-7641
Health Care and Rehabilitation Services of Southeastern VT *(**Windham** and **Windsor** Counties)*	(800) 622-4235
HowardCenter – First Call *(**Chittenden** County)*	(802) 488-7777
HowardCenter – Adult Crisis *(**Chittenden** County)*	(802) 488-6400
Lamoille County Mental Health *(**Lamoille** County)*	(802) 888-4914 *After Hours:* (802) 888-4231
Northeast Kingdom Human Services, Inc. *(**Essex**, **Caledonia** and **Orleans** Counties)*	*St. Johnsbury* - (802) 748-3181 1-800-649-0118 *Newport*- (802) 334-6744 1-800-696-4979
Northwestern Counseling and Support Services *(**Franklin** and **Grand Isle** Counties)*	(802) 524-6554 1-800-834-7793
Rutland Mental Health Services *(**Rutland** County)*	(802) 775-1000
United Counseling Service *(**Bennington** County)*	*Manchester* - (802) 362-3950 *Bennington* - (802) 442-5491
Washington County Mental Health Services *(**Washington** County)*	(802) 229-0591

Attachment 8

ADULTS AGES 18 & OVER PSYCHIATRIC CRISIS BEDS IN VERMONT

HI-(6 beds) Washington County Mental Health –		**802-229-0591**
Contact Emergency Screeners		
Care Bed-(2 beds) Northeast Kingdom Mental Health -		**802-748-6961**
Contact facility directly		
Bayview-(2 beds) Northwest Counseling and Support Services-		**802-524-6554**
Contact Emergency Screeners		
Assist Program-(6 beds) Howard Center-		**802-488-6400**
Contact Emergency Screeners		**802-488-6240**
Alternatives-(6 beds) Heath Care and Rehabilitation Services-		**802-885-7280**
Contact facility directly		
Battelle House-(6 beds) United Counseling Services-		**802-442-1216**
Contact facility directly		
Crisis Stabilization Inpatient Diversion(CSID)-(4 beds) Rutland -		**802-747-3587**
For Step-down referrals		
Second Spring Crisis Beds-(2 beds) Collaborative Solutions-		**802-433-6183**
Contact Registered Nurse on Duty		
Chris' Place-(1 bed) Clara Martin Center-		**802-728-4466**
Contact Emergency Screeners		**800-639-6360**
Alyssum-(2 beds) Peer Support-		**802-767-6000**
Contact facility directly		
Cottage Crisis-(1 bed) CSAC-		**802-388-6754**
Contact Annette Armstrong		
Oasis House-(2 beds) Lamoille Community		**802-888-5026**
Connections-	**(Evenings & Weekends)**	**802-888-4231**
Contact LCC Mobile Crisis Team		

Attachment 9

PATHWAYS VERMONT

Pathways Vermont is a non-profit organization operating throughout the state of Vermont. Pathways started in Vermont in January 2010 with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). Pathways brings the Evidence-based Practice of Housing First to Vermont and partners with the Vermont State Department of Corrections and Department of Mental Health to help realize the goal of creating a statewide system of Housing First services.

TOLL-FREE PHONE NUMBER: (888) 492-8218

FAX NUMBER: (855) 362-2766

Chittenden County:
191 North Street
Burlington, VT 05401

Franklin County:
5 Lemnah Drive
St, Albans, VT 05478

Washington County:
54 South Main Street
Suite 2
Barre, VT 05461

Windham County - Brattleboro:
116 Birge Street
Brattleboro, VT 05301

Windham County - Bellows Falls:
7 Canal Street
Unit 113
Bellows Falls, VT 05101

Pathways Vermont - The Wellness Co-op:
43 King Street
Burlington, VT 05401

Administrative Offices:
1233 Shelburne Road
Suite D4
South Burlington, VT 05401

Attachment 10

SUBSTANCE ABUSE SERVICES

Key to Substance Abuse Program Services Available

A: Adolescents **D**: Detox **I**: Intensive Outpatient **O**: Outpatient

R: Residential **HH**: Halfway House **HUB**: Opioid Treatment Hub

PIP: Public Inebriate Program **PC**: Project Crash

RC: Recovery Center **W**: Women Only **B**: Buprenorphine

Addison County

- Counseling Service of Addison County (A, O, PC)
  89 Main Street, Middlebury
  Tel: (802) 388-6751
- Turning Point Center of Addison County (RC)
  228 Maple Street, Middlebury
  Tel: (802) 388-4249

Bennington County

- Bennington School (A, R)
  192 Fairview Street, Bennington
  Tel: (802) 447-1557
- Northshire United Counseling Service (O)
  Stephen Lundy Building, Route 7A, Manchester Center
  Tel: (802) 362-3950
- Turning Point Center of Bennington (RC)
  465 Main Street, Bennington
  Tel: (802) 442-9700
- United Counseling Service (A, O, PC, PIP)
  Ledge Hill Drive, Bennington
  Tel: (802) 442-5491

Chittenden County

- Community Health Center (B, O)
  617 Riverside Avenue, Burlington
  Tel: (802) 864-6309
- Day One (I, O)
  UHC Campus, 1 So. Prospect Street, Burlington
  Tel: (802) 847-3333
- HowardCenter, Act One/ Bridge Program (D, PIP, R)
  184 Pearl Street, Burlington
  Tel: (802) 488-6425
- HowardCenter, Centerpoint Adolescent Treatment Services (A, I, O)
  1025 Airport Drive, So. Burlington
  Tel: (802) 488-7711
- HowardCenter, Chittenden Clinic (HUB)
  75 San Remo Drive, So. Burlington
  Tel: (802) 488-6450
- HowardCenter, Mental Health & Substance Abuse Services (A, I, O, PC)
  855 Pine Street, Burlington
  Tel: (802) 488-6100
- HowardCenter, The Chittenden Center (HUB)
  UHC Campus, 1 So. Prospect Street, Burlington

Tel: (800) 413-2272 (toll free)

- Lund Family Center (A, O, W)
  Cornerstone Drug Treatment Center
  P. O. Box 4009, Burlington
  Tel: (802) 864-7467
- Maple Leaf Farm (D, R)
  10 Maple Leaf Road, Underhill
  Tel: (802) 899-2911
- RISE IV (H)
  37 Elmwood Avenue, Burlington
  Tel: (802) 463-9851
- Spectrum Youth and Family Services (A, O)
  31 Elmwood Avenue, Burlington
  Tel: (802) 864-7423
- Turning Point Center of Chittenden County (RC)
  191 Bank Street, Burlington
  Tel: (802) 861-3150

Franklin/Grand Isle Counties

- HowardCenter (O, PC, PIP)
  172 Fairfield Street, St. Albans
  Tel: (802) 524-7265
- Northwestern Counseling Services in Franklin County (A)
  107 Fisher Pond Road, St. Albans
  Tel: (802) 524-6554
- Turning Point of Franklin County (RC)
  182 Lake Street, St. Albans
  Tel: (802) 782-8454

Lamoille County

- Behavioral Health & Wellness Center (A, O, PC)
  65 Northgate Plaza, Suite 11, Morrisville
  Tel: (802) 888-8320
- North Central Vermont (RC)
  275 Brooklyn Street, Morrisville
  Tel: (802) 851-8120
- Treatment Associates (OP, IOP)
  65 Portland Street, Morrisville
  Tel: (802) 888-0079

Northeast Kingdom - *Orleans / Essex / Caledonia*

- BAART Behavioral Health Services (HUB)
  475 Union Street, Newport
  Tel: (802) 334-0110
  and
  1097 Hospital Drive, St. Johnsbury
  Tel: (802) 748-6166
- Journey to Recovery Community Center (RC)
  58 Third Street, Newport
  Tel: (802) 487-0233
- Kingdom Recovery Center (RC)
  297 Summer Street, St. Johnsbury
  Tel: (802) 751-8520
- Northeast Kingdom Human Services (A, I, O, PC)
  2225 Portland Street, St. Johnsbury
  Tel: (802) 748-1682
  and
  154 Duchess Avenue, Newport
  Tel: (802) 334-5246

Orange County

- Clara Martin Center (A, O, PC)
  Box G, Randolph

Tel: (802) 728-4466
and
P. O. Box 278, Bradford
Tel: (802) 222-4477

- Valley Vista (A, D, R)
  23 Upper Plain, Bradford
  Tel: (802) 222-5201

Rutland County

- Evergreen Services (I, O, PC)
  135 Granger Street, Rutland
  Tel: (802) 747-3588
- Recovery House, Inc. (D, H, PIP, R)
  98 Church Street, Wallingford
  Tel: (802) 446-2640
- Rutland Mental Health Court Square (A, O)
  7 Court Square, Rutland
  Tel: (802) 775-4388
- Turning Point Recovery Center of Rutland (RC)
  141 State Street, Rutland
  Tel: (802) 773-6010
- West Ridge Center for Addiction Recovery (HUB)
  1 Scale Avenue, Building 10, Rutland
  Tel: (802) 776-5800

Washington County

- Central Vermont Addiction Medicine (HUB)
  300 Granger Road, Berlin
  Tel: (802) 223-2003
- Central Vermont Substance Abuse Services (A, I, O, PC, B)
  100 Hospitality Drive, Berlin
  Tel: (802) 223-4156
- Treatment Associates (OP, IOP)
  73 Main Street, Suite 27, Montpelier
  Tel: (802) 225-8355
- Turning Point Center of Central Vermont (RC)
  489 Main Street, Barre
  Tel: (802) 479-7373
- Washington County Youth Services (A, O)
  38 Elm Street, Montpelier
  Tel: (802) 229-9151

Windham County

- Brattleboro Retreat (HUB)
  1 Anna Marsh Lane, Brattleboro
  Tel: (802) 258-3700
- Habit OpCo (HUB)
  16 Town Crier Drive, Brattleboro
  Tel: (802) 258-4624
- Health Care & Rehabilitation Services of Southeastern Vermont (O)
  1 Hospital Court, Bellows Falls
  Tel: (802) 463-3947
  and
  51 Fairview Street, Brattleboro
  Tel: (802) 254-6028
- RISE I (H)
  435 Western Avenue, Brattleboro
  Tel: (802) 463-9851
- RISE II (H)
  11 Underhill Avenue, Bellows Falls
  Tel: (802) 463-9851
- RISE III (H, W)
  178 Linden Street, Brattleboro

Tel: (802) 463-9851

- Starting Now (I)
  1 Anna Marsh Lane, Brattleboro
  Tel: (802) 258-3705
- Turning Point of Windham County (RC)
  112 Hardwood Way, Brattleboro
  Tel: (802) 257-5600

Windsor County

- Clara Martin Center - Quitting Time (I, O, PC)
  39 Fogg Farm Road, Wilder
  Tel: (802) 295-1311
- Health Care & Rehabilitation Services of Southeastern Vermont (A, I, O, PC)
  390 River Street, Springfield
  Tel: (802) 886-4500
  and
  49 School Street, Hartford
  Tel: (802) 295-3031 or (800) 622-4235 (crisis)
- Turning Point Recovery Center of Springfield (RC)
  7 Morgan Street, Springfield
  Tel: (802) 885-4668
- Upper Valley Turning Point (RC)
  200 Olcott Drive, White River Junction
  Tel: (802) 295-5206

Out of State

- Habit OpCo (HUB)
  254 Plainfield Road, West Lebanon, NH
  Tel: (603) 298-2146
- Phoenix House, Inc. (A, R)
  3 Pierce Road, Dublin, NH
  Tel: (603) 563-8501

Additional Resources

Individual Practitioners, who are State approved or certified and specializing in substance abuse treatment, can be found in your local telephone book under "Counseling, Alcoholism or Drug Abuse."

Attachment 11

STATE OF VERMONT

SUPERIOR COURT FAMILY DIVISION

_____ Unit Docket No.

In re: _____

[proposed patient's name]

APPLICATION FOR EMERGENCY EXAMINATION

NOW COMES _____

(Print full name of applicant)

of _____

(Print complete address of applicant)

Telephone Number: _____ Date: _____

Relationship to, or interest in, proposed patient* _____

and makes application for the emergency examination of _____

(Print full name of proposed patient)

of _____

(Print complete address of proposed patient)

***NOTE:** Only the following persons may make application for an individual's emergency examination: a guardian, spouse, parent, adult child, close adult relative, a responsible adult friend, a person who has the individual in his or her charge or care (e.g., a superintendent of a correctional facility), a law enforcement officer, a licensed physician (**Caution:** the same physician cannot be both applicant and certifying physician), a head of a hospital or his or her written designee, or a mental health professional (i.e., a physician, psychologist, social worker, mental health counselor, nurse, or other qualified person designated by the Commissioner of Mental Health).

Reason for Application

(BE SPECIFIC! State the facts you have gathered, from either (1) your own personal observations, or (2) a reliable report to you by someone who personally observed the proposed patient's behavior, that lead you to believe that the proposed patient needs an emergency examination and is a person in need of treatment. Please distinguish between what is current information and what is historical.)

(WRITE LEGIBLY! Failure to write legibly may result in the court's discharge of the proposed patient before the person has been properly treated.)

(NOTE: In emergency circumstances where a certification by a physician is not available without serious and unreasonable delay, *do not use this form*. Instead apply to a superior court judge for a warrant for an emergency examination.)

1. Personal Information (P*roposed patient's age, gender, marital status, residence, ethnicity, race, nationality, employment information, and any other relevant personal information.*)
   Click here to enter text.

2. Location of Assessment (*Where did the applicant meet and interview the proposed patient.*)
   Click here to enter text.

3. Familiarity with Proposed Patient and Other Relevant Information (*Include information on alternatives to hospitalization, etc.*)
   Click here to enter text.

4. Mental Status Examination (*Include information about the proposed patient's appearance, attitude, behavior, mood, affect, speech, thought process and content, cognition, insight, judgment, neuro-vegetative symptoms, and any other relevant information about the proposed patient's mental status. Quote proposed patient if possible.*)
   Click here to enter text.

5. Threatening or Dangerous Behavior (*Provide details, including time, place, witnesses, surrounding circumstances, and any other relevant information. Quote proposed patient if possible.*)
   Click here to enter text.

6. Eyewitnesses (*Provide names and contact information for anyone else who saw the threatening or dangerous behavior.*)
   Click here to enter text.

7. Other Neurological Issues *(List other neurological or developmental issues that affect the proposed patient's mood or mental status, including brain injury, disease, or developmental disability.*)
   Click here to enter text.

8. Substance Use (*If known, list all substances recently used by the proposed patient prior to this application and provide a general summary of current and past substance abuse.*)
   Click here to enter text.

9. Criminal History (*List any known past criminal behaviors where charges were brought, including any current criminal charges pending against the proposed patient.*)
   Click here to enter text.

10. Need for Hospitalization (*Provide a recommendation for disposition. Explain why the proposed patient needs hospitalization and cannot receive adequate treatment in the community.*)
    Click here to enter text.

Signed under the penalties of perjury pursuant to 18 V.S.A. Section 7612(d)(2):

Date of Application

Signature of Applicant

Printed Name of Applicant

Note to Applicant: This application, along with a signed physician's certificate, must accompany the proposed patient when she or he is taken to the hospital for an emergency examination (second certification) by a psychiatrist.