



proud past, promising future

# Clark County Regional Support Network Policy Statement

---

**Policy No.:** CM19  
**Policy Title:** Voluntary Inpatient Services Authorization and Extension  
(formerly titled: Inpatient Services Authorization)  
**Effective Date:** September 1, 2001

---

**Policy:** All initial voluntary psychiatric inpatient admissions and extensions of stay for RSN-funded Clark County residents shall be authorized for payment by a Clark County Regional Support Network (CCRSN) Care Manager. An approved assessor may make an initial determination regarding medical necessity for inpatient care based on their face-to-face clinical assessment and provide required clinical information to the CCRSN Care Manager. Based on the clinical assessment, the CCRSN shall approve, deny or negotiate a diversion with the approved assessor making the request for inpatient authorization. Authorization decisions shall be made within specified timeframes and include medical review by a psychiatrist when necessary. Authorizations of payment are given to the admitting hospital/provider that will provide the individual's treatment.

**Reference:** 42 CFR 400; WAC 388-550-2600, 0005, 1050; Washington State Mental Health Division RSN Interlocal Agreement; Washington State Department of Social and Health Services, Health and Recovery Services Administration RSN Community Psychiatric Inpatient Instructions and Requirements August 1, 2007 and Inpatient Hospital Psychiatric Admissions August 2007 (or their successors); CCRSN Policy and Procedures: CM03 Notice of Action, CM09 Involuntary Treatment Services, CM13 Intake and Assessment, CM19-A Psychiatric Inpatient Covered Diagnoses, CM19-B Inpatient Certification forms, QM05 Element of Care Clinical Guidelines, CM21 Inpatient Services – Administrative Disputes and Clinical Appeals, AD04 Payment Process and Fiscal Accountability

## Definitions:

Approved assessor is a mental health inpatient provider, Emergency Department Mental Health Professional or Designated Mental Health Professional (DMHP).

RSN-funded individual is an individual who has a verified current Medicaid coupon or who meets financial eligibility criteria for Washington psychiatric indigent funds.

## Procedure:

1. Request for Initial Authorization of Payment for Inpatient Services
  - a. CCRSN shall ensure that a Care Manager who is a credentialed Mental Health Professional is available 24 hours a day, 7 days a week to respond to requests for authorization of payment for inpatient hospitalization. Scenarios requiring initial authorization include:
    - i. initial assessment (prior to initial admission);
    - ii. change in legal status (from involuntary to voluntary admission);

- iii. change in principal diagnosis;
  - iv. change in hospital of service (transfer).
- b. To request CCRSN authorization of payment, an approved assessor shall complete a face-to-face evaluation and call a CCRSN Care Manager within 24 hours of the evaluation. The CCRSN Care Manager shall respond to a request for authorization within two hours of receiving the request from an approved assessor.
- c. The Care Manager shall review required information provided by the assessor by telephone and complete the CCRSN Voluntary Inpatient Authorization Form (CM19-B) to document the authorization request and the authorization decision. Required information includes but is not limited to:
- i. demographic information (including county of residence);
  - ii. financial eligibility information (including Medicaid status and income level when known);
  - iii. current clinical information (including diagnosis(es), current risk assessment, co-morbidity issues, individual's ability to contract for safety in a least restrictive setting);
  - iv. current treatment plan (including current medications prescribed, name of prescriber, current outpatient crisis plan);
  - v. less restrictive alternatives options attempted and outcome;
  - vi. additional information the Care Manager believes is necessary to make a determination of medical necessity for psychiatric in-patient care.
2. Determination of Medical Necessity for Authorization of Payment for Inpatient Services
- a. The CCRSN Care Manager shall make a determination of medical necessity in making the authorization decision. Medical necessity for inpatient hospitalization is indicated when, because of a mental disorder, an individual has an extreme inability to function safely in a less restrictive environment without 24- hour physician or nursing supervision, as evidenced by a review of the following dimensions:
- i. presence of a covered mental health diagnosis for psychiatric inpatient care;
  - ii. acuity of the mental health condition;
  - iii. functioning indicates disturbance in one or more of the following areas: affect; behavior; thought processes; and judgment with evidence of recent severe deterioration and inability to care for health/safety needs, evidence that the deterioration is below baseline functioning and that inpatient treatment will benefit the individual, *and/or*,
  - iv. imminent risk of suicide and/or harm to others: inability to exhibit adequate behavioral control to ensure safety of self or others at less restrictive levels of care, evidence or report of recent suicidal ideation or self-destructive behavior usually within the last 24 hours and/or the presence of a realistic and plausible plan;
  - v. well defined homicidal ideation or aggressive behavior with specific victim and accessible means, inability to contract for safety of self or others, *and*;
  - vi. support system and/or outpatient services are not adequate to ensure the individual's safety and meet the individuals needs;
  - vii. expected benefit of an inpatient level of care as defined by the CCRSN Element of Care Clinical Guidelines;
  - viii. availability of less restrictive/diversion resources.
- b. The CCRSN Medical Director shall authorize inpatient requests for children or adolescent admissions and is available to consult with the CCRSN Care Manager regarding inpatient authorization requests for adults.

- c. The Care Manager shall make a final decision regarding authorization, based on determination of medical necessity, within 12 hours of the request for authorization from the requesting assessor, except in cases where an expedited review is in process.
3. Authorization of Payment for In-patient Services
    - a. When the CCRSN Care Manager makes or obtains a final decision to certify medical necessity and authorize payment for inpatient services, the Care Manager shall give verbal authorization to the person making the request, indicating the number of initial days authorized; complete the Initial Certification Form (Form DSHS 13-821 or its successor); and forward the Initial Certification Form to the CCRSN Office Assistant.
    - b. The CCRSN Office Assistant shall assign an inpatient authorization billing number, record it on the Initial Certification Form, and fax the form to the admitting hospital by the next business day following the date the initial verbal authorization was given. For involuntary admissions, CCRSN issues authorization numbers and follows the procedures as outlined in QM28.
    - c. The CCRSN Care Manager shall contact the CCRSN Medical Director to consult when he or she determines that medical necessity for inpatient care is met for children and adolescents under the age of eighteen. The Medical Director shall make the final decision to authorize payment for inpatient services for children or adolescents under the age of eighteen. The CCRSN Medical Director shall be available 24 hours per day, seven days per week for consultation with a CCRSN Care Manager, regarding individuals of all age groups.
    - d. Individuals with Medicare and/or private insurance coverage will be admitted to the Evaluation and Treatment facility only when there is a compelling clinical rationale and with the approval of the CCRSN Clinical Manager.
  4. Denial of Authorization of Payment for In-patient Services
    - a. When the CCRSN Care Manager assesses that medical necessity for inpatient care may not be met, the Care Manager shall recommend diversion to a less restrictive level of care options to the hospital.
      - i. If the hospital agrees, the hospital shall implement the plan for diversion.
      - ii. If the hospital does not agree, the Care Manager shall review the potential denial with the CCRSN Medical Director, who is a licensed, Board-certified psychiatrist. The Medical Director shall make the final decision to approve or deny authorization of payment for inpatient services for individuals of all ages.
    - b. If the Medical Director determines that medical necessity for inpatient care is met, the Care Manager will follow the authorizations procedures in Section 3 of this policy.
    - c. If the Medical Director determines that medical necessity for inpatient care is not met, the Care Manager shall give verbal notification of denial to the person making the request and offer an expedited review with the CCRSN Medical Director.
    - d. If the requesting hospital chooses not to move ahead with the expedited review, the Care Manager shall:
      - i. record the denial on the Initial Certification Form and fax the completed form to the hospital requesting authorization by the next business day; and
      - ii. forward the Initial Certification Form to the CCRSN Grievance and Quality Management Coordinator.
      - iii. The CCRSN Grievance and Quality Management Coordinator shall issue a Notice of Action, as outlined in Policy CM03, to individuals who have current Medicaid eligibility.

5. Expedited Review of Denial

- a. If the hospital requests an expedited review, the CCRSN Care Manager shall provide telephone access to the CCRSN Medical Director within two hours of the request, by telephone. At the conclusion of the expedited review, the CCRSN Medical Director shall inform the caller of the decision to approve or deny authorization for payment for inpatient services. The CCRSN Medical Director shall notify the Care Manager of the decision after the conclusion of the review.
  - i. If authorization is approved, the Care Manager shall follow the procedures above in Section 3 of this policy.
  - ii. If authorization is denied, the Care Manager shall follow the procedures above in Section 4.d of this policy.

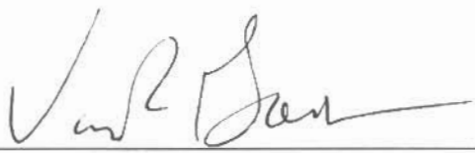
6. Authorization for Extension of Inpatient Services

- a. The hospital shall contact a CCRSN Care Manager by telephone during regular business hours to request extension of the authorization for payment of inpatient services at least 24 hours prior to the expiration date of the currently authorized period.
- b. The Care Manager shall gather clinical information for review, which may include, but is not limited to:
  - i. course of care - treatment rendered (medical and psychiatric services rendered and individual response to treatment thus far) and changes in diagnosis, treatment plan and discharge plan;
  - ii. current status - mental status (diagnosis, risk of harm, thought content, behavioral presentation) and medical status (diagnosis, labs, withdrawal);
  - iii. anticipated outcomes for continued stay – proposed treatment plan (planned interventions, goal of continued stay and justification why a less restrictive alternative is not appropriate at this time) and;
  - iv. discharge plan (anticipated continued length of stay, involvement of individual, formal and natural supports in the discharge planning, and identification of barriers to discharge and plans to address these).
- c. If medical necessity for continued stay is met, the Care Manager shall verbally inform the caller of the number of additional days authorized and fax the completed Extension Certification Form (Form DSHS 13-822 or its successor) to the hospital.
- d. If medical necessity for continued stay is not met, the Care Manager shall follow procedures outlined in Section 4.d of this policy.

7. Retrospective Authorization of Payment for Inpatient Services

- a. Retrospective authorization may only occur if the individual becomes eligible for medical assistance after admission or in the rare situations when circumstances beyond the control of the hospital prevented the hospital from requesting an authorization prior to admission.
- b. CCRSN authorization or denial decisions will be based on the individual's condition and services rendered at the time of admission and over the course of the hospital stay until the date of notification or discharge, as applicable.
- c. In instances when the retrospective request is related to a rare situation beyond the control of the hospital, the hospital shall detail the nature of the situation when making the retrospective request.
- d. Retrospective Requests Prior to Discharge
  - i. The hospital will submit a request for authorization for the current day and days forward. A CCRSN Care Manager shall respond to the hospital within two hours of the request and provide certification of authorization or denial within 12 hours of the request, as described in sections 3 and 4 in this policy.

- ii. For days prior to the current day (i.e., admission date to the day before the CCRSN Care Manager was contacted), the hospital will submit a separate request for authorization. CCRSN will provide a determination within 30 days upon receipt of the required clinical documentation for those days prior to the hospital's request to CCRSN for authorization.
- e. Retrospective Requests After Discharge
  - i. The hospital will submit a written request for authorization which includes all pertinent clinical information for determining medical necessity and financial eligibility to CCRSN within the timeframe specified in the Washington State Department of Social and Health Services, Health and Recovery Services Administration RSN Community Psychiatric Inpatient Instructions and Requirements, for the entire episode of care.
  - ii. CCRSN shall provide a written notice of authorization decision within 30 days of the receipt of the written request and required documentation.

Approved By:  \_\_\_\_\_ Date: 12/9/08

**Vanessa Gaston, Director**  
**Clark County**  
**Department of Community Services**