Level 3.7 Medically Monitored Intensive Inpatient Services

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) Performance Standards

Performance Standards are intended to give guidance for contracted services as part of the HealthChoices program, with a goal to promote the utilization and progress toward providing best practices performances, to increase the quality of services and to improve outcomes for members.

Use of Performance Standards

Disclaimer: These Performance Standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is a Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) expectation that providers apply these Performance Standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews; but also share with providers as needed to communicate expectations and best practices. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type and specialty. Providers must then comply with all applicable Pennsylvania regulations and requirements, including but not limited to The Pennsylvania Code Title 55, Chapter 1101; Title 28, Part V Department of Drug and Alcohol Program requirements; the American Society of Addiction Medicine (ASAM) guidelines; as well as all associated Medical Assistance (MA) Bulletins, licensing requirements and any contractual agreements made with Magellan in order to be eligible for payment for services.

Please routinely visit the link below and look for the "Compliance Alerts" accordion to stay up to date on Compliance Alerts:
https://www.magellanofpa.com/for-providers/

Level of Care Description

Level 3.7 is appropriate for patients with biomedical, emotional, behavioral and/or cognitive conditions that require highly structured 24-hour services including direct evaluation, observation, and medically monitored addiction treatment. Medically monitored treatment is provided through a combination of direct patient contact, record review, team meetings and quality assurance programming. These services are differentiated from Level 4.0 in that the population served does not have conditions severe enough to warrant medically managed inpatient services or acute care in a general hospital where daily treatment decisions are managed by a physician.

Scope of Services

3.7 Medically Monitored Intensive Inpatient Services are provided in a residential facility that is licensed by the Pennsylvania Department of Drug & Alcohol Programs (DDAP) as a Medically Monitored Intensive Inpatient Services provider. 3.7 programs are designed to serve individuals with substance use disorders (SUD) with moderate levels of impairment of social, occupational, or school functioning by providing 24-hour professionally directed evaluation, care, and treatment. Such inpatient programs are necessary when the provision of a safe and stable living environment is required for adequate recovery. The primary goal of services is rehabilitation from SUD. Clinical and medical services are provided 24/7, including the use evidenced-based treatment modalities.

Service Description

Services are provided in freestanding, appropriately licensed facilities located in a community setting or a specialty unit in a general or psychiatric hospital or other licensed health care facility. The interdisciplinary team is made up of physicians credentialed in addiction who are available on-site 24 hours daily, registered nurses, and additional appropriately credentialed nurses, addiction counselors, behavioral health specialists and clinical staff who are knowledgeable about the biological and psychosocial dimensions of SUD and psychiatric conditions; and who have specialized training in behavior management techniques and evidence-based practices.

Patients with greater severity of withdrawal, biomedical conditions, and emotional, behavioral, or cognitive complications receive stabilizing care including directed evaluation, observation, medical monitoring, 24-hour nursing care and addiction treatment.

Service Exclusions

While receiving treatment at a 3.7 level of care, members are not eligible for the following services: Acute Inpatient Psychiatric Hospital, Extended Acute Care (EAC), SUD Detoxification, 3.5 Rehabilitation, 3.1 Halfway House, Substance Abuse Partial Hospitalization, Substance Abuse Intensive Outpatient treatment, Substance Abuse Case Management, Crisis Residential, Community Residential Rehabilitation (CRR), Residential Treatment Facilities (adult or child), Family Based Therapy, Intensive Behavioral Health Services (IBHS), Applied Behavioral Analysis (ABA), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Psychiatric Rehabilitation (site-based and mobile), and Dual Diagnosis Treatment Team (DDTT).

Referral Process

If a member seeks 3.7 level of care, the member can be assessed at any site that completes ASAM assessments. A list of providers can be found on the Magellan website, www.Magellanofpa.com, or by calling 1-866-780-3368. A member may also call a provider directly to get instructions on how to access services at their facility. Once a member has been assessed and the level of care has been determined, the assessor or a designated professional from the facility would contact Magellan to seek a pre-certification for the recommended level of care.

Admission Process

When completing assessments, the level of risk is to be considered as part of level of care placement criteria. Level of risk will be evaluated for each ASAM dimension. When identifying the level of risk, both treatment and nontreatment needs are to be incorporated into the risk assessment as well as protective factors, history, current presentation, and any recent change in situation. The risk rating is expected to change as treatment progresses. Documentation in the record should support the risk ranking.

A comprehensive biopsychosocial assessment of all members should be completed within 3 days of admission to a Medically Monitored Intensive Inpatient Services program as outlined in DDAP licensure standards. The comprehensive assessment is to include an evaluation of the member's strengths, a clear description of the presenting problem, identification of supportive family/ friends, an assessment of the member's attitude towards and ability to participate in the treatment process, and a discussion of which treatment interventions have been most helpful in the past. The initial evaluation should also include a complete psychiatric history as reported by the member and a mental status examination including the evaluation of mood, affect, thought content, presence or absence of suicidal or homicidal ideation and a cognitive assessment. A review of prior adherence or non-adherence to treatment and the relationship between poor adherence and relapse should be explored. The identification of physical health needs must also be clearly screened, and appropriate referrals are made and documented. During the assessment of the member's social supports, the provider should give the member information about any mutual support groups that are available.

Additional requirements for the initial assessment and evaluation are included in the 3.7 Level of Care Assessment section of the ASAM Criteria. 3.7 admission is appropriate when specifications are met in at least two of the six dimensions, and at least one of which is dimension 1, 2 or 3:

- Dimension 1: Patient needs withdrawal management protocol.
- Dimension 2: At least one of the following:
    a. Interaction of the patient's biomedical condition and continued alcohol and/or other drug use places the patient at significant risk of serious damage to physical health or concomitant biomedical conditions; OR
    b. A current biomedical condition requires 24-hour nursing and medical monitoring or active treatment, but not the full resources of an acute hospital.
- Dimension 3: If significant emotional, behavioral, or cognitive conditions and impairment are present, the patient must be admitted into a co-occurring capable, a co-occurring enhanced program, a program with a Certificate of Approval as meeting the criteria in the Co-occurring Disorder Competent Bulletin, or through a client referral to a mental health provider.
- Dimension 4: At least one of the following:
    a. Despite experiencing serious consequences or effects of the addictive disorder and/or behavioral health program, the patient does not accept or relate the addictive disorder to the severity of the presenting problem; OR
    b. Patient is in need of intensive motivating strategies, activities and processes only available in a 24-hour structured medically monitored setting; OR
    c. Ongoing 24-hour psychiatric monitoring to assure follow through with the treatment regime, and to deal with issues such as ambivalence about adherence to psychiatric medications and a recovery program.
- Dimension 5: At least one of the following:
    a. Patient is experiencing an acute psychiatric or substance use crisis, marked by intensification of symptoms of his or her addictive or mental disorder which poses a serious risk of harm to self or others in the absence of 24-hour monitoring and structured support; OR

b. Patient is experiencing an escalation of relapse behaviors and/or reemergence of acute symptoms, which places the patient at serious risk to self or others in the absence of the type of 24-hour monitoring and structured support found in a medically monitored setting; OR
c. The intensity or modality of treatment protocols to address relapse require that the patient receive Level 3.7 program to safely and effectively initiate antagonist therapy or agonist therapy.

- Dimension 6: At least one of the following:
  a. Patient requires continuous medical monitoring while addressing his or her substance use and/or psychiatric symptoms because his or her current living situation is characterized by a high risk or initiation or repetition of physical, sexual or emotional abuse, or active substance abuse such that the patient is assessing as being unable to achieve or maintain recovery at a less intensive level of care; OR
  b. Family members or significant others living with the patient are not supportive of his or her recovery goals and are actively sabotaging treatment, or their behavior jeopardizes recovery efforts; OR
  c. Patient is unable to cope, even for limited periods of time, outside of 24-hour care.

Treatment or Service Plan

Providers should have a written plan (i.e., service description) describing how and when initial treatment plans will be completed along with other admission criteria. The initial treatment plan is to be completed on the day of admission. A formal, comprehensive treatment plan must be developed by the primary counselor in collaboration with the member, within fifteen (15) days of admission to the program.

The individualized treatment plan should drive service delivery. The initial treatment plan should be completed by a member of the clinical team (i.e. counselor, nurse, clinical manager) and should be individualized to the member. Providers are to use the comprehensive biopsychosocial assessment, which should include a Strengths, Needs, Abilities and Preferences (SNAP), the information obtained regarding previous treatment services and member input as the foundation for the development of a treatment plan. The initial assessment process is expected to clarify the strengths of the member and the critical issues to be addressed in treatment. The treatment planning process leads to the development of strategies and interventions to address critical issues.

The member is to fully participate with the treatment team in the development of his/her treatment and rehabilitation plan. Providers should seek signatures on the treatment plan from the member and other treatment team members as appropriate or maintain documentation of the coordination of care among treatment team members on a standardized case consultation documentation form.

Elements for inclusion in the comprehensive treatment/service plans are found in the 3.7 Level of Care Assessment section in the ASAM Criteria. In addition, goals should be realistic and achievable, and written in language that is easily understood by the member. How the goals of this episode of care fit

with the member's overall plan for recovery should be discussed during the treatment planning process. The plan should also include case management and treatment with other integrated providers.

Expectations of Service Delivery

At a minimum, the member should receive daily clinical services as described in the 3.7 Therapies section of the ASAM Criteria, unless refused by the member. Suicide and homicide risk assessments should be completed for all members, but more frequently for identified members that have an elevated risk. Recovery supports should be included as part of the clinical process.

Psychoeducational groups that best address the needs of the residents at the time should be offered, but at a minimum, should include topics such as coping skills development, relapse prevention, harm reduction, social support development, and substance use disorder management skills. In addition, the provider should aim to help individuals return to productive daily activity and family living. Programs are to create a therapeutic environment and milieu by providing the necessary structure and opportunity for interventions in real time to foster recovery.

Programs are to deliver services in a culturally competent manner. Evidence-based practices should be used during treatment. Programs are also expected to include MAT as part of the treatment planning continuum and educate members about the risks and benefits of MAT. Programs are also expected to provide education to members about naloxone/NARCAN® and the risks of overdose.

Care Coordination

Providers must ensure (with appropriate member consent) that information regarding the member's progress is provided to the agency where the member will be continuing care. The aftercare provider should be made aware of the member's current treatment plan goals and their current progress toward goals.

Providers must also ensure that all necessary referrals to the next service or support providers are completed in a timely manner. Needs, such, as housing supports, transportation, job training, and childcare must be addressed. Housing referrals usually require more fulfillment time than other types of referrals so should be addressed and ensued very early in treatment.

The member must have access to prescribed medications during transition periods. Residential providers are responsible for knowing the date of the next psychiatric appointment and for ensuring that the member has an adequate prescription of medications prior to discharge from their facility, usually at least two weeks. Family members should be included in care coordination discussions, when appropriate.

Discharge Planning and Transition

When a member is no longer assessed as meeting ASAM criteria for 3.7 level of care, the expectation is that the member is offered a clinical recommendation as to what level of care would be most appropriate for them according to ASAM criteria. Examples include Level 3.5 (Clinically Managed Services), Level 2.5 (Partial Hospitalization Services), Level 2.1 (Intensive Outpatient Services), or Level 1 (Outpatient Services.) Throughout this process, it is the expectation that Magellan members are actively involved in the discharge and aftercare planning process and are agreeable to all locations, dates, and times of scheduled appointments. These appointments would include but are not limited to medication management, physical health, behavioral health, medication-assisted therapy, etc.

Aftercare appointments for behavioral health treatment are expected to be within 7 days of discharge. Walk-in appointments do not meet Magellan's expectations of adequate discharge planning. If a member chooses a walk-in appointment, this should be documented. If an outpatient provider declines to offer a scheduled appointment, assertive efforts should be attempted to secure an appointment with other outpatient providers. If this is not successful or the member declines aftercare appointments, providers should document this barrier and inform the Magellan Care Manager.

All discharges should be reported to Magellan via a telephonic review as soon as the treatment episode is complete or within 24 -48 hours of discharge. This includes Against Medical Advice (AMA) Discharges, whereby offering a discharge appointment within the standard of seven days remains a provider's responsibility.

For all unplanned discharges, it is the expectation of the provider to communicate with Magellan what efforts the clinical team made in order to motivate the member to remain in treatment. Furthermore, it is a state regulation that providers notify member's emergency contacts upon any unplanned discharge, when provider has a signed consent from the member to do so.

Documentation

The documentation in an individual's record allows mental health and substance use professionals to evaluate and plan for treatment, monitor health care over time, and facilitate communication and continuity of care among healthcare professionals involved in the individual's care. It ensures accurate and timely claims review and payment, promotes appropriate utilization review and quality of care evaluations, and can be used for research and education.

Magellan has established minimum record keeping requirements that align with Pennsylvania Medical Assistance regulations. Specifically:

- The record must be legible throughout.
- The record must identify the individual on each page.
- Entries must be signed and dated by the responsible licensed provider. Care rendered by ancillary personnel must be count-signed by responsible licensed provider.
- Alterations of the record must be signed and dated.

- The record must contain a preliminary working diagnosis, as well as final diagnosis, and the elements of a history and physical examination upon which the diagnosis is based.
- Treatments, as well as treatment plans, must be entered in the record. Drugs prescribed as part of treatment, including quantities and dosages, must be entered in the record. If a prescription is telephoned to pharmacist, the prescriber's records require a notation to this effect.
- The record must indicate the progress at each session, change in diagnosis, change in treatment and response to treatment.
- The record must contain the results, including interpretations, of diagnostic tests and reports of consultations.
- The disposition of the case must be entered into the record.
- The record must contain documentation of the medical necessity of a rendered, ordered, or prescribed service.
- The documentation of treatment or progress notes for all services, at a minimum, must include:
  - The specific services rendered.
  - The date the service was provided.
  - The name(s) of the individual(s) who rendered the services.
  - The place where the services were rendered.
  - The relationship of the services to the treatment plan – specifically, any goals, objectives and interventions.
  - Progress at each session, any change in diagnosis, changes in treatment and response to treatment.
  - The actual clock hours that services were rendered. For example: the recipient received one hour of psychotherapy. The medical record should reflect that psychotherapy was provided from 10:00 a.m. to 11:00 a.m.

Magellan has also established some documentation guidelines for providers and services that are reimbursed under an all-inclusive daily rate. Specifically:

- A completed American Society of Addiction Medicine (ASAM) Summary Form (https://www.magellanofpa.com/media/5448/ddap-efm-1002-asam-placement-summary-sheet.pdf) must be present in a member's record prior to or at the start of a level of care/program to receive payment.
- Daily progress notes must be present for all dates of service billed. Clear and concise documentation is required for substantiating payments made to the provider and must meet the required standards as set forth above.
- Progress Notes/ Daily Entries must document the interventions used, the individual's response, and relate to the treatment plan goals. Interventions should be individualized and specific; use of vague language such as "listened and provided positive feedback" or "watched a video" would not be considered sufficient.
- Group therapy notes should include a brief description of the group. They must also include individualized information for each participant including their behavior during

the group session, level of participation and response to interventions/ information discussed.

- 3.7 Providers must implement behavioral health/ substance use interventions for each day of service billed, including all weekends and holidays. Staffing patterns must align with all DDAP Regulations, ASAM Requirements and any applicable MA Bulletins to allow for meaningful treatment to be provided every day that the member is physically in the facility.

In accordance with this requirement that interventions are provided daily, it is Magellan's expectation that each date of service that is billed have corresponding documentation in the member's record. This documentation should include all interventions, both formal and direct treatment (i.e. structured individual and group sessions) as well as those interventions that are less traditional. Please note that the intervention may be delivered by any staff member and there is no minimum time requirement for the intervention if it is documented; however documenting medication dosing only for detoxification or rehabilitation is NOT considered sufficient substantiation of payment for a day of service. Providers must also provide all services and programming as outlined in their approved Service Descriptions.

Outcomes

All 3.7 providers should have policies and procedures in place to evaluate outcomes for the program. Some of the indicators that could be considered include:

- Member satisfaction
- Average Length of Stay
- Readmission Rate
- Linkages with other programs
- Follow up after discharge from higher levels of care
- Member engagement in services
- Use of one or more validated tools appropriate to the members served

Complaint Process

Magellan provides a formal mechanism for all members to express a complaint related to care or service, to have any complaints investigated and resolved, and to receive a timely and professional response to their complaint in compliance with the HealthChoices Program Standards and Requirements Appendix H. This Complaint process is managed by Magellan's Quality Improvement Team. Complaint information is integrated as a key indicator for informing patient safety, credentialing, quality improvement activities, and analyzed for trending and opportunities throughout the network.

When a member files a complaint directly with Magellan, Magellan partners with the provider to address the concern. A member's decision to file a complaint with Magellan should not compromise their care or services. Providers are expected to adhere to their provider agreement with Magellan

regarding cooperation with appeal and grievance procedures. The identified provider will receive an acknowledgement letter summarizing the complaint items and requesting documentation to be submitted for the review. The response and documentation should be faxed to 888-656-2380 on or before the deadline listed in the letter. Additional information and follow up activities might be requested.

Magellan uses information gained from member complaints to identify areas where opportunity for improvement may exist. Magellan may request corrective action of a provider in response to supported complaints and identified trends in complaints. If Magellan identifies a supported (substantiated) complaint involving an agency, Magellan staff will collaborate with providers to develop a Complaint Resolution Plan to address the concern. Please review the Provider Communication shared with network providers here about this important and collaborative process.

Grievance Process

Magellan and the Pennsylvania HealthChoices Program Standards and Requirements defines a grievance as a request by a member, the member's representative or health care provider (with written consent of the member), to have Magellan or a utilization review entity reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Magellan reviews requests from providers for behavioral health services to ensure that approved services are medically necessary and appropriate.

If a level-of-care request is not authorized at the level, frequency or duration as requested, Magellan members are entitled to grieve a medical necessity denial. At the time of a denial, Magellan informs members of this right and how to proceed. Each medical necessity grievance is handled in a timely manner consistent with the clinical urgency of the situation and in compliance with the HealthChoices Program Standards and Requirements Appendix H.

If a level-of-care request is not authorized at the level, frequency or duration requested, it is the expectation that the behavioral health provider will meet with the member, and the member's family if appropriate, to discuss treatment changes and options. This discussion will include, but not be limited to, a review of the services that are authorized, a review and revision of the recovery plan based on authorized services, a referral to additional and/or an alternative provider if indicated, other options available to the member, and a review of member grievance rights and procedures as outlined in the denial letter, should the member choose to grieve the non-authorization decision.

Quality Management

Quality care for members and their families is important. Magellan is committed to continuous quality improvement and outcomes management through its company-wide Quality Improvement Program that includes assessment, planning, measurement, and re-assessment of key aspects of care and

services. Magellan has collaborated with Counties and providers to develop a Quality Improvement Program that strives to improve the delivery of services to HealthChoices' members.

Magellan's Quality Improvement Program's policies and procedures are structured to support compliance with the accreditation requirements of several organizations, including the National Committee for Quality Assurance (NCQA) and URAC. Assessment of compliance with these requirements is integrated into our quality improvement activities.

Per Magellan's contractual agreement, providers must cooperate and participate with all quality improvement procedures and activities. Providers shall permit access to all portions of the medical record that resulted from member's admission, or the services provided. Magellan's utilization review program and/or quality improvement program may include on site review of covered services and shall permit Magellan staff on site access.

In support of our Quality Improvement Program, providers are essential quality partners. It is important that providers are familiar with our guidelines and standards and apply them in clinical work with members to provide, safe, effective, patient-centered, timely, and equitable care in a culturally sensitive manner. Please refer to the Magellan National Provider Handbook and Provider Handbook Supplement for HealthChoices' Program Providers for additional information and guidelines.

In addition to adhering to state and federal regulations, providers are responsible to:

- Follow policies and procedures outlined in Magellan's Provider Handbook and Provider Handbook Supplement.
- Meet treatment record standards as outlined in the Treatment Record Review Tool found under Audit Tools in the Appendix of Magellan's Provider Handbook.
- Provide treatment records as requested for quality-of-care issues and adhere to clinical practice guidelines and HEDIS®-related measures.
- Participate as requested in treatment plan reviews, site visits and other quality improvement activities.
- Use evidence-based practices.
- Adhere to principles of member safety.
- Attend or log on to provider training and orientation sessions.
- Participate in the completion of a remediation plan if quality of care concern arises.
- Encourage use of member and clinician outcome tools including use of the PHQ-9 and other standardized tools at intake and established treatment intervals, and to review real-time reports together.
- Incorporate the use of secure technology into their practice to make accessing services more convenient for members, e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, electronic referrals to other practitioners or programs, and online access to personal health record information.
- Assist in the investigation and timely response of member complaints.
- Assist in the investigation and timely response of adverse incidents.

Please note: Reporting requirements for Magellan remain consistent and in line with the PA DHS Bulletin, OMHSAS-15-01. A copy of all reportable incidents must be submitted to Magellan's Quality Management Department within 24 hours of an incident or upon notification of an incident. The types of incidents that are reported to Magellan include: Death, Attempted Suicide, Significant Medication Error, Need for Emergency Services, Abuse/Childline Report, Neglect, Injury/Illness, Missing Person, Seclusion, Restraint, and Other.

Magellan requires an electronic submission process. This can be accessed at Magellanofpa.com.