API – Tools, Suggestions

I think the best advice is to communicate with the insurance UR staff and get to know the ones you work with often. If you develop a reputation for being prompt, informed, honest, concise, and organized then it will go a long way to helping the UM process flow smoothly. On days when the schedule is more hectic, and you need to talk with someone outside your review time or for some specific concern, if you have a relationship with them it can be very helpful.

Tracking template: we have a daily census of our admissions emailed to us each morning before 8am. This is an automated report based on our electronic chart records, but something similar could be maintained manually. I used the format of this report below, and just changed a couple of the column labels. Our census report is divided by region and facility, since our UMs are assigned certain facilities in a geographic area. At the hospital, your census may be divided by ward or unit, but could also possibly be divided by UM caseload.

We have an electronic charting system that gives us a "caseload" list and we access the member's records, review, auths, etc., through that. If the hospital has electronic charting, perhaps there is something similar available. I rely on my caseload list and a Word document to manage my caseload. The Word document is just a quick list of names and due dates for my use, and I have to keep the electronic chart updated too. When I worked at the state hospital in Pueblo, the social workers had a daily printout of their caseload and notated on it any patients due for review, with what insurer, and other information to remind them to call the insurer. They also spoke to the outpatient providers or mental health centers for discharge planning and continuity of care.

Patient Name	Insurance Name/ ID#	Age/ DOB	Admit Date	Current Auth Start Date	Current Auth Expiration Date	Concurrent Review Due Date	Authorization Status
John Smith	Medicaid X1234567	48 4/9/63	10/21/11	10/21/11	10/24/11	10/24/11	Approved
Annie Bling	Tricare 154987545	33 11/23/78	10/20/11	10/21/11	10/23/11	Report DC date when pt leaves	Denied 10/23/11 P2P done, deny

Insurance:
UM staff should know every patient's pay source. This should be listed in a conspicuous and consistent place in the chart, and if they have a daily census printout it should be on there. If there is more than one insurance then know which is primary, and review with both as needed. This includes Medicare since the reported number of bed days left may not reflect claims from other providers that have not been submitted yet, but which might beat yours through.

Authorizations:
Every patient with insurance should have an authorization number for their admission. This authorization number should be listed in a consistent place on the chart. With the authorization number you will be given the authorized dates and told when the concurrent review is due for ongoing treatment. DOCUMENT these dates clearly and focus on this information! This will guide the rest of your communication with the insurer.

Do not accept admissions if there is no authorization number given to you. If the admission is not pre-certified, and you call later for the authorization it is possible that the request for treatment may be denied. The hospital can lose payment in this situation. Depending on the particular insurance plan, some insurers may have different pre-authorization requirements, but it is always a good idea to call and ask before assuming you can call later.

Diagnoses:
Request a copy of the diagnoses the insurer covers. If they have a policy of not releasing that information in total, then you can talk with them about it in general and learn what is excluded, if anything. Write this down and share among the hospital UM team.

Levels of Care:
Insurers offer different levels of care (inpatient, partial, residential, etc.), and knowing what they have to offer can help facilitate discharge planning. For example: Sub-acute level of care may be called different things, such as an alternative treatment unit or "ATU", but in many cases the treatment is almost as intensive as inpatient and is appropriate for many members instead of inpatient hospitalization. If there is an ATU and the insurer is contracted with them, then an ATU can be very useful for a step-down to a lower and less restrictive level of care, for more stabilization before returning home. There can be a great deal of difference in how an insurer wants to manage Levels of Care, with commercial insurances being quite different from Medicaid, for example. Discuss with your UM staff the types of facilities they have access to, and any quirks about authorization. Examples: Medicare will not pay for ATU treatment, but Medicaid may depending on the contract. Commercial insurances often have maximum benefit levels, and a typical residential treatment stay for an adolescent will be longer than the time allowed by the insurer.

Medical Necessity Criteria:
Talk with the insurer about the Medical Necessity Criteria (MNC) for each level of care. You can ask for the criteria from the insurers you frequently review with. If they won't release their internal documents to you, it's still possible to discuss this and learn what they want to focus on during reviews. MNC is usually based on acuity and available lower levels of care.

MNC typically will focus on Risk to Self/SI, Risk to Others/HI, and Grave Disability. When a request for continued treatment is denied, it is often due to MNC no longer being met. At this point, the insurer may judge that the patient could be seen at a lower level of care for continuing treatment. Many insurers will offer a Peer to Peer review after denying continued treatment, which allows the hospital's doctor and the insurer's doctor to speak together about symptoms, other treatment concerns, and at times new information comes to light that will allow treatment to be authorized again. If your doctor thinks that the patient meets MNC, he/she should request this conversation with the insurer.

If, after a Peer to Peer review, the decision is that treatment is still denied, then there is an appeals process. Ask your insurer what this process is, and discuss with them how to proceed. Remember, this is based on MNC for each level of care, so if inpatient treatment is denied, it's possible the insurer would consider sub-acute, partial, or another lower level of care.

Discharge Planning:

Insurers want providers to start thinking about discharge from the very day of admission. This can help keep treatment progress on a timely path, and any barriers to discharge can usually be identified and resolved so as to not delay discharge. If discharge is delayed for a non-clinical reason, or if medical necessity criteria are no longer met, and you are not able to release the patient then the hospital may lose payment. For example: If an adolescent patient cannot return home because of abuse, then the social services agency needs to be involved immediately to placement for that child. If the SS agency has not found placement by the time the patient could have discharged--based on clinical information, then the hospital will likely be denied for any days' stay past the point client could have left but didn't.

Talk to the patient's existing providers if there are any. Discuss recent symptoms and any concerns about discharge readiness or potential for problems that might lead to re-admission, such as treatment or medication compliance. The hospital doctor may need to discuss medications with the outpatient prescriber to help maintain progress gained in hospital. Gather information from the outpatient providers and family about what the patient's baseline is like. This will help recognize discharge readiness and help the providers and family prepare for the patient's return home.

Concurrent Reviews:

Contact the UM staff in a timely manner, and do not miss a review. Insurers can administratively deny treatment that is not pre-certified, and this type of denial is not appealable. Insurers may do the concurrent review by phone or fax, so get to know their process and follow it. For example: if an insurer does reviews by phone and appointment, then make sure you have an appointment on the day they tell you to review and call on time. Be prepared, the more informed you are the better the review will be.

- Have updated diagnostic and medication information
- Be able to report progress in symptom and/or behavior reduction
- Use treatment plan's measurable goals as much as possible, to report progress
- Discuss discharge plans and any potential barriers. The UM may be able to offer advice or guidance to help you.
- Report on family and support network involvement, as appropriate—especially for minors.
- Do not exaggerate or try to amplify symptoms to get more days authorized. You will benefit in the long run by being forthright. While we have to focus on auths and payment, it really is about a person and treatment. A denial isn't a punishment, but it can help focus treatment direction.
- See list below for more information.

Common questions asked on Initial/Admission Reviews:

- What level of care (LOC) you are requesting
- Is the patient voluntary or on involuntary hold
- Diagnoses: all 5 axes
- Presenting Problem: why does the patient need treatment now?
  - SI: plan/intent/means/hx attempts or gestures; other Risk to Self issues
  - HI: plan/intent/means/ hx attempts or aggression; other Risk to Others issues
  - Psychosis: list and describe symptoms present, such as auditory hallucinations, command hallucinations, paranoia, delusions, disorganized thoughts, etc.
  - Significant mood disturbance or other high-risk behaviors, such as property destruction, fire-setting, animal cruelty, reckless driving, etc.
- Symptoms: based on DSM-IV-TR criteria
  - Be able to list the symptoms which meet the diagnosis given
  - This may include behavioral examples to illustrate acuity of the problem
- Medications: is the member on medications already, and if so list them with doses and frequencies
- Current Psychiatric treatment: who is prescribing meds? Who is the therapist?
- Drug/Alcohol involvement:
  - What was on the UDS/tox screen?
  - What was the BAL level?
  - What does client report using? Include age of onset, last use, quantity of use, frequency of use, and other pertinent information—such as how the patient acquires the drug. This may include other risky behaviors such as stealing, prostitution, dealing, etc.
- Developmental delays or mental retardation: this can impair functioning and be a focus of treatment, and may impact how the mental illness can be treated. Treatment planning should accommodate any impairments or limitations the patient has.
- Organic diagnoses: such as dementia, delirium, TBI, Parkinson's. Symptoms from these and other medical diagnoses may present as a mental illness or mental health issue, but are due to a physiological cause which may not benefit from inpatient psychiatric treatment, and instead need medical treatment. They should be assessed carefully and include medical workups as needed, to determine course of treatment.
- Initial Treatment Plan: should include measurable goals
- Discharge Plan: should include frequent and consistent contact with the patient's existing outpatient providers, or referrals to providers if the patient has not been in treatment. The patient's family or support network should also be included, at the patient's discretion and with HIPAA compliance.
- Report the estimated length of stay and anticipated discharge date.
- DOCUMENT THE AUTHORIZED DATES, AND VERIFY THE DATE AND TIME FOR THE NEXT CONCURRENT REVIEW. Clarify this if it's not clear; do not assume you know. For example: authorization of 10-24-11 to 10-26-11 is not the same as authorization of 10-24-11 through 10-26-11. It's not just semantic—its money lost if you miss a review due to misunderstanding how the auth was communicated.

Common questions for Concurrent Reviews:

- Updated diagnoses, after the attending doctor's assessment
- Updated medications, including any concerns about compliance, side effects, parental permission, etc.
- Current symptoms or problem behaviors:
  - Update Risk to Self/SI information, and clarify details such as plan, intent, reduction in severity, future orientation or not, belief in treatment benefit or not, etc. Just saying "the patient is still suicidal" is not sufficient detail for some insurers.
  - Update Risk to Others/HI information. Report any aggression, violence, intimidating behaviors, posturing, seclusion or restraint episodes, etc. Consider Duty to Warn requirements, if applicable and follow through as needed.
  - Give updates on any psychotic symptoms that remain, and describe progress since admission in symptom reduction. Remember, many patients' baseline will still include some psychosis or negative symptoms. Discuss current symptoms as compared to the patient's baseline information. How much more progress is reasonable to expect for each patient as treatment progresses.
- Discuss doctor's goals for the patient and what the doctor's reason for requesting continued stay is.
- Coordination of care is very important. Discuss family involvement and communicate with outpatient providers. These people can often give important information about recent events, stressors, and will be the ones to help the patient re-adjust to being in the community. Depending on type of insurance, you will need to remember the HIPAA privacy requirements.
- Report on the treatment plan; give the measurable goals for the patient. Report progress based on those goals. If the patient is doing self-assessments daily, then report those scores. Report what the patient's participation is like in group and individual therapy—is he learning skills, demonstrating using the skills, talking about stressors or triggers, etc.
- Discharge Plan: progress on plans for discharge. Where will the patient go to live, what outpatient services will be provided and when. Safety planning should be complete before discharge and reviewed with the support network as appropriate, etc.
- Estimated length of stay: when does the attending doctor think client may be ready to discharge?
- DOCUMENT THE AUTHORIZED DATES, AND VERIFY THE DATE AND TIME FOR THE NEXT CONCURRENT REVIEW. Clarify this if it's not clear; do not assume you know. For example: authorization of 10-24-11 to 10-26-11 is not the same as authorization of 10-24-11 through 10-26-11. It's not just semantics—its money lost if you miss a review due to misunderstanding how the auth was communicated. If the UM says they're authorizing 3 more days, clarify exactly what days and when the next concurrent review is due.

I keep a daily log of my caseload, as a Word document that I update throughout the day. However, this is a way to quickly remind myself what needs to be done and not a substitute for the official chart or electronic record.

If you use electronic charting, it depends on how the system's forms were created and arranged as to what information can be entered and reviewed. If you use a paper chart it can be awkward to see the information if the UM staff is in another building or unit and needs to check when a review is due or get more info while on a call or completing a fax form, or if someone else has the chart out already.

Review Due Date/ Time/Notes:	Patient Name/ID#:	Admission Date:	Dates Authorized:	Insurance Name/ Phone #/ Contact Name:
10-27-11, 11am 800-544-4321	John Smith A-384738	10-21-11	10-21-11 thru 10-24-11: 4 days Reviewed 10-24. 10-25-11 thru 10-27-11: 3 days Due 10/27.	Insurance Name 800-544-4321 Mable Jones
11-1-11, 3pm Fax rvw form to UR 800-545-5325 fax #	Suzy Q G-454873	10-19-11	10-19-11 thru 10-25: 7 days Rvw'd 10-25. 10-26 thru 11-1-11: 7 days	Medicare-managed by Advantage. 800-545-5300 Wanda Moore