Statewide Inpatient Psychiatric Programs Admission Process and Level of Care Criteria

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Florida Medicaid Policy

Access Behavioral Health adheres to the specifications of the *Florida Medicaid Statewide Inpatient Psychiatric Program Coverage Policy* (December 2015) and all requirements therein. The policy specifies SIPP facility requirements (including licensure, Florida Medicaid provider eligibility, and accreditation) and program requirements

In accordance with s. 409.976(2), F.S., ABH will pay statewide inpatient psychiatric program (SIPP) providers, at a minimum, the payment rates established by the Agency.

Clinical Practice Guidelines

ABH adopts the evidence-based clinical practice guidelines of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the Florida Medicaid Drug Therapy Management Program for Behavioral Health. These treatment guidelines are made available to providers on the ABH website: https://abhfl.org.

Description of Services

Statewide Inpatient Psychiatric Programs are designed for high-risk children and adolescents (under age 21) who have been diagnosed and present with complex conditions that require extended treatment in a secure setting in order to more adequately treat their psychiatric and psychosocial needs.

These facilities provide intensive psychiatric services to children in a locked residential setting and are designed to serve those high-risk youths that fail to benefit from acute inpatient or traditional outpatient treatment settings.

These residential programs can improve outcomes for children and adolescents both by providing a course of active psychiatric treatment within a structured residential treatment setting and by providing or facilitating access to community-based aftercare mental health services with linkages to schools, community resources, and family/natural supports.

Treatment in a SIPP is seen as a component in the continuum of a child's care, with the goals of:

1. Stabilization of presenting problems and symptoms and adequate resolution to allow safe return of the child to the family and community
2. Reduction of recidivism of admission into acute psychiatric or SIPP services by providing aftercare services and/or linkages with appropriate community services
3. Design of aftercare treatment plans that can be effectively implemented

4. For children in the state's custody, incorporation of permanency goals into the treatment and discharge plans and active coordination with the appropriate Community Base Care (CBC) Coordinator.

For SIPP admissions and continued stays determined as medically necessary, Access Behavioral Health reimburses statewide inpatient psychiatric programs at established Medicaid payment rates for codes 0100 and 0101.

SIPP Pre-admission Process

A pre-admission staffing is required when a recommendation by a Florida Psychiatrist or Psychologist for SIPP placement is made for a member in a Medicaid Managed Medical Assistance plan where ABH is the managed behavioral health organization.

The purpose of the pre-admissions staffing is to address cases where:

- current services in place do not seem to be working,
- when there is a significant/severe crisis where the child may not have been linked to services, but has had a significant single episode that cannot be managed on an outpatient basis,
- when the child is at significant risk in the community, or
- when the child is requiring multiple hospitalizations so quickly that services cannot be put into place.

The referring provider must arrange the date and time for the pre-admission staffing and ensure that all involved parties are in attendance. The child being referred to the SIPP, as well as the child's legal representative/guardian should be in attendance. Others included are Department of Children and Families' representatives, AHCA representatives, parole officers, or guardian advocates, as appropriate.

Access Behavioral Health (ABH) participates in the pre-admission staffing as well as a representative from the member's sub-capitated network community behavioral health provider. ABH and the member's sub-capitated provider representative assess the services history and current services being rendered in an effort to promote referral to the least restrictive setting. If the member's sub-capitated network provider is able to identify additional services that could be tried before an admission to a SIPP is determined (i.e. case management, TBOSS, WRAP, CAT), it may be deemed more appropriate to transfer the care of the child to the network provider in lieu of admission to a SIPP.

Admission Procedures

SIPP providers must receive authorization from Access Behavioral Health for admission into a SIPP when the admission requires a fee for service payment.

Monitoring and Oversight of SIPP Providers

ABH will not authorize SIPP services to any facility that does not meet the requirements as specified in the *Florida Medicaid Statewide Inpatient Psychiatric Program Coverage Policy* (December 2015), including licensure, Medicaid eligibility and accreditation. In addition, SIPP providers must meet ABH credentialing and contracting requirements which specify adherence to ABH SIPP admission processes and level of care criteria.

ABH maintains oversight of SIPP services utilization by issuing prior authorization and conducting continued stay reviews when the admission requires a fee for service payment. SIPP admissions consist of pre-admission/prior-authorization reviews and authorizations for continued stay(s). These reviews also verify the facility's compliance with applicable Medicaid regulations as outlined in this document relating to pre-admission, admission, treatment planning (as specified on page 6), and utilization management.

An ABH care coordinator participates in quarterly calls with the Agency for Health Care Administration and/or representatives from the member's Managed Medical Assistance Plan, as requested. Both members who are currently in a SIPP and members discharged within the past year are discussed on the call. The member's current status and progress toward treatment goals, with emphasis on services to be provided or currently being provided in the community, is addressed.

Care Coordination/Case Management of SIPP Services

ABH designates care coordination/case management staff who are responsible for identifying and providing care coordination/case management to members who remain in the hospital for non-clinical reasons (i.e., absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk members and members with multiple agency involvement in accordance with Attachment II, Exhibit A, Section V.E.4.g. (3). ABH Care Coordinators must be a Florida licensed Registered Nurse, Licensed Mental Health Counselor (LMHC), or Licensed Clinical Social Worker (LCSW) with 3 years' experience in behavioral health care, preferably in acute care. Experience in inpatient behavioral health utilization management/care coordination is required.

An ABH care coordinator, as well as case managers from the member's sub-capitated network community behavioral health provider, participates in SIPP pre-admission staffings, SIPP weekly Treatment Team meetings, monthly Discharge/Transition Plan staffings, and as needed Residential Review committee meetings for their members. This ensures proper post-discharge care coordination/case management with the treatment team, the planned outpatient provider, and the child's parent/legal guardian.

Care Coordination includes:

1. Completing a comprehensive review of the members medical record from another treatment provider for the purpose of assessment and treatment planning
2. Coordinating the delivery of all mental health services, including coordination with the primary physical health care provider, associate providers, Department of Children and Families/Community Based Care, the legal system, and community programs and supports
3. Coordinating the delivery of optional or community based services with other agencies and programs involved in the member's care
4. Ensuring continuity of care for members who are disenrolled from the Plan
5. Collaborating and communicating with providers in ensuring the availability of all support services and resources required by the member
6. Monthly reports to the health plans on all members under the age of twenty-one (21) years receiving out-of-home behavioral health treatment, in accordance with Section XVI., Reporting Requirements, and the Managed Care Plan Report Guide.

ABH maintains a log of admission and discharge dates (or potential discharge dates) on all members admitted to the SIPP, as well as authorization status for those cases where authorization and continued stay review is required. ABH provides a weekly update of this log (of their members only) to network provider community behavioral health center case managers.

SIPP to SIPP Transfers

Mid-treatment SIPP to SIPP transfers are allowed at the discretion of the interdisciplinary team when it is determined it is in the best interest and safety of the member. Upon acceptance by another SIPP Program, the member may transfer to the new program. The mode of transport is determined by the current SIPP and should consider the safety of the member and all parties involved. Proper release of information documents should be completed and member records should be transferred to the receiving facility. Authorization for the receiving SIPP will continue based on medical necessity.

Treatment Planning

SIPP services must be supervised by a treatment team consistent with 42 CFR 441, Subpart G. ABH uses provider contacting and pre-admission/admission, continued stay and discharge reviews to verify the facility's compliance with applicable Medicaid regulations related to treatment planning.

Services must include the following:

1. An individual plan of care developed and implemented within 14 days after admission in accordance with 42 CFR 441, Subpart G; a treatment plan is an individualized written program for a member developed by health care professionals based on the need for medical care established by the attending physician and designed to meet the medical, health, and/or rehabilitation needs of a member.
2. Psychiatric or psychological assessment, and diagnosis

3. Routine medical and dental treatment
4. Clinical and therapy services
5. Mandatory family or other caregiver involvement that supports the member in meeting treatment goals and returning to the community
6. Peer support groups directed toward meeting the member's specific treatment goals
7. A certified education program provided in accordance with Rule 6A-6.0361, F.A.C.
8. Comprehensive discharge (aftercare and follow-up services) planning, developed and implemented in accordance with the SIPP provider's licensure
9. Recreational, vocational (for members ages 16 and older), and behavior analysis services (when necessary)
10. Time out in accordance with 42 CFR 483 (when necessary, regardless of licensure type)
11. Seclusion and restraint in accordance with 42 CFR 482 or 42 CFR 483 (when necessary and as appropriate to the provider's licensure type)
12. Therapeutic home assignment - Clinical interventions that allow a member to practice acquired skills in an identified discharge setting

Discharge Planning

Participation in discharge staffings by an ABH care coordinator, the member's SIPP treatment team, the outpatient provider and the parent/legal guardian ensures discharge planning that is multi-disciplinary and fully considers the needs of the member. Coordination of aftercare services must begin at least thirty (30) days prior to discharge from a residential treatment setting in accordance with Attachment II, Exhibit A, Section V.E.4.c. (17).

ABH ensures that members receive the clinically indicated behavioral health service within seven (7) days of discharge from an inpatient setting. When the member is prescribed medication, ABH ensures that the clinically indicated behavioral health services scheduled within seven (7) days of discharge is a behavioral health program clinician who can provide medication management for medication monitoring in accordance with Attachment II, Exhibit A, Section V.E.4.g. (4), and Attachment II, Exhibit A, Section V.E.4.g. (5).

Discharge planning includes:

1. Assisting the individual transitioning from one level of care to another
2. Assisting the individual in transitioning to another service provider
3. Referrals to needed services, monitoring outcomes of the referral efforts, and subsequent follow-up
4. Assistance provided related to accessing physical health care
5. Coordinating care among multiple providers
6. Reports to referral source or others
7. Consultation with others regarding the care and treatment of the individual
8. Outreach efforts on behalf of the individual

ABH SIPP Level of Care Criteria for Clinical Decision Making

Members must meet the following criteria:

1. Be under the age of 21 years
2. Require placement in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance
3. Be eligible under one of the following Medicaid eligibility categories:
    a. TANF-related
    b. Supplemental Security Income (SSI)
    c. SSI-related

There are no emergency admissions into a SIPP. The following applies to all SIPP admissions:

1. Children and adolescents must receive prior approval for admission into a SIPP.
2. The provider is required to notify Access Behavioral Health at least 24 hours prior to the admission, preferably 72 hours in advance when possible.
3. The child or adolescent must be assessed by a psychologist or by a Florida-licensed psychiatrist, with experience or training in childhood disorders.
4. Medical clearance must be given by a psychiatrist prior to admission.
5. The child or adolescent must be in good physical health (e.g., no acute medical conditions or life threatening medical problems).
    a. Acceptance of a child or adolescent with chronic illness will be a joint decision between Access Behavioral Health and the provider.
6. The child or adolescent must have age-appropriate cognitive ability.
7. The child or adolescent's legal guardian must be contacted to obtain admission approval. The family has the right to refuse the referral.
8. Individuals who are in State custody may not be referred or admitted without a face-to-face independent evaluation by a qualified evaluator in accordance with C 39.407, F.S., which concurs with the findings of medical necessity for this level of care.

Exclusion Criteria

Children and adolescents meeting any one of the following criteria are not considered appropriate for care in a SIPP:

1. Less intensive levels of treatment will appropriately meet the needs of the child or adolescent
2. The primary diagnosis is substance abuse, mental retardation, or autism
3. The member is not expected to benefit from this level of treatment
4. The presenting problem is not psychiatric in nature and will not respond to psychiatric treatment
5. The youth has a history of long-standing violations of the rights and property of others

6. A pattern of socially directed disruptive behavior (e.g., gang involvement) is the primary presenting problem or remaining problem after any psychiatric issue has stabilized
7. Members cannot be admitted to a SIPP if they have Medicare coverage, reside in a nursing facility or ICF/DD, or have an eligibility period that is only retroactive or are eligible as medically needy
8. Receiving any other 24-hour service
9. Lack of medical clearance from a psychiatrist for admission

Admission Criteria

The following criteria are to be used for admission to a SIPP facility when reimbursement is to be made on behalf of eligible Access Behavioral Health members:

1. All admissions are non-emergency and voluntary.
2. Medical clearance must be given by a psychiatrist prior to admission.
3. The child or adolescent has age appropriate cognitive ability to benefit from treatment.
4. The child or adolescent has the cognitive and developmental ability to benefit from treatment and group setting.
5. CFR 441.152 Federal requirements A, B, and C shall be met for admission to a SIPP.
    a. Ambulatory care resources available in the community do not meet the treatment needs of the member (42 CFR 441.152(a)). A reasonable course of acute inpatient treatment and/or intensive outpatient services has failed to bring about adequate resolution of significant symptoms to permit placement in a less restrictive setting in the community. To meet this requirement, one of the following shall be established:
        i. A lower level of care will not meet the member's treatment needs. Examples of lower levels of care include
            1. Family or relative placement with outpatient therapy;
            2. Day or after-school treatment;
            3. Foster care with outpatient therapy;
            4. Therapeutic foster care;
            5. Group childcare supported by outpatient therapy;
            6. Therapeutic group childcare;
            7. Partial hospitalization; and
            8. Custodial care.
        ii. An appropriate lower level of care is unavailable or inaccessible and a reasonable course of acute inpatient treatment has failed to resolve significant symptoms to permit a safe return to the community.
    b. Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist (42 CFR 441.152(a)). To meet this requirement, all of the following criteria must be met:

i. An ICD-10 diagnosis is present and has been established through a documented comprehensive bio-psychosocial diagnostic assessment. The diagnosis must indicate the presence of a psychiatric disorder that is severe in nature and requires more intensive treatment than can be provided on an outpatient basis. As an example, the following diagnoses may indicate the need for SIPP care when acute inpatient treatment has not adequately resolved significant symptoms and behaviors: Major Depressive Disorder, active Post Traumatic Stress Syndrome with continued fragility, and newly diagnosed psychotic disorders. A concurrent substance abuse disorder may be present.
    1. The member is currently experiencing problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as a, b, c, or d:
        a. Self-care Deficit (not Age Related): Basic impairment of needs or nutrition, sleep, hygiene, rest, or stimulation related to the member's mental disorder and severe and long-standing enough to prohibit participation in an available alternative setting in the community, including refusal to comply with treatment (e.g., refuse medications), **OR**

        b. Impaired Safety (Threat to Self or Others): Evidence of intent to harm self or others caused by the member's mental disorder; and unable to function in community setting, provided that such intent does not constitute a clinically emergent situation. Threats to harm self or others accompanied by one of the following:
            i. Severely depressed mood
            ii. Recent loss
            iii. Recent suicide attempt or gesture or past history of multiple attempts or gestures
            iv. Concomitant substance abuse
            v. Recent suicide or history of multiple suicides in family or peer group, **OR**

        c. Impaired Thought and/or Perceptual Processes (Reality Testing): Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (e.g., paranoia, hallucinations, delusions) and it is likely that the member will suffer serious harm.
        Indicators:
            i. Disruption of safety of self, family, peer, or community group

ii. Impaired reality testing sufficient to prohibit participation in any community educational alternative
iii. Not responsive to outpatient trial of medication or supportive care
iv. Requires sub-acute diagnostic evaluation to determine treatment needs, **OR**

d. Severely Dysfunctional Patterns: Family, environmental, or behavioral processes that place the member at risk. ***Indicators (one of the following):***

i. Family environment is causing escalation of member's symptoms or places member at risk.
ii. The family situation is not responsive to available outpatient or community resources and intervention.
iii. Instability or disruption is escalating.
iv. The situation does not improve with the provision of economic or social resources.
v. Severe behavior or established pattern of behavior prohibits any participation in a lower level of care (e.g., habitual runaway, prostitution, repeated substance abuse).

2. The child or adolescent has a serious impairment of functioning compared to others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of
    a. Deficits in cognition, control, or judgment due to diagnosis(es);
    b. Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance;
    c. Prognostic indicators that predict the effectiveness of treatment.
    d. The facility requesting prior authorization describes a proposed plan of active treatment based on comprehensive assessment that addresses medical, psychiatric, neurological, psychological, social, educational, and substance abuse needs, specifically
    e. Services shall be under the supervision of a physician advisor;
    f. Intervention of qualified professionals shall be available 24 hours a day; and

g. Multiple therapies (e.g., group counseling, individual counseling, pre-vocational therapy, family therapy, recreational therapy, expressive therapies, etc.) shall be actively provided to the member. Families or surrogates must be involved in the treatment. Family therapy with families or surrogates must be included unless clinically contraindicated, with an expectation of at least one family session per week.

ii. The services can reasonably be expected to improve the member's condition within a reasonable timeframe of three to six months or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).

1. The treating facility shall provide a description of the plan for treatment illustrating the required services available at a SIPP level of care.
2. The treating SIPP facility shall provide a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan shall include discrete, behavioral, measurable, and time-framed discharge criteria.
3. The benefits of SIPP care are expected to result in maintaining or improving the member's level of functioning.

Continued Stay Criteria

The following are criteria to be used for continued stay in a SIPP facility when reimbursement is to be made on behalf of eligible Access Behavioral Health members. Continued stay review is conducted through ABH staff attendance at monthly SIPP discharge staffings and review of documented progress summary and treatment recommendations.

Requirements A and B shall be met for continued stay:

A. Ambulatory care resources available in the community do not meet the treatment needs of the member (42 CFR 441.152(a)). To meet this requirement, one of the following shall be established:

a. A lower level of care is unsafe and will place the member in imminent danger of harm. Examples of lower levels of care include:

i. Family or relative placement with outpatient therapy;
ii. Day or after-school treatment;
iii. Foster care with outpatient therapy;
iv. Therapeutic foster care;
v. Group childcare supported by outpatient therapy;
vi. Therapeutic group childcare;
vii. Partial hospitalization; and

viii. Custodial care.

b. Clinical evidence exists that a lower level of care will not meet the member's treatment needs.

c. The member's mental disorder could be treated with a lower level of care, but because the member suffers one or more complicating concurrent disorders, SIPP care is medically necessary.

i. Example: Major Depressive Disorder with Epilepsy

B. Proper treatment of the member's psychiatric condition continues to require services on an inpatient basis under the direction of a psychiatrist (42 CFR 441.152(a)). To meet this requirement, all of the following criteria must be met:

a. The patient continues to have a psychiatric condition or disorder that is classified as an ICD-10 diagnosis. A concurrent substance abuse disorder may be present.

b. The member continues to experience problems related to the mental disorder diagnosed in B.1 above in one of the following categories designated as (i), (ii), (iii), and (iv):

i. **Self-care Deficit (not Age Related):** Impairment of ability to meet physical needs that place the member at risk of self-harm. ***Indicator:***

1. Self-care deficit severe and long-standing enough to make participation in an alternative setting in the community unsafe.

ii. **Impaired Safety (Threat to Self or Others)**: Continued evidence of intent to harm self or others caused by the member's mental disorder, provided that such intent does not constitute a clinically emergent situation. ***Indicators:***

1. Continued suicidal/homicidal ideation with expression of plan of intent
2. Potential for aggressive behavior requiring infrequent.

iii. **Impaired Thought and/or Perceptual Processes (Reality Testing)**: Inability to perceive and validate reality to the extent that the patient cannot negotiate his/her basic environment, nor participate in family or school (e.g., paranoia, hallucinations, and delusions), and it is likely that the member will suffer serious harm. ***Indicators:***

1. Disruption of safety of self, family, peer, or community group
2. Impaired reality testing sufficient to prohibit participation in any community educational alternative
3. Requires continued sub-acute diagnostic evaluation to determine treatment needs

iv. **Severely Dysfunctional Patterns:** Family, environmental, or behavioral processes that place the member at risk of serious harm ***Indicators (one of the following):***

1. Family contacts and interaction and/or family environment are causing escalation of member's symptoms and place the member at risk of serious harm.
2. Instability or disruption is escalating.
3. Severe behavior prohibits any participation in a lower level of care (e.g., habitual runaway, prostitution, repeated substance abuse).

c. The child or adolescent has a serious impairment of functioning compared with others of the same age due to the psychiatric diagnosis, in one or more major life roles (school, family, interpersonal relations, self-care, etc.) as evidenced by documented presence of
    i. Deficits in cognition, control, or judgment due to diagnosis;
    ii. Circumstances resulting from those deficits in self-care, personal safety, social/family functioning, academic or occupational performance; and
    iii. Prognostic indicators that predict the effectiveness of treatment.
d. The facility has updated the initial plan of treatment and has identified clinical evidence that continued intensive services are still required at this level of care, specifically
    i. Services shall be under the supervision of a physician advisor;
    ii. Intervention of qualified professionals shall be available 24 hours a day; and \
    iii. Multiple therapies (group counseling, individual counseling, recreational therapy, expressive therapies, family therapy, etc.) shall be actively provided to the member.
e. The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed (42 CFR 441.152(a)).
    i. The treating SIPP facility has developed a plan for continuing treatment illustrating the required intensity of services available at a SIPP level of care.
    ii. The treating SIPP facility has provided a plan for discharge and aftercare placement and treatment. A comprehensive discharge plan was initiated as soon as the initial assessment was completed and included discrete, behavioral, and time-framed discharge criteria with documentation of referral to outpatient providers for placement and identified aftercare services.
    iii. There is evidence that discharge to available community resources will likely result in exacerbation of the mental disorder to the degree that continued SIPP hospitalization would be required or would result in regression.

Discharge Criteria

The following requirements shall be met prior to discharge from a SIPP facility:

- The member has received maximum benefit from his or her present plan of care

OR

- The child has failed to benefit from a reasonable course of SIPP care, and documentation supports that a suitable alternative placement is established that will meet the child's needs, and the discharge plan includes input from family or legal guardian and the multidisciplinary team.

OR

- Severe medical problems have arisen that cannot be managed by the SIPP facility. If it is determined that a child will require extensive medical attention, the SIPP may work with Access Behavioral Health to coordinate the discharge plan from the SIPP, so that other services can be accessed.

Medical Necessity Review for Continued Stay

Review Procedures

It is the responsibility of the SIPP provider to contact Access Behavioral Health for continued stay reviews at least 24 hours (preferably 48 hours) prior to the expiration of the current certified period of stay. Access Behavioral Health conducts continued stay reviews for all plan members when the admission requires a fee for service payment.

The following information is required to complete a continued stay review:

1. Current treatment plan
2. Current ICD-10-CM diagnosis
3. Assessment of treatment progress with regard to admitting symptoms
4. Summary of treatment provided up to the point of review
5. Assessment of need for further treatment
6. Current discharge criteria and discharge date and plan (presence of a well-written plan and implementation efforts)
7. If discharge date changes, an explanation as to rationale for change
8. Current consent for any new psychotropic medications added and as needed/emergency treatment order (PRN/ETO) medications
9. The estimated length of stay for the member and plans for discharge

An Access Behavioral Health licensed clinical reviewer will review the information to make a determination. Within 24 hours, the reviewer will determine if the member continues to meet criteria for continued stay or defer the request to an Access Behavioral Health psychiatrist to make a determination. Once a decision is made, it will be immediately available to the provider via fax or phone call.

Review Timeframes

- Reviews shall be conducted monthly, at least every 30 days.

Service Authorization

For all SIPP authorizations, days will be authorized not to exceed 31 days. The Access Behavioral Health clinical reviewer will complete the continued stay review based upon the information provided by the provider representative. The information must be sufficient for the clinical reviewer to make a determination that medical necessity criteria are met. Access Behavioral Health generates a letter with the continued stay certification and faxes or mails a copy to the SIPP provider on behalf of member or legal guardian within one business day. The letter includes an authorization number and the effective dates for the authorization.

Information Pending

If the continued stay request does not provide sufficient information to determine if it meets medical necessity criteria for additional days, the Access Behavioral Health clinical reviewer will place the review in an "information pending" status and allow the provider to provide additional information within one business day. The provider representative may contact Access Behavioral Health with the requested information via phone or fax.

If no additional information is provided, the review will automatically be deferred to an Access Behavioral Health psychiatrist who will make a determination based upon the available information.

Peer to Peer Process

In case of a denial, the SIPP provider may request an informal telephonic peer review with the Access Behavioral Health psychiatrist to discuss why the member cannot be treated less restrictively. The peer review must be scheduled within one business day of the denial determination. The review must be completed within 72 hours of notification of the denial. After the peer review, the Access Behavioral Health psychiatrist may approve or deny the authorization request.

When an Access Behavioral Health board-certified psychiatrist denies the authorization, a letter will be generated that includes the physician statement of the action, provides the rationale for the action, and medical necessity criteria, which support the determination. A letter of denial will be sent to the SIPP provider and member/legal guardian. The notice of action letter will include an explanation of the rights of the member/legal guardian and the provider to request a reconsideration of the determination.

Following a peer-to-peer review, the Access Behavioral Health psychiatrist may authorize additional days. A letter is generated and sent to the provider and the

member/legal guardian indicating that Access Behavioral Health reversed the initial adverse determination through the informal peer review.

The peer-to-peer review process is provided as an additional step in the appeal process and does not supersede the formal reconsideration process for the member/legal guardian or provider.

Appeals Process

Access Behavioral Health is not delegated reconsideration appeals. Appeals must be sent directly to the appropriate Medicaid Managed Medical Assistance Plan provider. Should an appeal be received by Access Behavioral Health, it will be faxed to the appropriate plan provider within 24 hours of receipt.

Fair Hearing Process

A member or a provider acting on behalf of a member (with the member's legal guardian's written permission) may request a fair hearing without going through the appeal process. A fair hearing may be requested any time up to 90 days from the date of a notice of action letter, or up to 90 days after an appeal decision.

A fair hearing may be requested by calling or writing to:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O Box 60127
Ft. Myers, FL 33906
(877) 254-1055 (toll-free)
239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com