PROCEDURE #13.7a		EFFECTIVE DATE	REVISED DATE
TITLE:	CONTINUED STAY REVIEW	**1/1/2023**	**6/1/2026**
ATTACHMENT TO		**REVIEW DATES**	
POLICY #:	13.7	**6/1/26**	
POLICY TITLE:	INPATIENT PSYCHIATRIC HOSPITAL STANDARDS		
CHAPTER:	SERVICE DELIVERY		

I. PURPOSE

A. To establish continued stay review (CSR) practices for inpatient psychiatric services.

B. Community Mental Health Service Providers (CMHSPs) are responsible for conducting utilization management activities, including prior authorization and continued stay review, in accordance with medical necessity criteria.

C. Lakeshore Regional Entity (LRE), in its role as the PIHP, monitors and assures CMHSP compliance with applicable MDHHS, Medicaid, and contractual requirements.

II. PROCEDURES

A. Prior Authorization (PA)

Admissions to a higher level of care (HLOC) must be authorized by the CMHSP Utilization Management (UM) function based on documented medical necessity using the most current Milliman Care Guidelines (MCG) or other approved criteria. Initial authorizations are generally limited in duration (e.g., 1–3 days) based on clinical presentation. Authorization determinations must comply with all applicable timeliness and documentation requirements outlined in Policy 13.7 and MDHHS/Medicaid standards. LRE monitors CMHSP adherence to these requirements.

B. Continued Stay Review CMHSPs are responsible for conducting continued stay reviews using appropriate clinical review processes, including telephonic review and/or secure transmission of clinical documentation (e.g., EHR, secure email, fax). Continued stay reviews must occur at intervals consistent with medical necessity and the most current Milliman Care Guidelines (MCG) or payer requirements. All continued stay determinations must be based on documented medical necessity and reflect the least restrictive, clinically appropriate level of care. LRE monitors CMHSP compliance with continued stay review frequency, documentation, and determination requirements.

1. First reviews should contain the following:
   a. Admitting clinical
   b. Psychiatric Diagnosis/es

c. Medical Diagnosis/es
d. Suicidal/Homicidal Ideation/Plan
e. Psychosis
f. SUD
g. Baseline functioning
h. Social Determinants of Health (SDoH)
i. Mental Health History (previous treatment, dx, admissions, etc.)
j. Current Clinical Update (no MD notes over 24 hours old)
    i. MD Notes
    ii. SW Notes
    iii. Nursing (Unit Notes)
    iv. Group Notes
k. Current Treatment
    i. Medications & other somatic treatments (e.g. ECT)
    ii. Cognitive and Behavioral Therapies
l. Treatment Plan until next review
    i. Med change (medication, dose, route)
    ii. Other somatic therapy change (e.g., ECT)
    iii. Other non-somatic therapy change (start EMDR, DBT, etc.)
    iv. Legal (AOT, guardian, etc.)
m. Discharge Planning (expectation start within 24 hours of admission)
    i. Estimated Length of Stay (ELOS)
    ii. Discharge location
    iii. Care Coordination
    iv. Other needs (pending test results)

C. <u>Inpatient Stepdown</u>

CMHSPs are responsible for coordinating all higher levels of care (HLOC) step-down planning and authorization. Step-downs may occur from inpatient psychiatric hospitalization to a crisis residential unit (CRU) or a partial hospitalization program (PHP), as clinically indicated. All step-downs require prior review and authorization by the CMHSP Utilization Management (UM) function. When a step-down is requested by the CMHSP and/or the inpatient provider, the following processes must be followed. LRE monitors CMHSP compliance with step-down criteria, medical necessity determinations, and timeliness of placement.

1. All step-down determinations must be supported by documented medical necessity using the most current Milliman Care Guidelines (MCG).
2. UM will review all criteria presented and provide clinical determination.
3. If all parties agree that a stepdown should proceed, UM and/or other CMHSP staff will secure the stepdown placement.
4. If stepdown placement to a CRU is not immediately available, UM staff will continue to review MNC for inpatient care each business day to determine ongoing eligibility for a lower level of care.

5. Admission to PHP would be anticipated the next business day, but not more than 72 hours after discharge from inpatient. If placement does not occur within a 72-hour time frame, then a reassessment should occur.
6. Medicare/Medicaid Step-Down Requests will be addressed internally by each CMHSP.

NOTE: Stepping up to inpatient level of care requires prior authorization and occur per CMHSP policy and/or procedure.

D. Discharge Plan

CMHSPs must ensure receipt and review of discharge summaries within 48 hours of discharge to support continuity of care and compliance with care transition requirements. Discharge planning is expected to begin within 24 hours of admission and must include coordination of behavioral health, physical health, and social supports, and support timely follow-up care.

1. Patient name
2. Patient date of birth (DOB)
3. Patient phone number
4. Patient address
5. Patient emergency contact information
6. Date of Admit
    a. Reason for admission
7. Date of Discharge
8. Attending psychiatrist's name and associated advance practice provider's (APP's) name, if an APP was involved in the person's care (as well as the collaborating physician when an APP was involved).
9. Discharge Diagnoses
    a. All psychiatric
    b. All medical
10. Hospital course/progress (this should be brief)
11. Results
    a. Labs
    b. Radiology
    c. Psych testing
    d. Any pending results
12. DC Treatment and other Recommendations
    a. Medications
        i. all instructions, (e.g., drug, dosage, directions (sig))
        ii. If LAI -- last dose/date of injection as well as date of next injection/recommended dose
        iii. Medications called into or e-prescribed and name/location of pharmacy
        iv. Any prescription or other medication (number/amount) given to the patient at discharge

13. Psychotherapy (as indicated)
14. SUD treatment (as indicated)
15. Follow up labs and/or other studies
16. Other DC needs
17. Follow up behavioral health appointment(s) to include: (i) date; (ii) clinician; and (iii) CMHSP/ provider name, address, and contact information for each of the following, as applicable:
    a. Psychiatry
    b. Psychotherapy
    c. Case Manager
    d. CMHSP Intake
18. Follow up physical health appointment(s)
    a. Primary care
    b. Other (e.g., endocrinology)
19. Legal
    a. AOT (e.g., 60/180 days)
    b. Deferral dates of expiration
    c. Court documents
    d. Guardianship status/involvement during hospitalization
        i. Specify type of Guardianship (plenary, partial, medical only, etc.)
20. Copy of admission psychiatric evaluation
21. Copy of admission history and physical
22. Copy of DC Instructions to patient
23. Anything else judged to be important by inpatient unit

E. Reauthorization

1. Providers must submit continued stay review information within required timeframes (before 3pm or otherwise agreed upon time) to support reauthorization determinations.
2. CMHSP Utilization Management must render determinations within required timeliness standards (24 hours from the time received), including compliance with Medicaid, MDHHS, and contractual utilization management requirements. Failure to submit required clinical information within established timeframes may result in retrospective review and/or administrative action consistent with CMHSP policy. Adverse determinations must be processed in accordance with applicable notice, appeal, and grievance requirements.
3. Failure to provide required CSR information within established timeframes may result in retrospective review in accordance with CMHSP policy and payer requirements.

F. Out-of-Region Providers

CMHSPs must ensure that out-of-region providers adhere to the same authorization, continued stay review, and documentation requirements as in-region providers. LRE monitors compliance with these expectations

G. Electro-Convulsive Therapy (ECT) Authorization

No prior authorization for ECT is required while a member is in an IP psychiatric facility. Prior authorization is required for outpatient ECT. CMHSPs will follow an ECT authorization process based on the American Psychiatric Association guidelines. CMHSPs must ensure ECT services are authorized and monitored in accordance with clinical guidelines and applicable Medicaid requirements.

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party