Alaska State Medicaid Program
Acute Care Medical Necessity Criteria
Effective April 15, 2009

In order to receive Certification, Criteria A, B, and C must be met:

Criterion A: Ambulatory care resources providing less restrictive levels of care that are available in the community do not meet the treatment needs of the recipient. 42 CFR 441.152(a) & 7AAC 43.552 (C) (2) (A)

To meet this criterion, A1 and A3, or A2 and A3 of the following must be established:

A.1. ☐ Documentation that the recipient is diagnosed with a mental illness and that the mental illness causes the person to present a likelihood of serious harm (imminent risk) to that person or others within the past week for children and past 48 hours for adults.

For example: Suicidal ideation with a plan; in possession of a weapon with intent to hurt another; a recent episode with intent to do severe bodily harm; making credible threats of harm; recent psychotic episode causing debilitating hallucinations.

OR

A.2. ☐ Documentation that the youth recipient's condition is severely impaired as a result of mental illness and substantially interferes with or limits the youth's role functioning in family, school, or community activities. For adults, documentation that the recipient's condition is gravely disabled and role functioning is severely impaired as a result of mental illness and substantially interferes with their ability to engage independently in personal care or community living activities and function independently in the role of worker, student, or homemaker. For both adult and youth, the recipient's symptoms and maladaptive behavior are not a result of intellectual, physical, or sensory deficits.

For example: Severe impairment in role functioning due to committing serious acts of destruction in home or classroom; person's hallucinations, delusions, or disorganized thinking severely impact their ability to meet needs for nutrition, sleep, hygiene, rest or housing.

AND

A.3. ☐ Documentation that less restrictive levels of care available in the community do not meet the treatment needs of the recipient or that a less intense level of care is unavailable or inaccessible for meeting the treatment needs; and, there is specific documentation showing how services can reasonably be expected to either improve recipient's condition or prevent regression so that the services will no longer be needed.

For example: Community behavioral health services may not provide required 24 hour care; psychiatric services needed may not be available at the frequency needed to maintain recipient in the community; the plan of care documents treatment goals and interventions that specifically relate to the primary and (if any) secondary diagnoses and identify discharge criteria to the extent the recipient can be treated in the community.

<u>Criterion B:</u> Documentation that proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. 42 CFR 441.152b-2 & 7AAC 43.552 (C) (2) (B)

To meet this criterion, ALL of the following must be established:

EITHER (for B1):

B.1a. ☐ The Certificate of Need (CON) for Elective, or NON-EMERGENCY ADMISSIONS: Must be certified with the signature of two (2) members of the Inpatient Interdisciplinary Team (IIT):

☐ A physician member of the IIT; AND

☐ Another member of the IIT have both signed and certified need for admission according to 7AAC43.552 (f) (1, 3).

OR

B.1b. ☐ The CON Question for EMERGENCY ADMISSIONS: "Has an appropriate physician certified need for hospitalization?"

AND

B.2. ☐ The psychiatric evaluation documents that the recipient has a DSM-IV-TR primary diagnosis of a mental health disorder classified as an Axis I Diagnosis between DSM-IV-TR 290. - and 316.-, excluding a substance abuse disorder. Any treatment for a substance abuse disorder must be secondary to the treatment for the mental health disorder.

In relation to B.2 criterion, please note:

- A seven (7) day maximum allowable limit on payment is placed on the following diagnostic codes if they are primary diagnoses unless documentation supports an imminent risk of serious harm to self or others if discharged; or unless a more specific diagnosis has been documented and included in the Plan of Care:

    1) Oppositional Disorder (313.81)
    2) Conduct Disorders (312.8-)

- A fourteen (14) day maximum allowable limit on payment is placed on the following three diagnostic codes if they are primary diagnoses unless a more specific diagnosis has been documented and included in the Plan of Care:

    1) Depression NOS (311.)
    2) Mood Disorder NOS (296.90) for youth at least 12 years of age
    3) Unspecified Mental Health Disorder Non-Psychotic (300.9)

AND

B.3. ☐ Documentation supports that the GAF at admission for the acute level of inpatient psychiatric care is 40 or below. The GAF may be higher in cases when there is imminent serious risk of harm to self or others.

AND

B.4. ☐ Documentation that the recipient is currently experiencing acute disturbances related to the mental disorder diagnosed in B.2 above.

For example: Impaired thought processes such as hallucinations, delusions, loose associations, paranoia, or other acute disturbances that puts recipient at imminent risk of harm; severely dysfunctional patterns of behavior related to the acute disturbances pertaining to the primary and (if any) secondary diagnoses; recent psychotropic medication changes that put patient at high risk for acute disturbance if not monitored in inpatient setting.

Criterion C: The services can reasonably be expected to improve the recipient's condition or prevent further regression so that acute care services will no longer be needed. 42 CFR 441.155, 441.156 & 7AAC 43.552(C) (2) (C)

To meet this criterion, ALL of the following must be established:

C.1. ☐ The diagnostic evaluation includes examination of medical, psychological, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for acute care.

C.2. ☐ The individualized Plan of Care clearly documents goals and measurable objectives derived from the diagnostic evaluation.

C.3. ☐ The individualized Plan of Care is developed by a team of professionals in consultation with the recipient. If the recipient is a youth, his or her parents and/or legal guardians in whose care she or he may be released after discharge are included in this team.

C.4. ☐ The individualized Plan of Care clearly documents appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently within their own environment.

C.5. ☐ The individualized Plan of Care clearly documents a comprehensive discharge plan that is based on treatment goals and objectives to the extent inpatient services are no longer necessary or treatment can be completed in the least restrictive environment (or lower level of care), specifies approximate discharge date based on achievement of those stated objectives, post-discharge service needs including any prospective post-discharge service providers and any other provisions necessary for transition to a lesser restrictive environment and adult services. Discharge plans must be continually updated to reflect changes and progress in treatment planning.