

KEPRO Provider Manual

Appendix C

Updated August 2016

Table of Content

Children Out of State Contract Hospitals (BLNKT)	3
Baxter Fund Services	8
Long-Term Supported Employment Services	13
Long-Term Supported Employment Services – Invoicing	23
Section 13 – Targeted Case Management for Children and Adolescents/Young Adults	29
Section 13 – Targeted Case management for Children with Chronic Medical Care Needs	37
Section 17 – Community Integration (CI) and Assertive Community Treatment (ACT)	39
Section 17 – Community Rehabilitation Services (CRS)	43
Section 17 – Specialized Group Services	46
Section 17 – All other Community Support Services	49
Section 21 – Home and Community Benefits for Adults with ID or AD	53
Section 21 – Home and Community Benefits for Adults with ID or AD – Crisis Intervention	60
Section 21 – Home and Community Benefits for Adults with ID or AD – Temporary Emergency Housing	62
Section 28 – Rehabilitation and Community Support Services for OCFS Providers	64
Section 28 – Rehabilitation and Community Support Services for School-Based Providers	67
Section 45 – Intensive Outpatient Program (IOP)	71
Section 45 – General Hospital Inpatient Psychiatric and Substance Abuse Units	75
Section 45 – Emergency Admissions to Out of State Hospitals for Adults and Children	77
Section 45 – Spring Harbor Hospital and Acadia Hospital – Adult Services	80
Section 45 – Spring Harbor Hospital and Acadia Hospital – Children’s Services	82
Section 45 – Maine State Hospitals Dorothea Dix and Riverview	84
Section 46 – Psychiatric Partial Hospitalization	86
Section 65 – Intensive Outpatient Program	90
Section 65 – Home and Community-Based Treatment (HCT) Services	94
Section 65 – Home and Community-Based Treatment (HCT) Services – MST and FFT	98
Section 65 – Child Assertive Community Treatment (ACT)	102
Section 65 – Outpatient Mental Health Services	104
Section 65 – Outpatient Substance Abuse Services	107
Section 65 – Medication Management Services	110
Section 65 – Children’s Day Treatment Provided by an Educational System	112
Section 92 – Behavioral Health Homes for Children and Adults	115
Section 97 – Appendix E Adult PNMI – Services for Persons with Mental Illness	118
Section 97 – Appendix F – Adult PNMI – Mixed medical and Remedial Facilities	124

Section 97 – Appendix D Child PNMI – Child Care Facilities	128
Section 97 – Appendix D Child PNMI – Treatment Foster Care	132
Section 97 – Appendix D Child PNMI – Multidimensional Juvenile Justice Program TFC	135
Section 97 – Intensive Temporary Residential Treatment Application – Appendix D Application for Children’s PNMI	138
Section 97 – Intensive Temporary Residential Treatment Application & Temporary High Intensity Service – Appendix D Application for Children’s PNMI	141
Section 65 and 97 – Child and Adult Crisis Residential Crisis Units	145

Children Out Of State Contracted Hospitals ONLY (Blanket) **Children's Emergency and Non-Emergency Out of State Approval Process**

The following KEPRO processes are required for:

1. Children's Emergency Out of State Approval Process (Contracted Hospitals)
2. Children's Non-Emergency Out of State Approval Process (Contracted Hospitals)

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Review
- C. Discharge Review

A. Initial Registration (IR) Process for Children Out Of State Contracted Hospitals ONLY

The Initial Registration will be entered by the Regional DHHS UR Specialist who authorized the admission. The provider will not need to enter an Initial Registration.

B. Continued Stay Review (CSR) Instructions for Children Out Of State Contracted Hospitals ONLY

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Children Out Of State Contracted Hospitals ONLY Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

Providers are responsible for completing necessary Continued Stay Reviews.

1. **Additional Information Page:** Place clinical rationale note in the "Additional Information" section indicating information you feel would be relevant in supporting the member's clinical need for services. Make sure to include current symptoms and behaviors as well as a specific discharge plan. Complete the "Treatment Progress" drop-down.

Member Information Guardian Information Administrative Requesting Agency Diagnostic Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS	APS Case Id: <div> Delete Request << Previous Save & Continue >> </div> <div> Additional Info <div> Notes: </div> </div> <div> Continuing Stay Review <div> Treatment Progress : --Select One-- </div> <div> Since the previous authorization how was the consumer progressed : </div> </div>
--	---

C. Children Out Of State Contracted Hospitals ONLY Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Children Out Of State Contracted Hospitals ONLY Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

Hospitals are responsible for discharging members from KEPRO CareConnection® within one (1) business day of the day that the member is discharged from the facility. The discharge *must* be submitted if a member has been registered for admission, regardless of whether or not a continued stay review was submitted.

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Complete all fields in red.

Discharge Info

APS Case Id: <input type="text"/>	Member ID: <input type="text"/>	Member Name: <input type="text"/>
Service code	Description	Billing Provider ID
Services Discharged: <input type="checkbox"/>	BLNKT Children Out of State Hospitals ONLY	Start date
End date	Last Updated	Submitted By

Discharge Date:

Was this Patient admitted involuntarily? : ☐ Yes ☐ No

If this admission was involuntary, did this admission convert from involuntary to voluntary? : ☐ Yes ☐ No ☐ N/A

Reason(s) for Discharge:

Change in Level Of Care:

Anticipated Step Down Service:

Service	Anticipated Date of First Appointment	Service	Anticipated Date of First Appointment
<input type="checkbox"/> Natural Supports	<input type="text"/>	<input type="checkbox"/> 6SMBN	<input type="text"/>
<input type="checkbox"/> Respite	<input type="text"/>	<input type="checkbox"/> Adult HomeBased Services	<input type="text"/>
<input type="checkbox"/> AA/NA	<input type="text"/>	<input type="checkbox"/> DLSS	<input type="text"/>
<input type="checkbox"/> Peer Support	<input type="text"/>	<input type="checkbox"/> Substance Abuse Tx	<input type="text"/>
<input type="checkbox"/> Outpatient	<input type="text"/>	<input type="checkbox"/> Crisis Services	<input type="text"/>
<input type="checkbox"/> Groups	<input type="text"/>	<input type="checkbox"/> Crisis Unit	<input type="text"/>
<input type="checkbox"/> Psychiatric/Med. Mgt.	<input type="text"/>	<input type="checkbox"/> Foster/Child Welfare	<input type="text"/>
<input type="checkbox"/> Case Management/C.I.	<input type="text"/>	<input type="checkbox"/> Adult Protective	<input type="text"/>
<input type="checkbox"/> Section 24	<input type="text"/>	<input type="checkbox"/> Supported Nursing Facility	<input type="text"/>
<input type="checkbox"/> Day Treatment	<input type="text"/>	<input type="checkbox"/> Medical Hospitalization	<input type="text"/>
<input type="checkbox"/> ACT/I.C.I.	<input type="text"/>	<input type="checkbox"/> Residential Treatment	<input type="text"/>
<input type="checkbox"/> Corrections	<input type="text"/>	<input type="checkbox"/> Other	<input type="text"/>

Treatment Progress :

Assessment Tool

Date LOCUS Completed(Most Recent):

LOCUS Composite Score :

Caregiver Questionnaire :

LOCUS Level of Care :

ASAM Level:

CAFAS/PECFAS

School/Work/Preschool : <input type="text"/>	Moods/Emotions : <input type="text"/>
Home : <input type="text"/>	Self-Harmful Behavior : <input type="text"/>
Community : <input type="text"/>	Substance Abuse (CAFAS Only) : <input type="text"/>
Behavior Towards Others : <input type="text"/>	Thinking/Communication : <input type="text"/>
Total Score : <input type="text"/>	

Living Situation Upon Discharge:

If the Member had a CI, ACT, or CRS Provider, did the Hospital obtain the Member's ISP from their CI, ACT, or CRS Provider? ☐ Yes ☐ No ☐ N/A

If the Member had a CI, ACT, or CRS Provider, did the Hospital invite the Member's CI, ACT, or CRS Provider to participate in treatment and/or discharge planning? ☐ Yes ☐ No ☐ N/A

If the Member had a CI, ACT, or CRS Provider who was invited to participate in treatment and/or discharge planning, did the CI, ACT, or CRS Provider actually participate in treatment and/or discharge planning? ☐ Yes ☐ No ☐ N/A

Plan for Transition Discharge :

Submit

OCFS Preadmission Process for Children's Emergency and Non-Emergency Out of State Approval

A. OOS Children's Emergency Hospital Admissions Process

1. A request for an out of state emergency hospital admission will follow the process laid out by OCFS/ CBHS.
 - a. Child determined to meet hospital level of care by ED physician or Agency psychiatrist.
2. Crisis attempts to locate hospital bed in-state.
3. If no beds available in Maine;
 - a. Mobile Crisis contacts Riverview Switchboard and requests Children's Regional on call staff be contacted.
 - i. The "region" is determined by the ED/Crisis location not child's residence.
 - b. Riverview pages appropriate pager.
 - c. On call person calls Riverview and is given name and contact information of the calling party.
 - d. On call person contacts mobile crisis to obtain information on case.
 - i. Patient demographics
 - ii. Brief description of crisis and why hospital is necessary.
 - iii. Attempts made to secure in-state bed.
 - e. On call person gives permission for crisis to seek out of state admission.
 - i. Current hospital availability
 - 1) Hampstead Hospital, Hampstead, NH
 - 2) Brattleboro Retreat, Brattleboro, VT
 - f. Mobile crisis faxes copy of assessment to on call worker's office once admission has been guaranteed and patient is en route to receiving hospital.
 - g. On call person generates a "Registration" in KEPRO CareConnection within 1 business day.
 - ii. May approve up to 30 days
 - iii. The BLNKT code is used for these cases
 - iv. Same information as provided for ITRT PA
 - v. Must include hospital per diem rate at end of "additional information" section
 - h. This will trigger KEPRO to generate an Authorization Number which will be sent to the hospital as a Download Notification.
 - i. The provider will complete any necessary continued stay reviews as required.

B. OOS Children's Non-Emergency Out of State Approval Process

Non-Emergency Hospital Admissions (Developmental Programs or Hospital to Hospital transfer)

1. Process involves DHHS staff and current providers
2. Child determined to need hospital level of care.
3. Discussions with DHHS Clinical Care Specialist (CCS) and receiving hospital.
4. Determination made that in-state facilities are not available or patient needs specialized services currently unavailable in Maine.
5. CCS contacts out of state hospital
 - a. Current hospital availability
 - i. Hampstead Hospital, Hampstead, NH
 - ii. Emma Pendleton Bradley Hospital, E. Providence, RI
 - iii. Brattleboro Retreat, Brattleboro, VT
6. Hospital accepts patient for admission and schedules admission date.
7. CCS generates a “Registration” in KEPRO CareConnection within 1 business day of admission.
 - a. May approve up to 30 days
 - b. The BLNKT code is used in these cases
 - c. Same information as provided for ITRT PA
 - d. Must include hospital per diem rate at end of “additional information” section
8. This will trigger KEPRO to generate an Authorization Number which will be sent to the hospital as a Download Notification.
9. The Provider will complete any necessary continued stay reviews as required.

Baxter Fund Services

The following KEPRO processes are required for:

1. Baxter Fund Services - Outpatient Therapy
2. Baxter Fund Services - Group Therapy
3. Baxter Fund Services - Medication Management
4. Baxter Fund/MaineCare - Outpatient Therapy
5. Baxter Fund/MaineCare - Group Therapy
6. Baxter Fund/MaineCare - Medication Management

The KEPRO processes for Baxter consumers *with* MaineCare are:

- A. Prior Authorization (PA)
- B. Continued Stay Reviews (CSR)
- C. Discharge Review

The KEPRO processes for Baxter consumers *without* Maine Care are:

- A. Initial Courtesy Review (ICR)
- B. Courtesy Continued Stay Review (CCSR)
- C. Discharge Review

*****Please note: Invoicing for Baxter Fund Services is completed via fax, using the “Baxter Billing Form”. Providers may request a blank billing form by contacting KEPRO Provider Relations at 866-521-0027, Option 1, or by e-mail at ProviderRelationsME@KEPRO.com *****

A. Prior Authorization or Initial Courtesy Review Process for Baxter Fund Services:

***Note:** Detailed, step-by-step instructions for entering Prior Authorizations and Initial Courtesy Reviews are available in Appendix B. Instructions below describe requirements that are specific to Baxter Fund Services PAs or ICRs. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Diagnostic Assessment Page:
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis” fields.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: []
Delete Request [] Save & Continue >>

Diagnostic Assessment
Date of Diagnostic Assessment: []

Diagnostic Information
Primary Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Other Medical Conditions: []

<< Previous Save & Continue >>

2. **Psychiatric Medication Page:** For Medication Management ONLY. All medications, both psychiatric and medical, should be entered in, using the “Add Medication” button. Answer the “Yes/No” questions. Click and “Save and Continue” when complete.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: []
Delete Request [] Save & Continue >>

Psychiatric Medications
Is the member currently prescribed any psychiatric medications? Yes ☐ No ☐
If yes, does member take medications as prescribed? Yes ☐ No ☐
Did you notify the member's PCP of this medication? Yes ☐ No ☐
Is the Member's PCP prescribing psychiatric medications to the member? Yes ☐ No ☐ N/A ☐

List Medications
Medication Type Medication Name Action
Add Medication

Additional Medication Info (Non-Prescribed, Vitamins, Supplements, Dosage, Frequency, Etc.)
Notes: []

3. **Clinical Indicators Page:** Please complete this page by choosing the “Current Severity” and “History of Severity” for each indicator as applicable. The most current symptoms and behaviors that a member has experienced over the previous authorization period should be reflected here.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

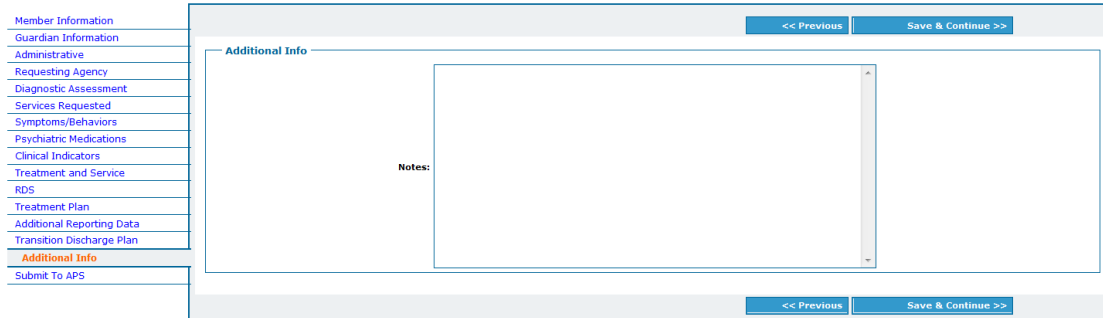
APS Case Id: []
Delete Request [] Save & Continue >>

Clinical Indicators Justifying Service Request
Risk/Danger To Self/Others
Current Severity (None, Mild, Moderate, Severe)
History of Severity (Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years)

Aggressiveness :	None	---Select---
Fire Setting :	None	---Select---
Assaultive :	None	---Select---
Homicidal Attempt :	None	---Select---
Homicidal Ideation :	None	---Select---
Self Care Deficit :	None	---Select---

4. **Additional Information Page:**
a. Please include a brief clinical presentation including how long the member has been receiving this service, the current issues of concern, the frequency and duration of

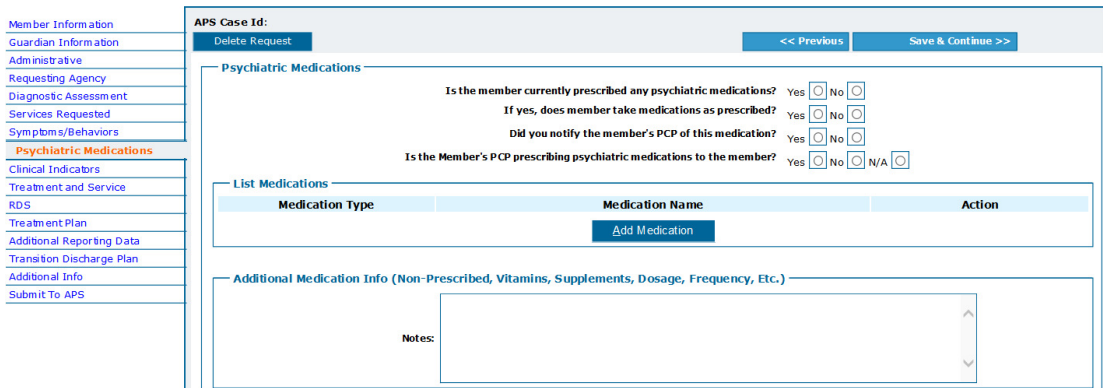
sessions, the overarching goal of treatment, treatment modality, and a statement of engagement/progress.



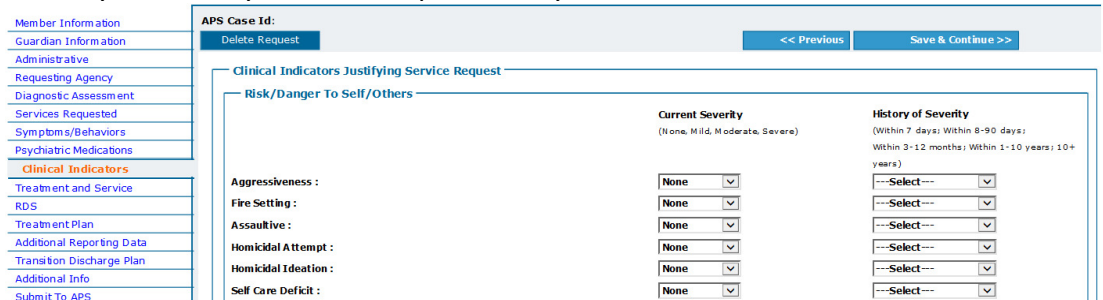
A. Continued Stay Review (CSR) or Courtesy CSR Instructions for Baxter Fund Services:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Baxter Fund Services Continued Stay Reviews or Courtesy CSRs. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Psychiatric Medication Page: **For Medication Management ONLY.** All medications, both psychiatric and medical, should be entered in, using the “Add Medication” button. Answer the “Yes/No” questions. Click and “Save and Continue” when complete.



2. Clinical Indicators Page: Update as necessary, choosing the “Current Severity” and “History of Severity” within the past 90 days.



3. Additional Information Page: Updated information should include a brief summary of previous review period, including any significant changes in status/circumstances. Update the issues of concern, any changes in goals of treatment, and a statement of engagement/progress.

Member Information Guardian Information Administrative Requesting Agency Diagnostic Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS	APS Case Id: Delete Request <div style="float: right;"> << Previous Save & Continue >> </div> <hr/> Additional Info <div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>Notes:</p> <hr/> Continuing Stay Review <p>Treatment Progress : --Select One--</p> <p>Since the previous authorization how was the consumer progressed : <div style="border: 1px solid black; height: 30px; width: 100%;"></div></p>
--	--

B. Discharge Instructions for Baxter Fund Services:

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Baxter Fund Services Discharges. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Discharge Info																																																					
APS Case Id: 	Member ID: Member Name: 																																																				
<table border="1"> <thead> <tr> <th>Service code</th> <th>Description</th> <th>Billing Provider ID</th> <th>Start date</th> <th>End date</th> <th>Last Updated</th> <th>Submitted By</th> </tr> </thead> <tbody> <tr> <td colspan="7">Services Discharged: <input type="checkbox"/></td> </tr> </tbody> </table>	Service code	Description	Billing Provider ID	Start date	End date	Last Updated	Submitted By	Services Discharged: <input type="checkbox"/>							<p>Discharge Date: </p> <p>Was this Patient admitted involuntarily? : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If this admission was involuntary, did this admission convert from involuntary to voluntary? : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Reason(s) for Discharge: -----Select-----</p> <p>Change in Level Of Care: -----Select-----</p>																																						
Service code	Description	Billing Provider ID	Start date	End date	Last Updated	Submitted By																																															
Services Discharged: <input type="checkbox"/>																																																					
Anticipated Step Down Service: <table border="1"> <thead> <tr> <th>Service</th> <th>Anticipated Date of First Appointment</th> <th>Service</th> <th>Anticipated Date of First Appointment</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Natural Supports</td><td></td><td><input type="checkbox"/> 63MBN</td><td></td></tr> <tr><td><input type="checkbox"/> Respite</td><td></td><td><input type="checkbox"/> Adult HomeBased Services</td><td></td></tr> <tr><td><input type="checkbox"/> AA/NA</td><td></td><td><input type="checkbox"/> DLSS</td><td></td></tr> <tr><td><input type="checkbox"/> Peer Support</td><td></td><td><input type="checkbox"/> Substance Abuse Tx</td><td></td></tr> <tr><td><input type="checkbox"/> Outpatient</td><td></td><td><input type="checkbox"/> Crisis Services</td><td></td></tr> <tr><td><input type="checkbox"/> Groups</td><td></td><td><input type="checkbox"/> Crisis Unit</td><td></td></tr> <tr><td><input type="checkbox"/> Psychiatric/Med. Mgt.</td><td></td><td><input type="checkbox"/> Foster/Child Welfare</td><td></td></tr> <tr><td><input type="checkbox"/> Case Management/C.I.</td><td></td><td><input type="checkbox"/> Adult Protective</td><td></td></tr> <tr><td><input type="checkbox"/> Section 24</td><td></td><td><input type="checkbox"/> Supported Nursing Facility</td><td></td></tr> <tr><td><input type="checkbox"/> Day Treatment</td><td></td><td><input type="checkbox"/> Medical Hospitalization</td><td></td></tr> <tr><td><input type="checkbox"/> ACT/I.C.I.</td><td></td><td><input type="checkbox"/> Residential Treatment</td><td></td></tr> <tr><td><input type="checkbox"/> Corrections</td><td></td><td><input type="checkbox"/> Other</td><td></td></tr> </tbody> </table>		Service	Anticipated Date of First Appointment	Service	Anticipated Date of First Appointment	<input type="checkbox"/> Natural Supports		<input type="checkbox"/> 63MBN		<input type="checkbox"/> Respite		<input type="checkbox"/> Adult HomeBased Services		<input type="checkbox"/> AA/NA		<input type="checkbox"/> DLSS		<input type="checkbox"/> Peer Support		<input type="checkbox"/> Substance Abuse Tx		<input type="checkbox"/> Outpatient		<input type="checkbox"/> Crisis Services		<input type="checkbox"/> Groups		<input type="checkbox"/> Crisis Unit		<input type="checkbox"/> Psychiatric/Med. Mgt.		<input type="checkbox"/> Foster/Child Welfare		<input type="checkbox"/> Case Management/C.I.		<input type="checkbox"/> Adult Protective		<input type="checkbox"/> Section 24		<input type="checkbox"/> Supported Nursing Facility		<input type="checkbox"/> Day Treatment		<input type="checkbox"/> Medical Hospitalization		<input type="checkbox"/> ACT/I.C.I.		<input type="checkbox"/> Residential Treatment		<input type="checkbox"/> Corrections		<input type="checkbox"/> Other	
Service	Anticipated Date of First Appointment	Service	Anticipated Date of First Appointment																																																		
<input type="checkbox"/> Natural Supports		<input type="checkbox"/> 63MBN																																																			
<input type="checkbox"/> Respite		<input type="checkbox"/> Adult HomeBased Services																																																			
<input type="checkbox"/> AA/NA		<input type="checkbox"/> DLSS																																																			
<input type="checkbox"/> Peer Support		<input type="checkbox"/> Substance Abuse Tx																																																			
<input type="checkbox"/> Outpatient		<input type="checkbox"/> Crisis Services																																																			
<input type="checkbox"/> Groups		<input type="checkbox"/> Crisis Unit																																																			
<input type="checkbox"/> Psychiatric/Med. Mgt.		<input type="checkbox"/> Foster/Child Welfare																																																			
<input type="checkbox"/> Case Management/C.I.		<input type="checkbox"/> Adult Protective																																																			
<input type="checkbox"/> Section 24		<input type="checkbox"/> Supported Nursing Facility																																																			
<input type="checkbox"/> Day Treatment		<input type="checkbox"/> Medical Hospitalization																																																			
<input type="checkbox"/> ACT/I.C.I.		<input type="checkbox"/> Residential Treatment																																																			
<input type="checkbox"/> Corrections		<input type="checkbox"/> Other																																																			
<p>Treatment Progress : -----Select-----</p> <p>Living Situation Upon Discharge: -----Select-----</p> <p>If the Member had a CI, ACT, or CRS Provider, did the Hospital obtain the Member's ISP from their CI, ACT, or CRS Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If the Member had a CI, ACT, or CRS Provider, did the Hospital invite the Member's CI, ACT, or CRS Provider to participate in treatment and/or discharge planning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If the Member had a CI, ACT, or CRS Provider who was invited to participate in treatment and/or discharge planning, did the CI, ACT, or CRS Provider actually participate in treatment and/or discharge planning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Plan for Transition Discharge : <div style="border: 1px solid black; height: 40px; width: 100%;"></div></p> <p style="text-align: right;">Submit</p>																																																					

Common Baxter Fund Services Questions:

Q: I am submitting my clinical authorization online in CareConnection. Am I supposed to submit my invoice online too?

A: No. KEPRO will continue to process Baxter Fund Services Invoices via fax, using the “KEPRO Baxter Invoice Form”. For a copy of the form, e-mail KEPRO Provider Relations at ProviderRelationsME@KEPROhealthcare.com

Q: I am not sure which Procedure Codes to use. Do I enter Initial Courtesy Reviews or Prior Authorizations?

A: If you are a MaineCare provider, and plan to bill at least part of the service to MaineCare, then you will need to use the HIPPA-compliant Procedure Codes listed below. You would enter the request as a Prior Authorization, and you will be issued an Authorization Number to bill MaineCare.

1. H0004 - Baxter Fund/MaineCare Individual Outpatient Therapy
2. H0004 HQ - Baxter Fund/MaineCare Outpatient Group Therapy
3. H2010 - Baxter Fund/MaineCare Medication Management

If you are not a MaineCare provider, and are billing only the Baxter Fund, then you would enter your request as an Initial Courtesy Review. You would use the Procedure Codes listed below.

1. 100-219 - Baxter Fund Services Individual Outpatient Therapy
2. 100-219 - Baxter Fund Services Outpatient Group Therapy
3. 100-219 - Baxter Fund Services Medication Management

Q: I work as an affiliate for another agency, in order to bill MaineCare for services. Do I enter my Baxter Fund clients under that agency, or under my CareConnection account as an independent provider?

A: If you would like to bill MaineCare for part of the services for a member, you will need to enter the member under the agency in CareConnection so they can bill MaineCare on your behalf. You will use the **Baxter Fund/MaineCare** Procedure Codes listed above, and you should follow the policies and practices as outlined by your agency. If the member does not have MaineCare, and no portion of the service will be billed to MaineCare, you will enter that member under your own agency in CareConnection, using the 100-219 Baxter Fund Services Procedure Codes.

Long Term Supported Employment Services

The following KEPRO processes are required for:

1. Long Term Supported Employment Services

The KEPRO processes are:

- A. Initial Courtesy Review (ICR)
- B. Courtesy Continued Stay Review (CCSR)
- C. Discharge Review

Introduction

KEPRO is contracted by the Department of Health and Human Services to provide prior authorization, utilization review and invoice processing for Long Term Supported Employment Services (LTSE). In order to be reimbursed for LTSE services, providers must follow all KEPRO as well as DHHS requirements for this service. **Please note** - KEPRO does not require LTSE providers to submit any paper forms to substantiate the information entered in the electronic request. KEPRO will not require client signatures on transitions plans or invoices. Providers should submit an electronic review request and maintain all paper forms at the agency level.

Transition Plan Review Process

Clinical Review is the process by which initial and ongoing eligibility for LTSE is determined through periodic Utilization Review. The information required for LTSE Transition Plans includes:

- Employer
- Position
- Client hourly wage
- Client hours worked
- Hours of LTSE support
- Nature of LTSE support
- Fade out plan
- LOCUS assessment within 1 year with LOCUS at or above 17
- Qualifying Axis I or II diagnosis within 1 year
 - OR verification of involvement with Section 17 Services within 2 years.

Holds

A LTSE Transition Plan will be placed on hold for 5 business days if one of the following events occurs:

- Client employer is not listed, or employment does not meet criteria for competitive employment.

- Client hourly wage is below minimum wage or not provided.
- Hours of LTSE support are not provided or support is over 25% of total hours worked and explanation and fade out plan are not provided.
- Nature of LTSE support is not provided.
- Fade out plan is not provided.
- LOCUS assessment is over 1 year (Initial plan only).
- Qualifying Axis I or II diagnosis not within 1 year.
 - OR verification of involvement with Section 17 Services not within 2 years (Initial plan only).

Administrative Close

A LTSE Transition Plan will be Administratively Closed if one of the following events occurs:

- Transition Plan has been on HOLD for information for more than 10 business days.
- Transition Plan information is for another client.

Wage Change

- If wages change between LTSE Transition Plan submissions, LTSE providers can call or e-mail the LTSE clinical Lead to report the change in wage.
- If wage documents in LTSE Invoice does not correspond to wage reported in LTSE Transition Plan the INVOICE will be put on HOLD for provider to contact the LTSE Invoicing Lead

Download Notification

- Providers will be notified of the status of their transition plan submissions through the Download Notification feature. More information about this feature can be found in Appendix A of the Provider Manual.
- Download Notifications should be checked on a regular basis to ensure providers are getting any notes/decisions about their submissions.

*Note: Detailed, step-by-step instructions for creating and entering reviews are available in Appendix B. Instructions below describe requirements that are specific to Long Term Supported Employment Services reviews only. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

A. Initial Courtesy Review Process for Long Term Supported Employment Services - Transition Plan:

1. Administrative Page: Please fill out the “Date Worker Assigned” field as the date that the Vocational Specialist will begin provided MH-LTSE services to client.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Administrative

Organization:

Authorization Type:

Status: New

Do you know the service start date?

Start Date for Current Authorization Request: 01 00 AM

This Request is:

Request Submitted:

Request Submitted Date: 04/13/2016

Review Type:

Category of Service:

Location Address:

Date of Referral: 09 30 AM

Location at time of Referral:

Date Case Worker Assigned:

Date Seen Face to Face:

<< Previous Save & Continue >>

2. Requesting Agency Page: Please fill out all fields with the contact information for the Vocational Specialist who is providing the services to the client.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id:

Delete Request

<< Previous Save & Continue >>

Requesting Facility/Agency/Clinician

Requesting Facility/Agency Name:

Requesting Staff First Name:

Requesting Staff Last Name:

Requesting Staff Phone (With Area Code):

Requesting Staff E-mail:

Utilization Manager/Supervisor Name:

Utilization Manager/Supervisor Phone:

Utilization Manager/Supervisor E-mail:

Is this agency/individual the treating provider? Yes No

3. Diagnostic Assessment Page: Fill out the “Date of Diagnostic Assessment” (within the past 12 months), the primary diagnosis and any other diagnosis (this information should be the same information found on the Diagnostic Intake form).

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Diagnostic Assessment

Date of Diagnostic Assessment:

Diagnostic Information

Primary Diagnosis: ICD10 Search

Diagnosis: ICD10 Search

Diagnosis: ICD10 Search

Diagnosis: ICD10 Search

Diagnosis: ICD10 Search

Other Medical Conditions:

<< Previous Save & Continue >>

4. Symptoms/Behaviors Page: Fill out the “Date LOCUS Completed (most recent “LOCUS Composite Score”, and “Agency Involvement” fields.

Member Information Guardian Information Administrative Requesting Agency Diagnostic Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS	APS Case Id: Delete Request	<< Previous Save & Continue >>
Symptoms/Behaviors Summary (Required For Section 17 Only)		
Has member become homeless or at risk of losing his or her current residence? ---Select---		
Is member causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior? ---Select---		
Is member at great risk of arrest because of behavior which results from his or her psychiatric diagnosis, or is presently incarcerated because of such behavior? ---Select---		
Does member present a clear risk of harming self or others without community supportive services? ---Select---		
Does member manifest great difficulty in caring for self, posing a threat to his or her life or limb without community support services? ---Select---		
Would member deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt community services? ---Select---		
Assessment Tool		
Date LOCUS Completed(Most Recent): <input type="text"/>		
Risk of Harm : ---Select---		
Functional Status : ---Select---		
Co-Morbidity : ---Select---		
LOCUS Composite Score : <input type="text"/>		
Caregiver questionnaire: ---Select---		
RATER ID# : <input type="text"/>		
Level of Stress : ---Select---		
Level of Support : ---Select---		
Treatment /Recovery Hist. : ---Select---		
Attitude/Engagement : ---Select---		
LOCUS Level of Care : ---Select---		
ASA M Level: ---Select---		
CHAT Score : ---Select---		

5. Clinical Indicators Page: Fill out the “Thought, Attention, and Cognition” section as applicable

Member Information Guardian Information Administrative Requesting Agency Diagnostic Assessment Services Requested Symptoms/Behaviors Psychiatric Medications Clinical Indicators Treatment and Service RDS Treatment Plan Additional Reporting Data Transition Discharge Plan Additional Info Submit To APS	Clinical Indicators Justifying Service Request	<< Previous Save & Continue >>
Thought, Attention And Cognition		
	Current Severity (None, Mild, Moderate, Severe)	History of Severity (Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years)
Decreased Concentration :	None	---Select---
Dementia :	None	---Select---
Disorganized Thinking :	None	---Select---
Distractible :	None	---Select---
Hallucinations :	None	---Select---
Paranoid :	None	---Select---
Poor Judgment :	None	---Select---
Thought Disorder :	None	---Select---

6. Treatment Plan Page:
- Fill out the “Individual Treatment Plan” as applicable.
 - Fill in the “Treatment Plan Goals” using the “Add New Goal” link. Please complete all sections including “Services to be provided” (1x1 job coaching, telephone contacts etc.), “Frequency of Services” (weekly, biweekly, PRN, etc.), “Duration of Services” (6/12 months), and “Provider of Services” (please enter the name of the individual providing the service NOT the name of the agency).

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: []
Delete Request [] << Previous Save & Continue >>

Individual Treatment Plan

Describe Member's Strengths and Skills: Positive family network
Positive personal skills
Interest in work/volunteer activity
Realistic, positive expectations and goals for future
Good problem-solving skills/ able to seek help when needed
Spiritual/cultural involvement
Natural support
Good physical health/self-care
Stable home setting
Involvement in social systems (family/friends)
Good self-awareness/self-understanding
Other
Consumer's strengths are incorporated into the treatment plan

Is the Member/Caregiver Involved in Forming the Treatment Plan? ☐ Yes ☐ No
List those involved with the development of the plan: []

Member's Expectation of Treatment and Perception of Needs: []

Family/Caregiver's Expectation of Treatment and Perception of Member's Needs: []

Disabilities and Accommodations Required For the Delivery of the Service: []

Justification for Not Addressing Needs Identified in the Assessment: []

Unmet Needs: []

Potential Barriers to Treatment: []

Criteria for Discharge: []

Is Substance Abuse an Issue? ☐ Yes ☐ No
Type of Substance: []
Amount/Frequency of Use: []
Length of Use/Last Use: []
Date Current Treatment Plan was Developed: []
Date Next Treatment Plan is to be Developed: []
Comments: []

Treatment Plan Goals

Add Treatment Plan Goal [] Add New Goal []

Treatment Plan Goals
Problem Statement: []
Treatment or Rehabilitation Goal: []
Target Date: []
Frequency of Services: []
Provider of Services: []
Services to be provided: []
Duration of Services: []

<< Previous Save & Continue >>

7. Additional Reporting Data Page:

- Section I – Complete the questions related to Vocational and Employment Status as appropriate and relevant (use drop down box - how many hours employed-ft/pt, etc.).
- Section II – FYI some sections will say “PASRR Level II” as a heading – enter the client’s provider information, mental status information, functional capacities evaluation, etc. (This information can be found on the Diagnostic Intake form.)

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Additional Required Reporting Data

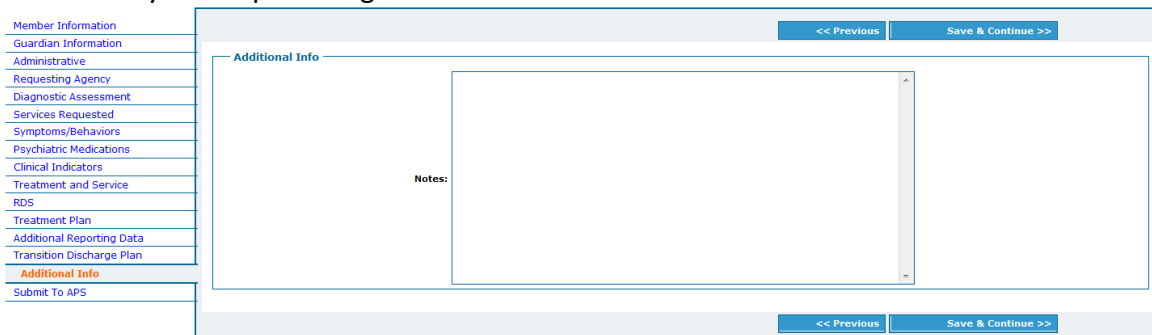
Current Living Situation: Select
Other Living Situation: []
Does the Member Receive a Rent Subsidy? No
Current Vocational/Employment Status: Select
Other Employment Status: []
Does the Member Receive Vocational Rehab Services? No
Was the Member involved with the legal system/ police within the last 6 months? Unknown
Since the last authorization period has the Member missed a significant number of days of school? Unknown

PASRR Level II

Current Physician(S)

Name	Fax	Phone	Ext.
[]	[]	[]	[]
[]	[]	[]	[]
[]	[]	[]	[]

8. Additional Information Page: In this section, please include all additional information that has not already been included in the “Treatment Plan” Section.
- Is the client a Class Member?
 - Employer Type (i.e. Non-Provider Business, Temp Agency, Self-Employed, CRP)
 - Where is the client working?
 - Is this a competitive employment position as defined by Maine OAMHS MH-LTSE policy? If not, please explain.
 - What is client’s job title?
 - How long has your client been working at this position?
 - Does your client have plans to change jobs?
 - Is client receiving any job development support in addition to MH-LTSE? If yes, please explain (who is providing it and why).
 - What are the material and substantial duties of this client’s job?
 - What does LTSE support do to help this client?
 - How many hours a week is client working? (Please be specific.)
 - How many hours of MH-LTSE job support are you providing per week? (Please be specific.)
 - Does the amount of MH-LTSE support equate to more than 25% of the client’s actual work hours? If so, please explain and show a schedule demonstrating how you plan to decrease the amount of MH-LTSE support you are providing.



B. Courtesy Continued Stay Review Process for Long Term Supported Employment Services -Transition Plan:

1. Diagnostic Assessment Page: Please update as appropriate.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Diagnostic Assessment

Date of Diagnostic Assessment :

Diagnostic Information

Primary Diagnosis : ICD10 Search

Diagnosis : ICD10 Search

Diagnosis : ICD10 Search

Diagnosis : ICD10 Search

Diagnosis : ICD10 Search

Other Medical Conditions :

<< Previous Save & Continue >>

2. Symptoms/Behaviors Page: Fill out the “Date LOCUS Completed (most recent)”, “LOCUS Composite Score”, and “Agency Involvement” fields.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id:
Delete Request

Symptoms/Behaviors Summary (Required For Section 17 Only)

Has member become homeless or at risk of losing his or her current residence?

Is member causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior?

Is member at great risk of arrest because of behavior which results from his or her psychiatric diagnosis, or is presently incarcerated because of such behavior?

Does member present a clear risk of harming self or others without community supportive services?

Does member manifest great difficulty in caring for self, posing a threat to his or her life or limb without community support services?

Would member deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt community services?

Assessment Tool

Date LOCUS Completed(Most Recent):

Risk of Harm : Level of Stress :

Functional Status : Level of Support :

Co-Morbidity : Treatment/Recovery Hist. :

LOCUS Composite Score : Attitude/Engagement :

Caregiver questionnaire: LOCUS Level of Care :

RATER ID # : ASAM Level:

CHA T Score :

3. Clinical Indicators Page: Please update all information in the “Thought, Attention and Cognition” section as appropriate.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Clinical Indicators Justifying Service Request

Thought, Attention And Cognition

	Current Severity (None, Mild, Moderate, Severe)	History of Severity (Within 7 days; Within 8-30 days; Within 3-12 months; Within 1-10 years; 10+ years)
Decreased Concentration :	None	---Select---
Dementia :	None	---Select---
Disorganized Thinking :	None	---Select---
Distractible :	None	---Select---
Hallucinations :	None	---Select---
Paranoid :	None	---Select---
Poor Judgment :	None	---Select---
Thought Disorder :	None	---Select---

4. Treatment Plan Page:

- a. Update the “Individual Treatment Plan” as applicable.
- b. Fill in the “Treatment Plan Goals” using the “Add New Goal” link. Please complete all sections including “Services to be provided” (1x1 job coaching, telephone contacts etc.), “Frequency of Services” (weekly, biweekly, PRN, etc.), “Duration of Services” (6/12 months), and “Provider of Services”

(please enter the name of the individual providing the service NOT the name of the agency).

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: [Field]
Delete Request [Button] << Previous Save & Continue >>

Individual Treatment Plan

Describe Member's Strengths and Skills : **Positive family network**
Positive family network
Interest in work/volunteer activity
Realistic, positive expectations and goals for future
Good problem-solving skills/ able to seek help when needed
Spiritual/Cultural involvement
Good physical health/self-care
Good physical health/self-care
Stable home setting
Good self-awareness/self-understanding
Good self-awareness/self-understanding
Other
Consumer's strengths are incorporated into the treatment plan

Is the Member/Caregiver Involved in Forming the Treatment Plan? ☐ Yes ☐ No

List those involved with the development of the plan : [Field]

Member's Expectation of Treatment and Perception of Needs : [Field]

Family/Caregiver's Expectation of Treatment and Perception of Member's Needs : [Field]

Disabilities and Accommodations Required For the Delivery of the Service : [Field]

Justification for Not Addressing Needs Identified in the Assessment : [Field]

Unmet Needs : [Field]

Potential Barriers to Treatment : [Field]

Criteria for Discharge : [Field]

Is Substance Abuse an issue? ☐ Yes ☐ No

Type of Substance : [Field]

Amount/Frequency of Use : [Field]

Length of Use/Last Use : [Field]

Date Current Treatment Plan was Developed : [Field]

Date Next Treatment Plan is to be Developed : [Field]

Comments : [Field]

Treatment Plan Goals

Add New Goal [Button]

Treatment Plan Goals
Problem Statement : [Field]
Treatment or Rehabilitation Goal : [Field]
Target Date : [Field]
Frequency of Services : [Field]
Provider of Services : [Field]
Date : [Field]

5. Additional Reporting Data Page:

- Section I – Update the questions related to Vocational and Employment Status as appropriate and relevant.
- Section II – FYI some sections will say “PASRR Level II” as a heading – please update these as appropriate and relevant.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

<< Previous Save & Continue >>

Additional Required Reporting Data

Current Living Situation : ----- Select -----
Other Living Situation : [Field]

Does the Member Receive a Rent Subsidy? : No

Current Vocational/Employment Status : ----- Select -----
Other Employment Status : [Field]

Does the Member Receive Vocational Rehab Services? : No

Was the Member involved with the legal system/ police within the last 6 months? : Unknown

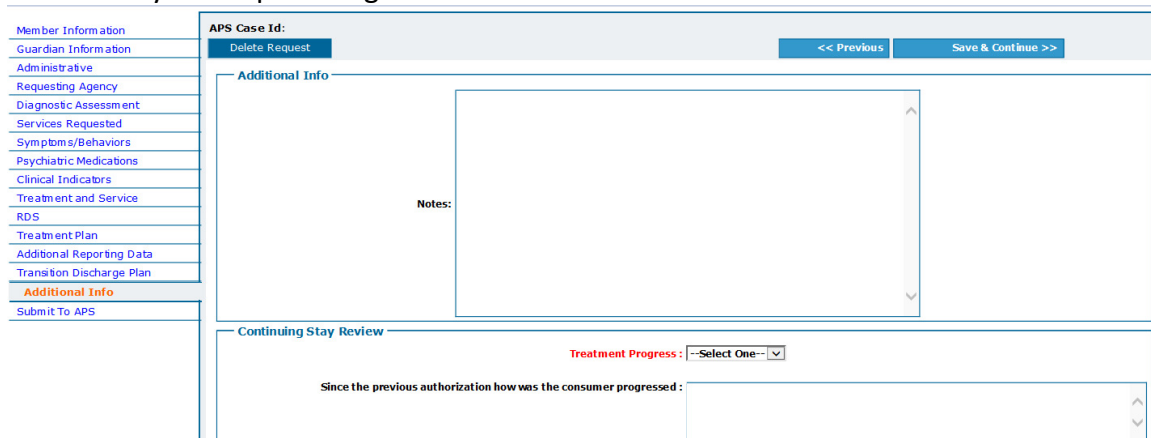
Since the last authorization period has the Member missed a significant number of days of school? : Unknown

PASRR Level II

Current Physician(S)

Name	Fax	Phone	Ext.
[Field]	[Field]	[Field]	[Field]
[Field]	[Field]	[Field]	[Field]
[Field]	[Field]	[Field]	[Field]

6. **Additional Information Page:** In this section, please include the following required information if it has not already been included in the “Treatment Plan” Section.
- Is the client a Class Member?
 - Employer Type (i.e. Non-Provider Business, Temp Agency, Self-Employed, CRP)
 - Where is the client working?
 - Is this a competitive employment position as defined by Maine OAMHS MH-LTSE policy? If not, please explain.
 - What is client’s job title?
 - How long has your client been working at this position?
 - Does your client have plans to change jobs?
 - Is client receiving any job development support in addition to MH-LTSE? If yes, please explain (who is providing it and why).
 - What are the material and substantial duties of this client’s job?
 - What does LTSE support do to help this client?
 - How many hours a week is client working? (Please be specific.)
 - How many hours of MH-LTSE job support are you providing per week? (Please be specific.)
 - Does the amount of MH-LTSE support equate to more than 25% of the client’s actual work hours? If so, please explain and show a schedule demonstrating how you plan to decrease the amount of MH-LTSE support you are providing.



C. Discharge Instructions for Long-Term Supported Employment Services - Transition Plan:

- Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from REHAB services.
- Complete all fields in red.

Discharge Info

APS Case Id: Member ID: Member Name:

Services Discharged:	Service code	Description	Billing Provider ID	Start date	End date	Last Updated	Submitted By
<input type="checkbox"/>							

Discharge Date:

Was this Patient admitted involuntarily? : ☐ Yes ☐ No

If this admission was involuntary, did this admission convert from involuntary to voluntary? : ☐ Yes ☐ No ☐ N/A

Reason(s) for Discharge:

Change in Level Of Care:

Anticipated Step Down Service:

Service	Anticipated Date of First Appointment	Service	Anticipated Date of First Appointment
<input type="checkbox"/> Natural Supports	<input type="text"/>	<input type="checkbox"/> 6SMBN	<input type="text"/>
<input type="checkbox"/> Respite	<input type="text"/>	<input type="checkbox"/> Adult HomeBased Services	<input type="text"/>
<input type="checkbox"/> AA/NA	<input type="text"/>	<input type="checkbox"/> DLSS	<input type="text"/>
<input type="checkbox"/> Peer Support	<input type="text"/>	<input type="checkbox"/> Substance Abuse Tx	<input type="text"/>
<input type="checkbox"/> Outpatient	<input type="text"/>	<input type="checkbox"/> Crisis Services	<input type="text"/>
<input type="checkbox"/> Groups	<input type="text"/>	<input type="checkbox"/> Crisis Unit	<input type="text"/>
<input type="checkbox"/> Psychiatric/Med. Mgt.	<input type="text"/>	<input type="checkbox"/> Foster/Child Welfare	<input type="text"/>
<input type="checkbox"/> Case Management/C.I.	<input type="text"/>	<input type="checkbox"/> Adult Protective	<input type="text"/>
<input type="checkbox"/> Section 24	<input type="text"/>	<input type="checkbox"/> Supported Nursing Facility	<input type="text"/>
<input type="checkbox"/> Day Treatment	<input type="text"/>	<input type="checkbox"/> Medical Hospitalization	<input type="text"/>
<input type="checkbox"/> ACT/I.C.I.	<input type="text"/>	<input type="checkbox"/> Residential Treatment	<input type="text"/>
<input type="checkbox"/> Corrections	<input type="text"/>	<input type="checkbox"/> Other	<input type="text"/>

Treatment Progress :

Living Situation Upon Discharge:

If the Member had a CI, ACT, or CRS Provider, did the Hospital obtain the Member's ISP from their CI, ACT, or CRS Provider? ☐ Yes ☐ No ☐ N/A

If the Member had a CI, ACT, or CRS Provider, did the Hospital invite the Member's CI, ACT, or CRS Provider to participate in treatment and/or discharge planning? ☐ Yes ☐ No ☐ N/A

If the Member had a CI, ACT, or CRS Provider who was invited to participate in treatment and/or discharge planning, did the CI, ACT, or CRS Provider actually participate in treatment and/or discharge planning? ☐ Yes ☐ No ☐ N/A

Plan for Transition Discharge :

Long Term Supported Employment Services - INVOICES

The following KEPRO processes are required for:

1. Long Term Supported Employment Services INVOICES

The KEPRO processes are:

- A. Initial Courtesy Review (ICR)
- B. Courtesy Continued Stay Review (CCSR)

Introduction

KEPRO is contracted by the Department of Health and Human Services to provide prior authorization, utilization review and invoice processing for Long Term Supported Employment Services (LTSE). In order to be reimbursed for LTSE services, providers must follow all KEPRO as well as DHHS requirements for this service. Please note - KEPRO does not require LTSE providers to submit any paper forms to substantiate the information entered in the electronic request. KEPRO will not require client signatures on transitions plans or invoices. Providers should submit an electronic review request and maintain all paper forms at the agency level.

Invoice Review Process

Invoice Review is the process by which billing information is reviewed using contract information and transition plans in order to assess whether invoices have:

- Enough contract money on the current fiscal year
- Enough units from authorized transition plan
- Client hourly wage
- Client hours worked
- Appropriate date range (one invoice per month)

Holds

An Invoice will be placed on HOLD for 5 business days if any of the following events occurs:

- Client hourly wage does not match what is listed in the transition plan
- Client hourly wage has changed from previous invoice and provider has not contacted the LTSE Clinical Lead to indicate the new wage
- Client hourly wage is below minimum wage

Administrative Close

An Invoice will be Administratively Closed if one of the following events occurs:

- Billing dates encompass more than one month
- Transition plan number is that of another member
- Transition plan has expired or is out of units
- Client hourly wage and rate are not entered in the correct format

- Any of the billing data is in the incorrect fields of the goal section of the **Treatment Plan** page.
- The agency has run out of contract dollars for the fiscal year

Billing Process

- Invoice submissions to KEPRO should be submitted no more than 30 days past the last billing day. For instance, billing for March 2012 needs to be submitted no later than April 30, 2012.
- Processed invoices are emailed on Monday to the Department and the designated contact person within each agency, if requested.
- Payments can take up to six weeks to receive. If it has been more than six weeks, please contact Jennifer Adams at jadams@KEPROhealthcare.com.

Download Notifications

- Providers will be notified of the status of their invoice through the Download Notification feature in KEPRO CareConnection. You must have UM access (as opposed to DSP access) in order to view the Download Notifications.
- More information about this feature can be found in Appendix A of the Provider Manual.
- Download Notifications should be checked on a regular basis to ensure providers are getting any notes and/or decisions about their submissions.

Long-Term Supported Employment – Invoice Instructions for KEPRO CareConnection®

Invoice Submission Overview

1. Providers submit an invoice to KEPRO via KEPRO CareConnection®.
2. Invoices are to be submitted by the last day of the month for the previous month of service.
3. KEPRO CareConnection® Overview:
 - a. 1st Invoice- Create an Initial Courtesy Review by copying the approved transition plan. Choose procedure code: 100-219 INVOICE ONLY-LTSE.
 - b. 2nd and ongoing invoices: Use the EXT function in KEPRO CareConnection® to create a Courtesy Continued Stay Review by extending (EXT) the last invoice for that client to create the new invoice.
 - c. The date that the invoice request is entered into KEPRO CareConnection® is listed as the authorization “Start Date” in the request. The Date Range of Service will then be reviewed and utilized elsewhere.
 - d. Units- The number of units being billed for that month for that client. 1 unit=1 hour.

- e. Billed Rate, Date Range of service, Authorization Number, and Vendor ID number will also be entered into KEPRO CareConnection® in each invoice.

The provider will only be paid for service provided within the authorized date range, for up to the number of units authorized and within the maximum contracted dollar amount for LTSE for that provider.

**Detailed directions with screen shots are available. Contact Jen Adams at jadams@KEPROhealthcare.com.*

Entering the Invoice in KEPRO CareConnection®:

If this is the first Invoice, please have on hand your originally authorized KEPRO Case ID for the transition plan. If this is a second or ongoing Invoice, please have on hand the KEPRO Case ID of the most recently authorized **Invoice**.

1. Under the **Search Request** screen, enter the KEPRO Case ID (based on the information above) and click **Search**.
 - a. If this is the first invoice for this member, click the **COPY** link. If this is a second or ongoing invoice, click the **EXT** link.
 - b. Record the new KEPRO Case ID number for future reference.
2. Administrative Page: If this is the first invoice, please follow the next set of instructions for completing the request. If this is a second or ongoing invoice, much of this information will already be filled out for you.
 - a. Under **Authorization Type**, select **Initial Courtesy Review** if this is the first invoice. Otherwise, **Courtesy Continued Stay Review** will already be highlighted for you.
 - b. Fill out the **Start Date** with the current date.
 - i. Under **Review Type**, choose **Adult Mental Health**.
 - ii. Under **Category of Service**, choose **Long-Term Supported Employment**.

Member Information	APS Case Id:	<< Previous	Save & Continue >>
Guardian Information			
Administrative	Administrative		
Requesting Agency	Organization : APS Healthcare Maine Testing Authorization Type : Initial Courtesy Review (CR) Status : New Do you know the service start date? Yes Start Date for Current Authorization Request : 04/15/2016 01 00 AM This Request is : Routine Request Submitted : Electronically Request Submitted Date : 04/15/2016 Review Type : Adult Services Category of Service : <ul style="list-style-type: none"> Community Integration Intensive Case Management Assertive Community Treatment Daily Living Support Services Skills Development Day Supports Specialized Group Services Crisis Support Services Hospital Services - Acute Home Based Group Psychotherapy Medication Management Psychotherapy PNMI Family PsychoEducational Community Rehabilitation Services Long Term Supported Employment Baxter Fund Services Dorothea Dix/Riverview RLS - Appendix C Partial Hospitalization Intensive Outpatient Program Home and Community Benefits for Adults Behavioral Health Homes 		
Diagnostic Assessment			
Services Requested			
Symptoms/Behaviors			
Psychiatric Medications			
Clinical Indicators			
Treatment and Service			
RDS			
Treatment Plan			
Additional Reporting Data			
Transition Discharge Plan			
Additional Info			
Submit To APS			

3. Requesting Agency Page: Please fill out all fields with your contact information.

Member Information	APS Case Id:	Delete Request	<< Previous	Save & Continue >>
Guardian Information				
Administrative	Requesting Facility/Agency/Clinician			
Requesting Agency	Requesting Facility/Agency Name : APS Healthcare Maine Testing Requesting Staff First Name : Train Requesting Staff Last Name : UM Requesting Staff Phone (With Area Code) : (123) 456-7890 Requesting Staff E-mail : Utilization Manager/Supervisor Name : Utilization Manager/Supervisor Phone : Utilization Manager/Supervisor E-mail : Is this agency/individual the treating provider? <input checked="" type="radio"/> Yes <input type="radio"/> No			
Diagnostic Assessment				
Services Requested				
Symptoms/Behaviors				
Psychiatric Medications				
Clinical Indicators				
Treatment and Service				
RDS				
Treatment Plan				
Additional Reporting Data				
Transition Discharge Plan				
Additional Info				
Submit To APS				

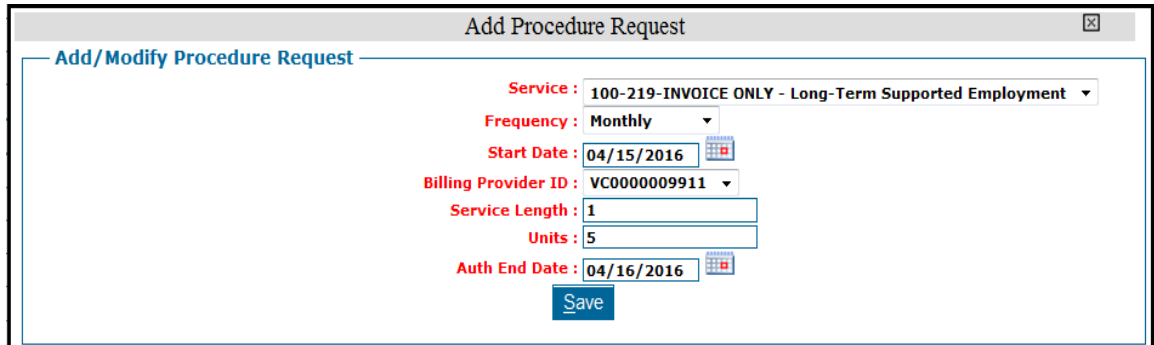
4. Services Requested Page:

- If this is the first invoice, choose **Add New Procedure Request**. If this is the second or ongoing invoice, the service code will already appear. Select the **Modify** link.

Member Information	APS Case Id:	<< Previous	Save & Continue >>
Guardian Information			
Administrative			
Requesting Agency			
Diagnostic Assessment			
Services Requested	Procedures Requested Add New Procedure Request There are no services added.		
Symptoms/Behaviors			

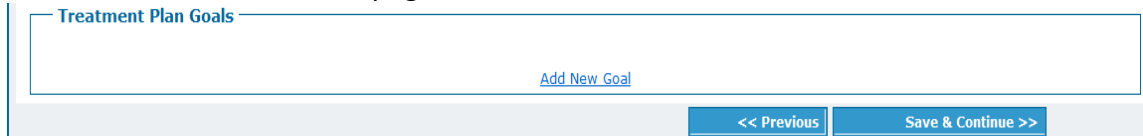
- Choose the **100-219 – INVOICE ONLY - LTSE** code under the **Service** drop-down.
- Choose the **Frequency** as monthly.
- Choose the **Billing Provider ID number** (this is the Vendor Code only).

- e. The **Service Length** will automatically populate, as will the **Units**. Place your cursor in the **Units** box, and re-enter as the number of number of units being billed. *Note - this field only accepts whole integers, so you may have to round up or down. The actual units used will be represented elsewhere.*
- f. The last field is **Auth End Date**. Please enter the current date.



5. Treatment Plan Page: To enter: Billed Rate, Date Range of service, Authorization number, and Total Amount of Invoice:

- a. At the bottom of the page, select **Add New Goal**.



- b. In the **Treatment or Rehabilitation Long-Term Goal** box, type the following sentence: Long-Term Supported Employment Invoice.
- c. In the red **Target Date** box, enter the current date.
- d. In the **Treatment or Rehabilitation Short Term Goals** box, type the following (replacing the zeroes with the actual rate): **Clients Hourly Rate: 0.00**
- e. In the lower **Progress since last review** box, type the following (replacing the zeroes with the actual number): **Client Hours Worked: 00**
- f. In the **Service to be Provided** box, enter the Authorization number (this is the KEPRO Case ID of the authorized transition plan request that covers the time frame and units being billed). Please enter only the number - no text.
- g. In the **Frequency of Services** box, enter the number of units to be billed. *Note - if you are billing for a fraction of a unit you may enter it in this field with a decimal.*
Examples: 12.5; 7.75; etc.
- h. In the **Duration of Services** box, enter the time frame being billed as the date range of that month. For example, for October 2009 invoicing, enter: 10-01-09 - 10-31-09
- i. In the **Provider of Services** box, please enter the total dollar amount you expect to be paid. Please note - this field will exist as a double-check for both providers and KEPRO staff. KEPRO will submit invoices based on each provider's contracted rate with the Department and available units on the transition plan.

Add Treatment Plan Goal

Treatment Plan Goals

Problem Statement :

Treatment or Rehabilitation Long Term Goal:

LTSE Invoice

Progress since last review:

Target Date:

04/15/2016

Treatment or Rehabilitation Short Term Goals:

Client Hourly Rate: 7.50

Progress since last review:

Client Hours Worked: 60

Target Date:

Interventions

Service to be provided :

111111

Frequency of Services :

5.5

Duration of Services :

03-01-16-3-31-16

Provider of Services :

137.50

Save

6. Additional Information Page: In the **Notes** text box, enter the following:

By submitting this invoice, this provider of LTSE services verifies that this invoiced amount of valid, billable service was provided consistent with all DHHS requirements and that the client's employer, job duties, and wage match what is documented in the Treatment Plan.

[Member Information](#)
[Guardian Information](#)
[Administrative](#)
[Requesting Agency](#)
[Diagnostic Assessment](#)
[Services Requested](#)
[Symptoms/Behaviors](#)
[Psychiatric Medications](#)
[Clinical Indicators](#)
[Treatment and Service](#)
[RDS](#)
[Treatment Plan](#)
[Additional Reporting Data](#)
[Transition Discharge Plan](#)
[Additional Info](#)
[Submit To APS](#)

<< Previous

Save & Continue >>

Additional Info

Notes:

By submitting this invoice, this provider of LTSE services verifies that this invoiced amount of valid, billable service was provided consistent with all DHHS requirements and that the client's employer, job duties, and wage match what is documented in the Treatment Plan.

<< Previous

Save & Continue >>

If this is not the 1st invoice, select **None** below the Additional Information dialog box .
Save and continue, and Submit to KEPRO.

Once approved, KEPRO will submit invoices to the State of Maine who will disburse payment to the provider.

Section 13: Targeted Case Management (TCM) for Children & Adolescents/Young Adults

The following KEPRO processes are required for:

1. TCM Behavioral Health
2. CM Developmental Disabilities

The KEPRO processes are:

- A. Contact for Service Notification
- B. Initial Registration
- C. Continued Stay Reviews
- D. Discharge Review

A. Contact For Service Notification (CFSN) Process for Targeted Case Management:

*Please Note: Detailed, step-by-step instructions for entering Contact for Service Notifications are available in Appendix B. Instructions below describe requirements that are specific to Targeted Case Management CFSNs. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

The Contact for Service Notification (CFSN) is required if the member must wait for service one or more days. Submit a CFSN to KEPRO at the point that a member first contacts the provider or is referred for service. A CFSN is not required if members are assigned to a Case Manager the same day that they are referred. If members are assigned to a service within 24 hours, with no waiting time, the provider may submit an Initial Registration or a Prior Authorization request (as appropriate), without first submitting a Contact for Service Notification.

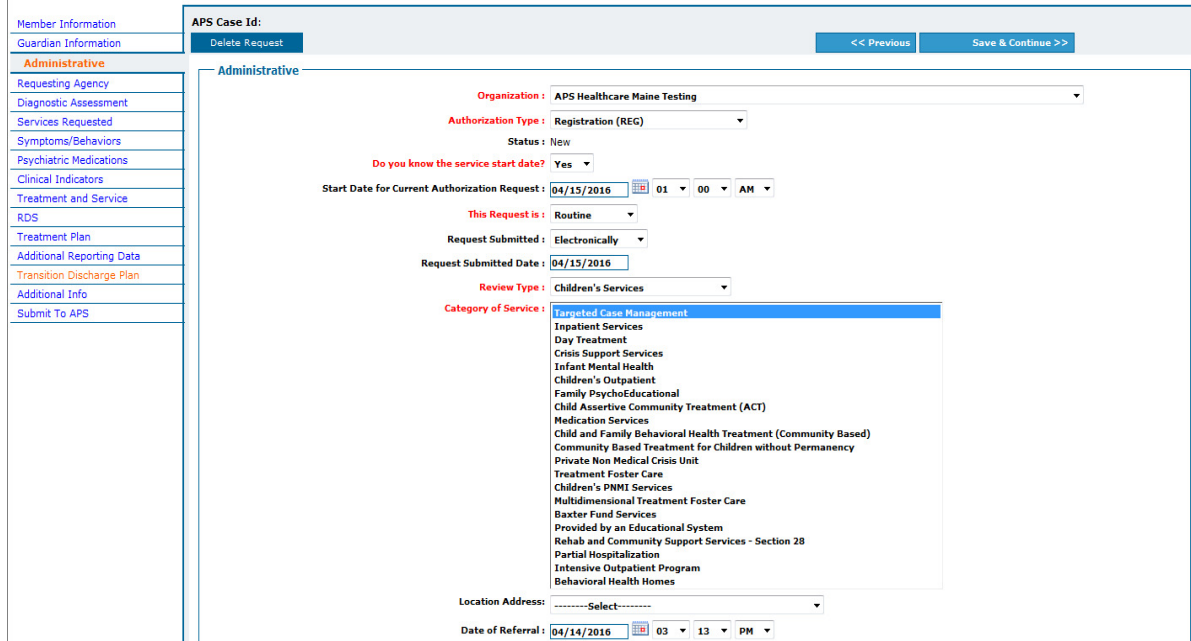
B. Initial Registration (IR) Process for Targeted Case Management

*Please Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Targeted Case Management Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

The Registration is created by using the **COPY** function in KEPRO CareConnection®, using the *last dated Contact for Service Notification for that member*. If there is no CFSN present, create a new review.

1. On the Administrative Page:
 - a. “Start Date for Current Authorization Request” must be the date of the *first* face to face contact

b. “Date of Referral” is the date the member was first referred to the agency.



Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: [Delete Request] [Previous] [Save & Continue]

Administrative

Organization: APS Healthcare Maine Testing

Authorization Type: Registration (REG)

Status: New

Do you know the service start date? Yes

Start Date for Current Authorization Request: 04/15/2016 01:00 AM

This Request is: Routine

Request Submitted: Electronically

Request Submitted Date: 04/15/2016

Review Type: Children's Services

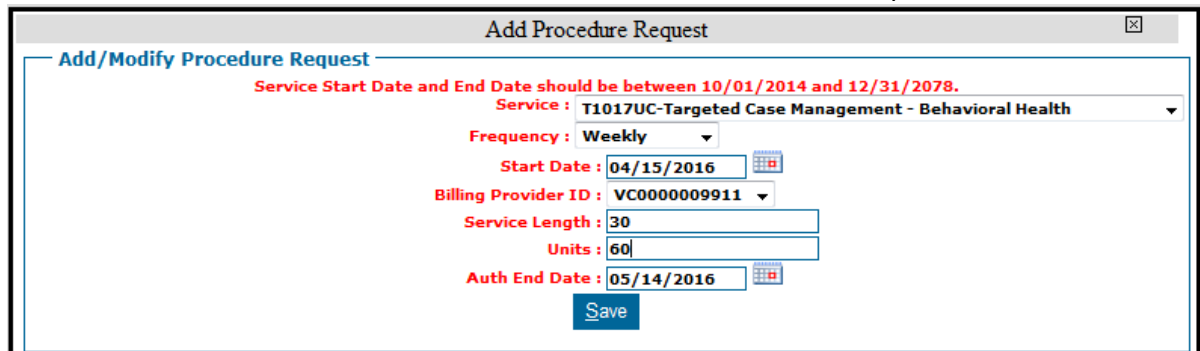
Category of Service: Targeted Case Management

- Inpatient Services
- Day Treatment
- Crisis Support Services
- Infant Mental Health
- Children's Outpatient
- Family PsychoEducational
- Child Asserbtive Community Treatment (ACT)
- Medication Services
- Child and Family Behavioral Health Treatment (Community Based)
- Community Based Treatment for Children without Permanency
- Private Non Medical Crisis Unit
- Treatment Foster Care
- Children's PNMI Services
- Multidimensional Treatment Foster Care
- Baxter Fund Services
- Provided by an Educational System
- Rehab and Community Support Services - Section 28
- Partial Hospitalization
- Intensive Outpatient Program
- Behavioral Health Homes

Location Address: Select

Date of Referral: 04/14/2016 03:13 PM

- On the Services Requested page, select the procedure code that matches that chosen on the initial CFSN, which will remove the member from the wait list reports.



Add Procedure Request

Add/Modify Procedure Request

Service Start Date and End Date should be between 10/01/2014 and 12/31/2078.

Service: T1017UC-Targeted Case Management - Behavioral Health

Frequency: Weekly

Start Date: 04/15/2016

Billing Provider ID: VC0000009911

Service Length: 30

Units: 60

Auth End Date: 05/14/2016

Save

C. Continued Stay Review (CSR) Instructions for Targeted Case Management

*Please Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Targeted Case Management Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

When submitting a CSR for the purpose of aligning it with the consumer's ISP, please make sure to note in the request "Submitted to Align CSR with ISP Date."

- The Guardian Information page must be fully completed and updated if necessary with each CSR.

Member Information

Guardian Information

Administrative

Requesting Agency

Diagnostic Assessment

Services Requested

Symptoms/Behaviors

Psychiatric Medications

Clinical Indicators

Treatment and Service

RDS

Treatment Plan

Additional Reporting Data

Transition Discharge Plan

Additional Info

Submit To APS

APS Case Id:

Delete Request

<< Previous

Save & Continue >>

Guardian Information

Guardian Type/Organization : --Select One--

Guardian First Name :

Guardian Middle Initial :

Guardian Last Name :

Guardian Phone :

Relationship to Member : --Select One--

Guardian Address :

Guardian City :

Guardian State : --Select One--

Zip Code :

Additional Information :

<< Previous

Save & Continue >>

- On the Administrative page, enter the “Start Date for Current Authorization Request” and the “Date Worker Assigned” field (if not already complete).

Member Information

Guardian Information

Administrative

Requesting Agency

Diagnostic Assessment

Services Requested

Symptoms/Behaviors

Psychiatric Medications

Clinical Indicators

Treatment and Service

RDS

Treatment Plan

Additional Reporting Data

Transition Discharge Plan

Additional Info

Submit To APS

APS Case Id:

Delete Request

<< Previous

Save & Continue >>

Administrative

Organization : APS Healthcare Maine Testing

Authorization Type : Continued Stay Review (CCSR)

Status : New

Do you know the service start date? Yes

Start Date for Current Authorization Request : 04/18/2016 01:00 AM

This Request is : Routine

Request Submitted : Electronically

Request Submitted Date : 04/18/2016

Review Type : Children's Services

Category of Service : Targeted Case Management
Inpatient Services
Day Treatment
Crisis Support Services
Infant Mental Health
Children's Outpatient
Family Psychoeducational
Child Assertive Community Treatment (ACT)
Medication Services
Child and Family Behavioral Health Treatment (Community Based)
Community Based Treatment for Children without Permanency
Private Non Medical Crisis Unit
Treatment Foster Care
Children's PNH Services
Multidimensional Treatment Foster Care
Baxter Fund Services
Provided by an Educational System
Rehab and Community Support Services - Section 28
Partial Hospitalization
Intensive Outpatient Program
Behavioral Health Homes

Location Address : -----Select-----

Date of Referral : 03/07/2016 01:00 AM

Location at time of Referral : Community

Date Case Worker Assigned : 03/11/2016

Date Seen Face to Face :

<< Previous

Save & Continue >>

- Requesting Agency Page: You must submit the name of the child’s Case Manager, his or her phone number, email address and supervisor’s name and contact information in this section. If a new case manager is assigned, this information must be updated at the time of the next Continued Stay Review. KEPRO regularly reports the names and contact information of Case Managers and their supervisors to Child Behavioral Health Services.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: [Delete Request] << Previous Save & Continue >>

Requesting Facility/Agency/Clinician

Requesting Facility/Agency Name: APS Healthcare Maine Inc
Requesting Staff First Name: Train
Requesting Staff Last Name: UM
Requesting Staff Phone (With Area Code): (123) 456-7890
Requesting Staff E-mail: []

Utilization Manager/Supervisor Name: []
Utilization Manager/Supervisor Phone: []
Utilization Manager/Supervisor E-mail: []

Is this agency/individual the treating provider? ☒ Yes ☐ No

4. Diagnostic Assessment Page:

- a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis.”

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

Diagnostic Assessment << Previous Save & Continue >>

Date of Diagnostic Assessment: []

Diagnostic Information

Primary Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search
Diagnosis: [] ICD10 Search

Other Medical Conditions: []

<< Previous Save & Continue >>

5. Symptoms/Behavior Page:

- a. **For Behavioral Health TCM Only**- When entering the CAFAS scores, the CAFAS Rater ID must be entered into the “Rater ID” field. Submit the date this CANS/CAFAS was completed in the “Date LOCUS Completed (most recent)” field. Although this field is labeled “LOCUS,” for TCM it is reported as “Date CAFAS/CANS Completed.” For CANS, Life Domain and Child Behavioral/Emotional Needs scores should be entered into the Additional Information section.
- b. For **Developmental Disabilities TCM** - –Enter the CHAT score from the drop down menu located in the Assessment Tool section - you may skip the CAFAS section. Submit the date the CHAT was completed in the “Date LOCUS Completed (most recent)” field. Although this field is labeled “LOCUS”, for TCM it is reported as “Date CHAT Completed”. Any symptoms/ behaviors/ functional impairments that were not able to be reflected in other sections of the request, progress, and brief rationale for continuation of service should be included on the Additional Info page.
- c. For all TCM services, please select any “Agency Involvement” and “Family/Social Involvement”.

6. Psychiatric Medications Page: Complete as applicable.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: [Delete Request] << Previous Save & Continue >>

Psychiatric Medications

Is the member currently prescribed any psychiatric medications? Yes ☐ No ☐

If yes, does member take medications as prescribed? Yes ☐ No ☐

Did you notify the member's PCP of this medication? Yes ☐ No ☐

Is the Member's PCP prescribing psychiatric medications to the member? Yes ☐ No ☐ N/A ☐

List Medications

Medication Type	Medication Name	Action
Add Medication		

Additional Medication Info (Non-Prescribed, Vitamins, Supplements, Dosage, Frequency, Etc.)

Notes:

7. Clinical Indicators Page: Please complete this page by choosing the “Current Severity” and “History of Severity” for each indicator as applicable. The most current symptoms and behaviors that a member has experienced over the previous authorization period should be reflected here.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit To APS

APS Case Id: [Delete Request] << Previous Save & Continue >>

Clinical Indicators Justifying Service Request

Risk/Danger To Self/Others

	Current Severity (None, Mild, Moderate, Severe)	History of Severity (Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years)
Aggressiveness :	None	---Select---
Fire Setting :	None	---Select---
Assaultive :	None	---Select---
Homicidal Attempt :	None	---Select---
Homicidal Ideation :	None	---Select---
Self Care Deficit :	None	---Select---

8. Individual Treatment Plan Page: Fill out the “Individual Treatment Plan” as applicable. Complete the “Treatment Plan Goals” as related to TCM roles/responsibilities. The “Criteria for Discharge” section should be updated at every request and reflect the stated Targeted Case Management goals.

Member Information
Guardian Information
Administrative
Requesting Agency
Diagnostic Assessment
Services Requested
Symptoms/Behaviors
Psychiatric Medications
Clinical Indicators
Treatment and Service
RDS
Treatment Plan
Additional Reporting Data
Transition Discharge Plan
Additional Info
Submit to APS

APS Case Id: []
Delete Request []

<< Previous Save & Continue >>

Individual Treatment Plan

Describe Member's Strengths and Skills:

Positive family network
Positive peer support
Interest in work/volunteer activity
Realistic, positive expectations and goals for future
Good problem-solving skills/ able to seek help when needed
Spiritual/Cultural involvement
Natural Support
Good physical health/self-care
Stable home setting
Involvement in and live activities/interests
Good self-awareness/self-understanding
Other
Consumer's strengths are incorporated into the treatment plan

Is the Member/Caregiver Involved in Forming the Treatment Plan? ☐ Yes ☐ No

List those involved with the development of the plan: []

Member's Expectation of Treatment and Perception of Needs: []

Family/Caregiver's Expectation of Treatment and Perception of Member's Needs: []

Disabilities and Accommodations Required For the Delivery of the Service: []

Justification for Not Addressing Needs Identified in the Assessment: []

Unmet Needs: []

Potential Barriers to Treatment: []

Criteria for Discharge: []

Is Substance Abuse an issue? ☐ Yes ☐ No

Type of Substance: []

Amount/Frequency of Use: []

Length of Use/Last Use: []

Date Current Treatment Plan was Developed: []

Date Next Treatment Plan is to be Developed: []

Comments: []

Treatment Plan Goals

Add New Goal

<< Previous Save & Continue >>

Treatment Plan Goals - Add Treatment Plan Goal

Problem Statement: []

Target Date: []

Interventions: []

Frequency of Services: []

Duration of Services: []

Provider of Services: []

9. Transition Discharge Plan Page: Please enter in the projected discharged date, any anticipated step down services, and identify the plan for discharge in the "Plan for Transition/Discharge" box.

Member Information	APS Case Id:	Delete Request				<< Previous		Save & Continue >>	
Guardian Information	Transition Discharge Plan								
Administrative	Is Discharge Anticipated During the Authorization Period? <input type="radio"/> Yes <input type="radio"/> No								
Requesting Agency	Projected Date of Transition/Discharge: <input type="text"/>								
Diagnostic Assessment			First Appt. Post Discharge	Day/Mo	First Appt. Post Discharge	Day/Mo			
Services Requested	<input type="checkbox"/> Natural Supports		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 6SM&N	<input type="checkbox"/>			
Symptoms/Behaviors	<input type="checkbox"/> Respite		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Adult HomeBased Services	<input type="checkbox"/>			
Psychiatric Medications	<input type="checkbox"/> AA/NA		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> DLSS	<input type="checkbox"/>			
Clinical Indicators	<input type="checkbox"/> Peer Support		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Substance Abuse Tx	<input type="checkbox"/>			
Treatment and Service	<input type="checkbox"/> Outpatient		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crisis Services	<input type="checkbox"/>			
RDS	<input type="checkbox"/> Groups		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crisis Unit	<input type="checkbox"/>			
Treatment Plan	<input type="checkbox"/> Psychiatric/Med. Mgt.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Foster/Child Welfare	<input type="checkbox"/>			
Additional Reporting Data	<input type="checkbox"/> Case Management/C.I.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Adult Protective	<input type="checkbox"/>			
Transition Discharge Plan	<input type="checkbox"/> Section 24		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Supported Nursing Facility	<input type="checkbox"/>			
Additional Info	<input type="checkbox"/> Day Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Medical Hospitalization	<input type="checkbox"/>			
Submit To APS	<input type="checkbox"/> ACT/I.C.I.		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Residential Treatment	<input type="checkbox"/>			
	<input type="checkbox"/> Corrections		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>			
	Plan for Transition/Discharge: <input type="text"/>								

10. Additional Information Page: Place a short clinical note in the “Additional Information” section indicating any other information you feel would be relevant in supporting the member’s clinical need for Case Management. For **Behavioral Health TCM**, Life Domain and Child Behavioral/Emotional Needs CANS scores should be entered here. For **Developmental Disabilities TCM**, include any symptoms/ behaviors/ functional impairments that were not able to be reflected in other sections of the request. Complete the “Treatment Progress” drop-down.

Member Information	APS Case Id:	Delete Request		<< Previous		Save & Continue >>	
Guardian Information	Additional Info						
Administrative	Notes: <input type="text"/>						
Requesting Agency							
Diagnostic Assessment							
Services Requested							
Symptoms/Behaviors							
Psychiatric Medications							
Clinical Indicators							
Treatment and Service							
RDS							
Treatment Plan							
Additional Reporting Data							
Transition Discharge Plan							
Additional Info							
Submit To APS							
	Continuing Stay Review						
	Treatment Progress: --Select One--						
	Since the previous authorization how was the consumer progressed: <input type="text"/>						

D. Discharge Instructions for Targeted Case Management

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Targeted Case Management Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Fully complete the discharge page. For **Behavioral Health TCM**, complete the “CAFAS” section. For **Developmental Disabilities TCM**, enter the CHAT score and date CHAT completed in the “Plan for Transition Discharge” section.

Section 13: Targeted Case Management - Children with Chronic Medical Care Needs

The following KEPRO processes are required for:

1. Targeted Case Management (TCM) for Children with Chronic Medical Care Needs

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Reviews
- C. Discharge Review

A. Prior Authorization Process for TCM - Children with Chronic Medical Care Needs:

***Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to TCM - Children with Chronic Medical Care Needs Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multiaxial Assessment Page:
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis” fields.
 - b. Fill out any additional Axis I– V information if applicable.
2. Treatment Plan Page:
 - a. Fill out the “Individual Treatment Plan” as applicable.
 - b. Fill in the “Treatment Plan Goals” using the “Add New Goal” link, located at the very bottom of the page. Please identify the overarching problem and needs in the “Problem Statement” box.
3. Transition Discharge Plan Page: Fill out as appropriate. Please note – if you answer “No” to the first question, please select “Other” on the “Anticipated Step Down Service” section in order to move forward.
4. Additional Information Page: Describe the specific functional impairments and how TCM service will assist in addressing needs. If possible, include the name of the provider who assessed the child, and the assessment used to identify the child’s current level of functioning. Please include any additional relevant information which supports the need for Case Management.

B. Continued Stay Review (CSR) Instructions for TCM - Children with Chronic Medical Care Needs:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to TCM - Children with Chronic Medical Care Needs Services Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multiaxial Assessment Page:
 - a. Fill out/update the “Date of Diagnostic Assessment” and “Primary Diagnosis” fields.
 - b. Fill out/update any additional Axis I– V information if applicable.
2. Treatment Plan Page:
 - a. Please complete all relevant fields, especially “Potential Barriers to Treatment” and “Criteria for Discharge”.
 - b. In the “Treatment Plan Goals” section, update existing long–term and short–term goals and identify progress towards goals.
 - c. Add new goals as applicable.
3. Transition Discharge Plan Page: Fill out as appropriate. An update to this page is required at each Continued Stay Review. Please note – if you answer “No” to the first question, please select “Other” on the “Anticipated Step Down Service” section in order to move forward.
4. Additional Information Page: Please include updated information regarding the continued need for the service. If you feel it would be helpful you can provide a narrative regarding the work that has been completed and the activities that are remaining.

C. Discharge Instructions for TCM - Children with Chronic Medical Care Needs:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to TCM - Children with Chronic Medical Care Needs Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 17: Community Support Services

The following KEPRO processes are required for:

1. Community Integration (CI)
2. Assertive Community Treatment (ACT)

The KEPRO processes are:

- A. Contact for Service Notification
- B. Prior Authorization
- C. Continued Stay Reviews
- D. Discharge Review

NOTE: This service can also be provided through Grant Funds. For more information about requesting Grant Funded services, please see the Frequently Asked Questions found on our website at this link: <http://www.qualitycareforme.com/documents/FAQGrantFundedAuths.pdf>

A. Contact For Service Notification (CFSN) Process for Community Support Services:

1. Providers have 1 business day to submit CFSNs to KEPRO for every member on their Community Support Services wait list.
2. The CFSN is a 730 day / 1 unit service authorization.

B. Prior Authorization (PA) Process for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Prior Authorizations and Grant Funded Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Administrative Page:
 - a. "Start Date for Current Authorization Request" must be the date of the *first* face to face contact.
 - b. The "Date of Referral" is the date the consumer was first referred to your agency (it may be the same as the consumer's first contact for service).
 - c. Make sure to select the "Location at Time of Referral".
 - d. Enter "Date Worker Assigned".
2. Multiaxial Assessment Page:
 - a. You must include the "Date of Diagnostic Assessment". The date must be current (within one year).

- b. Enter an eligible “Primary Diagnosis”, any additional diagnoses, and the “Axis V GAF” score. Diagnosis must meet Section 17 eligibility requirements per MaineCare Regulations 17.02-3A.
 3. Symptoms/Behaviors Page:
 - a. Complete the “Symptoms/Behaviors Summary” section at the top of the page to demonstrate eligibility for Section 17 services.
 - b. In the Assessment Tool section, include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - c. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
 4. Psychiatric Medications Page: Although not required, it is helpful to include some information.
 5. Clinical Indicators Page: With specific focus on “Risk/Danger To Self/Others” section.
 6. Complete the RDS page to the best of your knowledge. Detailed instructions for RDS completion can be found on our website at this link:
<http://www.qualitycareforme.com/documents/AdultMHRDSInstr.pdf>
 7. Transition/Discharge Plan Page: **For CI services only**:
 - a. Answer the question “Is Discharge Anticipated during the Authorization Period?” If “yes,” enter the anticipated discharge date in the “Projected Date of Transition/Discharge” box.
 - b. Fill out the rest of the page as applicable.
 8. Additional Information Page: Include any other information relevant to consumer eligibility for Section 17 services. Include a brief clinical description supporting member’s need for services.
- For Community Integration Services only, please include the following:**
- a. Add the reason for referral.
 - b. Identify 1-3 mental health needs and how CI services / LOC would be beneficial in meeting those needs.
 - c. Enter the projected length of stay in service (if not mentioned on the Transition/Discharge Plan page). This can be an actual date or estimated time frame i.e. 12 months, 12-18 months, etc.
- For ACT services only, please include the following:**
- a. Information that demonstrates how member has recently had unsuccessful attempts at outpatient or CIS treatment and/or requires a higher level of care in order to live in the least restrictive environment.

- b. Information that demonstrates how member requires treatment from a multi-disciplinary team including access to treatment 24 hrs/day 7 days wk.

C. Continued Stay Review (CSR) Instructions for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews and Grant Funded Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multiaxial Assessment Page:
 - a. Correct or update if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 17 services and are consistent with the units of service requested.
2. Symptoms/Behaviors Page:
 - a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 17 services.
 - b. In the "Assessment Tool" section, include the "Date LOCUS Completed" (must be current, within one year), LOCUS Subscales, "LOCUS Composite Score", "Level of Care", and "Rater ID#".
 - c. Indicate "Agency Involvement" and "Family/Social Involvement" if applicable.
3. Psychiatric Medications Page: Answer the questions and enter medications, including non-psychiatric medications, if available.
4. Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
5. Complete the Treatment and Service page.
6. RDS Page: Detailed instructions about RDS completion can be found on our website at this link: <http://www.qualitycareforme.com/documents/AdultMHRDSInstr.pdf>
 - a. Complete/Revise the ISP Status at the top of the page.
 - b. Complete/Update the RDS as appropriate.
7. Treatment Plan and Goals Page: Complete all information, consistent with the consumer's ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
8. Complete the Additional Required Reporting Data page.

- a. Identify the specific and measureable criteria for discharge.

9. Complete the Transition Discharge Plan page.

10. Additional Information Page:

- a. Include any additional information needed to demonstrate continued eligibility for Section 17 services and/or to demonstrate that the authorization request is consistent with the consumer's needs.
- b. When submitting a CSR for the purpose of aligning it with the consumer's ISP, note on this page "Submitted to Align CSR with ISP Date."

D. Discharge Instructions for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red and fill in the "Date LOCUS Completed", "LOCUS Composite Score", and "LOCUS Level of Care" fields.

Section 17: Community Rehabilitation Services

The following KEPRO processes are required for:

1. Community Rehabilitation Services

The KEPRO processes are:

- A. Contact for Service Notification
- B. Prior Authorization
- C. Continued Stay Reviews
- D. Discharge Review

NOTE: This service can also be provided through Grant Funds. For more information about requesting Grant Funded services, please see the Frequently Asked Questions found on our website at this link: <http://www.qualitycareforme.com/documents/FAQGrantFundedAuths.pdf>

A. Prior Authorization (PA) Process for Community Rehabilitation Services:

***Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Community Rehabilitation Services Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Administrative Page:

- a. "Start Date for Current Authorization Request" must be the date of the *first* face to face contact.
- b. The "Date of Referral" is the date the consumer was first referred to your agency (it may be the same as the consumer's first contact for service).
- c. Make sure to select the "Location at Time of Referral".
- d. Enter "Date Worker Assigned".

2. Multiaxial Assessment Page:

- a. You must include the "Date of Diagnostic Assessment". The date must be current (within one year).
- b. Enter an eligible "Primary Diagnosis", any additional diagnoses, and the "Axis V GAF" score. Diagnosis must meet Section 17 eligibility requirements per MaineCare Regulations.

3. Symptoms/Behaviors Page:

- a. In the Assessment Tool section include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - b. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
4. Although not required, it is helpful to include some information on the Psychiatric Medications and the Clinical Indicators pages.
5. Complete the RDS page to the best of your knowledge. Detailed instructions about RDS completion can be found on our website at this link:
<http://www.qualitycareforme.com/documents/AdultMHRDSInstr.pdf>
6. On the Treatment Plan page choose at least one strength or skill from the top box.
7. Transition/Discharge Plan Page:
 - a. “Is Discharge Anticipated During the Authorization Period?” Answer yes or no. If yes, enter in the “Projected Date of Transition/Discharge” as mmddyyyy.
 - b. “Plan for Transition/Discharge” box- Write a brief explanation regarding planned length of stay and discharge criteria.
8. Additional Information Page: Include any other information relevant to consumer eligibility for Section 17 services. Include a brief clinical description supporting member’s need for this level of service. Why is a lower level of care not sufficient? What is the discharge plan for the member?

B. Community Rehabilitation Services Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Community Rehabilitation Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

11. Multiaxial Assessment Page:
 - a. Corrected or updated if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 17 services and are consistent with the units of service requested.
12. Symptoms/Behaviors Page:
 - a. In the Assessment Tool section include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.

- b. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
- 13. Psychiatric Medications Page: Answer the questions and enter medications, if available.
- 14. Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
- 15. Complete the Treatment and Service page.
- 16. RDS Page: Detailed instructions about RDS completion can be found on our website at this link: <http://www.qualitycareforme.com/documents/AdultMHRDSInstr.pdf>
 - a. Complete/Revise the ISP Status at the top of the page.
 - b. Complete/Update the RDS as appropriate.
- 17. Treatment Plan Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
- 18. Complete the Additional Required Reporting Data page.
- 19. Complete the Transition Discharge Plan page.
 - a. Identify the specific and measureable criteria for discharge.
- 20. Additional Information Page:
 - a. Include any additional information needed to demonstrate continued eligibility for Section 17 services and/or to demonstrate that the authorization request is consistent with the consumer’s needs.
 - b. When submitting a CSR for the purpose of aligning it with the consumer’s ISP, note on this page “Submitted to Align CSR with ISP Date.”

C. Community Support Rehabilitation Discharge Instructions:

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Community Rehabilitation Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

- 1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
- 2. Complete all fields in red.
- 3. Complete the “Date LOCUS Completed”, “LOCUS Composite Score”, and “LOCUS Level of Care” fields.

Section 17: Community Support Services

The following KEPRO processes are required for:

1. Specialized Group Services - WRAP
2. Specialized Group Services - Recovery Workbook
3. Specialized Group Services - TREM
4. Specialized Group Services - DBT

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Reviews
- C. Discharge Review

A. Initial Registration Process for Community Support Group Services:

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Community Support Group Services Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

The following pages must be completed for all Community Support Group Services Registrations:

- a. Administrative Page
- b. Requesting Agency Page
- c. Services Requested Page

B. Continued Stay Review (CSR) Instructions for Community Support Group Services:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Community Support Group Services Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Administrative Page:
 - a. The “Date of Referral” is the date the consumer was first referred to your agency (it may be the same as the consumer’s first contact for service).
 - b. Make sure to select the “Location at Time of Referral”.
2. Multiaxial Assessment Page:

- a. Update if needed. The “Date of Diagnostic Assessment” must be current within one year.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 17 services and are consistent with the units of service requested.
3. Symptoms/Behaviors Page:
 - a. Update the “Symptoms/Behaviors Summary” to demonstrate continued eligibility for Section 17 services.
 - b. In the Assessment Tool box, complete/update the “LOCUS Date Completed (must be current, within one year)”, LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#” fields. The date of LOCUS assessment and other LOCUS information must be current within one year.
 - c. Indicate “Agency Involvement” and “Family/Social Involvement”.
4. On the Psychiatric Medications Page: Answer the questions and enter medications, if available.
5. On the Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
6. Complete the Treatment and Service page.
7. RDS Page:
 - a. Complete/Revise the “ISP Status” field at the top of the page.
 - b. Complete/Update the RDS as appropriate.
8. Treatment Plan and Goals Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
9. Complete the Additional Required Reporting Data page.
10. Complete the Transition Discharge Plan page.
11. Additional Information Page:
 - a. Include any additional information needed to demonstrate continued eligibility for Section 17 services and/or to demonstrate that the authorization request is consistent with the consumer’s needs. As these specialty groups are time specific (i.e. WRAP 12 sessions, Recovery Workbook 30 sessions, TREM 33 sessions, and DBT 1 yr.), please submit additional information supporting continuation of these services when exceeding stated time limits.

- b. When submitting a CSR for the purpose of aligning it with the consumer's ISP, note on this page "Submitted to Align CSR with ISP Date."

C. Discharge Instructions for Community Support Group Services:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Community Support Group Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Fully complete the discharge page. Make sure to include the most recent "Date LOCUS Completed", "LOCUS Composite Score", and "LOCUS Level of Care". Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to.

Section 17: Community Support Services

The following KEPRO processes are required for:

1. Daily Living Support Services (DLSS)
2. Skills Development
3. Skills Development - Group Therapy
4. Skills Development - Ongoing Support to Maintain Employment
5. Day Supports - Day Treatment
6. Day Supports – Clubhouse

The KEPRO processes are:

- A. Contact for Service Notification
- B. Initial Registration
- C. Continued Stay Reviews
- D. Discharge Review

NOTE: Daily Living Support Services can also be provided through Grant Funds. For more information about requesting Grant Funded services, please see the Frequently Asked Questions found on our website at this link:

<http://www.qualitycareforme.com/documents/FAQGrantFundedAuths.pdf>

A. Contact For Service Notification (CFSN) Process for Community Support Services:

1. Providers have 1 business day to submit CFSNs to KEPRO for every member on their Community Support Services wait list.
2. The CFSN is a 730 day / 1 unit service authorization.

B. Initial Registration Process for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Initial Registrations and Grant Funded Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Administrative Page:

- a. “Start Date for Current Authorization Request” must be the date of the *first* face to face contact.
- b. The “Date of Referral” is the date the consumer was first referred to your agency (it may be the same as the consumer’s first contact for service).
- c. Make sure to select the “Location at Time of Referral”.

- d. Enter “Date Worker Assigned”.
2. Multiaxial Assessment Page:
 - a. You must include the “Date of Diagnostic Assessment”. The date must be current (within one year).
 - b. Enter an eligible “Primary Diagnosis”, any additional diagnoses, and the “Axis V GAF” score. Diagnosis must meet Section 17 eligibility requirements per MaineCare Regulations.
3. Symptoms/Behaviors Page:
 - a. In the Assessment Tool section, include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - b. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
4. Psychiatric Medications Page: Although not required, it is helpful to include some information.
5. Clinical Indicators Page: Although not required as eligibility requirements, it is helpful to include some information in this section.
6. Complete the RDS page to the best of your knowledge.
7. Transition/Discharge Plan Page: Fill out as applicable.
8. Additional Information Page: Include any other information relevant to consumer eligibility for Section 17 services. Include a brief clinical description supporting member’s need for services.

C. Continued Stay Review (CSR) Instructions for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews and Grant Funded Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multiaxial Assessment Page:
 - a. Correct or update if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 17 services and are consistent with the units of service requested.
2. Symptoms/Behaviors Page:

- a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 17 services.
 - b. In the “Assessment Tool” section, include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - c. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
3. Psychiatric Medications Page: Answer the questions and enter medications, if available.
4. Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested. Although not required as eligibility requirements, it is helpful to include some information in this section.
5. Complete the Treatment and Service page.
6. RDS Page:
 - a. Complete/Revise the ISP Status at the top of the page.
 - b. Complete/Update the RDS as appropriate.
7. Treatment Plan and Goals Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
8. Complete the Additional Required Reporting Data page.
9. Complete the Transition Discharge Plan page.
10. Additional Information Page:
 - a. Include any additional information needed to demonstrate continued eligibility for Section 17 services and/or to demonstrate that the authorization request is consistent with the consumer’s needs.
 - b. When submitting a CSR for the purpose of aligning it with the consumer’s ISP, note on this page “Submitted to Align CSR with ISP Date.”

D. Discharge Instructions for Community Support Services:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.

2. Complete all fields in red.
3. Complete the “Date LOCUS Completed”, “LOCUS Composite Score”, and “LOCUS Level of Care” fields.

Section 21: Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder

The following KEPRO processes are required for:

1. Home Support (Habilitation, residential, waiver)
2. Home Support (Habilitation, residential, waiver) with Medical Add-On
3. Agency Home Support (Habilitation, residential, waiver)
4. Agency Home Support (Habilitation, residential, waiver) with Medical Add-On

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Request
- C. Discharge Summary

**Note: Detailed, step-by-step instructions for entering Prior Authorizations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Home and Community Benefits for Adults for each of these processes. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed. The Section 21 FAQ's are also available to providers, and can be found on our website at this link:*

<http://www.qualitycareforme.com/documents/FAQSection21WaiverServicesAdult3.2103.pdf>

General Submission Guidelines

- Changes in hours need to follow the established PCP process and Service Proposal Addendums need to be submitted to the OADS Resource Coordinators. Once reviewed, the Resource Coordinators will notify providers to proceed with requests for hours through KEPRO.
- Submit Prior Authorizations and Continued Stay Reviews as needed for each member of the home at the same time. Authorization start and end dates should be the same for all members of a home.
- Authorizations are for a maximum of 182 days. This reflects members' weekly hours multiplied by 26 weeks and daily hours multiplied by 182
- KEPRO cannot make edits to requests once submitted finalized. If errors regarding dates and units are made, the request will be closed and the provider will have to re-submit. Original request dates will be honored if appropriate.
- If an authorization needs to be shortened due to MaineCare eligibility, providers should request units based on a standard 182-day authorization period. Once MaineCare eligibility is reinstated, the authorization can be updated to reflect the appropriate authorization period.

- Authorization requests for increased hours cannot have a start date prior to the date of submission. If requests for increases are submitted with start date prior to the date of submission, the start date will be adjusted by the KEPRO Care Manager.
- If requests are made for a change in hours, and billing occurs based on previous authorizations, the current authorization start date cannot be retroactive to dates of service already billed to MaineCare.
- Double-check date ranges and unit calculations prior to submission, to avoid billing errors or delays in receiving EIS Authorization Numbers.
- Submit both Agency Home Supports and Agency Home Supports with Medical Add-On requests together, and double-check to ensure that the dates for each match, as well as the dates for any housemates.
- For Agency Home Supports with Medical Add-On requests, include any additional medical components/procedures not covered in the assessment questions in the Additional Information section of the review as well. It is important to include length of time spent for each additional procedure.
- The use of the PASRR Level II section and Functional Evaluation, while not required, is recommended as these sections provide useful information related to services for Agency Home Supports and Agency Home Supports with Medical Add-On.

A. Prior Authorization Instructions for Home and Community Benefits for Adults:

1. Administrative Page:
 - a. Complete the “Date of Referral” field.
 - b. Complete the “Location at time of Referral” field.
2. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the “Primary Diagnosis” field.
 - c. Complete the remainder of the page as applicable for the specific member.
3. Services Requested Page:
 - a. Medical Add-On services cannot be requested without also requesting either Home Supports or Agency Home Supports as well.
4. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
5. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Add New Goals” link to add treatment plan goals.

- i. “Problem Statement” – Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs.
 - ii. “Treatment or Rehabilitation Long-Term Goal” – What change in behaviors/symptoms will be reduced? What skills will be developed throughout service?
 - iii. “Treatment or Rehabilitation Short-Term Goal” – Goals for the next 180 days. Describe in terms of the specific functional impairment/ behaviors/symptoms.
 - iv. Using the fields in the “Interventions” area, identify specific nature of supports, i.e. hand-over-hand, verbal prompt, visual cues, etc.
 - v. Please be sure to update goals with each review and update the expected completion date of each goal.
6. Additional Information Page: Information from “The Home Support Frequency Tool” should be entered in this field, including:
 - a. Reason for Request: Please indicate if request is being submitted due a new member coming into service or due to member moving.
 - b. Member Information: Describe specific daily support needs of member. If there are hours of 1:1 or greater support needed regularly please describe the functional deficits: Behavioral, Medical, Safety, Communication that require this level of support. Provide rationale for why staff cannot be shared, the risks to lower levels of staffing, what past efforts have been made to reduce staffing if applicable, and what would be needed to be in place to safely reduce staffing. Does member/consumer have day program, work, volunteer or natural supports in place that are attended without staff support, if so how many hours per week?
 - c. Program/House Information (Should be identical for each member in the home): Indicate total weekly hours for the home. Indicate weekly hours for the member and how these hours were determined/calculated. Identify the other members in the home (by case ID, unless this is the first housemate to be submitted) and their weekly staffing hours. Please note that staffing hours in the home are shared by members in the home regardless of specific staff assignments. Example: 8 hours with 3 staff and 3 members in the home is shared equally even if one member has a 2:1 and the other 2 members share one staff.
 - d. Template for Hours per Member: Determine the number of weekly hours per member at each staffing ratio. Example:

Staffing Ratio	Hours	Days Per Week	Hours per Week	Hours per Member
1:1	2	7	14	14
2:1	17	7	119	59.5
2:1	5	2	10	5
Total				78.5

Another option for calculating support hours is to subtract community/other support hours from the total hours for the home. If there are members that do not have community or other supports then those hours would be added to that member's requested units.

Example:

- 2 person home, 1 staff to 2 members 24/7
- 1 member receives 20 hours of community service
- Hours calculated as follows:
 24/7 for 2 members = 168 hours total for the week
 168 hours minus 20 hours of community support = 148 hours
 148 hours divided by 2 members = 74 hours for each member
 74 hours + 20 hours for the member who stays at home = 94 hours for member
Double-checking our calculation yields: 94 hours for member A + 74 hours for member B = 168 total hours for the week.

- e. If the request is for Agency Home Supports with Medical Add-On services, please also include the following information:
 - i. How many hours are being requested for Medical Add-On per 182 days?
 - ii. If this is a new request for Medical Add-On services, confirm that you have updated your Service Proposal and obtained approval from your Resource Coordinator the Planning Team.
 - iii. What are the specific interventions that will be utilized and what is the daily time needed for each in 1 hour increments? Please add these up and be specific with your requested amount. Requests cannot be edited once submitted.
 - iv. A specific physician's order should be in place for each requested service to be authorized, per the MaineCare Benefits Manual. (Copies may be required.)
 - v. Is each intervention addressed in PCP? (Documentation may be required.)
 - vi. What level of staff are performing intervention and in what setting? (i.e., RN at residence, etc.) The staff must be agency staff, generally performing a service at your facility.
 - vii. Is consumer a diabetic?
 - viii. Is there a seizure disorder? Are seizures controlled or uncontrolled?
 - ix. Is there chronic or current skin breakdown? Wound care? Other skin issues?
 - x. Does consumer have a tracheotomy? Frequency of care?
 - xi. Does consumer have catheters? Care needed?
 - xii. Are there any respiratory treatments?
 - xiii. Level of ADL assistance? How many staff are required? How much time daily is needed in 1 hour increments?
 - xiv. G, J, or PEG tubes?

B. Continued Stay Request Instructions for Home and Community Benefits for Adults:

1. Administrative Page:
 - a. Complete the “Date of Referral” field.
 - b. Complete the “Location at time of Referral” field.
2. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the “Primary Diagnosis” field.
 - c. Complete the remainder of the page as applicable for the specific member.
3. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
4. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Modify” link to update treatment plan goals.
5. Transition Discharge Plan Page:
 - a. “Plan for Transition Discharge” – Specific but brief description of which functional impairment, symptom, or behavior will be improved.
 - i. How will progress be measured: what is the evidence of readiness for lower level of care or decreased utilization?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What are the current or expected barriers for decreased utilization?
 - iv. Are there any referrals to other services, and if so, what is the current status?
7. Additional Information Page: Information from “The Home Support Frequency Tool” should be entered in this field, including:
 - a. Reason for Request: Please indicate is to continue service due to current authorization ending or due to a change in service, i.e. member moving in or out of home, change due to an absence, addition or reduction of community supports, etc. If due to a change, please indicate the date of the PCP meeting.
 - b. Member Information: Describe specific daily support needs of member. If there are hours of 1:1 or greater support needed regularly please describe the functional deficits: Behavioral, Medical, Safety, Communication that require this level of support. Provide rationale for why staff cannot be shared, the risks to lower levels of staffing, what past efforts have been made to reduce staffing, and

- what would be needed to be in place to safely reduce staffing. Does member/consumer have day program, work, volunteer or natural supports in place that are attended without staff support, if so how many hours per week?
- c. Program/House Information (Should be identical for each member in the home): Indicate total weekly hours for the home. Indicate weekly hours for the member and how these hours were determined/calculated. Identify the other members in the home (by case ID, unless this is the first housemate to be submitted) and their weekly staffing hours. Please note that staffing hours in the home are shared by members in the home regardless of specific staff assignments. Example: 8 hours with 3 staff and 3 members in the home is shared equally even if one member has a 2:1 and the other 2 members share one staff.
- d. Template for Hours Per Member: Determine the number of weekly hours per member at each staffing ratio. Example:

Staffing Ratio	Hours	Days Per Week	Hours per Week	Hours per Member
1:1	2	7	14	14
2:1	17	7	119	59.5
2:1	5	2	10	5
Total				78.5

Another option for calculating support hours is to subtract community/other support hours from the total hours for the home. If there are members that do not have community or other supports then those hours would be added to that member's requested units.

Example:

- 2 person home, 1 staff to 2 members 24/7
- 1 member receives 20 hours of community service
- Hours calculated as follows:

24/7 for 2 members = 168 hours total for the week

168 hours minus 20 hours of community support = 148 hours

148 hours divided by 2 members = 74 hours for each member

74 hours + 20 hours for the member who stays at home = 94 hours for member

Double-checking our calculation yields: 94 hours for member A + 74 hours for member B = 168 total hours for the week.

- e. If the request is for Agency Home Supports with Medical Add-On services, please also include the following information:
- i. How many hours are being requested for Medical Add-On per 182 days?
 - ii. If this is a new request for Medical Add-On services, confirm that you have updated your Service Proposal and obtained approval from your Resource Coordinator.
 - iii. What are the specific interventions that will be utilized and what is the daily time needed for each in 1 hour increments? Please add these up and be specific with your requested amount. Requests cannot be edited once submitted.

- iv. A specific physician's order should be in place for each requested service to be authorized, per the MaineCare Benefits Manual. (Copies may be required.)
- v. Is each intervention addressed in PCP? (Documentation may be required.)
- vi. What level of staff are performing intervention and in what setting? (i.e., RN at residence, etc.) The staff must be agency staff, generally performing a service at your facility.
- vii. Is consumer a diabetic?
- viii. Is there a seizure disorder? Are seizures controlled or uncontrolled?
- ix. Is there chronic or current skin breakdown? Wound care? Other skin issues?
- x. Does consumer have a tracheotomy? Frequency of care?
- xi. Does consumer have catheters? Care needed?
- xii. Are there any respiratory treatments?
- xiii. Level of ADL assistance? How many staff are required? How much time daily is needed in 1 hour increments?
- xiv. G, J, or PEG tubes?
- xv. Describe any other needs.

6. Discharge Summary Instructions for Home and Community Benefits for Adults:

- 1. Discharge the member within 5 days of the actual discharge from services.
- 2. Complete all fields in red.

Section 21: Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder

The following KEPRO processes are required for:

1. Crisis Intervention Services

The KEPRO processes are:

- A. Registration
- B. Continued Stay Request
- C. Discharge Summary

Note: Detailed, step-by-step instructions for entering Registrations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Home and Community Benefits for Adults for each of these processes. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed. The Section 21 FAQ's are also available to providers, and can be found on our website at this link: <http://www.qualitycareforme.com/documents/FAQSection21WaiverServicesAdult3.2103.pdf>*

A. Registration Instructions for Home and Community Benefits for Adults:

1. Administrative Page -
 - a. Complete the "Date of Referral" field.
 - b. Complete the "Location at time of Referral" field.

B. Continued Stay Request Instructions for Home and Community Benefits for Adults:

1. Administrative Page:
 - a. Complete the "Date of Referral" field.
 - b. Complete the "Location at time of Referral" field.
2. Multiaxial Assessment Page:
 - a. Complete the "Date of Diagnostic Assessment" field.
 - b. Provide the current primary diagnosis.
3. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
4. Treatment Plan Page:
 - a. Complete the "Describe Members' Strengths and Skills" field.

- b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Add” and “Modify” links to add/update treatment plan goals.
5. Transition Discharge Plan Page:
 - a. “Plan for Transition Discharge” – Specific but brief description of which functional impairment, symptom, or behavior will be improved.
 - i. How will progress be measured: what is the evidence of readiness for lower level of care or decreased utilization?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What are the current or expected barriers for decreased utilization?
 - iv. Are there any referrals to other services, and if so, what is the current status?
6. Additional Information Page: May be used to provide other applicable information about the delivery of service as needed. Include the specific discharge plan for the member.
 - a. Complete the “Treatment Progress” field.

C. Discharge Summary Instructions for Home and Community Benefits for Adults:

1. Discharge the member within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 21: Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder

The following KEPRO processes are required for:

1. Temporary Emergency Housing Services

The KEPRO processes are:

- A. Registration
- B. Continued Stay Request
- C. Discharge Summary

Note: Detailed, step-by-step instructions for entering Registrations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Home and Community Benefits for Adults - Temporary Emergency Housing for each of these processes. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed. The Section 21 FAQ's are also available to providers, and can be found on our website at this link:*

<http://www.qualitycareforme.com/documents/FAQSection21WaiverServicesAdult3.2103.pdf>

A. Registration Instructions for Home and Community Benefits for Adults - Temporary Emergency Housing:

The following pages must be completed for all Home and Community Benefits for Adults - Temporary Emergency Housing Registrations:

- a. Administrative Page
- b. Requesting Agency Page
- c. Services Request Page

B. Continued Stay Request Instructions for Home and Community Benefits for Adults - Temporary Emergency Housing:

7. Administrative Page:

- a. Complete the "Date of Referral" field.
- b. Complete the "Location at time of Referral" field.

8. Multiaxial Assessment Page -

- a. Complete the "Date of Diagnostic Assessment" field.
- b. Complete the "Primary Diagnosis" field.
- c. Complete the remainder of the page as applicable for the specific member.

9. Clinical Indicators Page:

- a. Complete indicators as applicable for the specific member.

10. Treatment Plan Page:

- a. Complete the “Describe Members’ Strengths and Skills” field.
- b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
- c. Complete the “Date Current Treatment Plan was Developed” field.
- d. Use the “Modify” link to update treatment plan goals.

11. Transition Discharge Plan Page:

- a. “Plan for Transition Discharge” – Specific but brief description of which functional impairment, symptom, or behavior will be improved.
 - i. How will progress be measured: what is the evidence of readiness for lower level of care or decreased utilization?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What are the current or expected barriers for decreased utilization?
 - iv. Are there any referrals to other services, and if so, what is the current status?

12. Additional Information Page: Information from “The Home Support Frequency Tool” should be entered in this field, including:

- a. Number of people in the home
- b. Staffing ratios
- c. Hours member is not in the home and why (work, day program, etc.)
- d. Behavioral, health, and medical information
- e. Current community supports/natural supports
- f. How are adult waiver services benefitting the member?
- g. Relevant information from the person-centered plan
- h. Identify areas the member has progressed towards identified goals and identify areas progress is slowing/not happening.
- i. Complete the “Treatment Progress” field.
- j. “Since the previous authorization how has the consumer progressed?” – How are services benefitting the member? Have there or will there be any adjustments to the delivery of service that will support progress?

C. Discharge Summary Instructions for Home and Community Benefits for Adults:

1. Discharge the member within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 28: Rehabilitation and Community Support Services for OCFS Providers

The following KEPRO processes are required for:

1. Services for Children with Cognitive Impairments and Functional Limitations - 1:1
2. Specialized Services for Children with Cognitive Impairments and Functional Limitations - 1:1

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Request
- C. Discharge Summary

**Note: Step-by-step instructions for creating Prior Authorizations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Section 28 Rehabilitation and Community Support Services for OCFS Providers. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed. The Section 28 FAQ's are also available to providers, and can be found on our website at this link:*

<http://www.qualitycareforme.com/documents/FAQSection28RehabCommSuppServices3.2103.pdf>

A. Prior Authorization Instructions for Rehabilitation and Community Support Services:

1. For all new admissions to service, KEPRO will be responsible for determining eligibility and Prior Authorization. This Prior Authorization will cover the 30-day assessment period.

B. Continued Stay Request Instructions for Rehabilitation and Community Support Services:

- If the assessment could not be completed within the authorized assessment period and the provider needs additional time to complete the assessment, the provider will be responsible for entering a Continued Stay Review. In this instance, the provider may request up to an additional 10 days and must provide an explanation of the circumstances in the request.
- If the member was seen for the assessment but will not be picked up for service beyond that, the provider will be responsible for entering a Discharge Summary.

1. Multiaxial Assessment Page:

- a. Complete as applicable for the specific member.

2. Symptoms/Behaviors Page:

- a. Complete the "Agency Involvement" and "Family Social Involvement" fields.

3. Psychiatric Medications Page:
 - a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” field to attach any current medications as applicable.
4. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
5. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Use the “Add New Goals” link to add treatment plan goals.
 - i. “Problem Statement” – Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs.
 - ii. “Treatment or Rehabilitation Long-Term Goal” – What change in behaviors/symptoms will be reduced or eliminated? At what functional or behavioral level will the member be?
 - iii. “Treatment or Rehabilitation Short-Term Goal” – Goals for the next seven days. Describe in terms of the treatment, rather than the behaviors/symptoms/functioning.
 - iv. Using the fields in the “Interventions” area, identify some sub-interventions, including teaching skills, specific treatment modalities, or providers that are recommended in the goals sections.
6. Additional Reporting Data Page:
 - a. Complete as applicable for the specific member.
7. Transition Discharge Plan Page:
 - a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
 - b. Complete the “Projected Date of Transition/Discharge” field as applicable.
 - c. Complete the “Anticipated Step Down Service” area as applicable.
 - d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - ii. What services will be recommended after discharge?
 - iii. What are the current or expected barriers to discharge?
 - iv. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.
8. Additional Information Page:

- a. Include a very brief overall summary of the progress during the last authorization period with a focus on the cognitive and functional limitations that precipitated the service.
- b. Note plans for the upcoming review period.
- c. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.
- d. If discharge had been planned for the prior review period and it has been determined that the member needs to continue service, please explain the barriers and/or new factors that contributed to that decision.
- e. Complete the “Treatment Progress” field.
- f. “Since the previous authorization how has the consumer progressed?”
 - i. How is the service benefitting the member?
 - ii. If progress is minimal, briefly describe barriers to progress and the plan to re-evaluate interventions.
 - iii. Have there been or will there be any adjustments to the delivery of service to support progress?
 - iv. Has there been a change in the family’s knowledge, skills, or ability to support member during or after treatment?

C. Discharge Summary Instructions for Rehabilitation and Community Support Services for Schools:

1. Discharge the member within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 28: Rehabilitation and Community Support Services for Schools

The following KEPRO processes are required for:

1. Services for Children with Cognitive Impairments and Functional Limitations - 1:1
2. Specialized Services for Children with Cognitive Impairments and Functional Limitations - 1:1

The KEPRO processes are:

- A. Eligibility Determination through Application
- B. Prior Authorization
- C. Continued Stay Review
- D. Discharge
- E.

****Note: Step-by-step instructions for creating Registrations and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Section 28 Rehabilitation and Community Support Services for Schools. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed. The Section 28 FAQ's are also available to providers, and can be found on our website at this link:***

<http://www.qualitycareforme.com/documents/FAQSection28RehabCommSuppServices3.2103.pdf>

Overview of the KEPRO Process for School-Based Section 28 services

1. Providers will submit a Referral Packet to apply the member for this service prior to the member enrolling in services to determine eligibility.
2. Providers will submit a Prior Authorization upon approval of Referral Packet. Providers will also fax the current Individual Education Plan and/or the Individualized Treatment plan at time of request.
3. Providers will submit a Continued Stay Review at the end of the Prior Authorization, or any time during the authorization period. Providers will also fax the current Individual Education Plan and/or the Individualized Treatment plan at time of each request.
4. Providers will complete a Discharge when the member no longer receives services.

A. Referral Packet instructions:

1. Referral packets can be found at <http://www.QualityCareforME.com>, under Providers, Manuals and Forms, Section 28 Referral. Follow the instructions provided and submit all the needed documents via fax at 866-325-4752. Completed packets will be reviewed for eligibility. Eligibility determination letters are mailed to the Caregiver/Guardians, and faxed to the referring provider.
2. Once eligibility has been approved, the Provider can enter a Prior Authorization.

B. Prior Authorization Submission for School-Based Section 28 Services Instructions :

Please fax the current Individual Education Plan and/or the Individualized Treatment plan at time of request.

1. Administrative Page:

- a. Fill out all fields as they apply.
- b. In the Authorization Type field, choose Prior Authorization if it is a student who is new to this provider, or request is for new services to an already-served student. If the student is already receiving the services and this is an extension, choose Continued Stay Review.
- c. In Review Type, choose Children's Services as the review type, and in the Category of Service, choose Section 28 Provided by an Educational System.

2. Multi-Axial Assessment Page:

- a. Axis I and/or II diagnoses are required in Prior Authorizations and Continued Stay Reviews.

3. Services Requested Page:

- a. In Service field, choose the service codes that correspond to the behavioral health services that will be provided for the review period requested. The dates and units will pre-populate for what is allowed for Prior Authorization for School-Based 28 Services.

4. Additional Information Page:

- a. Include Functional Assessment Scores information in this section. Describe the presenting issues for the child, and the plan to address their needs.

C. Continued Stay Review Requests for School-Based Section 28 Services Instructions:

Please fax the current Individual Education Plan and/or the Individualized Treatment plan at time of request.

1. Administrative Page:

- a. All fields as they apply. In the Authorization Type field, choose Continued Stay Review for a member already receiving services.

2. Multi-Axial Assessment:

- a. Axis I and/or II diagnoses are required in Continued Stay Reviews. Update at each time of request.

3. Services Requested Page:

- a. In Service field, choose the service codes that correspond to the behavioral health services that will be provided for the review period requested.
- b. Fill in the requested dates and units, and please make them correspond to what is planned to be used for the authorization period.

4. Symptoms/Behavior Page:
 - a. Involvement and Family/Social Involvement are required fields.
5. Psychiatric Medications Page:
 - a. List current psychiatric medications.
6. Clinical indicators Page:
 - a. Fill in severity for those that apply, and the history of severity.
7. Treatment Plan Page:
 - a. It is recommended that a behavioral health treatment plan is entered in this section in the first Continued Stay Review. By providing this treatment plan in the Treatment Plan Goals section, rather than the Additional Information section; when the service is extended, the completed fields will carry over the information that was entered in the last review, and can be easily edited, saving time from having to create new information each time a case is extend. Click on "Add New Goal," which opens a box with the fields described in the box below.
 - b. If more than one intervention will be used to address the same behaviors, open a new goal and reference the behaviors, and add the info that is specific to that intervention/service.
8. Transition/Discharge Plan Page:
 - a. In the text field, indicate the criteria, plan and time frame for a reduction in intensity of service, and eventual discharge of service. Note the observable progress will signal when the member might be ready to decrease to fewer units per day/week, and to eventually discharge. If there is a planned reduction of units within this period, provide the steps and the timeline for doing so.
9. Additional Information Page:
 - a. Briefly summarize the behavioral health needs, and provide any information that has not been captured elsewhere in the request. If there is a change in the number of units since the last review, or if significant variability is expected within the upcoming 180 days, provide some description here. Any external factors that contribute to increased behaviors, symptoms or need in this period, or high usage of the service in this request can be listed here. Include the Functional Assessment Scores and dates.
 - b. Fill out the Treatment Progress since last review.
 - i. Speak in terms of measurable change, either progress made, or deterioration in progress.

- ii. Provide some information about what contributes to progress/deterioration, and if any modifications need to be made to support progress

D. Discharge for School-Based Section 28 Services Instructions:

1. Discharge the member within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 45: Intensive Outpatient Program

The following KEPRO processes are required for:

1. Intensive Outpatient Program – Behavioral Health
2. Intensive Outpatient Program – Substance Abuse

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Request
- C. Discharge Summary

Note: Step-by-step instructions for creating Prior Authorizations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Section 45 Intensive Outpatient Program services. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.*

E. Prior Authorization Instructions for Intensive Outpatient Program:

1. Administrative Page:
 - a. “Review Type” – Choose either Adult Services or Children’s Services, as appropriate.
 - b. “Category of Service” – Choose Intensive Outpatient Program.
 - c. Complete the “Location at Time of Referral” field.
2. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
3. Services Requested Page:
 - a. Choose the appropriate program in the “Service” drop-down.
4. Symptoms/Behaviors Summary Page:
 - a. “Assessment Tools” area – not required for Mental Health programs. For Substance Abuse programs, complete the “ASAM” field.
 - b. For children’s services, complete the “Family/Social Involvement” field.
 - c. Complete the remainder of the page as applicable for the specific member.
5. Psychiatric Medications Page:
 - a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” button to attach any current medications.
 - c. Use the “Notes” field to note any medications that have been discontinued since the last review or are planned in the near future. You may also note a brief

description of medications that will be stabilized at time of discharge, if known or planned.

6. Clinical Indicators Page:

- a. Complete indicators as applicable for the specific member.

7. Treatment and Service History Page:

- a. Complete the “Is member receiving integrated MH/SA services?” field.
- b. Complete the “How long has member been receiving this service?” field.
- c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
- d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.

2. Treatment Plan Page:

- a. Complete the “Describe Members’ Strengths and Skills” field.
- b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
- c. Complete the “Date Current Treatment Plan was Developed” field.
- d. Use the “Add New Goals” link to add treatment plan goals.
 - i. “Problem Statement” – Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs.
 - ii. “Treatment or Rehabilitation Long-Term Goal” – What change in behaviors/symptoms will be reduced or eliminated? At what functional or behavioral level will the member be?
 - iii. “Treatment or Rehabilitation Short-Term Goal” – Goals for the next seven days. Describe in terms of the treatment, rather than the behaviors/symptoms/functioning.
 - iv. Using the fields in the “Interventions” area, identify some sub-interventions, including teaching skills, specific treatment modalities, or providers that are recommended in the goals sections.

3. Transition Discharge Plan Page:

- a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
- b. Complete the “Projected Date of Transition/Discharge” field as applicable.
- c. Complete the “Anticipated Step Down Service” area as applicable.
- d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will progress be measured?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What services will be recommended after discharge?
 - iv. What are the current or expected barriers to discharge?
 - v. Are there any referrals to other services, and if so, what is the current status?

- vi. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
 - vii. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.
4. Additional Information Page:
- a. Note plans for the upcoming review period.
 - b. Overview of participation/attendance to this point.
 - c. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.
- F. Continued Stay Request Instructions for Partial Hospitalization:**
1. Multiaxial Assessment Page:
- a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
2. Symptoms/Behaviors Summary Page:
- a. “Assessment Tools” area – not required for Mental Health programs. For Substance Abuse programs, complete the “ASAM” field.
 - b. For children’s services, complete the “Family/Social Involvement” field.
 - c. Complete the remainder of the page as applicable for the specific member.
3. Psychiatric Medications Page:
- a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” button to attach any current medications.
 - c. Use the “Notes” field to note any medications that are planned in the near future. You may also note a brief description of medications that will be stabilized at time of discharge, if known or planned.
4. Clinical Indicators Page:
- a. Complete indicators as applicable for the specific member.
5. Treatment and Service History Page:
- a. Complete the “Is member receiving integrated MH/SA services?” field.
 - b. Complete the “How long has member been receiving this service?” field.
 - c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
 - d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.
6. Treatment Plan Page:
- a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Modify” link to update treatment goals as applicable.
7. Transition Discharge Plan Page:
- a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
 - b. Complete the “Projected Date of Transition/Discharge” field as applicable.
 - c. Complete the “Anticipated Step Down Service” area as applicable.

- d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will progress be measured?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What services will be recommended after discharge? What are the dates those services will start?
 - iv. What are the current or expected barriers to discharge?
 - v. Are there any referrals to other services, and if so, what is the current status?
 - vi. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
 - vii. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.
- 8. Additional Information Page:
 - g. Include a very brief overall summary of the progress in the past seven days with a focus on the *current* risk/safety issues and the intense behaviors that precipitated the service. For Substance Abuse services, in every CSR please state any substance use or abstinence within the review period, and if the member has used, what is being done to address this in treatment.
 - h. Note plans for the upcoming review period.
 - i. Overview of participation/attendance to this point.
 - j. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.
 - k. If discharge had been planned for the prior review period and it has been determined that the member needs to continue service, please explain the barriers and/or new factors that contributed to that decision.
 - l. Complete the “Treatment Progress” field.
 - m. “Since the previous authorization how has the consumer progressed?” – How is the intensive outpatient program benefiting the member? Have there or will there be any adjustments to the delivery of service that will support progress?

G. Discharge Summary Instructions for Partial Hospitalization:

Intensive Outpatient Program staff are responsible for discharging members from the KEPRO CareConnection® web portal with one (1) business day of the day the member is discharged from the program.

- 1. Complete all fields in red.
- 2. Use the “Plan for Transition Discharge” field to note any additional pertinent information.

Section 45: Hospital Services - General Hospital Inpatient Psychiatric and Substance Abuse Units

The following KEPRO processes are required for:

1. General Hospital - Inpatient Psychiatric Units
2. General Hospital - Substance Abuse Units

The following hospitals are subject to the requirements of the Maine ASO: Hospitals that provide service to MaineCare members, under Section 45 of the MaineCare Benefits Manual, including services for non-compensated adults and Hospitals with a dedicated psychiatric or substance abuse unit. Hospitals that do not have a dedicated psychiatric or substance abuse unit are **not subject to the requirements of the Maine Behavioral Health ASO.*

The KEPRO processes are:

- A. Initial Registration
- B. Discharge Review

General Hospital Inpatient Psychiatric and Substance Abuse Units - Utilization Review Process

Process Overview

1. KEPRO has implemented a system of utilization review for all admissions to general hospital psychiatric and substance abuse units.
2. All new admissions will be registered in the KEPRO CareConnection® online web portal as Initial Registrations by designated hospital staff.
3. At the time of discharge, hospital staff will enter a Discharge Review into the KEPRO CareConnection® online web portal.
4. Authorization records will be reported to DHHS and reconciled with submitted claims.

A. Initial Registration Process for General Hospital Inpatient Psychiatric and Substance Abuse Units

***Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to General Hospital Inpatient Psychiatric and Substance Abuse Units. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

The following pages must be completed for all General Hospital Inpatient Psychiatric and Substance Abuse Units:

- a. Member Information Page (if not using a MaineCare ID Number)
- b. Administrative Page

- i. Additional field: "Location"
- c. Requesting Agency Page
- d. Services Requested Page

B. Discharge Process for General Hospital Inpatient Psychiatric and Substance Abuse Units

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to General Hospital Inpatient Psychiatric and Substance Abuse Units. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 1 day of the actual discharge from services.
2. Complete all fields in red.
3. Complete the "Living Situation Upon Discharge" field.
4. Complete the three "Yes/No" fields just below the "Living Situation Upon Discharge" field:
 - a. Did the Hospital obtain the Member's ISP from their CI, ICI, ICM, or ACT Provider?
 - b. Did the Hospital invite the Member's CI, ICI, ICM, or ACT Provider to participate in treatment or discharge planning?
 - c. Did the Member's CI, ICI, ICM, or ACT Provider participate in treatment or discharge planning?

Out Of State Hospitals

Emergency Admissions to Out of State (OOS) Psychiatric or Inpatient Detox Facilities for Both Child and Adult

The following KEPRO processes are required for:

1. Adult Out Of State Hospitals ONLY
2. Child Out Of State Hospitals ONLY - EXCEPT Contracted – Blanket (See separate documentation for Blanket authorizations)

The KEPRO processes are:

- A. Prior Authorization– Via fax
- B. Continued Stay Reviews- Telephonic
- C. Discharge Review- Telephonic

A. Prior Authorization Process for Out Of State Hospitals ONLY

Maine Behavioral Health ASO

Out-of-State Review Process for Psychiatric and Substance Abuse Inpatient and Residential Services v11/30/09

Emergency Admissions to Out of State (OOS) Psychiatric or Inpatient Detox Facilities for both Child and Adult

- Emergency admissions are reimbursed by MaineCare without prior authorization except members age 18-65 at facilities that are “Institutes for Mental Disease” (IMD).
- Out of State Hospitals must contact MaineCare Provider Enrollment to become a MaineCare provider, in order to bill for services provided (1-800-321-5557 Option 6 or (207)287-4082).
- If the member is age 18-65, providers will be directed to MaineCare Provider Enrollment to determine if their facility is an IMD.
- IMD’s are not reimbursed by MaineCare for Members age 18-65 and such admissions are not reviewed by KEPRO.

KEPRO has 2 primary roles with emergency OOS admissions for MaineCare Members:

1. Conduct utilization review from day 3 of the admission
2. Coordinate discharge planning, with Maine providers, when appropriate.

Process:

1. OOS Provider contacts MaineCare Provider Enrollment to become a MaineCare provider (and determine if they are an IMD if member is age 18-65).
2. OOS Provider faxes Intake Evaluation to KEPRO (1-866-325-4752)

3. KEPRO contacts OMS Provider Relations Unit (624-7539 option 8) to verify that the provider is a MaineCare provider (and not an IMD, if member is 18-65).
4. If it is anticipated that the member will be inpatient beyond 3 days, the OOS provider will be directed to enroll with KEPRO as a provider in CareConnection, and to complete telephonic Continued Stay Requests and a Discharge Review as appropriate.

Children age 17 and under in Ongoing OOS Psychiatric Hospital or Residential Treatment

Out-of-State PNMI and Inpatient Providers who are providing ongoing psychiatric service to MaineCare members and billing MaineCare are subject to the same MaineCare and Utilization Review Requirements as In-State service behavioral health providers.

KEPRO Contacts for out of state hospitalizations are as follows:

Provider Relations Staff: Ami Tait

Care Manager Staff for Out of State Adult hospitalizations: Kelly Parnell LCSW

Care Manager Staff for Out of State Child hospitalizations: Carolyn Blackburn LCSW

Out of State Providers must be enrolled with the Office of Maine Care Services as a MaineCare Provider. Instructions are available at this link:

<http://www.maine.gov/bms/providerfiles/providermatrixhtm.htm>

Out-of-State providers must be registered with KEPRO before authorizations can be issued. Registration instructions and forms are available at this link:

http://www.qualitycareforme.com/MaineProvider_KEPROCC_Mand_Enroll.htm

The KEPRO-Maine website is: www.qualitycareforme.com

B. Out Of State Hospitals ONLY Continued Stay Review (CSR) Instructions

Please have your most recently authorized KEPRO Case ID number available. Contact KEPRO at 1-866-521-0027 and a telephonic continued stay review will be conducted. The following information will be included in the review:

1. Guardian Information Page
2. "Start Date for Current Authorization Request" on the Administrative page
3. Requesting Agency
4. Multiaxial Assessment
 - a. "Primary Diagnosis" and axis 1-5 if available
5. Symptoms/Behavior
6. Psychiatric Medications
7. Clinical Indicators
8. Individual Treatment Plan

9. Transition Discharge Plan

C. Out Of State Hospitals Discharge Instructions

Hospitals are responsible for discharging members from KEPRO CareConnection® within one (1) business day of the day that the member is discharged from the facility. The discharge *must* be called into KEPRO if a member has been registered for admission, regardless of whether or not a continued stay review was submitted. A discharge not captured in KEPRO CareConnection® will affect Length of Stay Reports that are posted on our website, www.qualitycareforme.com.

Section 45: IMD Hospital Services – Adults Age 21-64 ONLY

The following KEPRO processes are required for:

1. Acadia Hospital
2. Spring Harbor Hospital

The KEPRO processes are:

- A. Initial Registration
- B. Discharge Review

Non-compensated Inpatient Adults: Spring Harbor & Acadia Hospitals Only

Spring Harbor and Acadia Hospitals – Adults Ages 21-64 ONLY

DHHS contracts with KEPRO to conduct prior authorization and utilization review for MaineCare funded behavioral health and substance abuse services. Data from the authorization system is used to improve service and system quality. A critical part of the system of care are the two IMD hospitals: Spring Harbor Hospital and Acadia Hospital. MaineCare member's aged 0-20 and 65+ are already reviewed with KEPRO Healthcare using the secure, online web-based clinical review system, KEPRO CareConnection®. Those review processes are described elsewhere.

- The following process is ONLY for adults ages 21-64.
- NOTE: Do NOT use this process for MaineCare member's ages 0-20 and 65+. Such use will result in NO MaineCare authorization for services for those members.

Process:

All patients ages 21-64 currently in the IMD hospitals will be registered in KEPRO CareConnection®.

1. At the time of admission, designated hospital staff will enter the admission as a "Initial Registration".
2. At the time of discharge, designated hospital staff will enter the "Discharge".

A. Instructions for Entering Registrations into KEPRO CareConnection®

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Spring Harbor and Acadia Hospitals – Adults Ages 21-64 ONLY. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Administrative Page:
 - a. “Review Type” is: Adult Mental Health.
 - b. “Category of Service” is: Hospital Services - Acute.
2. Multiaxial Assessment Page: Please fill out the “Primary Diagnosis” field.
3. Additional Information Page: Please enter a short description of the reason for admission.

B. Instructions for Submitting a Discharge in KEPRO CareConnection®

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Spring Harbor and Acadia Hospitals – Adults Ages 21-64 ONLY Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
3. Complete all fields in red.
4. Complete the following questions:
 - a. Did the Hospital obtain the Member's ISP from their CI, ICI, ICM or ACT Provider?
 - b. Did the Hospital invite the Member's CI, ICI, ICM or ACT Provider to participate in treatment or discharge planning?
 - c. Did the Member's CI, ICI, ICM or ACT Provider participate in treatment or discharge planning?

Section 45: IMD Hospital Services – Children ONLY

The following KEPRO processes are required for:

1. Acadia Hospital
2. Spring Harbor Hospital

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Review
- C. Discharge Review

A. Initial Registration (IR) Process for Child IMD Hospital Services

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Child IMD Hospital Services

Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Administrative Page:
 - a. “Start Date for Current Authorization Request” must be the date of the *first* face to face contact.
 - b. “Date of Referral” is the date the member was first referred to the agency.

B. Child IMD Hospital Services Continued Stay Review (CSR) Instructions

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Child IMD Hospital Services

Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Multiaxial Assessment Page:
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis”.
 - b. Fill out any additional Axis I - IV information, if available.
2. Symptoms/Behavior Page: Please select any “Agency Involvement”, and “Family/Social Involvement”.
3. Psychiatric Medications Page: Complete as applicable.

4. Clinical Indicators Page: Please complete this page by choosing the “Current Severity” and “History of Severity” for each indicator as applicable. The most current symptoms and behaviors that a member has experienced over the previous authorization period should be reflected here.
5. Individual Treatment Plan Page: Fill out the “Individual Treatment Plan” as applicable, including the “Treatment Plan Goals” section. The “Criteria for Discharge” section should be updated at every request.
6. Additional Required Reporting Data Page: Fill out the top of the page as applicable.
7. Transition Discharge Plan Page: Please enter in the projected discharged date, any anticipated step down services, and identify the plan for discharge in the “Plan for Transition/Discharge” box.
8. Additional Information Page: Place a short clinical note in the “Additional Information” section indicating any other information you feel would be relevant in supporting the member’s clinical need for services. Complete the “Treatment Progress” drop-down.

C. Child IMD Hospital Services Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Child IMD Hospital Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

Hospitals are responsible for discharging members from KEPRO CareConnection® within one (1) business day of the day that the member is discharged from the facility. The discharge *must* be submitted if a member has been registered for admission, regardless of whether or not a continued stay review was submitted. A discharge not captured in KEPRO CareConnection® will affect both the Hospital Occupancy and Length of Stay Reports that are posted on our website.

1. Check off any anticipated step down services including dates of first appointments for these services. If none, leave blank.
2. Identify Treatment Progress.
3. Enter in the Plan for Transition Discharge in the box provided.

Section 45: Maine State Hospitals

The following KEPRO processes are required for:

1. Dorothea Dix
2. Riverview

The KEPRO processes are:

- A. Initial Registration
- B. Discharge Review

Process:

All patients currently in the state hospitals will be registered in KEPRO CareConnection®.

1. At the time of admission, designated hospital staff will enter the admission as an “Initial Registration” into KEPRO CareConnection®.
2. At the time of discharge, designated hospital staff will enter the discharge into KEPRO CareConnection®.

A. Instructions for Entering Registrations into KEPRO CareConnection®

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Dorothea Dix /Riverview Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Additional Information Page: Please enter a short description of the reason for admission.

B. State Hospitals Dorothea Dix /Riverview Only Discharge Instructions

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Dorothea Dix /Riverview Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

Hospitals are responsible for discharging members from KEPRO CareConnection® within one (1) business day of the day that the member is discharged from the facility. A discharge not

captured in KEPRO CareConnection® will affect both the Hospital Occupancy and Length of Stay Reports that are posted on our website.

5. Complete all fields in red.
6. Complete the following questions:
 - a. Did the Hospital obtain the Member's ISP from their CI, ICI, ICM or ACT Provider?
 - b. Did the Hospital invite the Member's CI, ICI, ICM or ACT Provider to participate in treatment or discharge planning?
 - c. Did the Member's CI, ICI, ICM or ACT Provider participate in treatment or discharge planning?

Section 46: Psychiatric Partial Hospitalization

The following KEPRO processes are required for:

1. Partial Hospitalization

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Request
- C. Discharge Summary

Note: Step-by-step instructions for creating Prior Authorizations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Section 46 Psychiatric Partial Hospitalization services. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.*

A. Prior Authorization Instructions for Partial Hospitalization:

1. Administrative Page:
 - a. “Review Type” – Choose either Adult Services or Children’s Services, as appropriate.
 - b. “Category of Service” – Choose Partial Hospitalization.
 - c. Complete the “Location at Time of Referral” field.
2. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
3. Symptoms/Behaviors Summary Page:
 - a. Complete the “Agency Involvement” and “Family/Social Involvement” field.
 - b. Complete the remainder of the page as applicable for the specific member.
4. Psychiatric Medications Page:
 - d. Complete the YES/NO questions at the top of the page.
 - e. Use the “Add Medication” field to attach any current medications as applicable.
 - f. Use the “Notes” field to note any medications that are planned in the near future.
You may also note a brief description of medications that will be stabilized at time of discharge, if known or planned.
5. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
6. Treatment and Service History Page:
 - a. Complete the “Is member receiving integrated MH/SA services?” field.
 - b. Complete the “How long has member been receiving this service?” field.

- c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
- d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.

7. Treatment Plan Page:

- a. Complete the “Describe Members’ Strengths and Skills” field.
- b. Complete the “Date Current Treatment Plan Developed” field.
- c. Use the “Add New Goals” link to add treatment plan goals.
 - i. “Problem Statement” – Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs.
 - ii. “Treatment or Rehabilitation Long-Term Goal” – What change in behaviors/symptoms will be reduced or eliminated? At what functional or behavioral level will the member be?
 - iii. “Treatment or Rehabilitation Short-Term Goal” – Goals for the next five days. Describe in terms of the treatment, rather than the behaviors/symptoms/functioning.
 - iv. Using the fields in the “Interventions” area, identify some sub-interventions, including teaching skills, specific treatment modalities, or providers that are recommended in the goals sections.

8. Transition Discharge Plan Page:

- a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
- b. Complete the “Projected Date of Transition/Discharge” field as applicable.
- c. Complete the “Anticipated Step Down Service” area as applicable.
- d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will progress be measured?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What services will be recommended after discharge?
 - iv. What are the current or expected barriers to discharge?
 - v. Are there any referrals to other services, and if so, what is the current status?
 - vi. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
 - vii. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.

9. Additional Information Page:

- a. Note plans for the upcoming review period.
- b. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.

B. Continued Stay Request Instructions for Partial Hospitalization:

1. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
2. Symptoms/Behaviors Summary Page:
 - a. Complete the “Agency Involvement” and “Family/Social Involvement” field.
 - b. Complete the remainder of the page as applicable for the specific member.
3. Psychiatric Medications Page:
 - a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” field to attach any current medications as applicable.
 - c. Use the “Notes” field to note any medications that have been discontinued since the last review or are planned in the near future. You may also note a brief description of medications that will be stabilized at time of discharge, if known or planned.
4. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
5. Treatment and Service History Page:
 - a. Complete the “Is member receiving integrated MH/SA services?” field.
 - b. Complete the “How long has member been receiving this service?” field.
 - c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
 - d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.
6. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Complete the “Date Current Treatment Plan was Developed” field.
 - c. Use the “Modify” link next to each treatment plan goal to update as applicable.
7. Transition Discharge Plan Page:
 - a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
 - b. Complete the “Projected Date of Transition/Discharge” field as applicable.
 - c. Complete the “Anticipated Step Down Service” area as applicable.
 - d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will progress be measured?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What services will be recommended after discharge?
 - iv. What are the current or expected barriers to discharge?
 - v. Are there any referrals to other services, and if so, what is the current status?

- vi. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
- vii. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.

8. Additional Information Page:

- a. Include a very brief overall summary of the progress in the past five days with a focus on the risk/safety issues and the intense behaviors that precipitated the service.
- b. Note plans for the upcoming review period.
- c. Overview of participation/attendance to this point.
- d. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.
- e. If discharge had been planned for the prior review period and it has been determined that the member needs to continue service, please explain the barriers and/or new factors that contributed to that decision.
- f. Complete the “Treatment Progress” field.
- g. “Since the previous authorization how has the consumer progressed?” – How is partial hospitalization benefiting the member? Have there or will there be any adjustments to the delivery of service that will support progress?

D. Discharge Summary Instructions for Partial Hospitalization:

Partial Hospitalization program staff are responsible for discharging members from the KEPRO CareConnection® web portal with one (1) business day of the day the member is discharged from the program.

- 1. Complete all fields in red.
- 2. Use the “Plan for Transition Discharge” field to note any additional pertinent information.

Section 65: Intensive Outpatient Program

The following KEPRO processes are required for:

1. Intensive Outpatient Program

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Request
- C. Discharge Summary

Note: Step-by-step instructions for creating Prior Authorizations, Continued Stay Requests, and Discharge Summaries are available in Appendix B. Instructions below describe requirements that are specific to Section 65 Intensive Outpatient Program services. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.*

A. Prior Authorization Instructions for Intensive Outpatient Program:

1. Administrative Page:
 - a. “Review Type” – Choose Substance Abuse.
 - b. “Category of Service” – Choose Intensive Outpatient Program.
 - c. Complete the “Location at Time of Referral” field.
2. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
3. Services Requested Page:
 - a. Choose the appropriate program in the “Service” drop-down.
4. Symptoms/Behaviors Summary Page:
 - a. Complete the “ASAM” field in the Assessment Tools section.
 - b. Complete the remainder of the page as applicable for the specific member.
5. Psychiatric Medications Page:
 - a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” field to attach any current medications as applicable.
 - c. Use the “Notes” field to note any medications that are planned in the near future.
You may also note a brief description of medications that will be stabilized at time of discharge, if known or planned.
6. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.

7. Treatment and Service History Page:
 - a. Complete the “Is member receiving integrated MH/SA services?” field.
 - b. Complete the “How long has member been receiving this service?” field.
 - c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
 - d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.

8. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Add New Goals” link to add treatment plan goals.
 - i. “Problem Statement” – Behaviors/symptoms, frequency, duration, the settings or triggers when the problem occurs.
 - ii. “Treatment or Rehabilitation Long-Term Goal” – What change in behaviors/symptoms will be reduced or eliminated? At what functional or behavioral level will the member be?
 - iii. “Treatment or Rehabilitation Short-Term Goal” – Goals for the next seven days. Describe in terms of the treatment, rather than the behaviors/symptoms/functioning.
 - iv. Using the fields in the “Interventions” area, identify some sub-interventions, including teaching skills, specific treatment modalities, or providers that are recommended in the goals sections.

9. Transition Discharge Plan Page:
 - a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
 - b. Complete the “Projected Date of Transition/Discharge” field as applicable.
 - c. Complete the “Anticipated Step Down Service” area as applicable.
 - d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - v. How will progress be measured?
 - vi. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - vii. What services will be recommended after discharge?
 - viii. What are the current or expected barriers to discharge?
 - ix. Are there any referrals to other services, and if so, what is the current status?
 - x. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
 - xi. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.

10. Additional Information Page:

- a. Note plans for the upcoming review period.
- b. Overview of participation/attendance to this point.
- c. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.

B. Continued Stay Request Instructions for Partial Hospitalization:

1. Multiaxial Assessment Page:
 - a. Complete the “Date of Diagnostic Assessment” field.
 - b. Complete the remainder of the page as applicable for the specific member.
2. Symptoms/Behaviors Summary Page:
 - a. Complete the “ASAM” field in the Assessment Tools section.
 - b. Complete the remainder of the page as applicable for the specific member.
3. Psychiatric Medications Page:
 - a. Complete the YES/NO questions at the top of the page.
 - b. Use the “Add Medication” field to attach any current medications as applicable.
 - c. Use the “Notes” field to note any medications that have been discontinued since the last review or are planned in the near future. You may also note a brief description of medications that will be stabilized at time of discharge, if known or planned.
4. Clinical Indicators Page:
 - a. Complete indicators as applicable for the specific member.
5. Treatment and Service History Page:
 - a. Complete the “Is member receiving integrated MH/SA services?” field.
 - b. Complete the “How long has member been receiving this service?” field.
 - c. Complete the “Number of Inpatient Admissions in the last 12 months.” field.
 - d. Complete the “Number of ER or other crisis episodes in the last 12 months.” field.
6. Treatment Plan Page:
 - a. Complete the “Describe Members’ Strengths and Skills” field.
 - b. Fill in remaining sections with a brief summary or note, as applicable to the specific member.
 - c. Complete the “Date Current Treatment Plan was Developed” field.
 - d. Use the “Modify” link to update treatment goals as applicable.
7. Transition Discharge Plan Page:
 - a. Complete the “Is Discharge Anticipated during the Authorization Period?” field.
 - b. Complete the “Projected Date of Transition/Discharge” field as applicable.
 - c. Complete the “Anticipated Step Down Service” area as applicable.

- d. “Plan for Transition Discharge” – Specific but brief description of what symptoms/behaviors/functioning will be improved.
 - i. How will progress be measured?
 - ii. How will the frequency or intensity of the interventions be phased out or reduced over time?
 - iii. What services will be recommended after discharge? What are the dates those services will start?
 - iv. What are the current or expected barriers to discharge?
 - v. Are there any referrals to other services, and if so, what is the current status?
 - vi. Describe the relationship of caregiver supports (i.e. biological parents, foster family, etc.) if applicable.
 - vii. If discharged is planned before treatment goals are achieved, or if discharge is happening unexpectedly or against provider advice, please explain.
- 8. Additional Information Page:
 - a. Include a very brief overall summary of the progress in the past seven days with a focus on the *current* risk/safety issues and the intense behaviors that precipitated the service. For Substance Abuse services, in every CSR please state any substance use or abstinence within the review period, and if the member has used, what is being done to address this in treatment.
 - b. Note plans for the upcoming review period.
 - c. Overview of participation/attendance to this point.
 - d. Note factors that are impacting treatment (negatively or positively) and how those will be addressed.
 - e. If discharge had been planned for the prior review period and it has been determined that the member needs to continue service, please explain the barriers and/or new factors that contributed to that decision.
 - f. Complete the “Treatment Progress” field.
 - g. “Since the previous authorization how has the consumer progressed?” – How is the intensive outpatient program benefiting the member? Have there or will there be any adjustments to the delivery of service that will support progress?

C. Discharge Summary Instructions for Partial Hospitalization:

Intensive Outpatient Program staff are responsible for discharging members from the KEPRO CareConnection® web portal with one (1) business day of the day the member is discharged from the program.

- 1. Complete all fields in red.
- 2. Use the “Plan for Transition Discharge” field to note any additional pertinent information.

Section 65: Home and Community-Based Treatment (HCT) Services (Excluding MST and FFT)

The following KEPRO processes are required for:

1. HCT Child & Family Behavioral Health Treatment – Bachelor’s level
2. HCT Child & Family Behavioral Health Treatment – Master’s Level
3. HCT Child Welfare – Bachelor’s level
4. HCT Child Welfare – Master’s level
5. HCT Collateral – Bachelor’s level
6. HCT Collateral – Master’s level
7. HCT Collateral – Child Welfare

The KEPRO processes are:

- A. Contact for Service Notification
- B. Prior Authorization
- C. Continued Stay Review
- D. Discharge Review

A. Contact For Service Notification (CFSN) Process for Home and Community-Based Treatment:

***Please Note: Detailed, step-by-step instructions for entering Contact for Service Notifications are available in Appendix B. Instructions below describe requirements that are specific to Home and Community-Based Treatment CFSNs. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

The Contact for Service Notification (CFSN) is required if the member must wait for service one or more days. Submit a CFSN to KEPRO at the point that a member first contacts the provider or is referred for service. A CFSN is **not** required if members are assigned to a clinician the same day that they are referred. If members are assigned to a service within 24 hours, with no waiting time, the provider may submit an Initial Registration or a Prior Authorization request (as appropriate), without first submitting a Contact for Service Notification.

1. For every 30 day period a child remains on a waiting list the provider must create a new CSFN. The provider adds a note updating the current status of the child, any referrals that have been made on behalf of the child, and the expected assignment date.
 - a. Go to “Services Requested” and enter the KEPRO case ID of the *last dated* CFSN and click on Search. When it appears, click the “COPY” button.

- b. Verify that the “Date of Referral” on the Administrative page is the date the member was first referred to the agency (may be the same as the member’s first contact for service).
- c. Complete all fields on the Services Requested page, using the *Add New Procedure Request* link. Choose **CFSNH2021 – HCT 30 Day Wait List Update Note** for the service code. Modifiers are not necessary for the 30 Day Wait List Update.
- d. On the Additional Info page, enter the updated note in the text field. The updated note should include the current status of the child, any referrals that have been made on behalf of the child, and expected assignment date at the agency.
- e. If the child is removed from the wait list without being assigned, the provider submits a Discharge from the VERY FIRST dated Contact for Service Notification. The provider must report in the Discharge the reason that the child is removed from the wait list, any referrals that were made, and the living situation of the child at time of discharge.

B. Prior Authorization (PA) Process for HCT:

*Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to HCT Prior Authorizations. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. On the Multiaxial Assessment page, enter a diagnosis supporting severe emotional disturbance.
2. On the Symptoms/Behaviors page, complete the “Agency Involvement” and “Family/Social Involvement” fields.
3. Fill out the Clinical Indicators page to the best of your knowledge.
4. On the Additional Info page, please describe the following:
 - a. Reason for referral and source of referral.
 - b. Treatment History- Have lower level of care options been attempted and if not, why? Is this a step down from higher LOC (crisis, residential, hospital)?
 - c. When did member/family last have 65 HCT services? If so, what is the reason for re-referring now?
 - d. Are other siblings involved in HCT?

C. HCT Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to HCT Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

When submitting a CSR for the purpose of aligning it with the consumer's ISP, please make sure to note in the request "Submitted to Align CSR with ISP Date."

1. Multiaxial Assessment Page: Fill out the "Date of Diagnostic Assessment", "Primary Diagnosis", and any additional Axis I-IV information, if available.
2. Symptoms/Behavior Page:
 - a. YOQ scores can be added on the Additional Info page, but are not required.
 - b. Update "Agency Involvement" and "Family/Social Involvement" as needed.
3. Psychiatric Medications Page: Complete as applicable.
4. Individual Treatment Plan Page:
 - a. Fill out the "Individual Treatment Plan" as applicable, including the "Treatment Plan Goals" section.
 - i. *1st Continued Stay Review* - It is recommended that there be specific goals related to increased individual and family functioning.
 - ii. Progress statements should relate to specific goals identified e.g. how is/will the individual/family be better prepared to deal with the challenges the resulted in HCT referral.
 - b. The "Criteria for Discharge" section should be updated at every request.
5. Additional Required Reporting Data Page: Fill out the top of the page as applicable.
6. Transition Discharge Plan Page:
 - a. Discharge planning information is required at 2nd CSR and ongoing.
 - b. Discharge plan should be as specific as possible e.g. specific services, referral and timeframes. Plan should include documentation of case coordination to support treatment progress and successful transition to appropriate level of care.
7. Additional Information Page:
 - a. In the "Additional Information" section, provide the following:
 - i. Areas of clinical focus for this authorization period
 - ii. Anticipated clinician strategies/interventions/models used to support family in meeting treatment goals;
 - iii. Anticipated BHP strategies/interventions/models used to support family in meeting treatment goals;

- iv. Anticipated clinical and BHP frequency and durations of sessions (Example: 2 hours family therapy, 1 hour individual therapy, 3 hours 1x/week social skills training, 2 hrs. 3x./week coaching and supporting morning routine, etc.);
 - v. Anticipated titration during this authorization period;
 - vi. Describe expected level of caregiver involvement and how treatment goals will better prepare caregiver to manage members' behaviors and symptoms;
 - vii. Describe how HCT is coordinating with other services in accordance with MaineCare Rule 65.06-9.H "Meet with other service providers to plan and coordinate treatment to ensure the integration of the treatment across the members' home, school, and community, and to achieve the desired outcomes and goals identified in the ITP."
- b. Complete the "Treatment Progress" drop-down.

C. HCT Discharge Instructions:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to HCT Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 65: Home and Community-Based Treatment (HCT) Services (MST and FFT ONLY)

The following KEPRO processes are required for:

1. HCT – MST
2. HCT – MST – Problem Sex. Behaviors
3. HCT – Collateral – MST
4. HCT – Collateral – MST – Problem Sex. Behaviors
5. HCT – FFT
6. HCT – Collateral – FFT

The KEPRO processes are:

- A. Contact for Service Notification
- B. Initial Registration
- C. Continued Stay Reviews
- D. Discharge Review

A. Contact for Service Notification (CFSN) Process for Home and Community-Based

Treatment:*Please Note: Detailed, step-by-step instructions for entering Contact for Service Notifications are available in Appendix B. Instructions below describe requirements that are specific to Home and Community-Based Treatment CFSNs. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.** The Contact for Service Notification (CFSN) is required if the member must wait for service one or more days. Submit a CFSN to KEPRO at the point that a member first contacts the provider or is referred for service. A CFSN is not required if members are assigned to a Case Manager the same day that they are referred. If members are assigned to a service within 24 hours, with no waiting time, the provider may submit an Initial Registration or Prior Authorization request (as appropriate), without first submitting a Contact for Service Notification.

1. For every 30 day period a child remains on a waiting list the provider must create a new CFSN. The provider adds a note updating the current status of the child, any referrals that have been made on behalf of the child, and the expected assignment date.
 - a. Go to “Services Requested: and enter in the KEPRO Case ID of the *last dated* CFSN and click on Search. When it appears, click the “COPY” button.
 - b. Verify that the “Date of Referral” on the Administrative page is the date the member was first referred to the agency (date may be the same as the member’s first contact for service).
 - c. Complete all fields on the Services Requested page, using the *Add New Procedure Request* link.

- i. **For FFT services, choose CFSNH2021 – HCT 30 Day Wait List Update Note.**
- ii. **For MST Services choose CFSNH2033 – HCT – MST 30 Day wait list Update Note.**
- d. On the Additional Info page, enter the updated note in the text field. The updated note should include the current status of the child, any referrals that have been made on behalf of child, and expected assignment date at the agency.
- e. If the child is removed from the wait list without being assigned, the provider submits a Discharge from the VERY FIRST dated Contact for Service Notification. The provider must report in the Discharge the reason that the child is removed from the wait list, any referrals that were made, and the living situation of the child at time of discharge.

B. Initial Registration Process for HCT:

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe the requirements that are specific to HCT – MST and FFT Initial Registrations. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

The following pages must be completed for HCT MST and FFT Registration:

- a. Administrative Page
- b. Requesting Agency Page
- c. Services Requested Page

C. HCT Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe the requirements that are specific to HCT – MST and FFT Continued Stay Review. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

When submitting a CSR for the purpose of aligning it with the consumer's ISP, please make sure to note in the request "Submitted to Align CSR with ISP Date."

1. Multiaxial Assessment Page: Fill out the "Date of Diagnostic Assessment", "Primary Diagnosis", and additional Axis I-IV information, if available.
2. Symptoms/Behavior Page:
 - a. In the Assessment Tool section, include the date CAFAS of YOQ completed (entered under the "Date LOCUS Completed" box".

- b. Enter CAFAS scores in the dropdown boxes, if applicable, and Rater ID#. If YOQ screening is used instead of CAFAS, enter zero in the rater ID field and CAFAS score fields. YOQ scores can be added on the Additional Info page.
 - c. Update “Agency Involvement” and “Family/Social Involvement” as needed.
3. Psychiatric Medications Page: Complete as applicable
4. Individual Treatment Plan Page:
 - a. Fill out the “Individual Treatment Plan” as applicable, including the “Treatment Plan Goals” section.
 - i. *1st Continued Stay Review* – It is recommended that there be specific goals related to increased individual and family functioning.
 - ii. Progress statements should relate to specific goals identified e.g. how is/will the individual/family be better prepared to deal with the challenges that resulted in HCT referral.
 - b. The “Criteria for Discharge” section should be updated as every request.
5. Additional Required Reporting Data Page: Fill out the top of the page as applicable.
6. Transition Discharge Plan Page:
 - a. Discharge planning information is required at 2nd CSR and ongoing.
 - b. Discharge plan should be as specific as possible e.g. specific services, referral and timeframes. Plan should include documentation of case coordination to support treatment progress and successfully transition to appropriate level of care.
7. Additional Information Page:
 - a. Place a clinical note in the “Additional Information” section indicating any other information you feel would be relevant in supporting the member’s clinical need for services. Add additional supporting clinical rationale for this service if there is inconsistency among clinical presentation, tools, units requested and goals.
 - b. If YOQ was used, enter score.
 - c. Complete the “Treatment Progress” drop-down.

C. HCT Discharge Instruction:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to HCT Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection within 5 days of the actual discharge from services.
2. Complete all fields in red

3. If a CAFAS score was used, the most recent CAFAS score is required at time of Discharge. Include the most recent CAFAS score and date completed (entered in the “Date LOCUS Completed” box).

Section 65: Child Assertive Community Treatment

The following KEPRO processes are required for:

1. Child Assertive Community Treatment (ACT)

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Reviews
- C. Discharge Review

A. Prior Authorization Process for Child ACT:

*Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Child ACT Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Administrative Page:
 - a. "Start Date for Current Authorization Request" must be the date of the *first* face to face contact.
 - b. "Date of Referral" is the date the member was first referred to the agency.
2. Multiaxial Assessment Page:
 - a. Fill out the "Primary Diagnosis".
 - b. Fill out any additional Axis I - IV information, if available.
3. Symptoms/Behavior Page:
 - a. Please select any "Agency Involvement" and "Family/Social Involvement".
4. Psychiatric Medications Page: Complete as applicable.
5. Individual Treatment Plan Page: Fill out the "Individual Treatment Plan" as applicable, including the "Treatment Plan Goals" section. The "Criteria for Discharge" section should be updated at every request.
6. Additional Required Reporting Data Page: Fill the page as applicable.
7. Additional Information Page: Place a clinical note in the "Additional Information" section indicating any other information you feel would be relevant in supporting the

member's clinical need for services. Please include what lower levels of care have been attempted. Complete the "Treatment Progress" drop-down.

B. Child ACT Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Child ACT Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

When submitting a CSR for the purpose of aligning it with the consumer's ISP, please make sure to note in the request "Submitted to Align CSR with ISP Date."

1. Multiaxial Assessment Page:
 - a. Fill out the "Primary Diagnosis".
 - b. Fill out any additional Axis I - IV information, if available.
2. Symptoms/Behavior Page:
 - a. Please select any "Agency Involvement" and "Family/Social Involvement".
3. Psychiatric Medications Page: Complete as applicable.
4. Individual Treatment Plan Page: Fill out the "Individual Treatment Plan" as applicable, including the "Treatment Plan Goals" section. The "Criteria for Discharge" section should be updated at every request.
5. Additional Required Reporting Data Page: Fill the page as applicable.
6. Additional Information Page: Place a clinical note in the "Additional Information" section indicating any other information you feel would be relevant in supporting the member's clinical need for services. Complete the "Treatment Progress" drop-down.

C. Child ACT Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Child ACT Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 65: Outpatient (OP) Mental Health Services

The following KEPRO processes are required for:

1. Child **and/or** Adult Comprehensive Assessment / Outpatient Therapy:
 - a. Mental Health Agency
 - b. Mental Health Agency - Co-occurring
 - c. Individual Licensed LCSW, LCPC, LMFT - Non Agency
 - d. Mental Health Agency - Deaf & Geriatric
 - e. Psychologist – Independent
 - f. TF-CBT Child OP Contracted Providers ONLY
2. Child **and/or** Adult Outpatient Group Therapy:
 - a. Mental Health Agency
 - b. Mental Health Agency - Co-occurring
 - c. Ind. Lic. LCSW, LCPC, LMFT - Non Agency
 - d. Psychologist - Independent
3. Family PsychoEducational - Child and Adult

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Review
- C. Discharge Review

A. Initial Registration Process for Outpatient Mental Health Services

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Mental Health Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

The following pages must be completed for all Outpatient Mental Health Registrations:

- a. Administrative Page
- b. Requesting Agency Page
- c. Services Requested Page

B. Outpatient Mental Health Continued Stay Review (CSR) Instructions

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Mental

Health Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. **Multiaxial Assessment Page:** Fill in the “Date of Diagnostic Assessment” field. Fill in the “Primary Diagnosis” as well as “Axis I” and “Axis II” fields if applicable. “Axis III” is a text box for medical issues. Please fill out “Axis IV” using the drop down menu to rate each Psychosocial Stressor as None, Mild, Moderate, or Severe. Enter in the “Axis V - GAF” and identify how the GAF has changed since the last review.
2. **Symptoms and Behaviors Page:** Please complete the “Agency Involvement” and “Family/Social Involvement” sections.
3. **Psychiatric Medications Page:** All medications, both psychiatric and medical, should be entered in using either the “Add Medication” button or in the “Notes” area at the bottom of the page.
4. **Clinical Indicators Page:** Choose the most current symptoms and behaviors that the member has experienced during the previous authorization.
5. **Treatment and Service History Page:** Complete as applicable.
6. **Treatment Plan Page:** Complete all relevant fields, especially “Potential Barriers to Treatment” and “Criteria for Discharge”. In the “Treatment Plan Goals” section, update any existing long-term and short-term goals and identify progress towards goals. Add any new long-term goals as applicable.
7. **Additional Required Reporting Data Page:** Complete only the top portion, stopping when you reach the “PASRR Level II” section.
8. **Transition Discharge Plan Page:** Complete as appropriate. An update to this page is required at each Continued Stay Review.
9. **Additional Information Page:** Enter a short clinical note outlining frequency of sessions and the focus of treatment. Include updated information regarding the continued need for the service. If you feel it would be helpful, you may provide a narrative regarding the work that has been completed and the activities that are remaining. Select the appropriate option from the “Treatment Progress” drop-down.

C. Outpatient Mental Health Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Discharge Reviews are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Mental**

Health Discharge Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 65: Outpatient Substance Abuse (SA) Services

The following KEPRO processes are required for:

1. Substance Abuse Comprehensive Assessment / Outpatient Therapy
 - a. Substance Abuse Agency
 - b. Substance Abuse Agency Non-Masters LADC
 - c. Substance Abuse Agency CADC
2. Substance Abuse Outpatient Group Therapy
 - a. Substance Abuse Agency
 - b. Substance Abuse Agency Non-Masters LADC
 - c. Substance Abuse Agency CADC

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Reviews
- C. Discharge Review

A. Initial Registration Process for Outpatient Substance Abuse Services

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Substance Abuse Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

• Initial Registration approvals will be authorized for the full 30 weeks of units within a 40 week timeframe. If the client is in need of additional service beyond the Outpatient regulation, a Continued Stay Review will be required to be submitted and approved by KEPRO.

1. Multiaxial Assessment Page:
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis”. The primary diagnosis must be a substance abuse diagnosis or v61.41 for affected other.
2. Services Requested Page: Be sure to complete this step twice, adding the group therapy code even if it is not needed at the time, as you will not be able to add it to the review later. Doing so will maintain alignment with the 30 weeks of treatment in a 40 week period.

Process for Requesting Services beyond 30 Weeks in a 40 Week Time Frame

Identify if this is a new “episode” of treatment or a Continued Stay Request

***If New Episode of Treatment** – Document the clinical information requested and complete steps for an **Initial Registration**. Supporting documentation in the “Additional Information Section” needs to include a treatment timeline and sufficient clinical rationale for the new treatment episode. See example below:

Client returned to treatment after completing an episode 6/12/09. He/she experienced a death of a close relative in the family and began drinking again as a result in an attempt to cope with the loss. Client reports that he/she attempted to use the skills learned in prior treatment episode, but that his/her emotions got the better of him/her. Client is seeking skill reinforcement and support for this relKEPROe and will work on community recovery support connections as a goal in treatment. Anticipated timeline for transition to these recovery supports in the community is 4 weeks.

***If Continued Stay Review Request (CSR)** –Request should be completed with supporting documentation, within 10 days of the authorization end date. Clinical rationale for the requested extension should include a timeline and plan for transition to the most appropriate level of care upon discharge. See example below:

Client will reach initial maximum benefit 6/12/09. Client has made steady progress on treatment goals around maintaining abstinence, acquiring skills to manage high risk situations, developing recovery supports, and practicing assertive communication. Client recently lost a close family member and is experiencing some anxiety around his/her safety in the community and in the family. Client has requested to continue in treatment to have some added support with the goal of preventing relKEPROe and building community based “grief supports” that client can move to in the next month. Anticipated extension beyond initial maximum benefit is 3 weeks.

B. Outpatient Substance Abuse Continued Stay Review (CSR) Instructions

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Substance Abuse Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. **Multiaxial Assessment Page**: Update if necessary.
2. **Symptoms and Behaviors Page**: Under the Assessment Tool section, choose the correct ASAM Level from the drop down box.
3. **Clinical Indicators Page**: Update any information if necessary.

4. Transition Discharge Plan Page: Please enter in the projected discharged date and identify the plan for discharge in the Plan for Transition/Discharge box.
5. Additional Information Page: Fill out the appropriate information as follows:
 - State whether the member is DSAT, Suboxone, Drug Court, or Affected Other
 - Progress
 - Rationale for extension
 - Focus of treatment during requested extension

C. Outpatient Substance Abuse Discharge Instructions

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Substance Abuse Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 65: Medication Management Services

The following KEPRO processes are required for:

1. Adult and Child Medication Management

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Review
- C. Discharge Review

A. Initial Registration Process for Medication Management Services

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Medication Management Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

The following pages must be completed for all Medication Management Registrations:

- A. Administrative Page
- B. Requesting Agency Page
- C. Services Requested Page

B. Medication Management Continued Stay Review (CSR) Instructions

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Outpatient Mental Health or Medication Management Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Multiaxial Assessment Page: Fill in the “Date of Diagnostic Assessment” field. Fill in the “Primary Diagnosis” as well as “Axis I” and “Axis II” fields if applicable.
2. Psychiatric Medications Page: All medications, both psychiatric and medical, should be entered in using either the “Add Medication” button or the “Notes” area at the bottom of the page.
3. Additional Information Page: If you are aware that the member is receiving either duplicative or non-concurrent services, please provide additional rationale for the service. Enter a short clinical note outlining frequency of sessions and the focus of treatment. Include updated information regarding the continued need for the service. If

you feel it would be helpful, you may provide a narrative regarding the work that has been completed and the activities that are remaining. Select the appropriate option from the “Treatment Progress” drop-down.

C. Medication Management Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Discharge Reviews are available in Appendix B. Instructions below describe requirements that are specific to Medication Management Discharge Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

7. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
8. Complete all fields in red.

Section 65: Children's Day Treatment Provided by an Educational System

The following KEPRO processes are required for:

1. Children's Day Treatment Provided by an Educational System - Master's
2. Children's Day Treatment Provided by an Educational System - Bachelor's

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Review
- C. Discharge Review

A. Section 65 Day Treatment Services Prior Authorization (PA) Instructions:

***Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Day Treatment Services Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multi-axial Assessment Page:
 - a. Enter the "Primary Diagnosis" for the member if known and include any additional diagnoses.
2. Services Requested Page:
 - a. Complete the "Services Requested" page by requesting **both** the Bachelor's (BHP) and Master's (Clinician) codes.
 - b. If you are requesting a minimal amount (less than 1 hour a week, or 26 units) of the Master's code. Please include in the Additional Information who will be providing Clinical Oversight and how this will be done, per MaineCare Benefits Manual (65.06-13 "Clinical staff assumes responsibility for the medical necessity and the ITP development. It's covered if: (1) provided in an appropriate setting as specified in the ITP, (2) supervised by an appropriate professional as specified in the ITP, (3) performed by a qualified provider, and (4) billed by that provider.")
3. Treatment Plan Page:
 - a. Include preliminary information or refer the reader to the faxed Treatment Plan
4. Additional Information Page:
 - a. Include the reason for referral and source of referral.
 - b. Discuss the current behaviors and/or symptoms of the Member that require this level of care.

- c. If desired, include the Functional Assessment score or any addition information that supports the Member's eligibility for this service.
5. Fax a copy of the working Individual Education Plan (IEP) or Individual Treatment Plan (ITP) for the member to 1-866-325-4752. At PA, these documents are sometimes in draft form, or being developed; fax what documents are available for the Member.
NOTE: A PA will not be authorized without supporting documentation of the IEP and/or ITP.
6. Providers submit a Prior Authorization (PA) request to request to enroll a member into service. A PA is to determine a Member's eligibility for the service. Eligibility is determined by:
 - a. Determination from the IEP team that this service is medically necessary
 - b. Battelle, Bayley, Vineland or clinical assessment determining significant impairment; the member must either have a significant functional impairment 2 standard deviations below the mean in one domain of development or 1.5 standard deviations below the mean in at least two areas of development on the Battelle, Bayley, or Vineland.
 - c. Within thirty (30) days of the start of service, the member must have received a multi-axial evaluation and must have been diagnosed either with an Axis I or Axis II behavioral health diagnosis.

B. Section 65 Day Treatment Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Section 65 Day Treatment Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multi-axial Assessment Page:
 - a. Correct or update if needed
2. Services Requested Page:
 - a. Complete the "Services Requested" page by modifying **both** the Bachelor's (BHP) and Master's (Clinician) codes.
 - b. If you are requesting a minimal amount (less than 1 hour a week, or 26 units) of the Master's code. Please include in the Additional Information who will be providing Clinical Oversight and how this will be done, per MaineCare Benefits Manual (65.06-13 "Clinical staff assumes responsibility for the medical necessity and the ITP development. It's covered if: (1) provided in an appropriate setting as specified in the ITP, (2) supervised by an appropriate professional as specified in the ITP, (3) performed by a qualified provider, and (4) billed by that provider.")

3. Symptoms and Behaviors Page:
 - a. Complete the Family/Social Involvement as well as the Agency Involvement sections.
4. Treatment Plan Page: (preliminary information, or refer reader to faxed Treatment Plan)
5. Additional Information Page

1. Fax a copy of the current Individual Education Plan (IEP) and/or Individual Treatment Plan (ITP) for the member. NOTE: a CSR will not be authorized without supporting documentation of the IEP and/or ITP.
2. An eligible diagnosis for the child must be included in all Continued Stay Reviews.
3. In the Services requested page, be sure to adjust the units for the code(s) requested to match what is needed for the upcoming 180 days. 780 is the maximum allowed for the BHP.
4. Include the ITP on the Treatment Plan Page, and discuss progress when appropriate. This information can also be included within the Additional Information Page.
5. The Additional Information Page is where to capture all other information. If no Master's Codes are requested, discuss Clinical Oversight of the treatment per MaineCare Rule. Summarize the behavioral health needs, and to provide any information that has not been captured elsewhere in the request. If there is a change in the number of units since the last review, or if significant variability is expected within the upcoming 180 days, provide some description here. Any external factors that contribute to increased behaviors, symptoms or need in this period, or high usage of the service in this request can be listed here.

C. Children's Day Treatment Provided by an Educational System Discharge Instructions

***Note: Detailed, step-by-step instructions for entering Discharge Reviews are available in Appendix B. Instructions below describe requirements that are specific to Children's Day Treatment Provided by an Educational System Discharge Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red.

Section 92: Behavioral Health Home Services for Children and Adults

The following KEPRO processes are required for:

1. Behavioral Health Homes (BHH)

The KEPRO processes are:

- A. Contact for Service Notification
- B. Prior Authorization
- C. Continued Stay Reviews
- D. Discharge Reviews

A. Contact For Service Notification (CFSN) Process for Behavioral Health Home Services:

1. Providers have 1 business day to submit CFSNs to KEPRO for every member on their Behavioral Health Home wait list.
2. The CSFN is a 730 day / 1 unit service authorization.

B. Prior Authorization (PA) Process for Behavioral Health Home Services:

***Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Behavioral Health Home Services Prior Authorizations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Administrative Page:
 - a. "Start Date for Current Authorization Request" must be the date of the *first* face to face contact. *Please note: BHH services typically have to begin on the 21st of the month.*
2. Multiaxial Assessment Page:
 - a. You must include the "Date of Diagnostic Assessment". The date must be current (within one year).
 - b. Enter the "Primary Diagnosis", any additional diagnoses, and the "Axis V GAF" score. Diagnosis must meet Section 92 eligibility requirements per MaineCare Regulations 92.03-2
3. Symptoms/Behaviors Page:

- a. **For Adults:** In the Assessment Tool section, include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - b. **For Children:** enter the CAFAS scores, the CAFAS Rater ID must be entered into the “Rater ID” field. Submit the date this CAFAS was completed in the “Date LOCUS Completed (most recent)” field. Although this field is labeled “LOCUS,” for TCM it is reported as “Date CAFAS Completed.”
 - c. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
4. Psychiatric Medications Page: Although not required, it is helpful to include some information.
 5. Clinical Indicators Page: With specific focus on “Risk/Danger To Self/Others” section.
 6. Additional Information Page: Include any other information relevant to consumer eligibility for Section 92 services. Include a brief clinical description supporting member’s need for services.

C. Continued Stay Review (CSR) Instructions for Behavioral Health Home Services:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Community Support Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Multiaxial Assessment Page:
 - a. Correct or update if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 92 services and are consistent with the units of service requested.
2. Symptoms/Behaviors Page:
 - a. **For Adults:** In the Assessment Tool section, include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - b. **For Children:** enter the CAFAS scores, the CAFAS Rater ID must be entered into the “Rater ID” field. Submit the date this CAFAS was completed in the “Date LOCUS Completed (most recent)” field. Although this field is labeled “LOCUS,” for TCM it is reported as “Date CAFAS Completed.”
 - c. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.

3. Psychiatric Medications Page: Answer the questions and enter medications, including non-psychiatric medications, if available.
4. Clinical Indicators page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
5. Complete the Treatment and Service page.
6. Treatment Plan and Goals Page: Complete all information, consistent with the consumer's ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
7. Complete the Additional Required Reporting Data page.
 - a. Identify the specific and measureable criteria for discharge.
8. Complete the Transition Discharge Plan page.
9. Additional Information page
 - a. Include any additional information needed to demonstrate continued eligibility for Section 92 services and/or to demonstrate that the authorization request is consistent with the consumer's needs.

D. Discharge Instructions for Behavioral Health Home Services:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Behavioral Health Homes. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all fields in red and fill in the "Date LOCUS Completed", "LOCUS Composite Score", and "LOCUS Level of Care" fields.

Section 97: Appendix E PNMI Community Residences for Persons with Mental Illness

The following KEPRO processes are required for:

1. Adult PNMI – Rehabilitation Services
2. Adult PNMI – Personal care

The KEPRO processes are:

- A. Contact for Service Notification
- B. Initial Registration
- C. Continued Stay Reviews
- D. Discharge Review

A. Contact For Service Notification Process for Adult PNMI Appendix E Services:

When a PNMI placement is prioritized by DHHS Office of Adult Mental Health Services (OAMHS), OAMHS staff will enter a Contact for Service Notification in KEPRO CareConnection® for the member, with the approved provider and location. This process will ensure close coordination between DHHS, Providers and KEPRO in PNMI placement and treatment. *This process does not apply to Substance Abuse Facilities.*

The Contact for Service Notification (CFSN) Review is an administrative submission of data which allows KEPRO to provide required data to DHHS. This data helps KEPRO and DHHS monitor and initiate quality improvement activities regarding waiting lists, unmet needs, and continuity of care.

1. The CFSN is completed by DHHS staff only to update the record in CareConnection when consumers are approved for placement by DHHS.
2. The CFSN is a 730 day / 1 unit service authorization.
3. When a consumer is assigned a case manager the provider submits an Initial Registration to KEPRO, using the same procedure code as the CFSN. This removes the consumer from the waiting list.
4. If a consumer is removed from the waiting list without being assigned, the provider submits a discharge from the CFSN. The provider must state the reason the consumer is being removed from the waiting list, note any referrals that were made and note the living situation of the consumer at time of discharge.

B. Initial Registration (IR) Process for Adult PNMI Appendix E Services:

***Please Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

Providers will request Initial Registration for Adult Mental Health PNMI Services in KEPRO CareConnection®. **There must be a CFSN from DHHS Office of Adult Mental Health Services in place in KEPRO CareConnection® before the provider submits the Initial Registration to KEPRO.**

Providers need to submit clinical information as part of this request for KEPRO to determine medical necessity for PNMI services. KEPRO will determine the clinical eligibility, assure that OAMHS approved the member for the placement, and issue the authorization for service, or not. If the Initial Registration request is approved it can be authorized for up to 90 days. The member must be both approved by OAMHS for a provider and a location as well as receiving prior approval for clinical eligibility by KEPRO.

Providers do not use the DHHS-entered Contact for Service Notification to start the Initial Registration request. However, providers of Adult Mental Health PNMI Services are expected to review and take into account the DHHS recommendations, found in the Contact for Service Notification for that member.

To locate the Contact for Service Notification, use “Search Responses” in KEPRO CareConnection® to locate and review that member’s “Contact for Service Notification” for the correct service. KEPRO will utilize the DHHS recommendations as part of the decision making process for utilization review.

Reminder: All PNMI Initial Registrations, Continued Stay reviews, and Discharges must be submitted to KEPRO within 24 hours of admission and discharge, to ensure that PNMI Bed Tracking is accurate. See page 5 of this document for PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements.

Clinical Documentation Requirements for Adult Mental Health PNMI

1. Administrative Page:

- a. “Start Date for Current Authorization Request” must be the date of the *first* face to face contact.
- b. The “Date of Referral” is the date the consumer was first referred to your agency (it may be the same as the consumer’s first contact for service).
- c. Make sure to select the “Location Address” and “Location at Time of Referral”.

2. Multiaxial Assessment Page: Make certain the diagnosis fields are complete and demonstrate eligibility for Section 97 PNMI services. Include the following:
 - a. “Date of Diagnostic Assessment” - must be current (within 1 year).
 - b. Enter the “Primary Diagnosis”, any additional diagnoses, and the “Axis V GAF” score.
3. Services Requested Page: Select the procedure code that matches that chosen on the CFSN, which will remove the member from the wait list reports.
4. Symptoms/Behaviors Page:
 - c. In the Assessment Tool section include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - d. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
5. Complete Clinical Indicators section, with specific focus on the “Risk/Danger to Self/Others” section at the top.
6. On the Treatment Plan Page: Choose at least one option from the “Describe Member’s Strengths and Skills” field.
7. Transition/ Discharge Page: Enter the projected length of stay for service and discharge criteria.
8. On the Additional Information page include any other information relevant to consumer eligibility for Section 97 services. Include a brief clinical description supporting member’s need for services.
 - a. Reason for referral
 - b. Treatment Team Recommendations
 - c. Why this Level of Care?
 - d. Identification of 1-3 mental health needs and how this service/ LOC would be beneficial in meeting those needs.
 - e. Rehab focus on mental health needs that were basis for admission.
 - f. Specifics of LOCUS Dimension Ratings in Additional Information.

C. Adult PNMI Appendix E Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Guardian Information Page should be corrected or completed if appropriate.
2. Administrative Page:
 - c. Make sure the “Location Address” is still accurate.
3. Multiaxial Assessment Page: Make certain the diagnosis fields are complete, up to date, and demonstrate continued eligibility for Section 97 services. “Date of Diagnostic Assessment” must be current (within one year).
4. Symptoms/Behaviors page:
 - a. In the Assessment Tool section include the “Date LOCUS Completed” (must be current, within one year), LOCUS Subscales, “LOCUS Composite Score”, “Level of Care”, and “Rater ID#”.
 - b. Indicate “Agency Involvement” and “Family/Social Involvement” if applicable.
5. Psychiatric Medications Page: Answer the questions and enter medication.
6. Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
7. Complete the Treatment and Service page.
8. Treatment Plan and Goals Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
9. Complete the Additional Required Reporting Data page.
10. Complete the Transition Discharge Plan page.
11. Additional Information Page:
 - a. Include any additional information needed to demonstrate continued eligibility for Section 97 services and/or to demonstrate that the authorization request is consistent with the consumer’s needs.
 - b. When submitting a CSR for the purpose of aligning it with the consumer’s ISP, note on this page “Submitted to Align CSR with ISP Date.”

D. Adult PNMI Appendix E Services Discharge Instructions:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed**

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Fully complete the discharge page. Make sure to include the most recent “Date LOCUS Completed”, “LOCUS Composite Score”, and “LOCUS Level of Care”. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to.

PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements

Statement from DHHS

It is an expectation of the Department of Health and Human Services that PNMI providers that are contracted with DHHS and subject to the requirements of the Maine Behavioral Health (BH) ASO will fully comply with these requirements. Compliance will be assessed and enforced by the Department by all appropriate methods.

PNMI Bed Tracking

DHHS will use PNMI & Section 65 Crisis Unit Bed Tracking data to locate open beds, and to assign members to provider facilities. It is critical that providers adhere to the following process for two reasons:

1. To ensure that Bed Tracking data is accurate
2. For providers to promptly obtain the MIHMS PA Billing number.

To ensure accurate PNMI & Section 65 Crisis Unit Bed Tracking & Occupancy Data, all facilities are required to do the following:

1. **Register the consumer with KEPRO within 24 hours of admission to the facility.**
2. **Ensure that there is no IKEPROe in authorized days between continued stay authorizations.**
3. **Discharge consumer with KEPRO within 24 hours of discharge from the facility.**

Providers may submit registrations and discharges on the following Monday, for all admissions/discharges that take place on Saturday and Sunday.

These steps must be followed for both MaineCare members and for consumers without MaineCare eligibility.

Consumers without MaineCare:

1. Adults without MaineCare- since DHHS is the payor for PNMI & Section 65 Crisis Unit services for adults without MaineCare, the Department requires that submissions to KEPRO include consumer names, addresses and other demographic information.

2. Children without MaineCare- submissions to KEPRO for children without MaineCare may be de-identified.
3. For consumers without MaineCare, providers must submit an Initial Courtesy Review, Courtesy Continued Stay Reviews and a Discharge, when appropriate.

Section 97: Appendix F PNMI Mixed Medical and Remedial Facilities

The following KEPRO processes are required for:

1. Appendix F Adult

The facilities listed below are subject to the requirements of the Maine BH ASO: ([Appendix F: Principles of Reimbursement for Non-Case Mixed Medical and Remedial Facilities; MaineCare Benefits Manual](#))

1. Mount St. Joseph PNMI
2. Madawaska Group Home AMHC
3. Skyhaven, AMHC
4. 8 Hudson Street, OHI
5. Franciscan Home, Northern Maine General Hospital—Eagle Lake

These PNMI must follow all utilization review requirements with the following exceptions:

- I. Appendix F Facilities will not receive a MIHMS Billing number from KEPRO.
- II. The KEPRO Case ID is the authorization number. The provider is responsible to maintain a record of authorizations and authorization numbers issued.
- III. Any denials of authorization requests will be reported to the Department and taken into account in Departmental funding of these facilities.

The KEPRO processes are:

- D. Initial Registration
- E. Continued Stay Review
- F. Discharge Review

A. Initial Registration Process for Adult PNMI Appendix F Services:

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

Reminder: All PNMI Registrations, Continued Stay reviews, and Discharges must be submitted to KEPRO within 24 hours of admission and discharge, to ensure that PNMI Bed Tracking is accurate. See page 3 of this document for PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements.

1. Administrative Page:
 - a. “Start Date for Current Authorization Request” must be the date of the *first* face to face contact.
 - b. The “Date of Referral” is the date the consumer was first referred to your agency.
 - c. Make sure to select the “Location Address” and “Location at Time of Referral.”

B. Adult PNMI Appendix F Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Guardian Information Page: Complete if appropriate.
2. Administrative Page: Enter the start date and confirm Location Address.
3. Multiaxial Assessment Page:
 - a. Should be corrected or updated if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 97 services and are consistent with the units of service requested.
4. Symptoms/Behaviors Page:
 - a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 97 services.
 - b. In the Assessment Tool box, complete the LOCUS date completed, LOCUS Subscales, LOCUS composite score, level of care and Rater ID#. This will auto-populate from the prior review. Correct/update if appropriate.
 - c. Indicate Agency Involvement and Family/Social Involvement
5. Psychiatric Medications Page: Answer the questions and enter medications, including non-psychiatric medications, if available.
6. Clinical Indicators Page: Complete the page to show that current clinical presentation is consistent with the number of units of service requested.
7. Complete the Treatment and Service page.

8. Treatment Plan and Goals Page: Complete all information, consistent with the consumer's ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
9. Complete the Additional Required Reporting Data page.
10. Complete the Transition Discharge Plan page.
11. Additional Information Page:
 - a. Include any additional information needed to demonstrate continued eligibility for Section 97 services and/or to demonstrate that the authorization request is consistent with the consumer's needs.

C. Adult PNMI Appendix F Services Discharge Instructions:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Adult PNMI Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Fully complete the discharge page. Make sure to include the most recent LOCUS date completed, score and LOCUS level of care. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to.

PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements

Statement from DHHS

It is an expectation of the Department of Health and Human Services that PNMI providers that are contracted with DHHS and subject to the requirements of the Maine Behavioral Health (BH) ASO will fully comply with these requirements. Compliance will be assessed and enforced by the Department by all appropriate methods.

PNMI Bed Tracking

DHHS will use PNMI & Section 65 Crisis Unit Bed Tracking data to locate open beds, and to assign members to provider facilities. It is critical that providers adhere to the following process for two reasons:

3. To ensure that Bed Tracking data is accurate
4. For providers to promptly obtain the MIHMS PA Billing number.

To ensure accurate PNMI & Section 65 Crisis Unit Bed Tracking & Occupancy Data, all facilities are required to do the following:

- 4. Register the consumer with KEPRO within 24 hours of admission to the facility.**
- 5. Ensure that there is no IKEPROe in authorized days between continued stay authorizations.**
- 6. Discharge consumer with KEPRO within 24 hours of discharge from the facility.**

Providers may submit registrations and discharges on the following Monday, for all admissions/discharges that take place on Saturday and Sunday.

These steps must be followed for both MaineCare members and for consumers without MaineCare eligibility.

Consumers without MaineCare:

1. Adults without MaineCare- since DHHS is the payer for PNMI & Section 65 Crisis Unit services for adults without MaineCare, the Department requires that submissions to KEPRO include consumer names, addresses and other demographic information.
2. Children without MaineCare- submissions to KEPRO for may be de-identified.
3. For consumers without MaineCare, providers must submit an Initial Courtesy Review, Courtesy Continued Stay Reviews and a Discharge, when appropriate.

Section 97: PNMI Appendix D Child Care Facilities

The following KEPRO processes are required for:

1. Child PNMI – Mental Health Level I
2. Child PNMI – Mental Health Level II
3. Child PNMI – Mental Retardation Level I
4. Child PNMI – Mental Retardation Level II
5. Temporary High Intensity Service
6. CBHS Approved ONLY – Room and Board

The KEPRO processes are:

- A. Continued Stay Reviews
- B. Discharge Review

Children’s PNMI Admission, Prior Authorization KEPRO CareConnection Requirements

All Children’s PNMI Services (except for Crisis Units) must have and Intensive Temporary Residential Treatment Application Approved by KEPRO prior to admission to Children’s PNMI. Please see the Section 97 ITRT/THIS Application Process for more information. The Applications and information needed ITRT and THIS are also available on QualityCareforME.com.

The Prior Authorization Process for Children receiving Mental Health Level I, Child PNMI – Mental Health Level II, Child PNMI – Mental Retardation Level I, Child PNMI – Mental Retardation Level II and Temporary High Intensity Service:

KEPRO Clinical Care Managers enter in a Prior Authorization Request into KEPRO CareConnection when a child is approved and admitted to a facility:

1. The agency that has accepted the member will call KEPRO or email MaineIntake@KEPROHealthcare.com within 24 hours of the child being admitted to the PNMI.
2. The KEPRO Care Manager will follow up with the contact person of the residential facility to confirm Prior Authorization with the Case ID number to receive the authorization number in the download notification.

A. PNMI Appendix D Child PNMI Continued Stay Review (CSR) Instructions:

***Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to PNMI Appendix D Child PNMI Services Continued Stay Reviews. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. The Guardian Information page should be corrected if appropriate.
2. Multiaxial Assessment Page:
 - a. Should be corrected or updated if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 97 services and are consistent with the units of service requested.
3. Symptoms/Behaviors Page:
 - a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 97 services
 - b. Indicate Agency Involvement and Family/Social Involvement
4. Psychiatric Medications Page: Answer the questions and enter medications, including non-psychiatric medications, if available.
5. Clinical Indicators Page: Complete the page to show current clinical presentation. The “Current Severity” and “History of Severity” dropdown information should reflect the past 7 days, or the past 8-90 days.
6. Complete the Treatment and Service page as appropriate.
7. Treatment Plan and Goals Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
 - a. “Potential Barriers to Treatment” field: Describe current or anticipated barriers to treatment progress.
 - b. “Criteria for Discharge” field: How will you know when member is ready for discharge?
8. Complete the Additional Required Reporting Data page as appropriate.
9. Complete the Transition Discharge Plan page:
 - a. Complete the “Projected date of Transition/Discharge” field.
 - b. Complete “Anticipated Step-Down Services” fields as appropriate.

- c. "Treatment Progress" field: This is an important section to be completed. For example, is the member making progress towards goals? Is the family participating in treatment?

10. Additional Information page: Briefly describe the following:

- a. Reason for Admission
- b. Brief explanation of *current* clinical presentation. Explanation/description of symptoms and behaviors across environments: home/school/community.
Example: *Moderate aggression within 8-90 days = Daily incidents of aggression; hitting, kicking, punching family members, school personnel and peers.*
- c. Explanation of Clinical Indicators: Have symptoms/behaviors increased or decreased over most recent review period? Please explain.
- d. Provide information on co-morbid medical and/ substance abuse issues.
- e. Recommended treatment modality; Is family participating in treatment? Is team working towards discharge? What is the anticipated timeline and the referrals to be completed for the transition?

C. PNMI Appendix D Child PNMI Services Discharge Instructions:

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to PNMI Appendix D Child PNMI Services Discharges. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Fully complete the discharge page. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to, as well as the "Living situation at time of discharge".

PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements

Statement from DHHS

It is an expectation of the Department of Health and Human Services that PNMI providers that are contracted with DHHS and subject to the requirements of the Maine Behavioral Health (BH) ASO will fully comply with these requirements. Compliance will be assessed and enforced by the Department by all appropriate methods.

PNMI Bed Tracking

DHHS will use PNMI & Section 65 Crisis Unit Bed Tracking data to locate open beds, and to assign members to provider facilities. It is critical that providers adhere to the following process for two reasons:

1. To ensure that Bed Tracking data is accurate
2. For providers to promptly obtain an Authorization Number for billing purposes

To ensure accurate PNMI & Section 65 Crisis Unit Bed Tracking & Occupancy Data, all facilities are required to do the following:

- 7. Register the consumer with KEPRO within 24 hours of admission to the facility.**
 - 1. Ensure that there is no IKEPROe in authorized days between continued stay authorizations.**
 - 2. Discharge consumer with KEPRO within 24 hours of discharge from the facility.**

Providers may submit registrations and discharges on the following Monday, for all admissions/discharges that take place on Saturday and Sunday.

These steps must be followed for both MaineCare members and for consumers without MaineCare eligibility.

Consumers without MaineCare:

1. Children without MaineCare- submissions to KEPRO for children without MaineCare may be de-identified.
2. For consumers without MaineCare, providers must submit an Initial Courtesy Review, Courtesy Continued Stay Reviews and a Discharge, when appropriate.

Section 97: PNMI Appendix D Child Care Facilities - Treatment Foster Care

The following KEPRO processes are required for:

1. Treatment Foster Care Level C
2. Treatment Foster Care Level D
3. Treatment Foster Care Level E

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Reviews
- C. Discharge Review

A. **Initial Registration Process for Treatment Foster Care Services:**

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Treatment Foster Care Services Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Administrative Page:
 - a. "Start Date for Current Authorization Request" must be the date of the *first* face to face contact.
 - b. The "Date of Referral" is the date the consumer was first referred to your agency (it may be the same as the consumer's first contact for service).
 - c. Make sure to select the "Location Address."
2. Services Requested Page: Select the appropriate service code/level.

Requesting a Level Change at time of Continued Stay Review Request

If a level change is needed, please submit a Continued Stay Review request from the most current authorization. Complete the request as described below, with current clinical documentation. In the "Additional Information" section, you must copy and paste the following message, inputting the appropriate levels where indicated:

****Requesting a Level Change from Level (C, D, E) to Level (C, D, E)****

- The KEPRO Care Manager will review the request and make a determination to either approve the request or refer it to the KEPRO Physician Advisor who will approve or deny the request.
- If a change in level is approved, the procedure code in the review will be changed to the newly approved TFC Level procedure code by KEPRO staff and the provider will be notified in the Download Notification.
- If the Physician Advisor does not approve the requested change in TFC level, but does decide that the child meets medical necessity for another level of TFC a partial authorization specifying the approved level will be issued.
- If the KEPRO Physician Advisor determines that a child does not meet medical necessity for Treatment Foster Care levels C, D or E, they will determine whether a child meets level of care for either Level A or Level B. A note describing the approved Level A or Level B will be placed in the provider Download as well as being included in the KEPRO report to the DHHS Levels of Care Program Manager.

B. Treatment Foster Care Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Treatment Foster Care Services Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

When submitting a CSR for the purpose of aligning it with the consumer's ISP, please make sure to note in the request "Submitted to Align CSR with ISP Date."

1. Multiaxial Assessment Page: Make certain the diagnosis fields are complete and demonstrate eligibility for Section 97 services. You must include the "Date of Diagnostic Assessment", the "Primary Diagnosis", and "Axis V GAF" score.
2. Symptoms/Behaviors Page:
 - a. Fill out the "Caregiver Questionnaire" drop-down.
 - b. In the Assessment Tool section, include the date CAFAS completed (entered in the "Date LOCUS Completed" box), CAFAS scores, and Rater ID#. ** CHAT scores are entered on the Additional information page.*

C. Treatment Foster Care Services Discharge Instructions:

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Treatment Foster Care Services Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Discharge the consumer in KEPRO CareConnection® within 5 days of the actual discharge from services.
2. Complete all items in red.
3. Include the most recent CAFAS Scores and date completed (entered in the “Date LOCUS Completed” box).
4. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to.

Denial/Partial Authorization Process

1. If KEPRO authorizes a decreased LOC within TFC (e.g. from E to D or E to C) KEPRO notifies provider via Download and DHHS via daily report and letter.
2. If KEPRO determines that a child does not meet DHHS LOC rules (and medical necessity criteria) for TFC, KEPRO will alert the DHHS LOC Manager.
3. KEPRO issues a Partial Authorization, for 60 days, with the expectation that the child will be discharged from TFC at the end of the 60 day authorization.
4. KEPRO will determine if the child is at level A or B, and notify DHHS via the care manager note and the provider via the provider note.

Appeal Process

1. If KEPRO decreases LOC within TFC (e.g. from E to D or E to C):
 - a. Provider may request reconsideration by KEPRO
 - b. If the Foster Family does not agree with the outcome of the reconsideration, they may request an Administrative Hearing with the DHHS Office of Administrative Hearings.
 - c. The Foster Family will contact the DHHS Levels of Care Program Manager to request the hearing.
 - d. The Department will request a copy of the clinical record from the KEPRO Appeals/Complaint Coordinator concerning the decision. KEPRO will fax a copy of the record to DHHS upon request.
 - e. The DHHS Levels of Care Program Manager will represent DHHS at the hearing.
 - f. If a Foster Family Appeal is upheld:
 - i. DHHS will fax a copy of the written decision to the KEPRO Quality Coordinator.
 - ii. The KEPRO Quality Coordinator will ensure that the DHHS decision is reflected in KEPRO CareConnection® and in the Download Notification to the provider.
 - iii. The authorized level is changed back to the level originally requested, as of the date of the original request.
2. If KEPRO determines that a child does not meet DHHS LOC rules (and medical necessity criteria) for TFC, and issues a denial or partial authorization of the request:
 - a. Provider may request reconsideration by KEPRO.
 - b. Member/Guardian may appeal to DHHS Office of Administrative Hearings.

Section 97: Appendix D Child Care Facilities – Multidimensional Juvenile Justice Program TFC

The following KEPRO processes are required for:

1. Multidimensional Juvenile Justice Program TFC

The KEPRO processes are:

- A. Prior Authorization
- B. Continued Stay Reviews
- C. Discharge Review

Children's PNMI Admission, Prior Authorization KEPRO CareConnection Requirements

All Children's PNMI Services (except for Crisis Units) must be prior authorized for admission by DHHS-OCFS UR Staff. Please see the DHHS-OCFS website for instructions about the ITRT process.

The Prior Authorization Process for Children Multidimensional juvenile Justice Program TFC

DHHS-OCFS Utilization Specialist enters a Prior Authorization Request into KEPRO CareConnection when a child is approved and admitted to a facility:

1. The OCFS Utilization Specialist will notify the treatment agency of final approval of admission.
2. The designated residential treatment provider will contact the OCFS Utilization Review Specialist on the day of admission to the facility to request that the Prior Authorization be entered into the KEPRO CareConnection system. The Utilization Review Specialist will acquire the correct MaineCare NPI from the provider at this time.
3. OCFS staff is responsible for entering the correct MaineCare NPI(s), procedure code, facility location, and relevant clinical information in the PA submission using KEPRO CareConnection.
4. The OFCS Utilization Review Specialist will submit the Prior Authorization request into KEPRO CareConnection for that child's admission within 1 business day of being informed of the admission date to the residential facility.

5. The KEPRO Care Manager will confirm the OCFS Prior Authorization, will process the request and will issue the authorization number to the provider in the download notifications.

A. Prior Authorization (PA) Process for Multidimensional Juvenile Justice Program TFC:

*Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Multidimensional Juvenile Justice Program TFC Services Prior Authorizations. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

The OFCS Utilization Review Specialist will submit the Prior Authorization request in KEPRO CareConnection for that child's admission within 1 business day of being informed of the admission date to the residential facility.

B. Multidimensional Juvenile Just Program TFC Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Multidimensional Juvenile Justice Program TFC Services Prior Authorizations. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Guardian Information Page: Should be corrected if appropriate
2. Multiaxial Assessment Page:
 - a. Should be corrected or updated if needed
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 97 services and are consistent with the units of service requested
3. Symptoms/Behaviors Page:
 - a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 97 services.
 - b. In the Assessment Tool box, complete the CAFAS date completed, CAFAS score, and Rate ID #. If using the CHAT assessment tool please select the total score from the drop down menu.
 - c. Indicate Agency Involvement and Family/Social Involvement.
4. Psychiatric Medications Page: Answer the questions and enter medications, including non-psychiatric medications, if available.

5. Clinical Indicators Page: Complete the page to show that current clinical presentation. The “Current Severity” and “History of Severity” dropdown information should reflect the past 7 days, or the past 8-90 days.
6. Complete the Treatment and Service page.
7. Treatment Plan and Goals Page: Complete all information consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
8. Additional Required Reporting Data Page: Complete the top section.
9. Transition Discharge Plan Page:
 - a. Complete the “Projected date of transition/Discharge” field.
 - b. Completed “Anticipated Step-Down Services” fields as appropriate.
 - c. “Treatment Progress: field: This is an important section to be completed. For example, is the member making progress towards goals? Is the family participating in treatment?
10. Additional Info Page:
 - a. Include any additional information needed to demonstrate continued eligibility for services and/or to demonstrate that the authorization request is consistent with the consumer’s needs.
 - b. If using the CHAT assessment tool subscale scores and total scores should be included in this section.

D. Multidimensional Juvenile Justice Program TFC Services Discharge Instructions:

*Note: Detailed, step-by-step instructions for entering Prior Authorizations are available in Appendix B. Instructions below describe requirements that are specific to Multidimensional Juvenile Justice Program TFC Services Prior Authorizations. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection within 5 days of the actual discharge from services.
2. Fully complete the discharge page. Make sure to include the most recent CAFAS or CHAT and date completed. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to.

Section 97: Intensive Temporary Residential Treatment Application - Appendix D **Application for Children's PNMI**

The following KEPRO processes are required for:

1. Child PNMI – Mental Health Level I
2. Child PNMI – Mental Health Level II
3. Child PNMI – Mental Retardation Level I
4. Child PNMI – Mental Retardation Level II
5. CBHS Approved ONLY – Room and Board

The KEPRO processes are:

- A. Faxing the Intensive Temporary Residential Treatment Application

Intensive Temporary Residential Treatment Application Process

If a youth's team has explored all other community-based options and have determined that residential treatment should be explored, the Application for Intensive Temporary Residential Treatment and it's supporting documents are submitted for review and determination of the medical necessity, based on Section 97 in the MaineCare Benefits Manual, for Children's PNMI Treatment.

Children's Intensive Temporary Residential Treatment Application Requirements

All required documents can be located on QualityCareforME.com; Select Providers, and MANUALS AND FORMS. Find [Section 97 - Intensive Temporary Residential Treatment \(ITRT\)](#), and a listing of the Application and other documents to aid in submitting the ITRT application. There is also information on the Process and a Consultation Guide to help a Youth's Treatment Team determine if Residential Treatment is the correct treatment.

Required Documentation to support need for Residential Treatment:

1. AXIS I-V diagnosis list provided by the most current licensed mental health provider within the last 6 months. (If using the DSM V, Axis V/GAF is not required)
2. GAF, CAFAS OR CHAT score completed within 10 days of the application date. Entire scoring tool must be submitted for CAFAS/CAHT, Written justification must be submitted for the GAF.

3. Treatment progress notes from ALL mental health providers from the past 2 months (i.e. Individual Clinicians, Psychiatry, HCT, RCS, Case Management, Crisis Programs, Hospitals, Therapeutic Foster Care, etc.)
4. Mobile Crisis Assessments from past 2 months, or within 6 months to support Application.
5. Physician/PCP letter – MaineCare Rule (97.02) requires that a physician or primary care provider must document and provide a letter stating that residential treatment is medically necessary for the member as a part of the prior authorization process. This can be a Primary Care Provider or the child's Psychiatric/Medication Provider.
6. Any incident reports from past 2 months from any provider (i.e. Police, Crisis, Hospital, School, Animal Control, Fire Department, Therapeutic Foster Care, etc.)
7. The most recent Evaluation, if applicable (i.e. Psychological, Psychiatric, Neurological, Psychosexual, etc.)
8. If the child is currently in a Correctional Facility, please provide the information listed above for the 2 months prior to the youth entering the facility.
9. **ALSO HELPFUL:** Discharge Summaries from Hospital or Crisis Units Level of Care from within 4-6 months of treatment.
10. **NOT NEEDED:** Treatment Plans, Crisis Plans, Individual Education Plans or other documents that do not support the mental health/behavioral health needs of the child.

If the child is already in a PNMI/Residential Facility, and a transfer is being requested, less information is needed. Required Documentation is as follows:

1. ITRT Application
2. Clinical Statement/Summary outlining the clinical rationale for the proposed change

KEPRO Process for Reviewing ITRT Applications

The Application is reviewed for completeness for supporting documents. The Intake Team from KEPRO will contact the referral source if additional information is needed. Providers have 7 days to provide all the needed documents. The can be faxed to 866-325-4752; can be mailed to 600 Sable Oaks Drive, South Portland, ME 04106; or dropped off in person.

When Application is complete:

1. The Application is reviewed by the Clinical Team
2. A determination is made, or sent to the Physician Team for additional review.
3. An email is sent to the referral source when a determination is made.
4. **If Approved**, the Approval Letter and list of the Children's PNMI locations in the state is faxed to the referral source. A letter is mailed to the Guardian.
5. **If Denied**, the Denial Letter is faxed to the referral source, and a letter to the Guardian.
6. The treatment team decides on the appropriate agencies/facilities for the youth, and calls to schedule interviews and to check on availability of placements.

7. When admitted, the Admitting Facility contacts KEPRO within 24 hours. An KEPRO Clinical Care Manager will enter Prior Authorization for the child.

Section 97: Intensive Temporary Residential Treatment Application & Temporary High Intensity Service- Appendix D Application for Children's PNMI

The following KEPRO processes are required for:

1. Child PNMI – Mental Health Level I
2. Child PNMI – Mental Health Level II
3. Child PNMI – Mental Retardation Level I
4. Child PNMI – Mental Retardation Level II
5. CBHS Approved ONLY – Room and Board
6. Temporary High Intensity Services

The KEPRO processes are:

- A. Faxing the Intensive Temporary Residential Treatment Application and supporting documents
- B. Faxing the Temporary High Intensity Service Application and supporting documents
- C. Continued Stay Review for Temporary High Intensity Service

Intensive Temporary Residential Treatment Application Process

If a youth's team has explored all other community-based options and have determined that residential treatment should be explored, the Application for Intensive Temporary Residential Treatment and its supporting documents are submitted for review and determination of the medical necessity, based on Section 97 in the MaineCare Benefits Manual, for Children's PNMI Treatment.

Children's Intensive Temporary Residential Treatment Application Requirements

All required documents can be located on QualityCareforME.com; Select Providers, and MANUALS AND FORMS. Find [Section 97 - Intensive Temporary Residential Treatment \(ITRT\)](#), and a listing of the Application and other documents to aid in submitting the ITRT application. There is also information on the Process and a Consultation Guide to help a Youth's Treatment Team determine if Residential Treatment is the correct treatment.

Required Documentation to support need for Residential Treatment:

1. AXIS I-V diagnosis list provided by the most current licensed mental health provider within the last 6 months. (If using the DSM V, Axis V/GAF is not required)

2. GAF, CAFAS OR CHAT score completed within 10 days of the application date. Entire scoring tool must be submitted for CAFAS/CAHT, Written justification must be submitted for the GAF.
3. Treatment progress notes from ALL mental health providers from the past 2 months (i.e. Individual Clinicians, Psychiatry, HCT, RCS, Case Management, Crisis Programs, Hospitals, Therapeutic Foster Care, etc.)
4. Mobile Crisis Assessments from past 2 months, or within 6 months to support Application.
5. Physician/PCP letter – MaineCare Rule (97.02) requires that a physician or primary care provider must document and provide a letter stating that residential treatment is medically necessary for the member as a part of the prior authorization process. This can be a Primary Care Provider or the child's Psychiatric/Medication Provider.
6. Any incident reports from past 2 months from any provider (i.e. Police, Crisis, Hospital, School, Animal Control, Fire Department, Therapeutic Foster Care, etc.)
7. The most recent Evaluation, if applicable (i.e. Psychological, Psychiatric, Neurological, Psychosexual, etc.)
8. If the child is currently in a Correctional Facility, please provide the information listed above for the 2 months prior to the youth entering the facility.
9. **ALSO HELPFUL:** Discharge Summaries from Hospital or Crisis Units Level of Care from within 4-6 months of treatment.
10. **NOT NEEDED:** Treatment Plans, Crisis Plans, Individual Education Plans or other documents that do not support the mental health/behavioral health needs of the child.

If the child is already in a PNMI/Residential Facility, and a transfer is being requested, less information is needed. Required Documentation is as follows:

3. ITRT Application
4. Clinical Statement/Summary outlining the clinical rationale for the proposed change

KEPRO Process for Reviewing ITRT Applications

The Application is reviewed for completeness for supporting documents. The Intake Team from KEPRO will contact the referral source if additional information is needed. Providers have 7 days to provide all the needed documents. The can be faxed to 866-325-4752; can be mailed to 600 Sable Oaks Drive, South Portland, ME 04106; or dropped off in person.

When Application is complete:

1. The Application is reviewed by the Clinical Team
2. A determination is made, or sent to the Physician Team for additional review.
3. An email is sent to the referral source when a determination is made.
4. **If Approved**, the Approval Letter and list of the Children's PNMI locations in the state is faxed to the referral source. A letter is mailed to the Guardian.
5. **If Denied**, the Denial Letter is faxed to the referral source, and a letter to the Guardian.

6. The treatment team decides on the appropriate agencies/facilities for the youth, and calls to schedule interviews and to check on availability of placements.
7. When admitted, the Admitting Facility contacts KEPRO within 24 hours. An KEPRO Clinical Care Manager will enter Prior Authorization for the child. The Care Manager will contact the PNMI with the KEPRO CareConnection Case Identification number to receive authorization number in the Provider's download.

Temporary High Intensity Service Process (THIS)

All required documents can be located on QualityCareforME.com; Select Providers, and **MANUALS AND FORMS**. Find [Section 97 - Intensive Temporary Residential Treatment \(ITRT\)](#), and underneath [Section 97 Temporary High Intensity Service Application](#). Here you will find the application and information needed for applying for THIS. It is the expectation that increased staffing within a child PNMI be Prior Authorized by KEPRO, and that a Continued Stay Review will be reviewed no less than every 7 calendar days. An Individualized Treatment Plan must be submitted and approved by KEPRO prior to the implementation. Typical length of this increased staffing is seven (7) days and is not meant to exceed thirty (30) days. In situations where this is sought for thirty or more days, the Continued Stay Review must provide adequate clinical support for medical necessity, as well as a plan to reduce and eventually end the Temporary High Intensity Service.

1. Complete the Temporary High Intensity Service Application
2. Include any supporting documentation to support the request. Some suggested documents are progress notes, incident reports, shift/milieu notes, crisis plan, Crisis Stabilization Until or hospitalization documentation.
3. Fax documents to KEPRO for Clinical Review. If additional information is needed, KEPRO may request it.
4. When approved, KEPRO Clinical Care Managers complete the Prior Authorization for THIS.

A. PNMI Appendix D Child PNMI Temporary High Intensity Service Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to PNMI Appendix D Child PNMI Services Continued Stay Reviews. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Guardian Information Page: should be corrected if appropriate.
2. Multiaxial Assessment Page:

- a. Should be corrected or updated if needed.
 - b. Make certain the diagnosis fields are complete and demonstrate continued eligibility for Section 97 services and are consistent with the units of service requested.
3. Symptoms/Behaviors Page :
 - a. Update the Symptoms/Behaviors Summary to demonstrate continued eligibility for Section 97 services
 - b. Indicate Agency Involvement and Family/Social Involvement
4. Psychiatric Medications page: Answer the questions and enter medications, including non-psychiatric medications, if available.
5. Clinical Indicators page: Complete the page to show current clinical presentation. The “Current Severity” and “History of Severity” dropdown information should reflect the past 7 days, or the past 8-90 days.
6. Treatment and Service Page: Complete as appropriate.
7. Treatment Plan and Goals Page: Complete all information, consistent with the consumer’s ISP, by answering or updating the applicable questions and adding or modifying goals at the bottom of the page.
 - a. “Potential Barriers to Treatment” field: Describe current or anticipated barriers to treatment progress.
 - b. “Criteria for Discharge” field: How will you know when member is ready for discharge?
8. Transition Discharge Plan Page:
 - a. Complete the “Projected date of Transition/Discharge” field.
 - b. Complete “Anticipated Step-Down Services” fields as appropriate.
 - c. “Treatment Progress” field: This is an important section to be completed. For example, is the member making progress towards goals? Is the family participating in treatment?
9. Additional Information Page: Briefly describe the following if it hasn’t been captured in other fields:
 - a. Reason for need for THIS.
 - b. Brief explanation of *current* clinical presentation. Explanation/description of symptoms and behaviors across environments: home/school/community. Requests are for 7 days, so keep the information specific to the 7 days of the THIS.

- c. Interventions tried and modified, and the plan for intervention to reduce the behaviors requiring this level of care.
- d. Continue to discuss the plan to reduce this level of support, changes needed to the child's treatment plan to allow for this change.
- e. Project the timeframe for reducing hours for the next 7 days.

C. PNMI Appendix D Child PNMI Services Discharge Instructions:

*Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to PNMI Appendix D Child PNMI Services Discharges. **Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Fully complete the discharge page. Enter anticipated discharge services and include the names of all agencies that the consumer is referred/transferred to, as well as the "Living situation at time of discharge".

Sections 65 and 96: Child and Adult Crisis Residential – Crisis Units

The following KEPRO processes are required for:

1. Adult Crisis Residential – Crisis Units
2. Child Crisis Residential – Crisis Units
3. Child PNMI Crisis Residential - Crisis Units

The KEPRO processes are:

- A. Initial Registration
- B. Continued Stay Reviews
- C. Discharge Review

A. Initial Registration (IR) Process for Sections 65 and 97: Child and Adult Crisis Residential – Crisis Units:

*Note: Detailed, step-by-step instructions for entering Initial Registrations are available in Appendix B. Instructions below describe requirements that are specific to Section 65: Child and Adult Crisis Residential – Crisis Units Initial Registrations. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. On the Administrative page:
 - a. Choose “Location Address”.

B. Sections 65 and 97: Child and Adult Crisis Residential – Crisis Units Continued Stay Review (CSR) Instructions:

*Note: Detailed, step-by-step instructions for entering Continued Stay Reviews are available in Appendix B. Instructions below describe requirements that are specific to Section 65: Child and Adult Crisis Residential – Crisis Units Continued Stay Review. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.

1. Guardian Information Page: Fill out or update if necessary.
2. Multiaxial Assessment page:
 - a. Fill out the “Date of Diagnostic Assessment” and “Primary Diagnosis”.
3. Symptoms/Behavior Page:
 - a. Please select any “Agency Involvement” and “Family/Social Involvement”.

4. Clinical Indicators Page: Complete this page by choosing the Current Severity, and History of Severity, for each indicator as applicable. The stated clinical symptoms should reflect the current symptoms and behaviors experienced, by this member, during the previous authorization period.
5. Individual Treatment Plan Page: Fill out the “Individual Treatment Plan” as applicable. The “Treatment Plan Goals” section and the “Criteria for Discharge” section should be updated at every request.
6. Transition Discharge Plan Page: Please enter in the projected discharged date, any anticipated step down services, and identify the plan for discharge in the “Plan for Transition/Discharge” box.

C. Child and Adult Crisis Residential – Crisis Units Discharge Instructions:

***Note: Detailed, step-by-step instructions for entering Discharges are available in Appendix B. Instructions below describe requirements that are specific to Section 65: Child and Adult Crisis Residential – Crisis Units Discharges. Please be sure to use BOTH the instructions in Appendix B AND the instructions below as needed.**

1. Discharge the consumer in KEPRO CareConnection® within 24 hours of the actual discharge from services.
2. Complete all fields in red.

PNMI & Section 65 Crisis Unit Bed Tracking and Bed Occupancy Report Requirements

Statement from DHHS

It is an expectation of the Department of Health and Human Services that PNMI providers that are contracted with DHHS and subject to the requirements of the Maine Behavioral Health (BH) ASO will fully comply with these requirements. Compliance will be assessed and enforced by the Department by all appropriate methods.

PNMI Bed Tracking

DHHS will use PNMI & Section 65 Crisis Unit Bed Tracking data to locate open beds, and to assign members to provider facilities. It is critical that providers adhere to the following process for two reasons:

1. To ensure that Bed Tracking data is accurate
2. For providers to promptly obtain the Authorization Number

To ensure accurate PNMI & Section 65 Crisis Unit Bed Tracking & Occupancy Data, all facilities are required to do the following:

- 1. Register the consumer with KEPRO within 24 hours of admission to the facility.**
- 2. Ensure that there is no IKEPROe in authorized days between continued stay authorizations.**
- 3. Discharge consumer with KEPRO within 24 hours of discharge from the facility.**

Providers may submit registrations and discharges on the following Monday, for all admissions/discharges that take place on Saturday and Sunday.

These steps must be followed for both MaineCare members and for consumers without MaineCare eligibility.

Consumers without MaineCare:

1. Adults without MaineCare- since DHHS is the payer for PNMI & Section 65 Crisis Unit services for adults without MaineCare, the Department requires that submissions to KEPRO include consumer names, addresses and other demographic information.
2. Children without MaineCare- submissions to KEPRO for children without MaineCare may be de-identified.
3. For consumers without MaineCare, providers must submit an Initial Courtesy Review, Courtesy Continued Stay Reviews and a Discharge, when appropriate.