Section 97 Children's Residential (PNMI) Submission Guidelines

PNMI Section 97 Clinical Documentation Guidelines

Per the MaineCare rule Chapter II, Section 97, it is important in every Continued Stay Review to provide a description of the behaviors and symptoms that necessitated residential treatment initially, and to describe how those are being addressed in residential treatment. Additionally, per MaineCare rule, providers must meet all the following requirements as part of their treatment plan: 1) A Description of the short-term and long-term treatment goals, focusing on specific benchmarks for the child to return home. 2) Family responsibility (i.e. visitation, family therapy sessions, contacting school, etc.) 3) Providers must include at least four family meetings per month as part of the treatment process unless documentation in the treatment plan indicates that such meetings are counterproductive to the child's progress. 4) Documentation of the current discharge planning and assessment at each clinical review of whether the child may be safely discharged.

Process:

The provider notifies KEPRO within 24 hours of the member entering the residential program. KEPRO enters a Prior Authorization in Atrezzo, which is authorized for a 30-day period, at the level that was determined at time of eligibility (Mental Health Level I or II; Intellectual Disabilities Level I or II). If the member does not have active MaineCare, an Initial Courtesy Review is entered.

Continued Stay Reviews can be requested for up to a 90-day period. If the member does not have active MaineCare, a Courtesy Continued Stay Review is entered. Continued Stay Reviews and Courtesy Continued Stay Reviews are clinically reviewed for eligibility and ongoing medical necessity.

Enter in the Case ID of the Prior Authorization, and click on extend.

Service Type: Section 97

Request Type: Continued Stay

Procedure: Level Determined at time of eligibility

-Up to 90 days can be requested

-Quantity: 1 unit= 1 day

Diagnosis: Update if there have been any changes

Clinical Information: Nothing is required at time of CSR

Attached documents: Upload the member's current treatment plan.

Questionnaires: Fill out the questionnaires in their entirety. The questionnaires ask all the information that is required to determine medical necessity. Please see below for discharge planning information to discuss with the team and include in the applicable sections in the Questionnaires.

Discharge Planning:

- Indicate if discharge is anticipated within the review period or not. Based on the progress made, what is the anticipated remaining length of stay? Has the estimated length of stay been communicated to the family/guardian, and what is their understanding of the target date of discharge?
- What is being done in treatment to prepare the family for discharge planning? If discharge is not expected by the end of the authorization period, how is treatment with member and family currently better preparing them for discharge and moving them forward to a transition back home?
- What is the current visitation schedule and the plan for increasing the duration of visits for the authorization period?
- What services will be recommended upon discharge and when will those referrals be made? Who on the team is responsible for making these referrals?
- If there are concerns about member's discharge disposition, it is important to clearly indicate the level of communication and planning in working with member's guardian, along with any barriers impacting this. Please indicate the frequency of communications and meetings. Include the specific resources that have been explored and what other resources will be considered in order for member to transition to a lower level of care.
- If barriers to discharge disposition are based on member's behaviors or perceived level of possible risk, please include what is being done to address these barriers. What other resources have been explored?