VERMONT

Agency of Human Services

STANDARD OPERATING PROCEDURES MANUAL

FOR

VERMONT MEDICAID

INPATIENT PSYCHIATRIC AND

DETOXIFICATION

AUTHORIZATIONS

Department of Vermont Health Access
Department of Mental Health

Revised March 12, 2013

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INTRODUCTION

This manual describes processes to be followed by admitting facilities, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) when Medicaid primary beneficiaries are hospitalized for psychiatric or detoxification services.

Acute inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition and in order to transfer the person to a less restrictive level of care.

"Detoxification" means the planned withdrawal of an individual from a state of acute or chronic intoxication, under qualified supervision and with or without the use of medication. Detoxification is monitoring and management of the physical and psychological effects of withdrawal, for the purpose of assuring safe and rapid return of the individual to normal bodily and mental function. (Vermont Statutes, Title 33 §702). Inpatient detoxification refers to the medically managed treatment regimen used to support the withdrawal of the addictive substance.

Utilization/Care Management System

In 2012 the Department of Mental Heath (DMH) and the Department of Vermont Health Access (DVHA) collaborated to create a utilization management system for all Medicaid funded inpatient psychiatric and detoxification services. In response to the closing of Vermont's State Hospital and the resulting decrease in the number of available psychiatric inpatient beds, the DMH formed an expanded Care Management Unit to actively support the system of care in Vermont.

The goals for the utilization/care management system are as follows:

- Clinical care is provided only as long as necessary for safety and/or other acute needs.
- There are standardized criteria for admission, continued stay and discharge throughout the system of care.
- Care is continuous between the ongoing community treatment teams and episodes of inpatient care. Ideally the hospital and community teams develop and share a common treatment plan developed in partnership with the individual and their family, beginning within 24 hours of admission.
- Resources of the public system are effectively and efficiently used.
- The care management system will ensure access to effective, appropriate, recovery-based services that promote an individual's mental wellness and resiliency, and support successful integration into the community.

The utilization review (UR) staff are available Monday – Friday, 7:45am – 4:30pm (excluding holidays). All decisions regarding authorization for nights, weekends and holidays will be made during regular business hours. Should the situation arise outside of the regular business hours in which the clinical presentation of a beneficiary changes and

additional days are needed, the inpatient facility will notify the UR staff on the next business day and provide the clinical justification for the additional days needed. Every effort will be made to render an authorization decision at that time, but no later than the end of the business day.

Any cases that do not meet criteria, or where there is a potential to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be referred to a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease for determination. This would include currently licensed mental health professionals such as a Licensed Clinical Social Worker (LCSW), Licensed Psychologist, Licensed Clinical Mental Health Counselor (LCMHC), Licensed Alcohol and Drug Counselor (LADC) or a physician. The DVHA and the DMH will have in effect inter-rater reliability mechanisms to ensure consistent application of review criteria for authorization decisions.

Retrospective Review

The DVHA and the DMH will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud.

Retrospective Authorizations

It is the responsibility of the provider to notify the DVHA or the DMH of an inpatient admission and to initiate and complete the concurrent review process. As such, the DVHA and the DMH are under no obligation to perform retrospective authorizations due to lack of notification. Requests for retrospective authorizations due to lack of notification by the provider are considered solely at the discretion of the DVHA and the DMH. In the instance of a beneficiary whose Medicaid eligibility becomes retroactive to the time of the inpatient hospitalization, but who at the time of admission was not eligible for Medicaid, the provider may request that the DVHA or the DMH complete a retrospective review for authorization. The request, either orally or in writing, is made to the DVHA or the DMH. The supporting clinical documentation demonstrating that the inpatient level of care criteria were met for the days requested must be submitted for review. The DVHA or the DMH UR staff will make an authorization determination within 14 days.

Requests for a retrospective authorization may be made to the DVHA Senior Behavioral Health Care Manager by phone at 802-879-8232 or in writing to:

The Department of Vermont Health Access
ATT: Quality Unit
312 Hurricane Lane Suite 201
Williston, VT 05495

Contact Information

Admission Notification	(855) 275-1212 (Toll-free Fax)
Department of Vermont Health Access (DVHA)	(802) 879-5900 (Phone)
Department of Mental Health (DMH)	(802) 828-1723 (Phone) (802) 828-1720 (Phone) (802) 828-1717 (Fax)

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CHILDREN AND ADOLESCENTS
PSYCHIATRIC ADMISSIONS

Criteria for Inpatient Hospitalization:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) has adopted the *Child and Adolescent Level of Care Utilization System* (CALOCUS) instrument for determining authorization for psychiatric inpatient level of care. The CALOCUS guidelines represent a resource efficient evidence-based approach to the management of inpatient admissions and continued length of stay.

The CALOCUS provides a framework for defining the appropriate intensity of services and resources to meet the needs of children and adolescents. The instrument is a method of quantifying the clinical severity and service needs of three quite different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders.

Admission Process:

Youth whose primary insurance is Vermont Medicaid are assessed by designated Emergency Services (ES) staff from the Vermont Community Mental Health Centers (CMHC) prior to being admitted to a psychiatric inpatient facility. The purpose of assessment prior to an inpatient admission is for continuity of care, identification of intervention strategies, and appropriate determination for involuntary hospitalization. This includes assessment for less restrictive alternatives and review of any existing crisis plan for the youth. An inpatient psychiatric admission may be recommended or supported by the ES staff when:

1. The youth is in need of hospitalization based on admission criteria, and
2. Community and support system resources are exhausted, and
3. A less restrictive alternative is not available

ES staff is provided with an admission notification form that includes a list of available resources that must be contacted in order to make decisions related to appropriate level of care and treatment options (***Attachment 1***). This admission notification form must be faxed to the Department of Vermont Health Access (DVHA) by the next business day following an admission and reflect inpatient criteria met, as well as alternatives considered and reasons for ruling them out. The ES staff also arranges for transportation and admission to a psychiatric inpatient facility.

Children and adolescents who are out-of-state at the time of the admission will be screened by the admitting facility. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Inpatient Psychiatric Services* (***Attachment 2***).

Concurrent Review

The admitting facility (provider) will contact the DVHA utilization reviewer within 24 hours or the next business day of the admission to begin the concurrent review process. The utilization reviewer will make every effort to accommodate the provider regarding the information gathering (fax, phone, secure electronic transmission), however, the utilization reviewer may request additional information if needed to determine the authorization. Based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the clinical information. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.

Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with this decision they may request a Secondary Review (**see page 21**).

The DVHA expects that beneficiaries will discharge with scheduled follow-up appointments. The discharge plan will contain documentation of these appointments or documentation of the beneficiary's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing supporting clinical information justifying the inpatient admission.
- Initiating discharge planning at the time of admission, including but not limited to contact with family or guardian, primary care provider (PCP), all outpatient behavioral health treatment providers, the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living, the Department for Children and Families, the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP), and the Local Educational Agency (LEA). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and identification of expected discharge date.
- Documentation of the beneficiary's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment

resources.

- Prompt notification to the DVHA utilization reviewer of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA utilization reviewer can support the provider with initiating and engaging in active discharge planning.
- Providing the DVHA utilization reviewer with the necessary and pertinent information regarding the need for continued inpatient level of care including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.
- Contacting the utilization reviewer on or before the last covered day to request authorization for additional inpatient days.

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VOLUNTARY ADULTS (NON-CRT)
PSYCHIATRIC ADMISSIONS

Criteria for Inpatient Hospitalization:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) have adopted the *Level of Care Utilization System* (LOCUS) instrument for determining authorization for psychiatric inpatient level of care. The LOCUS guidelines represent a resource efficient evidence-based approach to the management of inpatient admissions and continued length of stay.

The LOCUS is an instrument that is sufficiently sensitive to distinguish appropriate needs and services for adults. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

For the specific cases of eating disorders, the DVHA and the DMH utilize the American Psychiatric Association (APA) Level of Care Guidelines for Patients with Eating Disorders.

Admission Process:

Adults whose primary insurance is Vermont Medicaid admitted to a facility for psychiatric inpatient services will be screened by the admitting facility (provider). All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The admitting facility will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Inpatient Psychiatric Services (**Attachment 2**)*.

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer will be assigned to begin the authorization process. All clinical information necessary to determine inpatient criteria are met will be provided with the admission notification form. The utilization reviewer will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the clinical information during the concurrent review. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.
Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with this decision they may request a Secondary Review (**see page 21**).

The DVHA and the DMH expect that beneficiaries will discharge with scheduled follow-up appointments. The discharge plan will contain documentation of these appointments or documentation of the beneficiary's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the utilization reviewer to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing supporting clinical information justifying the inpatient admission.
- Initiating discharge planning at the time of admission, including but not limited to contact with family or guardian, primary care provider (PCP), and all outpatient behavioral health treatment providers. The provider will contact the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) as needed. Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and expected discharge date.
- Documentation of the beneficiary's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment resources.
- Prompt notification to the utilization reviewer of barriers to active discharge planning including difficulties reaching the treatment team members. The utilization reviewer can support the provider with initiating and engaging in active discharge planning.
- Providing the utilization reviewer with the necessary and pertinent information regarding the need for continued inpatient level of care including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.
- Contacting the utilization reviewer on or before the last covered day to request authorization for additional inpatient days.

MEDICALLY MANAGED DETOXIFICATION

Criteria for Inpatient Hospitalization:

To ensure that the medically managed detoxification services are provided at an appropriate level of care and with the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) has adopted the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders for determining authorization for inpatient level of care. The ASAM Patient Placement Criteria represent a resource efficient evidence-based approach to the management of inpatient admissions and continued length of stay.

Admission Process:

All adults (ages 18 and over) whose primary insurance is Vermont Medicaid admitted to an inpatient facility for medically managed detoxification services will be screened by the admitting facility (provider). All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The provider will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Inpatient Psychiatric Services. (**Attachment 2**)*

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer will be assigned to begin the authorization process. All clinical information necessary to determine inpatient criteria are met will be provided with the admission notification form. The utilization reviewer will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review, based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the clinical information during the concurrent review. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.

Upon determination that clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day or the change in authorization status. If the inpatient facility disagrees with this decision they may request a Secondary Review (**see page 21**).

If, following completion of the medically managed detoxification process, the beneficiary demonstrates evidence of significantly acute psychiatric co-morbidity requiring inpatient care, the inpatient facility will be responsible for ensuring that the continued inpatient care is billed using the appropriate diagnosis. The hospital must notify the utilization reviewer of the request for continued inpatient stay on the last authorized day of the

medically managed detoxification process. The *Level of Care Utilization System* (LOCUS) instrument will be utilized for determining authorization for continued inpatient level of care.

The DVHA expects that beneficiaries will discharge with scheduled follow-up appointments. The discharge plan will contain documentation of these appointments or documentation of the beneficiary's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the utilization reviewer to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 hours or the next business day and providing supporting clinical information justifying the inpatient admission.
- Initiating discharge planning at the time of admission, including but not limited to contact with family or guardian, primary care provider (PCP), and all outpatient behavioral health treatment providers. The provider will contact the appropriate state liaison from the Department of Mental Health, the Department of Disability, Aging and Independent Living and/or the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) as needed. Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and expected discharge date.
- Documentation of the beneficiary's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment resources.
- Prompt notification to the utilization reviewer of barriers to active discharge planning including difficulties reaching the treatment team members. The utilization reviewer can support the provider with initiating and engaging in active discharge planning.
- Providing the utilization reviewer with the necessary and pertinent information regarding the need for continued inpatient level of care including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.
- Contacting the utilization reviewer on or before the last covered day to request authorization for additional inpatient days.

COMMUNITY REHABILITATION & TREATMENT (CRT)

Criteria for Inpatient Hospitalization:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) have adopted the *Level of Care Utilization System* (LOCUS) instrument for determining authorization for psychiatric inpatient level of care. The LOCUS guidelines represent a resource efficient evidence-based approach to the management of inpatient admissions and continued length of stay.

The LOCUS is an instrument that is sufficiently sensitive to distinguish appropriate needs and services for adults. It provides clear, reliable, and consistent measures that are succinct, but sufficient to make care or quality monitoring judgments.

Admission Process:

Initial interview and evaluation by Designated Agency screener

Staff from the Designated Agencies (DA) evaluate all proposed CRT psychiatric inpatient admissions. These staff are referred to as screeners.

The screener interviews and evaluates all individuals identified in need of psychiatric hospitalization for purposes of:

- Continuity of care
- Recommendation of immediate intervention strategies
- Determination of appropriateness for hospitalization
- Determination of appropriateness for involuntary hospitalization

This encounter includes assessment for less restrictive alternatives and review of any existing crisis plan for the individual. This screener records this information on the *CRT Crisis Intake Worksheet* (**Attachment 3)**.

If an involuntary hospitalization is sought, an *Application for Emergency Examination* must be completed (**Attachment 10)**. For further information see page 17.

If the admitting facility (provider) determines (through an emergency department or 'transfer' from a medical unit or another hospital) that a beneficiary presenting for admission is a CRT enrollee, the individual's DA emergency services program must be contacted to begin the assessment process. All emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. All elective admissions will require notification prior to admission. The provider will fax to the DVHA the *Vermont Medicaid Admission Notification Form for Inpatient Psychiatric Services (**Attachment 2)**.

For CRT inpatient hospitalization, the payer source upon admission remains the same payer throughout the episode of care regardless of any changes that occur during the course of treatment. For example, if an individual is enrolled in a CRT program after

being admitted to an inpatient facility for psychiatric services, the payer that covered the stay at the time of admission remains the payer for the entire episode of care. Conversely, if an individual is enrolled in a CRT program at the time of admission and is disenrolled prior to discharge from the inpatient facility, the original payer remains for the entire episode of care.

Concurrent Review:

During regular business hours, upon receipt of the admission notification form a utilization reviewer will be assigned to begin the authorization process. All clinical information necessary to determine inpatient criteria are met will be provided with the admission notification form. The utilization reviewer will contact the provider with the initial authorization decision or will request further information if necessary by the next business day. For purposes of concurrent review, based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the inpatient facility within 24 hours or 1 business day of receipt of the clinical information during the concurrent review. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization for additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.

Upon determination that the clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day for payment or the change in authorization status. If the inpatient facility disagrees with this decision it may request a Secondary Review (**see page 21**).

The DMH expects that beneficiaries will discharge with scheduled follow-up appointments. The discharge plan will contain documentation of these appointments or documentation of the beneficiary's refusal of appointments. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

INVOLUNTARY ADMISSIONS/EMERGENCY EXAMINATIONS

Admission Process:

A Qualified Mental Health Professional (QMHP) must evaluate all individuals regardless of treatment provider, program or payer source to determine the necessity for an involuntary hospitalization. A QMHP who is also employed by a hospital psychiatric unit must not be working in that capacity at the same time he/she is acting in the role of a QMHP. By agreement with the Department of Mental Health (DMH) and designated general hospitals, only QMHPs who are designated by the DMH Commissioner or designee and employed by a Designated Agency (DA) can screen and serve as the applicant for involuntary psychiatric admissions. (See ***Attachment 4*** for a detailed description of requirements and responsibilities.) The QMHP reports all admissions to the DMH Admission's Office and completes the *Application for Emergency Examination* (**Attachment 10)**.

Authorization Criteria for Continued Stay:

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) have adopted the *Level of Care Utilization System* (LOCUS) instrument for determining authorization for psychiatric inpatient level of care. The LOCUS guidelines represent a resource efficient evidence-based approach to the management of inpatient admissions and continued length of stay. The LOCUS is an instrument that is sufficiently sensitive to distinguish appropriate needs and services for adults. It provides clear, reliable, and consistent measures that are succinct but sufficient to make care or quality monitoring judgments.

Concurrent Review:

For all Medicaid primary involuntary admissions, upon receipt of the admission notification form, during regular business hours, the DMH will assign the admission to a utilization reviewer to begin the authorization process. All clinical information necessary to determine inpatient criteria are met will be provided on the admission notification form and/or the application for emergency examination. The utilization reviewer will contact the admitting facility (provider) with the initial authorization decision or to request further information if necessary. For purposes of concurrent review, based on information provided, the utilization reviewer will assign authorization in increments of 24 hours up to 7 days based upon the beneficiary's acuity level, unless extenuating circumstances exist and care providers agree to an exception. The utilization reviewer will render an authorization decision to the provider within 24 hours or 1 business day of receipt of the clinical information during the concurrent review. It is the provider's responsibility to contact the utilization reviewer on or before the last covered day to request authorization of additional inpatient days. If the provider does not contact the utilization reviewer to request authorization of additional inpatient days, the authorization will end and the utilization reviewer will generate a payment authorization in the MMIS.

Upon determination that the clinical criteria for inpatient level of care are no longer met, the utilization reviewer will inform the provider of the last covered day for payment or

the change in authorization status. If the provider disagrees with this decision they may request a Secondary Review (**see page 21**).

The DMH expects that beneficiaries will leave with scheduled follow up appointments documented on the discharge plan or documentation of the beneficiary's refusal. The discharge plan will be sent to the utilization reviewer and upon receipt a payment authorization will be entered into the MMIS.

In order for the utilization reviewer to make authorization determinations, the provider is responsible for:

- Initiating discharge planning at the time of admission, including but not limited to contact with family or guardian, primary care provider (PCP), the DMH assigned Care Manager and all outpatient behavioral health treatment providers. Discharge planning must include frequent coordination with team members, specific recommendations for aftercare and expected discharge date.
- Documentation of the beneficiary's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment resources.
- Providing the utilization reviewer with the necessary and pertinent information regarding the need for continued inpatient level of care including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.
- Prompt notification to the DMH Care Manager of barriers to active discharge planning including difficulties reaching the treatment team members. The DMH Care Manager can support the provider with initiating and engaging in active discharge planning and will update with the utilization reviewer of any discharge problems.
- Contacting the utilization reviewer on or before the last covered day to request authorization for additional inpatient days.

Dispute Resolution: Involuntary Hospitalization

If there is disagreement between the evaluating psychiatrist and a Qualified Mental Health Professional (QMHP) regarding the need to place a person on an **involuntary** status either at the time of admission or during the hospital stay, there is a process for resolution that must be followed.

When a person who is (1) evaluated in the emergency room, or (2) has been admitted to a hospital, expresses an intent to leave and the evaluating psychiatrist believes the person meets clinical/legal criteria for emergency examination but the QMHP does not agree:

1. If the QMHP decides that the circumstances do not warrant an emergency examination and an alternate proposal is not acceptable to the evaluating psychiatrist, the QMHP must review the circumstances with his/her supervisor

for confirmation of that decision. (Vermont statutes require that a person receive services in the least restrictive setting.) The QMHP then shall notify the evaluating psychiatrist of the position of the supervisor concerning the need for an emergency examination.

2. If the evaluating psychiatrist and the QMHP's supervisor disagree as to the need for an emergency examination, the evaluating psychiatrist then must contact the Designated Agency (DA) Medical Director or designated DA psychiatrist to inform him/her of that disagreement and review the case for resolution.

3. If the DA Medical Director or DA psychiatrist disagrees that the person meets emergency examination criteria, and the evaluating psychiatrist continues to assess that an emergency examination is warranted, the evaluating psychiatrist may seek an alternative "interested person", as defined in the emergency examination statute, to complete the appropriate paperwork. (The "interested person" should not be a subordinate of the psychiatrist.) After obtaining the application from the alternative "interested person," the evaluating psychiatrist may detain the person awaiting an evaluation by a second psychiatrist. As required by law, the examination by the second psychiatrist must be performed within one working day after the admission of the person for emergency examination.

4. If a second psychiatrist does not certify that this is a person meeting emergency examination criteria, then the person is required by law to be immediately released and returned to the place from which s/he was taken, or to some place as the person reasonably directs.

Note: All persons involved must be willing and make themselves available to testify in court.

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SECONDARY REVIEW

In the event an inpatient facility requests payment authorization from the Department of Vermont Health Access (DVHA) or the Department of Mental Health (DMH) for a particular beneficiary and payment authorization is denied or authorized at a lower payment status, the inpatient facility may request a secondary review. This process is not an appeals process; however, it does allow the provider to supply additional information. It is not a process for a review of policy or for review of any decision other than a decision to not authorize payment for a particular beneficiary. Requests for a secondary review must be made no later than 14 days after the utilization reviewer first gives notice, either written or oral, to the inpatient facility that payment for that particular beneficiary will not be authorized beyond a certain date or will be authorized at a lower payment status. The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe payment authorization is justified in that particular case. All clinical data must be submitted within the 14-day notice period (***Attachment 5***) and sent to the utilization reviewer. The DVHA and/or the DMH will notify the inpatient facility of its secondary review decision within 14 days of receipt of notice of the request with a possible extension of up to 14 additional calendar days if the enrollee or inpatient facility requests extension or the DVHA and/or DMH justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's interest.

CRT Beneficiaries
Reviews for CRT beneficiaries will include clinical representatives from the designated community agency, the inpatient facility and the DMH clinical staff who are delegated by the DMH Commissioner to serve this function. Delegated staff will conduct a clinical review and may issue a decision or request additional information from persons with knowledge of the issues prior to making a decision. The DMH Medical Director is encouraged to informally consult with another psychiatrist who has no vested interest in the determination regarding medical/clinical necessity and the clinical review process. The Medical Director will render a determination regarding authorization or denying the payment.

Non-CRT Beneficiaries
For all non-CRT beneficiaries the inpatient facility may request a discussion between clinicians involved in the care of the beneficiary and the DVHA and/or DMH clinical staff in order to further clarify the clinical information. The DVHA and/or DMH clinical staff will review the records, consider the discussion and undertake the reconsideration. The final secondary review decision will be made by an individual other than the original party. In the event of a disagreement between the inpatient facility and the DVHA and/or DMH regarding the secondary review decision, the inpatient facility's physician and/or Medical Director may request to speak with the DVHA and/or DMH designated physician for a final review of the authorization decision. There is no additional review after the third level of review, except at the sole discretion of the Commissioner or his/her designee.

<u>Expedited Decisions</u>

For cases in which the inpatient facility indicates or the DVHA and/or DMH determines

that following the standard timeframe could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function, the DVHA and/or DMH must make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later that 3 working days after receipt of the request for this service.

SUB-ACUTE AND AWAITING PLACEMENT STATUS

Sub-Acute Status

In order to determine when a beneficiary is eligible for the sub-acute status the following criteria will be utilized:

- The beneficiary no longer meets criteria for acute level of care determined by the authorization criteria. This determination will be based on the beneficiary meeting criteria for Level of Care 5 or below on the *Child and Adolescent Level of Care Utilization System* (CALOCUS) or *Level of Care Utilization System* (LOCUS) or Level III.7 or below on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders and is able to be discharged should the appropriate level of care be available, and;

- The beneficiary is no longer receiving acute inpatient services and has moved to sub-acute services. The criteria include, but are not limited to, that the initial psychiatric and medication evaluations have been completed and any significant medication adjustments have been made, and;

- No discharge placement has been identified or a discharge placement has been identified but is not available.

For beneficiaries whose clinical presentation results in significant difficulties in securing a discharge placement, authorization at acute level of care may continue for up to 45 days subsequent to the beneficiary no longer meeting Level of Care 5 or below. This 45 days period is to allow for active discharge planning and further stabilization to secure a placement. (*The 45 day marker will be used as a guideline for all cases that fall into this category*.) It is expected that regular active discharge planning will be happening prior to a beneficiary's move to sub-acute status. Once the beneficiary is moved to sub-acute status, regularly scheduled phone conferences will be put into place to include all appropriate parties involved in the discharge planning. These phone conferences may include the hospital social worker, hospital utilization reviewer, the DVHA and/or the DMH utilization reviewer, the appropriate State department representative (DMH, DAIL, DCF, ADAP), and the local provider representative.

Awaiting Placement Status

Awaiting Placement days are those days approved at an acute inpatient facility when a beneficiary is awaiting placement to a lower level of care and there has been a lack in timely and appropriate discharge planning.

The decision to change a beneficiary's authorization to awaiting placement status will be made when the beneficiary no longer meets criteria for acute inpatient level of care based on the utilization of the CALOCUS, LOCUS or ASAM instrument for determining authorization.

The utilization reviewer will notify the inpatient facility utilization reviewer no later than

24 hours or one business day prior to the change to awaiting placement status. Awaiting placement designation will not be assigned until such time.

The inpatient facility must initiate adequate placement efforts and shall document such efforts and contacts. Once awaiting placement status begins, the inpatient facility must continue placement efforts until placement occurs. The facility may be required to submit its documentation to the DVHA and/or DMH utilization reviewer.

APPEAL OF PAYMENT DENIAL

Vermont Medicaid beneficiaries are notified of authorization decisions in writing, which includes their right to appeal. Beneficiaries may request an internal appeal for any level-of-care Medicaid payment authorization decision that results in a denial or reduction of services. Appeals are made by telephone or in writing to the Department of Vermont Health Access (DVHA) (***Attachment 6***). An expedited appeal can be requested if a delay would adversely affect the beneficiary's health (***Attachment 6***). An appeal occurs only after all means to come to agreement about the most appropriate course of treatment are exhausted. Appeal responses are issued in writing and state the reviewer's understanding of the issues under review, reference to the information used to make the determination and the clinical criteria used to render the decision. If a beneficiary disagrees with the decision from the appeal, they may ask the department that made the decision for a fair hearing. They have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision, to ask for a fair hearing. The beneficiary may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing. They may also call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

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INTER-RATER RELIABILITY

The following procedures are in place to ensure consistent application of the review criteria. All utilization reviewers or any designated staff responsible for authorization of psychiatric or detoxification inpatient services will complete these procedures.

New Hires

All new reviewers will be required to complete the following steps before performing authorizations.

1. Complete the *Level of Care Utilization System* (LOCUS) Training Manual, the *Child and Adolescent Level of Care Utilization System* (CALOCUS) Training Manual, and the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM PPC-2R) Manual.
2. Complete the post-training exam.
3. Rate sample cases using all three authorization tools.

If a score of 80% is reached on the exam and sample cases, the reviewer may begin performing authorizations. If the reviewer receives a score of less than 80%, additional training will be provided including sample cases to review until the reviewer reaches a score of 80% or above. After the first 3 months of reviewing, 3 sample cases will be reviewed by the supervisor. Should the supervisor disagree with the application of the review criteria on more than one case, additional training will be provided and quarterly chart reviews will continue for the first year.

Annual Reviews

All reviewers will be required to take the Annual Criteria Competency Training. Reviewers must receive a score of at least 80% to continue authorizations. Should a reviewer receive a score of less than 80%, additional training will be provided with sample cases to review until the reviewer receives a score of at least 80%.

All reviewers will participate in a peer review of 3 randomly selected cases. If more than one case per reviewer results in a disagreement with the application of the review criteria, 3 additional cases will be reviewed. Should the additional review result in a disagreement of more than one case, the process of retraining will occur.

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PROGRAM INTEGRITY

Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code should be chosen that most accurately describes the service that was provided, claims should be submitted for only those days that were authorized, and claims should accurately reflect placement status (against medical advice, acute, sub-acute or awaiting placement). It is a felony under Vermont law knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from Vermont Medicaid:

- File a claim for services that were not rendered
- File a false claim
- File a claim for unauthorized items or services
- Bill the beneficiary or the beneficiary's family for an amount in excess of that allowed by law or regulation
- Fail to credit the state or its agent for payments received from social security, insurance or other sources
- Receive unauthorized payment

Questions regarding coding, claims and billing issues should be directed to Provider Relations (HP) at 1-800-250-8427.

Questions regarding authorizations should be directed to the DMH or DVHA Utilization Reviewer responsible for the authorization or to the DVHA Senior Behavioral Health Care Manager at (802) 879-8232.

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VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Attachment 1

Vermont Medicaid Child & Adolescent Inpatient Admission Notification Form

The following information and justification must be provided **in full** to the **Department of Vermont Health Access, (Toll-free fax #855-275-1212)** at the time of the inpatient admission:

Admission date: _____ Admit facility _____
Child/adolescent name: _____
Address: _____
Medicaid Unique ID: _____Date of Birth _____
Parent/guardian name: _____
Parent/guardian consent on file? ____yes ____no
DCF custody? _____yes _____no
If in DCF custody, name of social worker assigned to case, district and telephone number
_____
CMHC active client? ____yes ____no
Status: ____voluntary ____involuntary
Referral source: _____
Screener name: _____ CMHC: _____

Alternatives considered:	Name of person who refused admission and reason for refusal:
____The Baird Center 802-488-6600	_____
____Home Intervention 802-479-1339	_____
____Northeastern Family Institute 802-658-2004	_____
____Crisis Respite Beds	_____
____Kinship care	_____
____In-home support	_____
____Other (please specify)	_____

(If no alternatives were considered, the reason must be clearly explained in narrative)

Assessment narrative to include clinical justification that satisfies criteria for hospitalization:

1 Evidence of mental illness (previous diagnosis or need for diagnostic clarity)

2 Description of current and recent behavior(s) and level of dangerousness to self or others (i.e., violence, suicidal plan and means, disorganized thinking and/or functioning)

3 Medical information (physical health, medications and compliance, complicating medical factors or medication issues)

4 Evidence of failure or unmanageability at less intensive levels of care (family functioning, strengths and availability of support systems such as school and community, previous and current mental health treatment)

(State the facts which you have gathered from your own personal observations and/or as reliably reported to you by another person which lead you to believe that the proposed patient is in need of inpatient hospitalization for treatment of a mental illness. If this information is contained in another document which has been completed at the time of this admission, that document can be faxed with this form with "see attached" written in this space.)

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Local contact for discharge planning (case manager, therapist, etc.):
Name _____ Agency_____
Phone _____

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Attachment 2

VERMONT MEDICAID ADMISSION NOTIFICATION FORM

Inpatient Psychiatric Services

The following information and justification must be provided to the Department of Vermont Health Access (DVHA) **(toll-free fax 855-275-1212)** within 24 hours or next business day of an urgent or emergent hospital admission. All elective (planned) admissions will require notification prior to admission for authorization. The Utilization Reviewer will contact the facility after notification is received by the DVHA to begin the authorization process.

There will be no authorization unless the following information is provided in full to DVHA

Date of Admission: _____ Admission Diagnosis:_____

Patient Last Name: _____First Name: _____

Medicaid ID Number: _____Date of Birth: _____

Physical Address_____

Does the patient have a guardian (DCF, or Public Guardian)? Y N (circle one)
If yes, guardian's name: _____

Is patient receiving mental health services in Vermont from a Community Mental Health Center (CMHC)? Y N (circle one) If yes, name of agency_____

If the answer to the previous question is "No", is the patient receiving other mental health services in Vermont? Y N (circle one) If yes, name of provider_____

Referral Source (if applicable) _____

Facility Name_____ VT Medicaid Provider Number_____

Contact Person for Authorizations _____ Phone #_____

Anticipated Discharge Date _____

Anticipated Discharge Referral to a CMHC? Yes No (circle one)

Please attach the admissions assessment to include justification for psychiatric inpatient admission, diagnoses and medications.

For inpatient detoxification admissions please include the date the patient began scoring for the detox protocol medication taper (i.e., suboxone, subutex, methadone, librium).

Attachment 3

CRT Crisis Intake Worksheet

For a **voluntary CRT** admission to a community hospital psychiatric unit, screeners are to provide the following information to DMH Admissions' staff. Additional information and a faxed copy of the EE paperwork are necessary for all **involuntary** admissions:

Individual's Name	
SSN	
Address	
Screening Agency	
Screener Name	
Does screener agree with admission?	
Primary Agency	
Admit Date	
Date Reported	
Time Reported	
Admit Facility	
Legal Status	
Reason for Admission:	
Danger to self	
Danger to others	
Non-adherent with recommended treatment	
Self Abusive	
Assaultive/Destructive	
Exhausted Program	
Medical Cofactor	
Personal Conflict	
Transitional	
Refused Options	
Other	
Alternatives Considered Referring Physician	

Estimated Length of stay	

Attachment 4

VERMONT DEPARTMENT OF MENTAL HEALTH

COMMISSIONER-DESIGNATED QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP)

DEFINITION

The definition of mental health professional from Title 18 of the Vermont Statutes Annotated, Section 7101(13):

"Mental health professional" means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse or other **qualified person designated by the commissioner**.

By agreement with DMH and designated general hospitals (DH), only QMHP's who are designated by the Department of Mental Health (DMH) Commissioner or designee, and employed by a Designated Agency (DA), can screen and serve as the applicant for involuntary psychiatric admissions.

QUALIFICATIONS

- **Education and Experience:**

1. **Master's degree in human services field (licensure preferred) and**:
   a. Clinical exposure to populations with major mental illness, **and**
   b. 1-2 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**
   c. Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

or

2. **Bachelor's degree in related human services field and**:
   a. Clinical exposure to populations with major mental illness, **and**
   b. 2-3 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**

Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

or

3. **Bachelor's degree in a field unrelated to human services and**:
   a. Clinical exposure to populations with major mental illness, **and**

b. 3-5 years experience providing community services for people with at least 2 of the following: mental illness, substance abuse or serious emotional disorders, **and**

c. Appropriate experience and training in crisis evaluation and intervention in a community setting, as determined by the DA Emergency Services Director or designee.

or

4. If an applicant does not meet the qualifications but meets other criteria and has experience in providing crisis services in the community to severely mentally ill individuals, an application may be submitted for designation consideration. The application should include information that explains the reason(s) for the exception.

♦ **Demonstrated Knowledge of and Training in:**

1. Vermont Mental Health Statutes
2. Emergency exam, warrant, non-emergency exam (process and documentation)
3. Emergency exam admission criteria and procedures
4. Conditional release, Order of Non-hospitalization
5. QMHP-specific training
6. Familiarity with community resources (i.e., crisis beds, respite options, general hospitals, or other options for voluntary treatment)
7. Screenings for involuntary treatment (observation preferred)
8. Special needs and services of populations being served
9. Forensic screening at court

Attachment 5

REQUEST FOR SECONDARY REVIEW
OF INPATIENT PSYCHIATRIC SERVICES

Agency of Human Services

This request must be submitted to the utilization reviewer no later than 14 days after the DVHA or DMH Utilization Reviewer first gives notice, either written or oral, to the inpatient facility that authorization for a particular beneficiary will end or authorization will begin at an alternate payment status.

Dates of Service to be Reviewed:

Date of Request:

Name of Provider:

Name of Beneficiary:

Beneficiary Medicaid ID Number:

Date of Admission:

Documented evidence that substantiates authorization criteria must include:

1. A narrative signed by a clinical staff that provides a brief background of the case and the reasons why the provider believes AHS should authorize payment.

2. Clinical data that supports the request for a secondary review. **Do not send the entire chart.**

The secondary review will consist of a review of current information, any new information, as well as documentation from the inpatient facility as to why they believe AHS should authorize payment in that particular case. The inpatient facility may request an oral discussion between clinicians involved in the care of the beneficiary and the DVHA or the DMH clinical staff in order to further clarify the clinical information.

Attachment 6

DVHA APPEALS PROCESS
FOR PATIENTS AND FAMILES

(Excerpt from the DVHA Health Care Programs Handbook. For further information go to: http://dvha.vermont.gov/for-consumers/healthcare-programs-handbook.pdf)

When You Don't Agree with an Action

An "action" is one of the following:

- Denial or limit of a covered service or eligibility for service, including the type, scope or level of service;
- Reduction, suspension or termination of a previously approved covered service or a service plan;
- Denial, in whole or in part, of payment for a covered service;
- Failure to provide a clinically-indicated covered service, by any provider
- Failure to act in a timely manner when required by state rule;
- Denial of your request to obtain covered services from a provider who is not enrolled in Medicaid (note, that the provider who is not enrolled in Medicaid cannot be reimbursed by Medicaid).

If you don't agree with an action, you may ask for that action to be reviewed. If the Department of Vermont Health Access made the decision, you can ask Member Services for your appeal or fair hearing (described below) by calling 1-800-250-8427, or writing to the address below. Call the customer service number on the back of your employer-sponsored insurance plan ID card for information about how to appeal a decision made by that plan.

Green Mountain Care Member Services
Department of Vermont Health Access
101 Cherry Street, Suite 320
Burlington, VT 05401

Appeal

Appeals are heard by a qualified person who did not make the original decision. You have 90 days from the decision date to ask the department that made the decision for an appeal. Your provider may ask for the appeal if you wish. In most cases we try to make a decision in 30 days, however it can take up to 45 days. You and the state can also request up to 14 more days but only if it might help you (for example, your provider needs more time to send information or you can't get to a meeting or appointment in the original time frame). The longest it will ever take is 59 days for a decision to be made. If your need for the denied benefit is an emergency, you may ask for an **expedited appeal**. If it is decided that your appeal is an emergency, you will get a decision within three working days. If you are told your benefit is changed because of a change in a federal or state law, you may not ask for an appeal but may ask for a fair hearing.

Attachment 7

MENTAL HEALTH 24 HOUR EMERGENCY SERVICES

Clara Martin Center *(**Orange** County)*	(800) 639-6360
Counseling Service of Addison County *(**Addison** County)*	(802) 388-7641
Health Care and Rehabilitation Services of Southeastern VT *(**Windham** and **Windsor** Counties)*	(800) 622-4235
HowardCenter – First Call *(**Chittenden** County)*	(802) 488-7777
HowardCenter – Adult Crisis *(**Chittenden** County)*	(802) 488-6400
Lamoille Community Connections *(**Lamoille** County)*	(802) 888-4914 *After Hours-* (802) 888-4231
Northeast Kingdom Human Services, Inc. *(**Essex**, **Caledonia** and **Orleans** Counties)*	*St. Johnsbury* - (802) 748-3181 1-800-649-0118 *Newport-* (802) 334-6744 1-800-696-4979
Northwestern Counseling and Support Services *(**Franklin** and **Grand Isle** Counties)*	(802) 524-6554 1-800-834-7793
Rutland Mental Health Services *(**Rutland** County)*	(802) 775-1000
United Counseling Service *(**Bennington** County)*	*Manchester* - (802) 362-3950 *Bennington* - (802) 442-5491
Washington County Mental Health Services *(**Washington** County)*	(802) 229-0591

Attachment 8

Adults ages 18 and Over
Psychiatric Crisis Beds in Vermont

HI-(6 beds) Washington County Mental Health – Contact Emergency Screeners	**802-229-0591**
Care Bed-(2 beds) Northeast Kingdom Mental Health - Contact facility directly	**802-748-6961**
Bayview-(2 beds) Northwest Counseling and Support Services- Contact Emergency Screeners	**802-524-6554**
Assist Program-(6 beds) Howard Center- Contact Emergency Screeners	**802-488-6400** **802-488-6240**
Alternatives-(6 beds) Heath Care and Rehabilitation Services- Contact facility directly	**802-885-7280**
Battelle House-(6 beds) United Counseling Services- Contact facility directly	**802-442-1216**
Crisis Stabilization Inpatient Diversion(CSID)-(4 beds) Rutland - For Step-down referrals	**802-747-3587** **802-775-4388**
Second Spring Crisis Beds-(2 beds) Collaborative Solutions- Contact Registered Nurse on Duty	**802-433-6183**
Chris' Place-(1 bed) Clara Martin Center- Contact Emergency Screeners	**802-728-4466** **800-639-6360**
Alyssum-(2 beds) Peer Support- Contact facility directly	**802-767-6000**
Cottage Crisis-(1 bed) CSAC- Contact Annette Armstrong	**802-388-6754**
Oasis House-(2 beds) Lamoille Community Connections- Contact LCC Mobile Crisis Team **(Evenings & Weekends)**	 **802-888-5026** **802-888-4231**

Attachment 9

Substance Abuse Services

Key to Substance Abuse Program Services Available

A: Adolescents D: Detox I: Intensive Outpatient O: Outpatient

R: Residential H: Halfway House PIP: Public Inebriate Program

RC: Recovery Center W: Women Only

Addison

Counseling Services of Addison County (A, O) Tel: (802) 388-6751
Fax: (802) 388-3108
Turning Point Center of Addison County (RC) Tel: (802) 388-4249

Bennington

Northshire United Counseling Service (O) Tel: (802) 362-3950 · Fax: (802) 362-0325
Turning Point Center of Bennington (RC) Tel: (802) 442-9700
United Counseling Service (A, O, PIP) Tel: (802) 442-5491 · Fax: (802) 442-3363

Chittenden

Day One (I, O) Tel: (802) 847-3333 · Fax: (802) 847-3326
HowardCenter Mental Health & Substance Abuse Services (A, I, O)
Tel: (802) 488-6100 · Fax: (802) 488-6153
HowardCenter Act One / Bridge Program (D, PIP, R)
Tel: (802) 488-6425 · Fax: (802) 488-6431
HowardCenter Centerpoint Adolescent Treatment Services (A, I, O)
Tel: (802) 488-7711 · Fax: (802) 488-7732
Lund Family Center – Cornerstone Drug Treatment Center (A, O, W)
Tel: (802) 864-7467 · Fax: (802) 864-1619
Maple Leaf Farm (D, R) Tel: (802) 899-2911 · Fax: (802) 899-9965
Rise IV (H) Tel: (802) 463-9851 · Fax: (802) 463-9814
Spectrum Youth and Family Services (A, O) Tel: (802) 864-7423
Fax: (802) 660-0576
Turning Point Center of Chittenden County (RC) Tel: (802) 861-3150

Franklin / Grand Isle

HowardCenter (O, PIP) Tel: (802) 524-7265 # 7 · Fax: (802) 524-5723
Northwestern Counseling Services in Franklin County (A)
Tel: (802) 524-6554 · Fax: (802) 527-8167
Turning Point of Franklin County Tel: (802) 363-6046

Lamoille

Behavioral Health and Wellness Center (A, O) Tel: (802) 888-8320
Fax: (802) 888-8136
North Central Vermont (RC) Tel: (802) 851-8120

Orange

Clara Martin Center (A, O) Tel: (802) 728-4466 · Fax: (802) 728-4197 (Randolph)
Tel: (802) 222-4477 · Fax: (802) 222-3242 (Bradford)
Valley Vista (A, D, R) Tel: (802) 222-5201 · Fax: (802) 222-5901

Orleans / Essex / Caledonia

Kingdom Recovery Center (RC) Tel: (802) 751-8520
Northeast Kingdom Human Services (A, I, O)
Tel: (802) 748-1682 · Fax: (802) 748-0211 (St. Johnsbury)
Tel: (802) 334-5246 · Fax: (802) 334-7455 (Newport)

Rutland

Evergreen Services (I, O) Tel: (802) 747-3588 · Fax: (802) 775-7196
Grace House (H, PIP) Tel: (802) 775-3476 · Fax: (802) 775-2984
Rutland Mental Health Court Square (A, O) Tel: (802) 775-4388
Fax: (802) 775-3307
Serenity House (D, R) Tel: (802) 446-2640 · Fax: (802) 446-2636
Turning Point Recovery Center of Rutland (RC) Tel: (802) 773-6010

Washington

Central Vermont Substance Abuse Services (A, I, O) Tel: (802) 223-4156
Fax: (802) 223-4332
Turning Point Center of Central Vermont (RC) Tel: (802) 479-7373
Washington County Youth Services (A, O) Tel: (802) 229-9151 · Fax: (802) 229-2508

Windham

Health Care & Rehabilitation Services of Southeastern Vermont (O)
Tel: (802) 463-3947 · Fax: (802) 463-1202 (Bellows Falls)
Tel: (802) 254-6028 · Fax: (802) 254-7501 (Brattleboro)
Rise I (H) Tel: (802) 463-9851 · Fax: (802) 463-9814 (Brattleboro)
Rise II (H) Tel: (802) 463-9851 · Fax: (802) 463-9814 (Bellows Falls)
Rise III (H, W) Tel: (802) 463-9851 · Fax: (802) 463-9814 (Brattleboro)
Starting Now (I) Tel: (802) 258-3705 · Fax: (802) 258-3794
Turning Point Center of Windham County (RC) Tel: (802) 257-5600

Windsor

Clara Martin Center – Quitting Time (I, O) Tel: (802) 295-1311 · Fax: (802) 295-1312

Health Care & Rehabilitation Services of Southeastern Vermont (A, I, O, PC)
Tel: (802) 886-4500 · Fax: (802) 886-4560 (Springfield)
Tel: (802) 295-3031 · Fax: (802) 295-0820 (Hartford)
Turning Point Center of Springfield (RC) Tel: (802) 885-4668
Upper Valley Turning Point (RC) Tel: (802) 295-5206

Out of State Resources

Phoenix House, Inc. (A, R) Tel: (603) 563-8501 · Fax: (603) 563-8296 (Dublin, NH)

Additional Resources

Individual Practitioners: Persons who are Licensed or Certified in specializing in substance abuse treatment can be found in the yellow pages of your local phone book under "*Counseling, Alcoholism,* or *Drug Abuse*".

Attachment 10

APPLICATION FOR
EMERGENCY EXAMINATION

To the Family Court comes_____

_____

(Please print full name of applicant)

of_____

_____

(Please print complete address of applicant)

Telephone Number_____

Relationship to or interest in proposed patient*_____

and makes application for the emergency examination of_____

_____

(Please print full name of proposed person in need of treatment)

of_____

_____

(Please print complete address of proposed person in need of treatment)

***NOTE:** Only the following persons may make application for an individual's emergency examination: a guardian, spouse, parent adult child, close adult relative, a responsible adult friend or person who has the individual in his or her charge or care (e.g. a superintendent of a correctional facility), a law enforcement officer, a licensed physician (**Caution:** same physician cannot be both applicant and certifying physician), a head of a hospital or his or her written designee, a selectman, a town health officer or a town service officer, or a mental health professional (i.e., a physician, psychologist, social worker, nurse or other qualified person designated by the Commissioner of Developmental and Mental Health Services).

REASON FOR APPLICATION: (State the facts which you have gathered either from your own personal observations or as reliably reported to you by another person which lead you to believe that the proposed patient is in need of emergency examination and which show that the person is a person in need of treatment.)
BE SPECIFIC!

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(If additional space is required, please continue on a separate sheet of paper)

Signed under the penalties of perjury pursuant to 18 V.S.A. Section 7612(d)(2)

Date of Application

Signature of Applicant

NOTE TO APPLICANT:

This application **MUST** accompany the proposed patient when he/she is to be taken to the hospital for an emergency examination. **If the proposed patient refused to submit to an examination by a licensed physician, you cannot use this form!** If the patient refuses examination, the applicant should consider applying to a judge for a Warrant for Immediate Examination under 18 V.S.A. §7505.

I hereby waive any right I have to receive a copy of the notice of hearing from the court pursuant to 18 V.S.A §7613. I understand that despite this waiver I may be called as a witness to testify at a hearing involving the above named proposed patient.

Signature of Applicant