Detroit Wayne Integrated Health Network
Adult Pre-Admission Review (PAR) Procedures, Updated January 2024

Steps	Procedures
Bed Census	COPE contacts each contracted psychiatric inpatient unit for updated bed status every 4 hours and recordsthe information in the preadmission review (PAR) disposition section (PAR-D).
Requests for Service (RFS)	The Request for Service (RFS) is initiated when a requesting facility contacts COPE due to a member experiencing abehavioral health crisis. Prior to contacting COPE, the hospital staff: • Checks to determine if the insurance and residential eligibility meet the requirements of an adult (18 years +)served by DWIHN. • Determines whether the individual is medically stable utilizing the MiSmart form. • Contacts COPE at 1-844-296-COPE (2673) to request pre-admission review (PAR).
Screening for Eligibility	During the initial call COPE staff: • Verifies eligibility, determine county of financial responsibility (COFR), all inquiries related to COFR that cannot be determined by COPE leadership will be escalated to DWIHN liaison Felicia Wynn (fwynn1@dwihn.org) (313)693-3289 and Elektra Campbell as backup (ecampbell@dwihn.org) (313)400-0409 Monday-Friday 9a-5p. For after-hours COFR consults, contact Daniel West (dwest1@dwihn.org) (734)419- 3159. • Asks about medical clearance (documentation of medical clearance including MiSmart formprovided to COPE for distribution to potential accepting levels of care). • Determines requested level of care • Determines whether member is on an AOT utilizing the MHWIN banner and inform the requesting facility. Therequesting facility will notify the assigned liaison of AOT status for coordination. • Determine status of petition and certification • Records demographic information on the member Requests information to determine whether the PAR will be completed telephonically or face-to-face.
Non-Eligible Members Due to Payer/Insurer	COPE may authorize inpatient services for the following payers on a case-by-case approval from DWIHN. Thoseapprovals considered are: • Medicare only or Medicare Primary (e.g. Medicaid/Medicare when the member is not enrolled in the MIHealth Link program) • COFR based on approval from DWIHN liaison Felicia Wynn (fwynn1@dwihn.org) (313)693-3289 and ElektraCampbell as

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	backup (ecampbell@dwihn.org) (313)400-0409 Monday-Sunday 9a-5p. Daniel West can be consulted after hours (dwest1@dwihn.org) (734)419-3159 • Veterans Administration (VA – service connected). o It is the responsibility of the requesting facility to determine whether Medicare days are available, and this information accompanies clinical information submitted when completing a request for service. COPE will request a printout from the requesting facility related to Medicare days left, and compare to their own printout. If the hospital's efforts to place persons with these payers exceeds 24-hours without a pending approval, a pre- admission review can be conducted by COPE after receiving approval from DWIHN. COPE will obtain the approval.
Telephonic Screening and Mobile Crisis Team Dispatch	When the RFS is being taken these 8 questions are asked per MCG Indicia 401 inpatient criteria. Have any of the following occurred in the last 24 hours? (1) Suicide Attempt (2) Suicidal Ideation/means (3) Homicide Attempt (4) Homicidal ideation/means (5) Serious Bodily Injury to Others (6) Damage to Property (7) Is the member actively using or tested positive for substances? (8) Is the member actively psychotic? Based on the responses provided COPE will determine if the RFS will be completed face to face or telephonically. All efforts are made, when appropriate, to have PARs completed face to face. Factors that contribute to PARs beingcompleted telephonically include: • volume of request for services is greater than Mobile Crisis Teams can manage with time and distance. • inclement weather. • the case is reconsidered for a telephonic screening. These exceptions are sometimes necessary in order to provide prompt services to the member waiting in theED.
Pre-Admission Review (PAR)	PAR assessment determines level of care based on medical necessity criteria. Telephonic Screen: COPE clinician contacts requesting facility to conduct the PAR assessment via telephone. Every effort will be made to complete the PAR within 2 hours of the request and circumstances documented if this standard is not met. The COPE clinician will use the information collected from the telephonic screening and the EDclinical packet to determine disposition and level of care for the member.

	Mobile Crisis Face to Face Screen: Mobile team is expected to arrive within 2 hours of the request for service. Dispatched team will arrive at the requesting facility and check in with the treatment team orcharge nurse. Team will meet face to face with DHWIN member to perform PAR assessment. The requesting facility will provide the COPE mobile staff with facilities to meet with the member that ensures members privacy and provide adequate space to interview the member comfortably. The Mobile Team will use the clinical packet, any crisis warning notes in MH-WIN to complete the PAR, determine disposition/ level of care for member. A disposition sheet will be given to requesting facility clinical staff with disposition decision. In the event that an ED clinical staff is not available, COPE team will give disposition sheet to charge nurse and document accordingly in MHWIN. COPE staff will delay screening if a member is unable to participate fully in the assessment (chemical restraints, medical concerns, aggression, etc). However, staff will attempt to gather necessary information from the requestingfacility treatment team. If a member is unable to participate fully in the assessment, the RFS will be canceled and called in once the patient is able to participate reasonably. COPE is to re-evaluate/re-screen member at least every 72 hours or as needed per clinical presentation. In the event a notification is made to the contracted screening agency or DWIHNrequesting a screening, made by a legal guardian/authorized representative, the screening agency will research the case (COFR, current DWIHN member, diagnosis, etc) and initiate a request for service for the hospital where the member currently is or where the member will be going at the time notification is made. A team will be dispatched to conduct screening, and if efforts to complete the screening are refused by the hospital upon team arrival, documentation is to be completed in MHWIN (attending physician, contact at hospital, reason for refusal, etc).
Disposition Decision	COPE staff conducting face-to-face reviews will provide the requesting facility with a disposition sheet indicating thelevel of care that has been determined. COPE staff conducting telephonic reviews will verbally provide the level of care that has been determined and document who the level of care was provided to in the ED. When COPE determines a disposition that differs from the requested level of care, COPE staff will consult with aphysician (COPE or requesting facility physician) to finalize the level of care

	(see next section). Adverse Benefit Determination (ABD) paperwork with accompanying physician's letter is to be provided at the time of the denial of arequested higher level of care, and if circumstances prevent providing the ABD/physician's letter in person, verbal education to the member is to be provided, reasons ABD paperwork/physician's letter is not provided in person, and the documentation is to be mailed to the confirmed last known address within 24 hours and documented. Disposition is to be verbally provided to the member when the disposition decision is made and documented, and when member is accepted to a level of care, documentation that the treatment team at the requesting facility is toprovide that information to the member is to be inputted within 30 minutes of screening agency notification to include initial length of stay, facility, and attending physician. When the requesting facility clinician does not agree with the disposition provided by the COPE clinician a request for a doctor to doctor consult can be requested by the hospital. The consult is to be completed within 3 hours of the request. The doctor to doctor consult is completed between the ED Doctor and the COPE psychiatrist.
Doctor to Doctor Review	A screening agency psychiatrist is available 24-hours a day, 7 days a week. The requesting facility can contact the screening agency to request a doctor-to-doctor consult if there is a disagreement in disposition authorization. If the doctor-to-doctor consult has not been completed within 3-hours of the request for service, the screening agency disposition will stand. Lack of contact from the requesting facility or their physician implies acceptance of the disposition. Potential outcomes of the doctor-to-doctor consultation (Outcome of the consult and rationale for the disposition authorization documented in MHWIN by the screening agency): 1. The requesting facility attending physician/psychiatrist and the screening agency attending psychiatrist agree on the disposition, the disposition will be authorized. 2. The screening agency recommends a higher level of care,

	and the requesting facility requests a lower level of care/discharge: a. A doctor-to-doctor consult occurs, the screening agency's doctor agrees with the hospital's recommendation, a lower level of care is authorized. b. A doctor to doctor occurs and the screening agency's doctor does not agree with the hospital's recommendation, the authorization stands but the requesting facility's clinical team may choose to discharge. The screening agency/DWIHN liaisons work towards discharge planning and lower level of care. The screening agencies input authorizations as applicable. c. Hospital does not wish to pursue a doc to doc. The authorization stands but the requesting facility's clinical team can choose to discharge. The screening agency/DWIHN liaisons work towards discharge planning and lower level of care, authorizations inputted as applicable. (Document the name of the physician at the facility recommending discharge/lower level of care disposition and attempt getting a copy of the physician note/consult indicating that recommendation. Upload in MHWIN) 3. The requesting facility requests a higher level of care, and the screening agency authorizes a lower level of care: a. A doctor-to-doctor consult occurs and there is an agreement, authorization changed to higher level of care. b. A doctor-to-doctor consult occurs, and the screening agency's doctor does not agree with the hospital, the authorization stands, and the denial for higher level of care is given. Adverse Benefit Determination (ABD) paperwork is provided with right to second opinion while the screening agency/DWIHN liaisons work toward discharge planning. c. The requesting facility/member/legal guardian disagrees with the denial of higher level of care by the screening agency and a second Opinion is requested, the second opinion process is followed.

	(Document the name of the physician at the facility recommending admission and attempt getting a copy of the physician note/consult indicating that recommendation. Provide it to appeals@dwihn.org as part of the second opinion process)
Authorization of Inpatient Admission	When a member meets medical necessity criteria for inpatient placement, COPE begins to search for bed placement.Members' packets are sent to all inpatient hospitals based on bed availability. Hospitals with vacancies within their own facility must complete review of the member's packet and confirm within 2 hours whether the facility has accepted the member. If the requesting facility sends clinical information to potential hospitals, they are to notify COPE of this, as only placements sought by COPE or within the awareness of COPE will be honored. When a member remains at the requesting facility for more than 23 hours, the DWIHN Hospital Liaison will contact the requesting facility and coordinate efforts to place member in the most appropriate level of care (see DWIHN Hospital Liaison contact information below). DWIHN Hospital Liaisons receive a list of these members daily prior to 9am. Should the requesting facility not notify COPE of an available bed at their facility, and another bed if found outside of the requesting facility, the member will be transferred to the bed found by COPE. Should member be considered for an enhanced rate due to nature of presentation, the assigned hospital liaison will be contacted to approve the enhanced rate, and COPE will distribute materials to potential accepting facilities with the offer of an enhanced rate. Members who present high acuity needs involving complex medical and psychiatric concerns (children under 12, complex physical and developmental issues, medical complications, older adults with complex needs, eating disorders, etc), screening agencies are to bypass the 24-hour in-network bed search, especially in situations where a member is better suited to be treated in a facility offering specialty services in line with the member's presenting concerns. Under these circumstances, the screening agencies are to document the reasons they have pursued availability out-of-network within the

	initial 24- hour period. Once the bed is secured the following information is obtained from the accepting hospital: • Date/Time • Staff entering information into MHWIN • Provider accepting member • Admitting Physician • Room Number • Unit Number It is the responsibility of the requesting facility to facilitate/arrange the transfer of the member to the accepting/admitting hospital. Unless the member is being serviced under General Fund, COPE will thenarrange transportation. Once the member arrives, the admitting hospital must call COPE to advise the patient has arrived to obtain authorization within 24 hours. Authorizations are not entered into MHWIN until member arrives at the inpatientfacilities. NOTE: Authorizations in MHWIN are transferred in real time to DWIHN for continued stay reviews. If the accepting/admitting hospital does not contact COPE for the inpatient authorization within 24-hours of the admission, an administrative denial may be given. The decision to issue a denial is on a case-by-case basis and is atthe discretion of DWIHN. If there is a need to appeal or dispute an authorization, an email should be sent to the DWIHN UM department at:appeals@dwihn.org For all County of Financial Responsibility (COFR), Single Case Agreement (SCA) and/or state hospitalization questions,please contact the assigned DWIHN Hospital Liaison. Communication regarding disposition and clinical presentation to MDHHS is to come directly from DWIHN rather than directly from the contracted screening entities
Diversion	Please utilize DWIHN levels of care grid as a reference to this section (reach out to a DWIHN liaison for the grid) COPE is responsible for securing placement of members. COPE diversion options are as follows: Crisis Residential Unit(CRU), Partial Hospitalization

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Program (PHP), Pre-placement Housing, Outpatient Services, Withdrawal Management and SUD Residential. Should member be given a disposition different from requested level of care, COPE is to providemember with the adverse benefit determination (ABD) paperwork and physician's letter at the moment the decision is made. Physician's letter must include detailed description of COPE physician decision, and signed by the director of COPE.

COPE calls the ED/Hospital once during an 8-hour shift to obtain the clinical status and medical status on membersawaiting bed placement. COPE clinicians enter a note in MHWIN regarding the member and includes the name andcredentials of the individual with whom he/she spoke. Members bed placements that take over 23 hours: COPE provides the list of members to the DWIHN Hospital Liaisons for further assistance (Liaisons notified daily of these members).

Crisis Residential (CRU)- referral is made upon completion of disposition to the Crisis Residential program for review. There is a 2-hour window for acceptance of the member for CRU. If there are no beds available at CRU (discharges pending), the member can potentially wait at a crisis stabilization unit (CSU) for the pendingdischarge. If there are no pending discharges, the disposition is changed to inpatient.
Crisis Stabilization Unit (CSU)- Crisis Stabilization units are secured units designed to stabilize and evaluatemembers in crisis, and therefore transportation from EDs require petition/certification. Members can be transferred to CSU without petition and certification on a case by case basis. There are 2 CSUs: COPE in Livonia (734)721-0200, Team Wellness in Detroit (313)969-5387.
Partial Hospitalization Program (PHP)- referral is made to New Oakland by COPE staff. Member is dischargedfrom the ED and will participate in the PHP program upon acceptance. COPE staff will secure crisis stabilization services to follow up with the member. If member is not able to start within 2 days of the authorized level of care, the request for service will need to be re-opened to determine if that level of care continues to be necessary.
Outpatient- member is discharged from the requesting facility. COPE secures mobile crisis stabilizationservices

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	for follow up with the member. • Withdrawal Management- member meets criteria to receive Withdrawal Management services prior to SUDresidential services. COPE secures placement at a Withdrawal Management facility. Once a member completes a Withdrawal Management Program, they can potentially be stepped down to a lower level of care. • SUD Residential- member meets criteria to receive SUD services and is not at risk for withdrawal management can be placed into a SUD residential program. COPE secures placement for SUD Residentialfacility. • Pre-placement housing is based on acceptance by the home providers. If all pre-placement housing providershave denied the member, communication with the residential department and/or assigned DWIHN liaison will be initiated. COPE secures follow up services with mobile crisis stabilization. • If a specialized residential placement is being sought, the RFS from COPE will need to be closed out (a bed search for acute inpatient placement is no longer warranted) and a residential referral will need to be submitted to residentialreferral@dwihn.org, and a residential care specialist will be assigned and take over as the point of contact throughout the placement search. The following are Medicaid covered services: Crisis Residential (CRU) (can be authorized if Medicaid is secondary),Mobile Crisis Stabilization Services, Partial Hospitalization Program (PHP), and Pre-placement Housing (formerly Transitional). If a member only has Medicare (no Medicaid) and needs these services, a general fund request will need to be made. PHP is a Medicare covered service and will not require a COPE authorization.

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Contact Information	**Assigned Hospital**
Felicia Wynn ***Hospital Liaison*** **(fwynn1@dwihn.org)** **(313)693-3289** **Lead COFR**	• DMC Sinai • DMC Detroit Receiving • Henry Ford Main • St. John Main • Team Wellness CSU
Elektra Campbell ***Hospital Liaison*** **(ecampbell@dwihn.org)** **(313)500-0309** **(313)549-1792** **Backup COFR**	• Corewell Royal Oak • Corewell Troy • St. John Providence/Novi • St. Mary Mercy Livonia • Corewell Farmington Hills • Henry Ford Wyandotte • St. John Main • COPE CSU • Corewell Grosse Pointe • Garden City • Henry Ford Brownstown • Mclaren group • Corewell Wayne • Corewell Taylor • Corewell Dearborn • Corewell Trenton • St. Joseph Ann Arbor
Wynee Cooper ***Hospital Liaison*** **(wcooper@dwmha.com)** **(313)405-3222**	• All children's cases regardless of hospital • Henry Ford Fairlane • Harper Hospital • UofM
Daniel West ***Director of Crisis Services*** **(dwest1@dwihn.org)** **(734)419-3159**	Any and all inquiries related to crisis services.