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104 Psychiatric Hospital (Recipients 65 & Over)

For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a free-standing psychiatric facility specializing in the diagnosis, treatment, and care of geriatric patients, for the purpose of maintaining or restoring them to the greatest possible degree of health and independent functioning.

The policy provisions for psychiatric hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 5.

104.1 Enrollment

HP enrolls psychiatric hospital providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychiatric hospital is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychiatric-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Psychiatric hospitals are assigned a provider type of 01 (Hospital). The valid specialty for psychiatric hospitals is Inpatient Psychiatric Hospital Over 65 (011).

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following requirements:

- Receive certification for participation in the Medicaid/Medicare program
- Possess a license as a free-standing acute geriatric psychiatric hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification,* Chapter 420-5-7. State hospitals that do not require licensing as per state law are exempt from this provision.
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Specialize in the care and treatment of geriatric patients with serious mental illness
- Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician
- Employ only staff who meet training certification standards in the area of geriatric psychiatry as defined by the State's mental health authority
- Be recognized as a teaching hospital affiliated with at least one four-year institution of higher education that employs a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness
- Provide outpatient and community liaison services throughout the state of Alabama directly or through contract with qualified providers
- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for its inpatient services for its initial cost reporting period, if a new provider
- Exist under the jurisdiction of the State's mental health authority

After enrollment, psychiatric hospitals are required to submit a monthly inpatient census report using the PSY-4 form. The census report must be received on or before the tenth of each month for the preceding month.

It is the facility's responsibility to ensure compliance with all federal and state regulations and to ensure that all required documentation is included in the recipient's record. Failure to comply will result in denial of payment and possible recoupment of reimbursements made previously.

104.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

The number of days of care charged to a recipient of inpatient psychiatric service is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used in reporting days of care for the recipient, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid reimbursement is available for the day of admission, but not the day of discharge.

Inpatient psychiatric services for recipients age 65 or over, are covered services when provided under the following circumstances:

- Psychiatric services are provided in a free-standing psychiatric hospital exclusively for the treatment of persons age 65 or over with serious mental illness.
- Psychiatric services are provided under the direction of a geriatric psychiatrist.
- The psychiatric facility providing services is enrolled as a Medicaid provider.
- The recipient is admitted to the psychiatric facility during the entire hospitalization.
- The recipient is age 65 years or older.

Inpatient psychiatric services for recipients age 65 and over are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care in an acute care hospital.

Therapeutic visits away from the psychiatric facility to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit.

- Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.
- Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.
- Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Division at Medicaid. Providers who have received payments for therapeutic visits will have funds recouped.

Certification of Need for Service

Certification of need for services is a determination that is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility.

The physician must certify for each applicant or recipient that inpatient services in a mental hospital are needed.

The certification must be made at the time of admission. No retroactive certifications will be accepted.

For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment.

The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record.

The PSY-6 form, which is the recertification of need for continued inpatient services, or acceptable equivalent approved by Medicaid, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician. The PSY-6 form or equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record.

The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status.

Medical, Psychiatric, and Social Evaluation

Before admission to a psychiatric facility or before authorization for payment, the attending physician, psychiatrist, or staff physician must make a medical evaluation of each individual's need for care in the facility. Appropriate professional personnel must make a psychiatric and social evaluation.

Each medical evaluation must include:

- Diagnosis
- Summary of present medical findings
- Medical history
- Mental and physical functional capacity
- Prognosis
- A recommendation by the physician concerning admission to the psychiatric facility or continued care in the psychiatric facility, for individuals who apply for Medicaid while in the facility

Plan of Care

The attending physician or staff physician must establish a written plan of care for each individual before admission to a mental hospital and before authorization of payment.

The plan of care must include the following:

- Diagnosis, symptoms or complaints indicating a need for admission to inpatient care
- Description of the functional level of the patient
- Treatment objectives
- Orders for medications, treatments, therapies, activities, restorative/rehabilitative services, diet, social services, and special procedures needed for health and safety of the patient
- Continuing care plans that include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family and community service providers upon discharge

The attending or staff physician and other appropriate staff involved in the care of the recipient must review the plan of care at least every 90 days or when significant changes occur in patient functioning or acuity.

The plan of care is evaluated to ensure that the recipient receives treatment that maintains or will restore the patient to the greatest possible level of health and independent functioning.

A written report of the evaluations and the plan of care must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Utilization Review (UR) Plan

As a condition of participation in the Alabama Medicaid program, each psychiatric facility must do the following:

- Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to the recipient.
- Maintain recipient information required for UR, which includes the certification of need for service and the plan of care.

- Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval.

Payment

Payment for inpatient services provided by psychiatric facilitates for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital. The per diem rate is based on the Medicaid cost report and all the requirements expressed in the *Alabama Medicaid Administrative Code,* Chapter 23*.* Ancillary charges (lab, x-ray, etc.) may not be billed in addition to the facility per diem rate.

Patient liabilities, if applicable, are deducted from the per diem. The hospital is responsible for collecting the liability amount from the patient and/or the patient's sponsor.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive two copies of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

NOTE:

If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100 per day for each calendar day after the due date.

104.3 Prior Authorization and Referral Requirements

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Claims for recipients enrolled in the Patient 1st Program **do not require a referral** from the recipient's assigned Primary Medical Provider (PMP).

Authorization for Admission

All admissions to psychiatric hospitals for recipients age 65 or older must be approved by Medicaid prior to payment authorization using the Alabama Prior Review and Authorization Request Form.

Medical records or other documentation may be requested when the medical necessity of the admission cannot be determined from the application form. Providers will receive notification when admissions are not found to be medically necessary.

Applications must be submitted within eight working days after admission. Applications that are not received within eight working days will be approved beginning the day the application is received, provided the criteria for admission are met.

Information required for admission review includes, but is not limited to the following:

- Recipient information that includes:
  - Admitting diagnosis
  - Events leading to hospitalization
  - History of psychiatric treatment
  - Current medications
  - Physician orders
  - Presenting signs and symptoms
- Verification that Certification of Need Form (PSY-5) has been completed
- Verification that medical, social, and psychiatric evaluations have been completed
- Verification that initial treatment plan (Plan of Care) is present on recipient's chart

Medicaid uses the Psychiatric Criteria for Age 65 or Over to approve or deny the admission.

- If the admission is approved, the facility receives approval to bill for the stay and assigns date for the initial continued stay review (CSR).
- If the admission cannot be approved based on the information received, additional information will be requested.
- If Medicaid determines that the admission is not medically necessary, the facility will be notified within two working days after a determination has been made.

Re-Admission Criteria

Medicaid will use the following criteria for re-admissions:

- Continued **need** to evaluate and treat for persistence of the patient's underlying psychiatric disease that led to psychiatric commitment / admission; and /or,

- Continued **need for** psychopharmacological and therapeutic interventions for modification and stabilization of the patient's behavior as related to the psychiatric disease**.**

Continued Stay Reviews

The hospital's utilization review personnel are responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

The initial continued stay review should be performed on the date assigned by Medicaid. Later reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record.

If the facility's utilization review personnel determine that the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed.

If a final decision of denial is made, the hospital notifies the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made.

The facility's utilization review personnel are responsible for notifying Medicaid whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

104.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, or family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

NOTE:
Copayment is not a third party resource. Do not record copayment on the UB-04.

104.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Psychiatric hospital providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

104.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

104.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

104.5.3 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

104.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

104.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

104.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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