

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

DXC 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.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

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; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for geriatric patients 65 or older.
- Employ only staff who meet training certification standards in the area of adult 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.

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

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. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/Medically Necessary Care.

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.

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.

NOTE:

A recipient may temporarily transfer to a nursing facility for a two-week trial period. This trial period is not a therapeutic visit. Refer to Chapter 26, Nursing Facility for additional information on admission to a nursing facility from an inpatient psychiatric hospital.

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.

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs)

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following; surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient.

Non- payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPCs for consideration should be limited to those that yield a serious adverse

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result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.

- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some OPPCs may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs).

The following OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable “OPPCs” include but are not limited to:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type.

A sample form is on the Alabama Medicaid Agency website at

http://medicaid.alabama.gov/content/4.0_Programs/4.4_Medical_Facilities/4.4.1_Hospital_Services/4.4.1.3_Adverse_Events.aspx

www.medicaid.alabama.gov although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

Reporting Hospital–Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Psychiatric hospitals and RTF’s should use the POA indicator on claims for these HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov. The following information will be

required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form:

Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)	T81.500A to T81.599A T81.60XA to T81.69XA
Air Embolism	999.1 (MCC)	T80.0XXA
Blood Incompatibility	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)	T80.30XA T80.319A T80.310A T80.311A T80.39XA
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)	L89.003 to L89.93 L89.004 to L89.94
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829 830-839 850-854 925-929 940-949 991-994	S02.0XXA to T07 S03.0XXA to S91.109A S06.0X0A to S01.90XA S07.0XXA to S77.20XA T26.50XA to T32.99 T33.011A-T70.9XXA
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)	T83.51XA B37.41 to B37.49 N10 N10 N15.1 N28.84 to N28.86 N11.9 to N13.6 N16 N30.00 and N30.01 N34.0 N39.0
Vascular Catheter-Associated Infection	999.31 (CC) 999.32 (CC) 999.33 (CC)	T80.218A to T80.219A T80.211A T80.212A
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10- 249.11 (MCC), 249.20- 249.21 (MCC)	E10.10 to E13.10 E11.00 to E13.01 E15 E08.00 to E13.10 E08.00 to E13.01
Surgical Site Infection, Mediastinitis, Following	519.2 (MCC) and one of the following procedure	J98.5 See CMS website for listing of associated

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Selected HAC	CC/MCC (ICD-9-CM Codes)	CC/MCC (ICD-10-CM Codes)
Coronary Artery Bypass Graft (CABG)	codes: 36.10-36.19.	Procedure Codes
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.	T84.60XA to T84.7XXA K68.11 to T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code- 278.01, 539.01 (CC), 539.81 (CC) OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95	Principal Diagnosis code E6601 and one of the secondary diagnosis codes: K68.11, K9501, K9581 or T81.4XXA See CMS website for listing of associated Procedure Codes
Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)	996.61 (CC) or 998.59 (CC) And one of the following procedure codes: 00.50, 00.51, 00.52, 00.53, 00.54, 37.80, 37.81, 37.82, 37.83, 37.85, 37.86, 37.87, 37.94, 37.96, 37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89	K68.11, T814XXA, T826XXA, T827XXA See CMS website for listing of associated Procedure Codes
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.13 (MC) 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 00.85-00.87, 81.51-81.52, 81.54.	T80.0XXA to T82.818A I26.90, I2699 I26.09, I26.99 I82.401 to I82.4Z9 See CMS website for listing of associated Procedure Codes
Iatrogenic Pneumothorax with Venous Catheterization	512.1 (CC) And the following procedure code 38.93	J95.811 and one of the following procedure codes: 05HM33Z

For ICD-10, please use the CMS Diagnosis Listing for POA Exempt Diagnosis Codes at: <https://www.cms.gov/Medicare/Coding/ICD10/index.html>

Select the appropriate fiscal year ICD-10-CM POA Exempt file for the dates of service of the claim. These codes are for recipient encounters occurring between October 1st through September 30th of each fiscal year.

All Diagnosis codes NOT present in the listing require POA indicator.

The psychiatric hospital or RTF may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Psychiatric hospitals and RTF's are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC.

In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

It is the responsibility of the psychiatric hospital or RTF to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

It is the psychiatric hospital or RTF's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services.

Payment

Payment for inpatient services provided by psychiatric facilities 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 Inpatient Utilization Review

1. The determination of the level of care will be made by a licensed nurse of the hospital staff.
2. Five percent of all admissions and concurrent stay charts will be retrospectively reviewed by the Medicaid Agency or designee on a monthly basis.
3. For an individual who applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made.
4. The following information shall be included on the Psychiatric Admission Form:
 - (a) Recipient information:
 1. Admitting diagnosis;
 2. Events leading to hospitalization;
 3. History of psychiatric treatment;
 4. Current medications;
 5. Physician orders;
 6. Presenting signs and symptoms.
 - (b) Events leading to present hospitalization
 - (c) History and physical
 - (d) Mental and physical capacity
 - (e) Summary of present medical findings including prognosis
 - (f) Plan of care.

104.4 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.

104.5 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.

104.6 Completing the Claim Form

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

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.

104.6.1 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.

104.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:
 ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.
 ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:
 ICD-9 or ICD-10 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.

104.6.3 Revenue Codes

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

104.6.4 Place of Service Codes

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

104.6.5 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 5.8, Required Attachments, for more information on attachments.

104.7 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	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N