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CHAPTER FORTY-ONE

PSYCHIATRIC FACILITIES FOR INDIVIDUALS UNDER AGE 21

Chapter 41. Psychiatric Facilities for Individuals Under Age 21

Rule No. 560-X-41-.01 Psychiatric Facilities for Individuals under age 21 - General

(1) Inpatient psychiatric services for recipients under age 21 are covered services when provided:

(a) Under the direction of a physician,

(b) By a psychiatric hospital enrolled as a Medicaid provider in accordance with Rule No. 560-X-41-.02; OR

(c) By a psychiatric residential treatment facility (RTF) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by other accrediting organization with comparable standards that is recognized by the State;

(d) Before the recipient reaches age 21 or, if the recipient was receiving services immediately before the recipient reached age 21, before the earlier of: (1) the date the recipient no longer requires the services or (2) the date the recipient reaches age 22, and

(e) To a recipient who is admitted to and remains in the facility for the course of the hospitalization; and

(f) As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 C.F.R. § 441.152.

(2) Inpatient psychiatric services for recipients under age 21 are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria.

(3) Residential psychiatric treatment services for recipients under age 21 are unlimited if medically necessary and the admission and continued stay reviews meet the approved psychiatric criteria. All treatment plan updates and certifications of need for services shall be performed as specified in Rule 560-X-41-.06.

(4) Referrals from a recipient's Patient 1st Primary Medical Provider (PMP) are not required for admissions to psychiatric hospitals or residential treatment facilities (RTFs).

(a) However, hospitals and RTFs should notify the recipient's PMP of the admission within 72 hours by faxing a copy of the recipient's face sheet to the PMP. Fax numbers for all PMPs may be found in the "About Medicaid" section on the Medicaid website, www.medicaid.state.al.us

(b) Ancillary services provided during the RTF stay may be billed fee-for-service if the recipient has been granted an exemption from the Patient 1st Program.

(c) Written requests for Patient 1st exemptions should be submitted to Medicaid by the recipient's case worker or the RTF at the time of admission to the residential facility.

(d) Requests must be submitted on the Patient 1st Medical Exemption Request found on the Medicaid website: medicaid.state.al.us under the Patient 1st tab. The block "Diagnosis/Other Information" should be checked and the statement "Recipient confined in RTF" entered in the appropriate space.

(e) Written notification shall be provided to Medicaid by the case worker or the RTF at the time of the recipient's discharge or transfer to another facility.

(f) All correspondence regarding Patient 1st should be mailed to:

Alabama Medicaid Agency
Attention: Patient 1st Program
P.O. Box 5624
Montgomery, AL 36103-5624

(5) Psychiatric hospitals and RTFs shall comply with all applicable regulations regarding the use of restraint and seclusion as cited in 42 C.F.R., Part 441, Subpart D, and 42 C.F.R., Part 483, Subpart G.

(6) The specific requirements for psychiatric medical records may be found at 42 C.F.R. § 482.61.

(7) The specific requirements for psychiatric facility staff may be found at 42 C.F.R . § 482.62.

Author: Solomon Williams, Associate Director, Institutional Services.
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7 and 7.16; 42 C.F.R. Part 441, Subpart D; Part 483, Subpart G; Sections 440.240; 482.61; 482.62.
History: Rule effective October 1, 1988. Amended: November 1, 1988; February 9, 1989; September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed June 11, 2015; effective July 16, 2015.

Rule No. 560-X-41-.02 Conditions of Participation

(1) **Hospitals**: In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient psychiatric services for individuals under age 21, a provider must meet the following conditions:

(a) Be certified for participation in the Medicare/Medicaid program;

(b) Be licensed as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7. State hospitals which do not require licensing as per state law are exempt from this provision (Alabama Code, Section 22-50-1, et seq.);

(c) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations;

(d) Have a distinct unit for children and adolescents;

(e) Have a separate treatment program for children and adolescents;

(f) Be in compliance with Title VI and VII of the Civil Rights Act of 1964 Section 504 of the Rehabilitation Act of 1973, and with the Age Discrimination Act of 1975.

(g) Execute an Alabama Medicaid Provider Agreement for participation in the Medicaid program;

(h) Submit a written description of an acceptable utilization review (UR) plan currently in effect; and

(i) Submit a budget of costs for medical inpatient services for its initial cost reporting period, if a new provider.

(2) Application by Alabama psychiatric hospitals for participation in the Medicaid program shall be made to the appropriate address indicated in the Provider Manual.

(3) Submission of a monthly inpatient census report using the PSY-4 form is required of enrolled psychiatric hospitals.

(a) The census report should list the names of all Medicaid children/adolescents who are admitted to and discharged from the hospital during the calendar month. This report should also list the names of the children and adolescents who remain in the hospital during the calendar month.

(b) This report must be received by Medicaid (all correspondence should be mailed to the appropriate address as indicated in the Provider Manual) on or before the tenth of each month for the preceding month.

(c) Failure to send the required reports within the specified time period will result in the hospital's reimbursement checks being withheld until the report is received.

(4) **Residential Treatment Facilities (RTFs)**: In order to participate in the Title XIX Medicaid program and to receive payment for residential psychiatric treatment services for individuals under age 21, RTFs must meet the following conditions:

(a) Be accredited by JCAHO, CARF, COA, or be certified as an Alabama RTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health/Mental Retardation (DMH/MR) the Department of Youth Services (DYS), or the Department of Children's Affairs (DCA). Upon enrollment and each time the RTF is recertified a copy of the certification letter must be sent to Medicaid within forty-five business days.

(b) Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;

(c) Execute a contract or placement agreement with DHR, DMH/MR, DYS, DCA, or Federally Recognized Indian tribes to provide residential psychiatric treatment services in the State of Alabama;

(d) Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;

(e) Submit a written description of an acceptable UR plan currently in effect;

(f) Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion upon enrollment and yearly on or before July 21;

(g) Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21;

(5) All correspondence regarding application and certification by Alabama RTFs for participation in the Medicaid program should be mailed to the appropriate address indicated in the Provider Manual.

Author: Jerri Jackson, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D; and Section 431.107.
History: Rule effective October 1, 1988. Amended September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed: March 21, 2005; effective June 16, 2005. **Amended:** Filed: October 22, 2007; effective January 16, 2008.

Rule No. 560-X-41-.03 Inpatient Psychiatric Benefits

(1) For purposes of this chapter, an inpatient is a person who has been admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient psychiatric services.

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

(3) Medicaid covers the day of admission, but not the day of discharge.

(4) Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient.

(a) Payments for therapeutic visits away from the hospital are limited to no more than two visits with each visit not exceeding three days in duration per 60 calendar days per admission per recipient. The first calendar day begins with the day of admission.

(b) Therapeutic visits away from the hospital exceeding three days in duration are not covered and no part of these visits may be billed to Medicaid.

(c) Therapeutic visit records will be reviewed retrospectively by the PA Unit. Payments for therapeutic visits in excess of the amount as described in (4)(a) above will be recouped.

(d) This policy applies only to visits away from the psychiatric hospital. Therapeutic visits away from the RTF are not limited by this policy.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, 4.19-A. 42 C.F.R. Section 436.1004.
History: Rule effective October 1, 1988. Amended September 13, 1989; and January 14, 1992. **Amended:** Filed June 19, 2000; effective September 11, 2000. **Amended:** Filed March 21, 2005; effective June 16, 2005.

Rule No. 560-X-41-.04 Certification of Need for Inpatient Hospital Services

(1) Certification of need for inpatient hospital services is a determination which is made by the certifying team as specified in (4) below regarding the Medicaid recipient's treatment needs for admission to the hospital.

(2) The appropriate team must certify that:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;

(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

(3) The appropriate certifying team must complete the PSY-2 form which is the certification of need for inpatient hospital services.

(4) Certification of need for services must be made by teams specified as follows:

(a) For an individual who is a Medicaid recipient and is a non-emergency admission to the facility the certification of need for services must be made prior to the admission. If the certification is completed subsequent to admission, payment cannot be made for the period prior to the date the certification is completed. Certification must be made by an independent team that:

1. Includes a physician;
2. Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
3. Has knowledge of the individual's situation.

(b) Certification of need for services may be made by the team as specified in Rule No. 560-X-41-.04 (4)(a) provided the team is not:

1. Employed and reimbursed by the facility; or
2. In partnership with the attending physician; or
3. On the treatment team caring for the patient.

(c) For an individual who applies for Medicaid while in the facility, the certification of need for services must:

1. Be made by the team responsible for the plan of care as specified in Rule No. 560-X-41-.06(3); and
2. Cover any period before application for which claims are made.

3. If the certification is completed subsequent to the filing of the application, payment cannot be made for the period prior to the date the certification is completed.

(d) For emergency admissions the certification of need for services must be made by the team responsible for the plan of care as specified in Rule No. 560-X-41-.06(3) within 14 working days after admission.

(5) An emergency admission is described as a situation where the patient's condition is such that prompt provision of care is necessary to prevent the death or serious impairment of the health of the patient or others due to the individual's psychiatric condition. The presence of a court order does not in itself justify characterizing an admission as an emergency.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 441, Subpart D.
History: Rule effective October 1, 1988. Amended: September 13, 1989; August 21, 1991; November 13, 1991. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.05 Medical, Psychiatric, and Social Evaluations

(1) Before admission to a psychiatric facility or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each recipient's need for care in the facility and appropriate professional personnel must make a psychiatric and social evaluation. The psychiatric evaluation must be completed within 60 days of admission. The specific requirements for psychiatric medical records may be found at 42 CFR, 482.61.

(2) Each medical evaluation must include:

(a) Diagnosis within the ICD-9 range of 290-316 (dates services prior and up to September 30, 2015) or ICD-10 range of F01.50 – F69, F80.0-F99, G44.209, H93.25, R37, R45.1-R45.2, R45.5-R45.82, R480, Z87.890 (dates of services October 1, 2015 and forward),

(b) Summary of present medical findings,

(c) Medical history,

(d) Mental and physical functional capacity,

(e) Prognosis, and

(f) A recommendation by a physician concerning:

1. Admission to the psychiatric facility, or

2. Continued care in the psychiatric facility for individuals who apply for Medicaid while in the facility.

Author: Solomon Williams, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.170, 482.61.

History: Rule effective October 1, 1988. **Amended:** September 13, 1989; August 21, 1991; and November 13, 1991. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed March 21, 2005; effective June 16, 2005. **Amended:** Filed August 27, 2015; effective October 1, 2015.

Rule No. 560-X-41-.06 Active Treatment

(1) Inpatient psychiatric services are covered by Medicaid only if they involve active treatment which means implementation of a professionally developed and supervised individual plan of care that is:

(a) Developed and implemented no later than 14 days after admission; and

(b) Designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

(2) An individual plan of care is a written plan developed for each recipient in accordance with (2)(a-f) below to improve the recipient's condition to the extent that inpatient care is no longer necessary. The plan of care must:

(a) Be based on a diagnostic evaluation that includes examination of the medical, psychosocial, social, behavioral, and developmental aspects of the recipient's situation and reflects the need for inpatient psychiatric care;

(b) Be developed by a team of professionals specified in (3) below in consultation with the recipient and their parents, legal guardians, or others in whose care he/she will be released after discharge;

(c) State treatment objectives;

(d) Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives;

(e) Include, at an appropriate time, 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, school, and community upon discharge; and

(f) Be reviewed at least every 30 days by the team specified in (3) below to determine that services provided are/were required on an inpatient basis, and recommend changes in the plan as indicated by the recipient's overall adjustment to the treatment.

(3) Team developing individual plan of care.

(a) The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or who provide services to patients in, the facility. Based on education and experience, including competence in child psychiatry, the team must be capable of:

1. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
2. Assessing the potential resources of the recipient's family;
3. Setting treatment objectives; and
4. Prescribing therapeutic modalities to achieve the plan's objectives.

(b) The team must include, as a minimum, either:

1. A Board-eligible or Board-certified psychiatrist licensed in the State of Alabama;

2. A licensed clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

3. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the State of Alabama.

(c) The team must also include one of the following:

1. A licensed social worker with specialized training or one year of experience in treating mentally ill individuals,

2. A registered nurse with specialized training or one year of experience in treating mentally ill individuals,

3. An licensed occupational therapist with specialized training, or one year of experience in treating mentally ill individuals, or

4. A psychologist who has a master's degree in clinical psychology or who has been certified by the State of Alabama.

(d) The specific staff requirements for psychiatric facilities may be found at 42 CFR 482.62.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D; 482.62
History: Rule effective October 1, 1988. Amended September 13, 1989; and November 13, 1991. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended**: Filed March 21, 2005; effective June 16, 2005

Rule No. 560-X-41-.07 Utilization Review (UR) Plan

As a condition of participation in the Title XIX Medicaid program, each psychiatric facility shall:

(1) Have in effect a written UR plan that provides for review of each recipient's need for services that the facility furnishes to him. This written UR plan must meet the requirements under 42 C.F.R. Section 456.201 through 42 C.F.R. Section 456.245;

(2) Maintain recipient information required for UR under 42 C.F.R. Section 456.211, which shall include the certification of need for service and the plan of care; and

(3) Provide a copy of the UR plan and any subsequent revisions to Medicaid for review and approval.

Authority: 42 C.F.R. Section 456.200 through 42 C.F.R. Section 456.245. Rule effective October 1, 1988. Effective date of this amendment September 13, 1989.

Rule No. 560-X-41-.08 Payment

(1) Payment for inpatient services provided by psychiatric hospitals shall be the per diem rate established by Medicaid for the hospital which is based on the Medicaid cost report and provisions of Chapter 23 of the Alabama Medicaid Administrative Code.

(2) Providers are required to file a complete uniform Medicaid cost report for each fiscal year. One copy of this report must be received by Medicaid within three months after the Medicaid cost report year-end.

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

(4) If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

(5) Medicaid pays for residential treatment services provided by RTFs according to the per diem rate established in the placement agreement between the RTF and the contracting state agency (DHR, DYS, DMH, DCA).

(6) Providers should not send recipients bills or statements for covered services once that recipient has been accepted as a Medicaid patient. Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold print, **"THIS IS NOT A BILL."** Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims. Providers may not bill the recipient for the difference between charges billed and the amount paid by Medicaid. Providers agree to accept the amount paid by Medicaid as payment in full. Providers may bill recipients only for the allowable copay amount, for services not covered by Medicaid, or when benefits have been exhausted.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 4.19-A, 42 CFR, Section 413.
History: Rule effective October 1, 1988. Amended: November 1, 1988; February 9, 1989; and September 13, 1989. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed: March 21, 2005; effective June 16, 2005

Rule No. 560-X-41-.09 Inpatient Review Criteria

(1) All patients seeking admission to a psychiatric hospital must require psychiatric services that can only be provided on an inpatient basis. These psychiatric services must involve implementation of a professionally developed and supervised individualized plan of care.

(2) The inpatient admission criteria utilized by Medicaid require a documented need for inpatient psychiatric services. A patient seeking admission to a psychiatric hospital must meet at least one of the following criteria:

(a) Inappropriate performance of activities of daily living as evidenced by:

1. inappropriate hygiene or grooming;
2. psychomotor agitation or retardation;
3. severe disturbances in appetite or sleep.

(b) Impaired safety as evidenced by:

1. inappropriate, depressed, agitated mood;
2. suicidal ideation, threat, gesture, or attempt;
3. substance abuse;
4. inappropriate behavior requiring intervention;
5. noncompliance with medication or treatment regimen.

(c) Impaired thought process as evidenced by:

1. verbal or behavioral disorganization;
2. thought disorganization, hallucinations, paranoid ideation, phobias, etc.;
3. impaired reality testing;
4. bizarre or delusional behavior;
5. disorientation or memory impairment to the degree of endangering patient's welfare;
6. severe withdrawal or catatonia.

(e) Inpatient treatment required due to:

1. failure of outpatient therapy;
2. failure of social or family functioning which places patient at increased risk;
3. treatment in a less restrictive environment not feasible due to patient's behavior;
4. need for intensive inpatient evaluation;
5. need for 24-hour skilled and intensive observation;
6. need for evaluation of drug tolerance;
7. recurrence of psychosis not responding to outpatient treatment;
8. toxic effects from therapeutic psychotropic drugs;
9. blood or urine positive for barbiturates, narcotics, alcohol, or other toxic agents in a patient displaying physical symptoms.

(3) All patients receiving inpatient psychiatric services must be involved with active treatment. "Active treatment" is defined as implementation of a professionally developed and supervised individualized plan of care. At least one professional member of the interdisciplinary treatment team must be involved in providing active intervention for an unresolved or active problem as noted on the plan of care. Appropriate members of the treatment team must document active intervention when a patient's placement options are unresolved.

(4) The continued stay criteria utilized by Medicaid require a documented need for continuation of inpatient psychiatric services. A patient seeking continued stay in a psychiatric hospital must meet at least one of the following criteria:

(a) Active intervention by at least one member of the interdisciplinary treatment team for an unresolved problem on the patient's treatment plan;

(b) Medication changes, administration of PRN medications, medications in liquid form (for suspected noncompliance);
(c) Episodes of inappropriate behavior requiring intervention;
(d) Noncompliance with treatment regimen;
(e) Suicidal ideation, threat, gesture, or attempt;
(f) No availability of placement options appropriate to patient's needs.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachments 3.1-A, p. 7.16 and 4.19-B, p. 8; 42 CFR, Part 441, Subpart D.
History: Rule effective September 13, 1989. Amended September 11, 2000. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.10 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 is a Medicaid recipient at the time of admission, the attending physician must sign a Psychiatric Admission form indicating the medical necessity of the admission.

(4) For an individual who applies for Medicaid while in the facility, the Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made.

(5) 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) Diagnosis within the ICD-9 range of 290-316 (dates services prior and up to September 30, 2015) or ICD-10 range of F01.50 – F69, F80.0-F99, G44.209, H93.25, R37, R45.1-R45.2, R45.5-R45.82, R480, Z87.890 (dates of services October 1, 2015 and forward)
(d) History and physical
(e) Mental and physical capacity
(f) Summary of present medical findings including prognosis

(g) Plan of care.

(6) Medicaid's Psychiatric Criteria for Psych Under 21 will be utilized in reviewing whether the admission and continued stay were appropriately billed.

Author: Solomon Williams, Associate Director, Institutional Services
Statutory Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.170-.171.
History: Rule effective September 13, 1989. **Amended:** August 21, 1991; November 13, 1991; June 14, 1994; September 11, 2000. **Amended:** Filed September 21, 2001; effective December 14, 2001. **Amended:** Filed July 20, 2012; effective October 16, 2012. **Amended:** Filed August 27, 2015; effective October 1, 2015.

Rule No. 560-X-41-.11 Inpatient Continued Stay Reviews

(1) The provider's interdisciplinary treatment team is responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

(2) Continued stay updates must include:
(a) Master Treatment Plan and subsequent changes;
(b) Utilization review worksheet;
(c) Physician's progress notes, nursing progress notes and, if requested, social worker's progress notes (individual and family sessions, discharge planning). The PA Unit may request this information when documentation included in (a) and (b) is insufficient to justify the continued hospital stay.

(3) Continued stay updates will be reviewed by the PA Unit and the next continued stay review date assigned upon approval of the continued hospitalization. Continued stay updates not received by the next review date will be approved on the date the information is received by the PA Unit provided the review criteria are met. These stays must be split billed to separate the authorized days from the non-authorized days.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: Title XIX, Social Security Act; State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Section 456.233-.234,
History: Rule effective August 21, 1991. Amended November 13, 1991; September 11, 2000. Amended: Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.12 Recertification of Need for Inpatient Care

(1) Recertification of need for inpatient care must be made on the PSY-3 form at least every 60 days after admission by the patient's attending physician and filed in the patient's medical record.

Author: Lynn Sharp, Associate Director, Policy Development Unit

Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 456.160.
History: Rule effective August 21, 1991. Amended November 13, 1991. Amended: Filed June 19, 2000, effective September 18, 2000.

Rule No. 560-X-41-.13 Certification of Need for Residential Treatment Services

(1) Recipients seeking admission to a residential treatment facility (RTF) shall require continuous and active psychiatric treatment and care in a facility which meets the standards in 560-X-41-.02 (4)(a-g).

(2) Recipients seeking admission to a RTF must meet at least one of the admission criteria listed in 560-X-41-.09 (2)(a-d).

(3) For elective or non-emergency admissions of individuals who are Medicaid-eligible when admitted to the RTF, a certification of the need for services shall be performed by an independent team that:

(a) Includes a physician;

(b) Has competence in diagnosis and treatment of mental illness (preferably in child psychiatry); and

(c) Has knowledge of the individual's situation.

(4) The independent team shall certify that:

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient; and

(b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

(c) Services can reasonably be expected to improve the recipient's condition or prevent further regression so that inpatient services will no longer be needed.

(5) The independent team shall complete and sign a Certification of Need for Services: Non-Emergency Admission form (# 370) not more than 30 days prior to admission. This form shall be filed in the recipient's medical record to verify compliance with this requirement. This form may be downloaded from the "Forms" section on the Medicaid website www.medicaid.state.al.us

(6) For emergency admissions or for individuals who become eligible for Medicaid after admission , a certification of need for services shall be performed by an interdisciplinary team. The team responsible for the plan of care must include either:

(a) A board-eligible or board-certified psychiatrist licensed in the State of Alabama; or

(b) A licensed clinical psychologist and a physician; or

(c) A physician licensed in the State of Alabama with specialized training and experience in diagnosis and treatment of mental illness and a psychologist with a master's degree in clinical psychology; and one of the following:

1. Licensed social worker with specialized training or one year of experience in treating the mentally ill; or

2. RN with specialized training or one year of experience in treating the mentally ill; or

3. Licensed occupational therapist who has specialized training or one year of experience in treating the mentally ill; or

4. Psychologist with a master's degree in clinical psychology.

(7) The interdisciplinary team shall perform the same certification of need for services as listed for elective and non-emergency admissions in (4)(a-c) above. The team shall complete and sign a Certification of Need for Services: Emergency Admission form (#371), within 14 days of the emergency admission. This form shall be filed in the recipient's medical record to verify compliance with this requirement. This form may be downloaded from the "Forms" section on the Medicaid website www.medicaid.state.al.us.

(8) For individuals who become eligible for Medicaid after their admission to the facility, this form shall be completed on or before the date of the application for Medicaid coverage and shall include all days for which Medicaid payment will be requested.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.14 Residential Continued Stay Reviews

(1) The RTF's interdisciplinary team shall be responsible for performing continued stay reviews on recipients who require continuous residential services.

(2) Recipients requiring continued stays in RTFs must meet at least one of the criteria listed in 560-X-41-.09(4)(a-f).

(3) The plan of care shall be reviewed at least every 30 days by the interdisciplinary team to:

(a) Determine that services are/were medically necessary; and

(b) Recommend changes in the plan as indicated by the recipient's overall adjustment to treatment.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.15 Recertification of Need for Residential Services

Recertification of need for residential services shall be noted on the recipient's plan of care by the attending physician at least every 30 days.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 441, Subpart D
History: New Rule Filed September 21, 2001; effective December 14, 2001.

Rule No. 560-X-41-.16 Reporting of Deaths and Serious Occurrences

(1) RTFs seeking enrollment with Medicaid must meet the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences.

(2) RTFs shall submit a written attestation of compliance with the federal rules at the time of enrollment. The written attestation must be signed by an individual who has the legal authority to obligate the facility.

(3) At a minimum, the attestation shall include:

(a) The name, address, telephone number of the facility, and provider number (if applicable);

(b) The signature and title of the individual who has the legal authority to obligate the facility;

(c) The date the attestation is signed;

(d) A statement certifying that the facility currently meets all of the requirements of 42 CFR, Part 483, Subpart G, governing the use of restraint and seclusion;

(e) A statement acknowledging the right of the State Survey Agency (or its agents) and, if necessary, the Centers for Medicare and Medicaid Services (CMS), to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences;

(f) A statement that the facility will notify Medicaid if it no longer complies with the requirements of the rule; and

(g) A statement that the facility will submit a new attestation of compliance in the event the individual who has the legal authority to obligate the facility is no longer in such position.

(4) RTFs may use the RTF Attestation Letter to fulfill this requirement. This form may be downloaded from the "Forms"section on the Medicaid website www.medicaid.state.al.us. The information in the form letter should be submitted to Medicaid on the facility's letterhead.

(5) Participating RTFs shall be required to report a resident's death, serious injury, or suicide attempt to Medicaid and the state-designated Protection and Advocacy system. In addition to the reporting requirements to Medicaid, RTFs shall report the

death of any resident to the CMS Regional Office in Atlanta, Georgia. These reports shall be filed with the agencies noted above no later than the close of business the next business day after the occurrence.

(6) RTFs shall report to the CMS Regional Office the death of any resident no later than the close of business the next business day after the resident's death. This report shall include:

(a) Name of the deceased resident;
(b) Description of the occurrence;
(c) Name, address, telephone number of the RTF; and
(d) Any other information the RTF is able to provide regarding the death.

(7) RTFs shall document in the resident's medical record that the death was reported to the CMS Regional Office.

(8) RTFs shall document in the resident's medical record that any serious occurrence, such as death, serious injury, or suicide attempt, was reported to Medicaid and the state-designated Protection and Advocacy system.

(9) Medicaid shall validate the attestations for a random sample of 20 percent of participating RTFs on an annual basis. The selected sample will be transmitted to the State Survey Agency in order to conduct on-site surveys to ensure the facilities have policies and procedures in place consistent with the attestation and are complying with the requirements of 42 CFR, Part 483, Subpart G.

Author: Lynn Sharp, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-A, pp. 7, 7.16; 42 CFR, Part 483, Subpart G
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