NSMHA Contract Memorandum 2006-001

Date: April 10, 2006

To: Tom Robinson, Volunteers of America

From: Chuck Benjamin, Executive Director

Subject: Memo from Wendi Gunther at MHD

We are forwarding to you a copy of the March 29, 2006, memo from Wendi Gunther at the Mental Health Division. Please contract Wendy Klamp, Quality Manager, if you have any questions or require further clarification. These instructions regarding Inpatient Authorization must be adhered to and are included in our current contract.

cc: Linda Carlson, Volunteers of America

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MENTAL HEALTH DIVISION PO BOX 45320 OLYMPIA WA 98504-5320 (360)902-8070

March 29, 2006

TO: RSN Administrators

From: Wendi Gunther Mental Health Division

RE: Inpatient Authorization and Length of Stay Extension

Recently, MHD has heard that there is some confusion in the community regarding what documentation is required for psychiatric inpatient authorization and length of stay extension approval in community hospitals. This memorandum is to clarify what documents need to be provided to the community hospitals in order for them to be able to bill MMIS correctly.

Per MAA Numbered Memorandum #01-03, in the Pre-Admission Certification for Psychiatric Admissions section, 'When a decision is made to approve voluntary admission, the MHD designee must document this decision on the Certification Form and provide this form to the hospital (Attachment 111, Form and Instructions):' This Numbered Memorandum is still in full effect. The RSNs or their designees will need to provide the hospitals with the Form as seen in (or similar to) Attachment 111 of the Numbered Memorandum. **A** copy of the form is attached for your convenience.

Also per MAA Numbered Memorandum #01-03, in the Length of Stay Extension for Voluntary Inpatient Hospital Admission section, "Any extension to a length of stay, as described above, requires written approval from the MHD designee. At admission or post-admission certification, the MHD designee will provide clear instructions for requesting length of stay extensions (See Attachment IV, Extension Request Form):' The RSlVs or-their designees will need to fill out the bottom half of the Extension Request for Hospitalization form and return it to the hospitals. A copy of the form is attached.

The hospitals need to have these forms to bill MAA. Any other form of authorization is not acceptable. In order to avoid unnecessary delay, please provide the hospitals with these forms immediately.

Please contact Chris Winans at 360-902-0844 if you have any questions. Thank you for your assistance.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medical Assistance Administration &
Mental Health Division

To: Advanced Registered Nurse Practitioners
Community Mental Health Centers
Free-Standing Psychiatric Hospitals
Hospitals
Managed Care Plans
Physicians
Psychiatrists
Psychologists
Regional Administrators
Regional Support Networks
CSO Administrators

From: James C. Wilson, Assistant Secretary
Medical Assistance Administration

Tim Brown, Assistant Secretary
Health and Rehabilitative Services

Subject: **Psychiatric Hospitalization**

Memorandum #: 01-03 MAA
Issued: February 1, 2001
Supersedes: 98-61 MAA

For further information, contact local RSN (see list enclosed)

This memorandum updates instructions regarding psychiatric inpatient management and supersedes Numbered Memorandum 98-61 MAA (January 1999).

See next page…

CRITERIA FOR INPATIENT PSYCHIATRIC CARE

Inpatient psychiatric care for all Medical Assistance Clients (on Title XIX and state programs) must be:

- ✓ Medically necessary (as defined in WAC 388-500-0005);
- ✓ Approved by the professional in charge of the hospital; and
- ✓ Certified by Mental Health Division designated professional contacts.

  These designees must operate under the direction of the Regional Support Network (RSN) or tribal authority, as appropriate. A current list of MHD designees is attached. (*Attachment II*)

FACILITIES ELIGIBLE TO PROVIDE PSYCHIATRIC CARE

DSHS reimburses for inpatient psychiatric care, as defined in chapters 246-320 and 246-322 WAC, only in the following facilities licensed by the Department of Health:

- ✓ Free-standing psychiatric hospitals;
- ✓ Medicare-certified distinct part psychiatric units; and
- ✓ General hospitals under contract with MAA when active psychiatric care is provided under the supervision of a psychiatrist.

AGE OF CONSENT FOR VOLUNTARY INPATIENT HOSPITAL ADMISSIONS

(Voluntary admissions occur as stated in chapters 71.05 and 7134 RCW)

- **12 years of age and under**: May be admitted only by the consent of the minor's parent/legal guardian.

- **13 through 17 years of age**: May be admitted on application of 1) the minor and the minor's parent/guardian; 2) the minor's parent/legal guardian without the minor's consent; or 3) the minor without parental consent.

- **18 years of age and older**: May be voluntarily admitted only with his/her written, voluntary and knowing consent to treatment.

Involuntary admissions may occur as stated in chapters 71.05 and 71.34 RCW.

PRE-ADMISSION CERTIFICATION FOR PSYCHIATRIC ADMISSIONS

- All psychiatric admissions for covered diagnoses *(Attachment I)* must be authorized prior to admission by the appropriate MHD designee *(Attachment II)*. To determine the appropriate MHD designee, consult the client's Medical Assistance Identification (MAID) card for county of residence. Refer to MAA's General Information Booklet for further information regarding the client's MAID card.

- **The MHD designee's responsibility:** To make determination of medical necessity for admission in consultation with the required professionals and others, as appropriate.

- **The hospital's responsibility:** To communicate with the Mental Health Division (MHD) designee, provide information required to make a decision concerning the need for care, and incorporate appropriate mental health specialists in the plan of care.

- A voluntary admission is determined medically necessary when all the following criteria are met:

  - ✓ Ambulatory care resources available in the community do not meet the treatment needs of the client;
  - ✓ Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;
  - ✓ The inpatient services can be reasonable expected to improve the client's condition or prevent further regression so that the services will no longer be needed; AND
  - ✓ The client has been diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association, the edition current at the time of admission.

- When a decision is made to approve voluntary admission, the MHD designee must document this decision on the Certification Form and provide this form to the hospital *(Attachment III, Form and Instructions)*.

- Requirements for certification of medical necessity for involuntary admission are satisfied through the initial detention process for involuntary treatment in accordance with chapters 71.05 or 71.34 RCW.

POST-ADMISSION CERTIFICATION

- The hospital must notify the MHD designee within 24 hours of any of the following changes in a client's status:

  - ✓ Conversion from involuntary to voluntary status under chapters 71.05 or 71.34 RCW;
  - ✓ Application for determination of Medical Assistance eligibility;
  - ✓ Change in the principal ICD-9-CM diagnosis code to a mental disorder; or
  - ✓ Hospital identifies need for extraordinary psychiatric service (e.g., electroconvulsive therapy).

- The MHD designee will determine whether to approve post-admission certification or extraordinary psychiatric service(s) within three calendar days of being notified of any of the above circumstances.

- If a hospital requests a certification decision retrospectively and/or outside the usual and expected procedures outlined above, the MHD designee may establish regional procedures to address such requests. The MHD designee has full authority to deny consideration of such requests.

- Although certification by the MHD designee is not required for persons who have been admitted to psychiatric inpatient care in accordance with Medicare standards, hospitals must notify the MHD designee of any person admitted for psychiatric inpatient care whose primary coverage is Medicare and whose secondary coverage is Medical Assistance.

LENGTH OF STAY EXTENSION FOR VOLUNTARY INPATIENT HOSPITAL ADMISSIONS

- Unless an extension has been approved by the MHD designee, the length of stay will be calculated using the 75th percentile. MAA will use this criteria (as published in HCIA's 1996 Length of Stay by Diagnosis and Operation, United States Western Region) for all non-DRG claims for hospital admissions. (*See Attachment V – PAS*). Hospitals may report ICD-9-CM discharge diagnosis codes at either the 3-digit category in accordance with current Mental Health Division (MHD) policy.

- Any extension to a length of stay, as described above, requires written approval from the MHD designee. At admission or post-admission certification, the MHD designee will provide clear instructions for requesting length of stay extensions (*See Attachment IV, Extension Request Form*).

OTHER LENGTH OF STAY EXTENSIONS

- **All clients involuntarily committed under chapters 71.34 or 71.05 RCW:** MAA will not reimburse for involuntary psychiatric care past the 20th day of care unless a length of stay extension is approved by the MHD designee (*See Attachment IV, Extension Request Form*). The MHD designee cannot deny extensions for youth waiting for a transfer to a Children's Long-Term Inpatient Program (CLIP).

- **Review of admissions under at Risk/Runaway Youth Act:** As defined in chapter 71.34 RCW, hospitals must provide the MHD designee access to review the care of a minor (regardless of source of payment) who has been admitted upon application of his/her parent or legal guardian. For the purposes of this review, all information requested must be made available to the MHD designee. The MHD designee must document in writing any subsequent determination of continued need for care, and include a copy of the determination in the minor's hospital record.

BILLING PRECEDURES

- Hospitals must submit UB-92 claim forms to MAA for voluntary or involuntary inpatient psychiatric admission according to MAA's Inpatient Hospital Services Billing Instructions and ITA Billing Instructions. The MHD designee will manage length of stay according to the client's legal status at admission. All claims for admissions to out-of-state hospitals will be managed as voluntary claims.

  Beginning with admissions occurring January 1, 1999, each claim for voluntary or involuntary admissions must indicate the 9-digit authorization code that identifies the specific admission and the MHD designee that authorized the admission. It is the responsibility of the hospital to contact the MHD designee to obtain this authorization code. In order for the claim to be paid, this authorization code (*See Attachment VI*) must be entered in form locator 63 on the UB-92 claim form.

- Physicians, psychologists or mental health professionals who participate as members of a DSHS-designated team which certifies the need for care for persons 20 years of age or younger, may each bill MAA under state-unique procedure code 9089M on a HCFA-1500 claim form. This service is described as certification activities related to an elective admission for inpatient psychiatric care of clients 20 years of age and younger. A 9-digit authorization code is not required for these claims.

PLAN OF CARE REQUIREMENTS

- At pre-admission or post-admission certification, the MHD designee may outline specific plan of care requirements for the inpatient stay. Planning requirements ensure that clients receive active treatment allowing for their discharge at the earliest possible time.

- At a minimum, an individual plan of care should be prepared within three calendar days of:

  - ✓ Admission; **OR**
  - ✓ Date of the application for Medical Assistance eligibility.

- The inpatient facility team must develop the individual plan of care. The team must include the following:

  - ✓ A board-eligible or board-certified psychiatrist; OR
  - ✓ A physician with training and experience in the diagnosis and treatment of mental illness; AND a certified counselor who has a master's degree in clinical psychology; OR
  - ✓ A clinical psychologist who has a doctoral degree;

  AND at least <u>one</u> of the following:

  - ✓ A psychiatric social worker; **OR**
  - ✓ A registered nurse; **OR**
  - ✓ An occupational therapist who has specialized training or one year of experience in treating clients with mental illness; **OR**
  - ✓ A certified counselor with a master's degree in clinical psychology; **OR**
  - ✓ A mental health professional certified in accordance with chapter 388-865 WAC.

The plan of care must include all of the following:

- Be based on a diagnostic evaluation the includes examination of the medical, behavioral, developmental, and substance abuse related aspects of the client's condition;

- Be developed in consultation with the:

  - ✓ Client and parent(s) or legal guardian (if the child is a minor); and
  - ✓ MHD designee; and/or
  - ✓ Client's designated direct care provider(s).

- Have documented treatment objectives;

- Have prescribed an integrated program of therapies, activities, and experiences designed to meet the objectives;

- Include: (a) post-discharge plans and (b) coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care after discharge; **AND**

- Be reviewed by the inpatient facility team (including a MHD designee) every 30 calendar days or more frequently, according to MHD designee requirements, to:

  - ✓ Determine that the client continues to require services on an inpatient basis; **AND**
  - ✓ Recommend changes in the plan as indicated by the client's status; **AND**
  - ✓ Ensure continuity of care with the outpatient mental health system.

Documentation that reflects the process and outcomes of the plan of care development must be included in the client's hospital record.

INFORMATION REQUIREMENTS

- Hospitals must provide the MHD designee with all the information listed below, in a format determined by the designee.

  - ✓ Name of inpatient facility;
  - ✓ Date of Admission;
  - ✓ Date of Discharge;
  - ✓ Client name, gender, ethnicity and date of birth;
  - ✓ Client Social Security Number;
  - ✓ Client residential zip code and county;
  - ✓ Client Patient Identification Code (PIC), if known;
  - ✓ Primary discharge diagnosis (ICD-9CM code);
  - ✓ Secondary discharge diagnosis (ICD-9CM code); and
  - ✓ Legal status at admission (voluntary or involuntary).

  This information must be provided to the designee within one month (or as soon as possible) of the discharge for all publicly funded (Title XIX and state programs), voluntary admissions and for all involuntary admissions regardless of payment source.

- Hospitals must also provide information pertaining to the cost of care of all publicly funded admissions, if requested by the MHD designee.

- In addition, hospitals must provide clinical information specified by the MHD designee as necessary for the hospital's active participation in and implementation of a plan of care.

ATTACHMENT III

_____REGIONAL SUPPORT NETWORK (AUTHOR, CODE # _____)
CERTIFICATION FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

NAME:_____DATE OF BIRTH:_____

PATIENT IDENTIFICATION CODE (PIC):_____

COUNTY OF RESIDENCE:_____

NAME OF HOSPITAL:_____

DATE OF ADMISSION TO PSYCHIATRIC INPATIENT CARE:_____

PERSON GIVING CONSENT TO CARE: ☐Client ☐Parent ☐Legal Guardian ☐Other

LEVEL OF INPATIENT CARE NEEDED: ☐ **ACUTE AND EMERGENT**

☐ **ACUTE AND ELECTIVE**

On this date, a screening was completed to assess this client's need for inpatient psychiatric treatment. Based on supporting documentation and/or presentation, we certify that the applicant

☐ **DOES** **or** ☐ **DOES NOT meet the following criteria:**

- Age appropriate application and/or consent requirements are met
- Ambulatory care resources available in the community do not meet the treatment needs of the client
- Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician
- The services can reasonably be expected to improve the client's level of functioning or prevent further regression of functioning, AND
- The client has been diagnosed as having an emotional/behavioral disorder as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association; **OR**
- The client was evaluated and met the criteria for emergency involuntary detention (RCW 71.05 or 71.34) but care was agreed to.
- In addition, for admission to long-term inpatient care, the client has been diagnosed with a severe psychiatric disorder which warrants extended care in the most intensive, restrictive setting.

Signatures of team members certifying need for service:

(1) _____DATE: _____TIME: _____

_____TITLE: _____
PRINT OR TYPE NAME

(2)_____DATE: _____TIME: _____

_____TITLE: _____
PRINT OR TYPE NAME

ATTACHMENT IV

_____REGIONAL SUPPORT NETWORK (AUTHOR. CODE# _____
EXTENSION REQUEST FOR HOSPITALIZATION

NAME: _____COUNTY OF RESIDENCE: _____

PATIENT IDENTIFICATION CODE (PIC): _____BIRTHDATE: _____

INPATIENT FACILITY: _____

PRINCIPAL DIAGNOSIS: _____

OTHER DIAGNOSES: _____

PRINCIPAL DIAGNOSTIC CODE: _____DATE OF ADMISSION: _____
(ICD-9 CODES)

MAXIMUM LENGTH OF STAY BY DIAGNOSIS (PAS days): _____ through **_____**

REASON FOR EXTENSION REQUEST: (Provide the following information below or in attached documents: Current problems requiring inpatient care, progress toward treatment goals, current medications, medical condition, current discharge plan, how will continued inpatient care improve or prevent deterioration of condition, why less restrictive care is not appropriate.)

_____

_____

_____

_____

_____

_____

NUMBER OF EXTENSION DAYS REQUESTED: _____ through _____

HOSPITAL REVIEWER SIGNATURE: _____DATE: _____

NUMBER OF EXTENSION DAYS APPROVED: _____ days through _____

NUMBER OF ADMINISTRATIVE DAYS APPROVED: _____ days through _____

NUMBER OF EXTENSION DAYS DENIED: _____ days through _____

AUTHORIZING SIGNATURE OF RSN:

_____DATE: _____

COMMENTS: _____

_____

_____

Send this form to: _____ Regional Support Network

_____

Distribution: County, RSN, Hospital _____

12/2000

INSTRUCTIONS FOR COMPLETING CERTIFICATION FORM FOR ADMISSION TO PSYCHIATRIC INPATIENT CARE

The purpose of the Certification Form is to document the professional's decision regarding the medical necessity for psychiatric inpatient care for an individual. Copies of the completed Certification Form should be kept in the client's hospital record and in the Regional Support Network (RSN)/county management site identified by each RSN. The Certification Form does not have to be provided to Medical Assistance Administration for claims processing. Nevertheless, the Certification Form documents RSN authorization for payment for hospital admission. In order to meet Federal, state and RSN requirements, the following minimal information be included on the Certification Form.

RSN Name and Authorization Code Number: The form must identify the authorizing RSN and the nine- digit code number assigned to each individual claim by the RSN.

Name: Name of client for whom care is being certified

Date of Birth: Self-explanatory

Patient Identification Code (PIC): The code obtained from the medical identification card. It is a fourteen- digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "JA **011060**JONES A".

County of Residence: County where the medical card was issued.

Name of Hospital: Hospital where the admission will occur.

Date of Admission to Psychiatric lnpatient Care: Actual date of admission to the above hospital.

Person Giving Consent to Care: Check one or more of the boxes to indicate the person(s) giving legal authorization for inpatient care. By state law the consent of a minor is not required for admission. Check the Client box if the person (age 13 years or older) being hospitalized gives their consent for inpatient care. Check the Parent box if the biological or adoptive parent authorizes care for their minor child (age 0-17 years). If the minor also gives consent for care, check both Client and Parent boxes. If the minor child is over the age of 13 years and does not give consent for care, check only the Parent box. Check the Legal guardian box if a person who has been assigned guardianship authority gives consent for medical care for the client. The Other box allows for additional persons who otherwise have been granted legal authority to consent for care, e.g. parent surrogate, DCFS social worker, Guardian ad litem.

Level of lnpatient Care Needed: Check one box only. Any admission delayed for lack of bed space is not considered to be an emergent admission.

Signatures of Team Members: The required professional(s) must sign and print/type their name and title, and date the form on the same date they sign it.

INSTRUCTIONS FOR COMPLETING LENGTH OF STAY EXTENSION FORM FOR PSYCHIATRIC INPATIENT CARE

The purpose of the Extension Request Form is to document the review of the continued medical necessity for psychiatric inpatient care past the 75th percentile of the Professional Activity Study (PAS) code as listed in the Length of Stay (LOS) by Diagnosis-Western Region. The hospital providing care is responsible for initiating an extension request and for completing the top part of the form. The responsible Regional Support Network (RSN) reviews the hospital request, approves or denies additional days of care, completes the bottom of the form and returns it to the hospital. If additional care is authorized by the RSN, the Extension Request Form must be submitted by the hospital with the Medicaid billing form UB-92 to Medical Assistance Administration for claims processing.

The one page Extension Request Form is the standard required format to be utilized statewide. The following information must be completed on each form or claims cannot be processed and will be denied. At their discretion RSNs may require additional information from the hospital in order to make length of stay determinations.

RSN Name and Authorization Code Number: The form must identify the responsible RSN and the nine- digit code number assigned to each individual claim by the RSN.

Name: Name of client for whom care is being certified.

County of Residence: County where the medical card was issued.

Patient Identification Code (PIC): The code obtained from the medical identification card. It is a fourteen- digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "JA **011060**JONES A".

Date of Birth: Self-explanatory.

Inpatient Facility: Hospital where the client is receiving care.

Principal Diagnosis: Descriptive principal diagnosis covering the primary or initial psychiatric hospital stay.

Other Diagnoses: List any other diagnosis codes that will be included on the Medicaid billing form UB92.

Principal Diagnostic Code: This is the International Classification of Diseases-9th Edition (ICD-9) code for the principal diagnosis.

Date of Admission: Actual date of admission to the above hospital.

Maximum Length of Stay by Diagnosis (PAS days): In the first blank list the maximum number of days allowed according to the 75th percentile of the Professional Activity Study (PAS) code as listed in the Length of Stay (LOS) by Diagnosis-Western Region. In the second blank indicate the date on which the maximum number of days will conclude.

Reason for Extension Request: Provide a complete justification of the reason(s) for the extension request. The responsible RSN makes a decision based on the information provided in this section and on any additional documentation they require. At a minimum the hospital should answer the parenthetical questions.

Number of Extension Days Requested: Indicate in the first blank the exact number of additional days currently being requested insofar as professional assessment can be made. In the second blank indicate the date on which the extension days will conclude.

Hospital Reviewer Signature: The hospital professional completing the form signs and dates the form here.

FOR REGIONAL SUPPORT NETWORK USE ONLY:

Number of Extension Days approved: After review of the required information, indicate in the first blank the number of additional acute inpatient days approved. In the second blank indicate the date on which the approved extension days will conclude.

Number of Administrative Days Approved: If any of the extension days requested by a hospital are determined to not be medically necessary, but continued stay is required to enable appropriate discharge, the reviewer indicates the approval for specific days of care with payment at the lower administrative rate;

Number of Extension Days Denied: If any of the extension days requested by a hospital are determined to not be medically necessary and discharge is recommended, the reviewer indicates the denial of payment for specific days of care.

Authorizing Signature of the RSN: The authorized reviewer signs and dates the form here.

Comments: The RSN reviewer may make comments regarding the extension request.

Form distribution: The hospital submits the partially completed form to the RSN-designated contact point for processing. The RSN returns the completed form to the hospital, retaining necessary copies for RSN use.