MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE

SUBJECT	BY
Update - JCAHO-Accredited RTF Services	Darlene C. Collins, M.Ed., M.P.H. Deputy Secretary for Medical Assistance Programs

NUMBER:	01-95-13, 11-95-09, 12-95-05, 13-95-02, 14-95-02, 17-95-06, 41-95-04, 50-95-04, 53-95-02, 1165-95-01
ISSUE DATE:	September 8, 1995
EFFECTIVE DATE:	September 8, 1995

SCOPE:

Base Service Units
Chief Juvenile Probation Officers
County CASSP Coordinators
County Human Service Administrators
County MH/MR Program Administrators
County C&Y Administrators
Enrolled Providers of Mental Health Services
General Hospitals
Health Insuring Organizations
Health Maintenance Organizations
Juvenile Court Judges Commission
Parents Involved Network
Pennsylvania County Commissioner's Association
Pennsylvania Community Providers Association
Physicians
Psychiatric Hospitals and Psychiatric Units
Rehabilitation Hospitals and Rehabilitation Units
Residential Treatment Facilities

This bulletin applies to services for any child with mental health needs, regardless of any additional diagnosis such as substance abuse or mental retardation, who is eligible for inpatient medical assistance services and is under 21 years of age (or, if receiving certified residential treatment facility services immediately before reaching 21, the earlier of: the date the recipient no longer requires the service; or the date the recipient reaches age 22). This bulletin not only applies to recipients participating in the fee-for-service program, but also to eligible recipients enrolled in a Health Maintenance Organization (HMO), Health Insuring Organization (HIO), or receiving placement service through the child welfare system and juvenile probation office.

PURPOSE:

The purpose of this bulletin is to supplement Medical Assistance Bulletin 01-93-04, 11-93-02, 13-93-02, 41-93-02, and 53-93-02. The information in this bulletin is applicable to residential treatment facilities (RTFs) accredited by the Joint Commission on Accreditation of HealthCare Organizations (JCAHO) as residential child and adolescent mental health facilities. To the extent, if any, that the information in this bulletin conflicts with previously issued information, the information in this bulletin will control.

This bulletin:

1. Formalizes the approval of RTF services for children in the custody of a County Children and Youth Agency (CCYA) and Juvenile Probation Office (JPO);

2. Reiterates Federal requirements applicable to JCAHO-accredited RTFs under Federal Medicaid regulations;

3. Discusses the role of the HIO or HMO in obtaining RTF admission certification for recipients participating in medical assistance managed care programs;

4. Revises information on how to invoice for JCAHO-accredited RTF services;

5. Specifies the Department's therapeutic leave requirements;

6. Specifies the Department's hospital leave requirements; and

7. Specifies the Department's absence without leave (AWOL) requirements.

PROCEDURES:

1. CHILDREN IN THE LEGAL CUSTODY OF THE COUNTY CHILDREN AND YOUTH AGENCY (CCYA).

For admissions on or after July 1, 1994, for children determined eligible for medical assistance and who require medically necessary mental health services while in the custody of the CCYA, the admission process must be followed as outlined in the medical assistance bulletins "Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Recipients" (01-93-04, 11-93-02, 13-93-02, 41-93-02, 53-93-02). Children in the legal custody of CCYA who require immediate placement may be placed in the RTF by the CCYA before the admission is certified by the Office of Medical Assistance Programs (OMAP), provided all of the following criteria are met:

a. the child has a DSM-IV diagnosis, Axis I through V or severe ICD-9-CM mental illness diagnosis, along with Axis III through V, and is not in a mental health crisis;

b. the child requires placement because of child safety and/or protection issues; and

c. the interagency treatment team recommends RTF placement to meet the child's treatment needs.

If a child is admitted to an RTF in accordance with the preceding criteria, all information to support the admission must be received by OMAP within 20 days of the child's admission. OMAP will render a decision within 21 days of receiving a complete request. If the request for services is approved, the effective begin date of the approval period will be the date the child was placed in the RTF.

If the admission certification is denied by OMAP, or information to support the admission is not received by the Department within 20 days of the child's admission to the RTF but OMAP does not approve the request for services, payment for the placement may be sought from the placing CCYA or JPO. Act 148 funds will be available for placements disapproved by OMAP for lack of medical necessity only for a maximum period of 90 days following the date of the denial notice issued by OMAP and only if the placing agency convenes an interagency team within 30 days of the denial to develop an appropriate, less restrictive placement alternative to the RTF.

2. FEDERAL MEDICAID REQUIREMENTS FOR JCAHO-ACCREDITED RESIDENTIAL TREATMENT FACILITY SERVICES.

In order to be eligible to receive payment for services provided to medical assistance recipients, the facility must adhere to Federal regulations which include requirements related to: certification of the medical necessity for admission, prior to admission, by an independent team of professionals; certification of the continued need for RTF services by professionals who meet the Federal standards; development of a plan of care by the appropriate team which actively treats the child's mental health needs; and implementation and updating of the plan of care according to specified time frames. Federal requirements relating to service provisions are found at 42 CFR Part 441 Subpart A (relating to general provisions), Subpart B (relating to early periodic screening, diagnosis, and treatment of individuals under age 21), and Subpart D (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs) or successor provisions. The facility must also have a utilization review plan which meets the requirements at 42 CFR Part 456 Subpart D (relating to utilization control: mental hospitals), Subpart G (relating to inpatient psychiatric services for individuals under age 21: admission and plan of care requirements), and Subpart I (relating to inspections of care in skilled nursing and intermediate care facilities and institutions for mental diseases) or successor provisions. Payment may be recouped or denied for failure to comply with any of the aforementioned requirements, as well as penalties applied under 42 CFR Part 456 Subpart J (relating to penalty for failure to make a satisfactory showing of an effective institutional utilization control program).

The Department of Public Welfare's (DPW's) admission certification procedures or instructions, and the Federal regulations take precedence over the facility's procedures, utilization review plan or treatment plan if a discrepancy occurs between the facility's policy or practice and the regulations of DPW or the Federal government.

All admissions are subject to the retrospective review by the Department. If the medical record documentation does not support the medical need for the admission or continued stay, payment may be denied for all or part of the stay. Suspected cases of fraudulent practices by the RTF may be referred for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit.

3. HIO and HMO.

HealthPass, HMOs and other managed care programs capitated through DPW are not responsible for reimbursement of residential treatment services if OMAP's fee-for-service admission requirements have been met, the admission certified, and

the child is actually admitted to an RTF. However, private managed care program coverage or another third party resource may be available for RTF care to the recipient through another source. In either case, whenever OMAP will be requested to make any payment toward RTF services, the admission must be certified by the Department and the medical necessity for the services must be documented in the medical record to avoid retrospective denial of payment.

If a child is enrolled in a DPW managed care program and the DPW managed care physician recommends residential treatment facility services, the managed care program must contact the child's county mental health administrator and work with that agency to complete the required information and ensure that an MA 325 admission certification request with the requisite supporting information is supplied to the Department as required in the bulletins on "Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Recipients" (01-93-04, 11-93-02, 13-93-02, 41-93-02, 53-93-02). If the child is in the custody of the CCYA or being placed by the agency, the DPW managed care program must also work with the CCYA representative. The recipient in a DPW managed care program may not be disenrolled from the program until certified by the fee-for-service program as requiring RTF services and actually admitted to an enrolled RTF. This means that the DPW managed care provider is responsible to continue providing appropriate mental health services to the child until the child is actually certified by OMAP for admission and admitted to the RTF.

All third party coverage available to the recipient for RTF services must be used prior to OMAP coverage for the RTF service. In this instance, if OMAP will be requested to make full or partial payment toward the cost of care (for example: full payment if the third party insurer does not cover any of the services being provided or coverage is exhausted prior to the admission; or partial payment for a deductible, coinsurance, to supplement a partial payment toward service, or when the insurance benefit becomes exhausted during the stay), the facility must also ensure that the admission is certified pursuant to OMAP's admission certification requirements.

4. INVOICING FOR RESIDENTIAL TREATMENT FACILITY SERVICES.

The JCAHO-accredited RTF must submit invoices for Department certified RTF services according to instructions in the provider handbook and subsequent bulletins.

For JCAHO-accredited RTF providers (provider type 53), the invoice used to bill the Department is the Federal Common Billing Form, known as the UB-92. RTFs were notified of the billing requirements and how to complete the UB-92 invoice in bulletin 53-94-01, effective April 1, 1994, and bulletin 53-94-03, effective April 4, 1994. Completed UB-92 invoices are submitted for processing to:

The Department of Public Welfare
Office of Medical Assistance Programs
P.O. Box 8150
Harrisburg, Pennsylvania 17105

5. THERAPEUTIC LEAVE:

Therapeutic leave is a period of absence from an institutional setting directly related to the treatment of the individual's illness. The therapeutic leave must be prescribed as a part of the child's individual treatment program. It is to be used as a part of a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from an inpatient status and return to the community at the earliest possible time. The RTF where the child is currently receiving treatment is responsible both clinically and fiscally for mental health services the recipient may require while on leave.

The first day of therapeutic leave is defined as 12 to 24 hours of continuous absence from the facility without staff presence for therapeutic reasons, without regard to the calendar day. Continuous absence for any portion of each additional 24-hour period for therapeutic reasons counts as an additional day of therapeutic leave. For example, if the child leaves the facility on therapeutic leave at 8 p.m. on Friday evening and returns at 3 p.m. on Saturday, the child has been out of the facility for 19 hours. Since 12 to 24 hours equals the first day of therapeutic leave, the child has used one day of therapeutic leave even though the child has been out of the facility on two different calendar days. Similarly, if the child leaves the facility at 10 a.m. on Saturday and returns at 9 p.m. on Saturday, the child has been out of the facility 11 hours. Since the first day of therapeutic leave equals 12 to 24 hours, no therapeutic leave days have been used. If the child leaves the facility at 10 a.m. on Saturday and returns at 4 p.m. on Sunday the child has been out of the facility 30 hours. This equals two days of therapeutic leave, 10 a.m. Saturday to 10 a.m. Sunday and a portion of the next 24 hour period from 10 a.m. to 4 p.m. on Sunday.

Medical assistance payment for therapeutic leave in an RTF is limited to a maximum of 48 therapeutic leave days per patient per calendar year. This limit applies even if the child is in continuous or intermittent treatment at one or more RTFs during the calendar year. The facility is responsible for keeping written records of the therapeutic leave days used before admission and during the child's stay in the facility. The RTF must not bill for therapeutic leave days in excess of the 48-day per calendar year limit. The limitation of 48 days does not prohibit additional therapeutic leave to be prescribed and used as appropriate. It does limit the days of therapeutic leave for which the Department will make payment. Therapeutic leave in excess of 48 days per year is shown in form locator 8 (non-covered days) on the UB-92.

The facility will continue to be eligible for a full per diem payment for each day the recipient is on documented therapeutic leave within the specified 48-day limitation. In order for therapeutic leave days to be compensable, documentation in the

child's medical record must include the physician's order for the therapeutic leave, a description of the desired outcome, the date and time and child went on therapeutic leave and when the child returned, as well as a written evaluation resulting from interviews with both the child and family or legal guardian after the leave period. The evaluation shall describe the treatment objectives of the leave and the outcomes. The facility must report therapeutic leave usage when requesting continued stay certification.

The facility must reserve the residential facility bed while the child is on compensable therapeutic leave. The facility may not use a reserved bed for which payment is made by the Office of Medical Assistance Programs.

6. HOSPITAL ADMISSIONS.

If the child requires hospitalization while in an RTF, the RTF must notify the primary county case manager and include the child's family (or the CCYA if the child is in the custody of the CCYA) in plans for the child's hospitalization. According to regulations governing hospitals at Chapter 1163.76 (b) (6), 1163.476 (b) (6), and 1151.65 (relating to the plan of care), the plan of care shall address post-hospital discharge care. Post-hospital discharge plans for mental health services must be coordinated with the primary county case manager and family or CCYA in advance of the child's planned discharge from the hospital in order to assure the child's continuity of care and availability of the proposed services on discharge.

a. Hospital Reserved Bed Days

When a recipient is admitted for a continuous 24-hour period to an acute care general hospital, rehabilitation hospital or rehabilitation unit of an acute care general hospital, psychiatric hospital or psychiatric unit of an acute care general hospital and the child is expected to return to the RTF, the Department will make a payment to the RTF to reserve the bed for the child's return to the facility. Either the same or a comparable bed must be available for the recipient upon return to the facility.

Payment for a hospital reserved bed day is one-third of the facility's per diem payment rate and is limited to 15 days per child per calendar year. This 15-day per calendar year limit is cumulative and applies regardless of whether the child received continuous or intermittent treatment at one or more RTFs or was admitted to one or more hospitals or units during the calendar year. Hospital reserved bed days in excess of 15 days per calendar year are a non-compensable service, and as such may be billed to the recipient under the conditions to Chapter 1101.63(a). If the reserved bed days paid for the Department are exhausted and return to the RTF is medically necessary but the recipient did not pay to reserve the bed, the child will be returned to the RTF's first available comparable bed.

b. Admission certification requirements

When RTF services are recommended as part of the post-hospital discharge plan, a complete admission certification package (MA 325 and supporting documentation) must be completed when the admission is:

1. To a different RTF; or

2. to the same RTF on or after the end of a previously certified period.

A complete MA 325 package is not required for a child who was admitted to a public or private psychiatric hospital or psychiatric unit of an acute care general hospital if the child's psychiatrist recommends return to the same RTF and the child returns before the end of the previously certified period. In this instance, an MA 325, Plan of Care Summary, and a Community Based Mental Health Services - Alternative of Mental Health Residential Treatment Services form, are not required. The treating psychiatrist must still prepare a signed and dated psychiatric evaluation recommending residential treatment services which explains why returning the child to the RTF is appropriate and necessary. This evaluation must also include treatment recommendations and recommendations on how to avoid future relapses. The psychiatric evaluation will then be used by the RTF to develop an updated treatment plan. Return of the child within the previously certified period must be prior approved by the Department to be compensable. A new certification period will be determined and a new admission certification number assigned.

An MA 325 package is not required for a child who was hospitalized in an acute care general hospital, rehabilitation hospital or unit during a certified RTF stay if the child continues to need RTF services and returns to the same facility before the end of a previously certified period. In this situation, an appropriate continued stay request must be made 21 calendar days prior to the last date of the previously authorized period (as if the child never left the facility to be hospitalized.) If the child will not return to the same RTF or will not return to the RTF during the certified period but medically needs RTF services, a new MA 325 and supporting documentation must be prepared to certify a new admission consistent with the procedures specified in the bulletins on "Payment for Mental Health Services Provided in a Residential Treatment Facility for Eligible Recipients" (01-93-04).

c. Billing for Hospital Reserved Bed Days

In order to receive payment for a hospital reserved bed day, a correctly completed paper UB-92 invoice must be submitted to the Bureau of Inpatient Programs. In addition to the information which is normally included on the invoice:

1. Indicate the number of days the child was hospitalized plus any other non-covered days in form locator 8 (non-covered days). The total of covered and non-covered days must equal the number of days included in form locator 6 (statement covers period),

2. Enter the appropriate information in form locators 42 (revenue code), 43 (description), 46 (units of service), and 47 (total charges). For a hospital reserved bed day invoice, use:

   Locator 42 - the revenue code for "other" based upon the room and board code which best indicates the number of beds in the child's room at the facility ("119" private; "129" semiprivate-two bed; "139" semiprivate - three or four beds; or "159" ward).

   Locator 43 - the description "reserved bed days" must be used.

   Locator 46 - the units of service shown must equal the number of days the child was hospitalized in a hospital or unit up to a total of 15 days per calendar year.

   If the child was hospitalized more than 15 days in the calendar year, days in excess of the maximum compensable hospital reserved bed days must not be shown in form locator 46 and must be shown in locator 8.

   Locator 47 - the amount entered is one-third of the facility's per diem rate times the number of compensable days shown in form locator 46.

   The total charges of revenue code "001" must equal the total of the other revenue codes shown in the column for total charges.

3. In form locator 84 (remarks), indicate that the child was admitted to a hospital or unit and show the dates of hospitalization and the name of the hospital where the child was admitted. Please record this information as small as possible (but still legibly) so that the claim reviewer will be able to read the information and have room to add additional information which is needed by the Department to process the claim.

   The completed invoice must be sent to the following address for special handling and manual pricing in order to receive payment for reserving the bed:

   Department of Public Welfare
   Office of Medical Assistance Programs
   Bureau of Inpatient programs
   P.O. Box 8047
   Harrisburg, PA 17105

Under standard invoicing procedures, after the initial invoice is submitted, subsequent invoices within a fiscal year are submitted as adjustments to the initial invoice. In the case of billing for reserved bed days, the first invoice submitted after the invoice covering the reserved bed days shall be shown as an initial invoice and should not include any of the days of care up to and including the invoice which included the reserved bed days. Form locator 6 (statement covers period) for subsequent invoices must not include previously billed periods which include reserved bed days or payment will be affected adversely.

For example, if the child was admitted on an RTF on March 1, 1995, hospitalized April 15, 1995, returned 7 days later and was still in the facility on April 30, 1995, the initial invoice and subsequent claim adjustments cover the period of March 1, 1995, through April 30, 1995. The bill which includes the 7 hospital reserved bed days must be correctly completed, include the additional information previously specified, and be mailed to the Bureau of Inpatient Programs for special handling. After the claim which included the hospital reserved bed days is approved for payment, the next claim is submitted as a type of bill "112" (form locator 4 - "Interim-First Claim"). The original admission date is still shown in form locator 17. However, the statement covers period (form locator 6) no longer begins with the original admission date. The "from" period starts with the first day of service after the "through" date of service on the prior invoice. Subsequent cumulative invoices are submitted as type of bill "117" (form locator 4 - "Replacement of Prior Claim") until the sooner of either the use and payment of additional hospital reserved bed days or the end of the fiscal year. At that time, the invoices begin again as a first claim with subsequent replacement bills cumulative to the last date of service on the bill.

7. ABSENCE WITHOUT LEAVE (AW0L)

If a child is AWOL, payment may be made under the Medical Assistance Program for up to 2 days, provided that the provider actively attempts to locate the child during the absence and documents these attempts and required notifications in the child's medical record. Each notation in the child's record shall be signed and dated upon entry and must give a date, time and summary of each action taken. Documentation of on-site and off-site searches must specify the date and hours of search, where the search was conducted, any pertinent findings, and be signed by staff who conducted the search.

The actions described in the paragraph are a minimum of actions which must occur when a medical assistance recipient goes

AWOL from the RTF. The facility may take additional appropriate action such as asking the child's roommate and friends at the facility where the child might be.

a. Upon determination that the child is AWOL, the facility must immediately file a police report and conduct an extensive search of the facility buildings, grounds and off-site areas where the staff believe the child might have gone.

b. If the child cannot be located within 2 hours of the initial determination that the child is missing, the facility must notify:

1. The Office of Mental Health, and

2. The CCYA if the child is in its custody, or the child's responsible family member or legal guardian, as appropriate, when the child is not in the custody of the CCYA. If the child is in the custody of a CCYA, that agency is responsible to notify the child's family, if legally appropriate.

c. At a minimum, attempts to locate the child must include at least 4 to 6 hours of off-facility grounds search during each 24-hour period that the child is AWOL.

d. When the child is found or returns voluntarily, the facility must notify all previously notified parties that the child is no longer AWOL. The date and time of return must be recorded in the child's record.

Absence without leave in excess of two days is not compensable and must not be shown as covered days on an invoice to the Department.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Division of Hospital and Program Development
P.O. Box 8047
Harrisburg, PA 17105-2675

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.