

6.1. Mental Health – Inpatient Hospital Psychiatric Services

DESCRIPTION OF SERVICES

Inpatient psychiatric care involves skilled psychiatric services in a hospital setting. The care delivered includes both medical and nursing care, and is expected to be delivered on a 24-hour basis, including weekends. For individuals not certified for involuntary admission, and in areas where residential crisis services, hospital diversion programs, or Core Service Agency (CSA) crisis response systems are available, Beacon shall request these levels of care be explored, when appropriate, before authorization for an inpatient stay is given.

PARTICIPANT ELIGIBILITY

Participants with Medicaid are eligible for this benefit. For uninsured participants, Beacon encourages the provider to request a courtesy review. When medical necessity criteria are met and a courtesy review is on file, the provider will only need to submit a claim, if and when the participant obtains Medicaid. If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days.

When an uninsured eligible participant presents with a major illness that requires hospital level of care, the institution providing that care is expected to assist the family with an application for Medicaid.

PROVIDER ELIGIBILITY

Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services. Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number, and who are treating psychiatric emergencies, are also eligible for reimbursement.

AUTHORIZATION PROCESS

Authorizations for inpatient mental health services can be requested telephonically, or electronically through Beacon. Telephonic authorizations are initiated by calling the Beacon customer service line (800-888-1965) & providing clinical information to a licensed Clinical Care Manager in the Clinical Department. Electronic authorizations are completed by the provider through submission of a request in Provider Connect. Provider Connect can be accessed 24/7, including weekends and holidays through the Beacon website: <http://maryland.beaconhealthoptions.com/provider-main.html>. If the level of care is medically necessary, services will be authorized. Providers obtain additional authorizations through the electronic submission of a continued stay request in Provider Connect.

To request initial authorizations for inpatient mental health services, providers are expected to submit the authorization request, with supporting clinical information, the day of admission but no later than 24 hours, or one calendar day from date of admission. Concurrent authorizations are to be submitted with supporting clinical information on the first uncovered day.

If a Beacon Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Beacon Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non-authorized case will be communicated both via ProviderConnect and telephonically to the provider (refer to Chapter 10 on Grievances and Appeals for further information).

Non-psychiatric physicians or nurse practitioners will be reimbursed by the Maryland Public Behavioral Health System (PBHS) for one history and physical per admission, and authorization is not required. Claims should be submitted to Beacon using CPT codes 99251-99255.

The Managed Care Organization (MCO) is responsible for all other non-psychiatric physician or nurse practitioner consultations which are not related to the psychiatric diagnosis. Authorization by the MCO may be required. The participant's primary care physician or the MCO Special Needs Coordinator should be contacted.

SERVICE RULES

Beacon authorizes inpatient care for hospital level care. In order for the provider's claim to be paid, an authorization request for emergency admission must be made within 24 hours by calling 800.888.1965 or by submitting a request in ProviderConnect. All continued stay requests require prior authorization. It is the provider's responsibility to enter a discharge when the participant completes inpatient treatment.

Clinical information that supports medical necessity criteria for inpatient levels of care must be provided.

Required clinical information includes:

- Current need for treatment
- Precipitating event(s)
- Treatment history
- Medications
- Substance use
- Medical history
- Risk assessment

If medical necessity is demonstrated, Beacon will authorize a specified number of days. If Beacon has authorized a hospital stay for a Medicaid recipient and the discharge diagnosis is a PBHS-covered psychiatric diagnosis, the claim will be paid for the authorized days.

Continued stay (concurrent) requests for authorization must be submitted on the first uncovered day. For example, after an initial authorization span of March 1 to March 4, if needed, the continued stay request should be submitted on March 4. The day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1 at 11:45 p.m., March 1 is a covered day. If the participant is discharged on March 4 at 4:00 p.m., March 4 is not a reimbursable day. March 3 would be considered the last day covered.

Providers are expected to initiate discharge planning at the beginning of service delivery. Providers are also required to submit the discharge plan in the authorization request.

Aftercare Planning

Aftercare planning is expected to begin at the time of admission (see COMAR 10.21.05).

Providers of inpatient services are expected to work collaboratively with the participants, parents, and/or legal guardians of participants to develop a discharge plan that will provide stability and adequate behavioral health treatment services. As the types of services and treatment programs vary from jurisdiction to jurisdiction, the provider should seek assistance from the appropriate CSA or Local Addictions Authority (LAA). This is determined by the participant's place of residence or jurisdiction that maintains legal custody. For example, for a Baltimore county participant that is hospitalized in Howard County, the provider should seek assistance from the Baltimore County CSA or LAA.

Only one psychiatric professional fee from a psychiatrist or nurse practitioner, per psychiatric inpatient day is covered. An additional authorization for professional fees is not needed.

During an inpatient stay, the PBHS will cover and pay for diagnostic testing and consultations that are related to the psychiatric treatment of the participant.

When an uninsured participant who requires inpatient care presents at an emergency department of a hospital with a psychiatric unit, that hospital must admit the participant to a bed on the hospital's psychiatric unit, if available, or arrange for disposition to another inpatient setting as required under the Emergency Treatment and Active Labor Act (EMTALA). The expectation is that participants will be admitted to these facilities without regard to ability to pay. If a person in need of psychiatric inpatient care is in an emergency department without a psychiatric unit, the emergency department will find the bed and refer the person for admission.

A participating hospital that has specialized capabilities, or facilities such as psychiatric hospitals, SHALL NOT refuse to accept an appropriate transfer of an individual (from a hospital in the United States) who requires such specialized capabilities or facilities IF the hospital has the capacity to treat the individual, 42 CFR §489.24(f). This provision applies to any participating hospital (those that accept Medicare and thus Medicaid) regardless of whether the hospital has a dedicated ED, §489.24(f)(i).

The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician and other treatment providers (e.g. substance use disorder treatment) when clinically indicated, with appropriate release of information.

Administrative Days

Administrative days are used when a participant no longer meets medical necessity criteria for a psychiatric inpatient unit and requires discharge to a nursing home or residential treatment center, however, a bed is not yet available. Administrative days are paid at a lower rate than a regularly authorized inpatient day.

CLAIMS PROCESS

Claims are submitted on a CMS 1500 form or on a UB-04 form with the appropriate billing codes.

- Claims must specify an ICD-10 code (not DSM 5 code) for reimbursement.
- Claims for unauthorized inpatient days will be denied.

Physicians conducting initial evaluations, treatment, history, and physicals and/or consultations on a medical floor should consult the Beacon Maryland Service Class Grid for professional billing codes at: http://maryland.valueoptions.com/provider/clin_ut/ValueOptions-Maryland-Service-Grid.pdf.