ALABAMA MEDICAID AGENCY
ADMINISTRATIVE CODE

CHAPTER 560-X-5
PSYCHIATRIC FACILITIES FOR INDIVIDUALS 65 OR OVER

TABLE OF CONTENTS

560-X-5-.01 General
560-X-5-.02 Participation
560-X-5-.03 Geriatric Inpatient Psychiatric Benefits
560-X-5-.04 Certification Of Need For Service
560-X-5-.05 Medical, Psychiatric, And Social Evaluation
560-X-5-.06 Plan Of Care
560-X-5-.07 Utilization Review (UR) Plan
560-X-5-.08 Payment
560-X-5-.09 Inspection Of Care
560-X-5-.10 Inpatient Utilization Review
560-X-5-.11 Continued Stay Reviews

560-X-5-.01 General.

(1) Inpatient psychiatric services for recipients age 65 or over, are covered services when provided:

(a) In a free-standing psychiatric hospital exclusively for the treatment of persons age 65 or over with serious mental illness (as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition);

(b) Under the direction of a geriatric psychiatrists;

(c) After the recipient reaches the age of 65; and

(d) To a patient remaining in a facility for the course of the hospitalization.

(2) Inpatient psychiatric services for recipients age 65 and over are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria.
Author: Solomon Williams, Associate Director, Institutional Services
Statutory Authority: State Plan, Attachment 3.1-14.
History: Rule effective October 1, 1982. Amended effective April 12, 1984. **Repealed:** Filed February 7, 1994; effective March 14, 1994. **New Rule:** Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed June 11, 2015; effective July 16, 2015.

560-X-5-.02 Participation.

(1) In order to participate in the Title XIX Medicaid program and to receive Medicaid payment for inpatient services for individuals 65 and older, a provider must meet the following requirements:

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

(b) Be licensed as an Alabama free-standing acute geriatric psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code Chapter 420-5-7. State hospitals that 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) Specialize in the care and treatment of geriatric patients with serious mental illness;

(e) Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician; or a full-time board certified adult psychiatrist with a minimum of 3 years' experience caring for geriatric patients 65 or older.

(f) Employ only staff who meet training/certification standards in the area of adult psychiatry as defined by the State's mental health authority;

(g) Be recognized as a teaching hospital, and affiliated with at least one four-year institution of higher education with a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness;

(h) Provide out-patient and community liaison services throughout the State of Alabama directly or through contract with qualified providers;

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

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

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

(l) Submit a budget of cost for its inpatient services for its initial cost reporting period, if a new provider; and

(m) Be under the jurisdiction of the State's mental health authority.

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

(3) It is the facility's responsibility to ensure compliance with all federal and state regulations and to ensure that all required documentation is included in the recipient's record. Failure to comply will result in denial of payment and possible recoupment of reimbursements made previously.

Author: Solomon Williams, Associate Director, Institutional Services

Statutory Authority: 42 C.F.R. Subpart E, Section 482.60 through Section 482.62.

History: Rule effective October 1, 1982. **Repealed:** Filed February 7, 1994; effective March 14, 1994. **New Rule:** Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997. **Amended:** Filed July 12, 2017; effective August 26, 2017. **Amended:** Published April 30, 2020; effective June 14, 2020.

560-X-5-.03 Geriatric Inpatient Psychiatric Benefits.

(1) For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a freestanding psychiatric facility specializing in the diagnosis, treatment and care of geriatric patients occupying beds, for the purpose of maintaining or restoring to the greatest possible degree of health and independent functioning.

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

(3) Medicaid reimbursement is available for the day of admission, but not the day of discharge.

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

(a) Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.

(b) Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.

(c) Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Program at Medicaid. Providers that have received payments for therapeutic visits will have funds recouped.

Author:
Statutory Authority: State Plan, Attachment 3.1-A, 4.19A. 42 C.F.R. Section 436.1004.
History: Rule effective October 1, 1982. **Repealed:** Filed February 7, 1994; effective March 14, 1994. **New Rule:** Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.

560-X-5-.04 Certification Of Need For Service.

(1) Certification of need for services is a determination which is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility.

(2) The physician must certify for each applicant or recipient that inpatient services in a mental hospital are or were needed.

(3) The certification must be made at the time of admission. No retroactive will be accepted.

(4) For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment.

(5) The physician must complete the PSY-5 form which is the certification of need for care. This form must be kept in the patient's record.

(6) The PSY-6 form, or acceptable equivalent approved by Medicaid, which is the recertification of need for continued inpatient services for each applicant or recipient, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician.

(7) The PSY-6 form, or acceptable equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record.

(8) The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status.

Author:
Statutory Authority: 42 C.F.R. Section 441, Subpart D.
History: Rule effective October 1, 1982. **Repealed:** Filed February 7, 1994; effective March 14, 1994. **New Rule:** Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.

560-X-5-.05 Medical, Psychiatric, And Social Evaluation.

(1) Before admission to a psychiatric facility or before authorization for payment, the attending physician, psychiatrist, or staff physician must make a medical evaluation of each individual's need for care in the facility. Appropriate professional personnel must make a psychiatric and social evaluation.

(2) Each medical evaluation must include:

(a) Diagnosis;

(b) Summary of present medical findings;

(c) Medical history;

(d) Mental and physical functional capacity;

(e) Prognosis; and

(f) A recommendation by the 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:
Statutory Authority: 42 C.F.R. Section 456.170.
History: Rule effective October 1, 1982. **Repealed:** Filed February 7, 1994; effective March 14, 1994. **New Rule:** Filed September 6, 1995; effective October 12, 1995.

560-X-5-.06 Plan Of Care.

(1) The attending physician or staff physician must establish a written plan of care for each individual before admission to a mental hospital and before authorization of payment.

(2) The plan of care must include:

(a) Diagnosis, symptoms or complaints indicating a need for admission to inpatient care;

(b) Description of the functional level of the patient;

(c) Treatment objectives;

(d) Orders for medication, treatments, therapies, activities, restorative/rehabilitative services, diet, social services and special procedures needed for health and safety of the patient; and

(e) Continuing care plans that include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family and community service providers upon discharge.

(3) The plan of care must be reviewed at least every 90 days or with significant changes in patient functioning or acuity by the attending or staff physician and other appropriate staff involved in the care of the recipient.

(4) The plan of care will be evaluated to ensure that the recipient is receiving treatment that maintains or will restore him to the greatest possible level of health and independent functioning.

(5) A written report of the evaluations described in Rule No. 560-X-5-.05 and the plan of care described in this section must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Author:
Statutory Authority: 42 C.F.R. Section 456.180.
History: New Rule: Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.

560-X-5-.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 Section 456.245;

(2) Maintain recipient information required for the UR Plan 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.

Author:
Statutory Authority: 42 C.F.R. Section 456.200 - 456.245.
History: New Rule: Filed September 6, 1995; effective October 12, 1995.

560-X-5-.08 Payment.

(1) Payment for inpatient services provided by psychiatric facilities for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital, which is based on the Medicaid cost report and all the requirements expressed in Chapter 23 of the Alabama Medicaid Administrative Code. Patient liabilities, if applicable, will be deducted from the per diem. The hospital will be responsible for collecting the liability amount from the patient and/or his/her sponsor. Providers should reference their billing manual for claim submission procedures.

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

(3) 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.

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

Author:
Statutory Authority: State Plan, Attachment 4.19-A; 42 C.F.R. Section 447, Subpart D.
History: New Rule: Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.

560-X-5-.09 Inspection Of Care.

(1) The Medicaid Quality Assurance Program will periodically perform an inspection of care and services provided to recipients in accordance with 42 C.F.R. Part 456, Subpart I. The review team must consist of psychiatrist or physician with knowledge and experience in the provision of care in mental institutions and

other appropriate mental health and social service personnel. This physician may not inspect the care of a recipient for whom he is the attending physician or for whom he has served as the consulting physician. The Medicaid Agency will determine, based on the quality of care and services provided in the facility and the condition of recipients in the facility, at what intervals inspections will be made. However, the review team must inspect the care and services provided to each recipient in the facility at least annually. The inspection must include:

(a) Personal contact with and observations of each recipient; and/or

(b) Review of each recipient's medical record. In making determination of adequacy of services, the team may consider items such as, but not limited to:

(a) The medical, social, and psychiatric evaluations and an assessment of the adequacy and completeness of the plan of care;

(b) The plan of care is followed;

(c) All services ordered are provided and properly documented;

(d) The attending physician reviews of prescribed medication regimens are made at the appropriate times and properly documented;

(e) Tests or observations of each recipient indicated by his medication regimen are made at appropriate times and properly documented;

(f) Professional progress notes are made as required and consistent with the observed condition of the recipient;

(g) The recipient receives adequate services based on observation;

(h) The recipient needs continued inpatient care; and

(i) Alternative care is available and appropriate.

(2) Each recipient's chart will be reviewed by the Medicaid review team to assure that the following items are included on the chart:

(a) Certification of need. (PSY-5)

(b) Recertifications. (PSY-6 or acceptable equivalent)

(c) Completed medical, social, and psychiatric evaluations.

(d) Current plan of care.

(3) The review team will also review the chart for:

(a) Physician, nurse, and other professional staff members' progress notes. These notes will be assessed for consistency with the observed condition of the patient.

(b) Services being provided as ordered.

(c) Completeness of the plan of care.

(d) Documentation supporting the need for continued hospitalization.

(e) Documentation of review of medication by a physician every 30 days.

(f) Discharge plan or a plan for alternative care.

(4) The review team must submit a report on each inspection that contains observations, conclusions, and recommendations as specified in 42 C.F.R. 456.611.

(5) At the time of the inspection, the team will also review each recipient's record for compliance with all state and federal regulations. Payments for admissions that are found to be out of compliance may be recouped by Medicaid.

Author:
Statutory Authority: 42 C.F.R. Part 456, Subpart I; Section 456-600 - 456.614
History: **New Rule:** Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.

560-X-5-.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 applies for Medicaid while in the facility, a Psychiatric Admission form must be signed by the attending physician at the time application for Medicaid is made.

(4) The following information shall be included on the Physician Admission Form:

(a) Recipient information:

1. admitting diagnosis;

2. events leading to hospitalization;

3. history of psychiatric treatment;

4. current medications;

5. physician orders;

6. presenting signs and symptoms.

(b) Events leading to present hospitalization.

(c) History and physical.

(d) Mental and physical capacity.

(e) Summary of present medical findings including prognosis.

(f) Plan of care.

(5) Medicaid's Psychiatric Criteria for Age 65 or Over will be utilized in reviewing whether the admission and continued stay were appropriately billed.
Author: Jan Sticka, Program Manager, Inpatient QI Program Associate Director, Institutional Services
Statutory Authority: 42 C.F.R. Section 456.171.
History: New Rule: Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997. **Amended:** Filed September 11, 2012; effective October 16, 2012. **Amended:** Filed November 12, 2013; effective December 17, 2013

560-X-5-.11 Continued Stay Reviews.

(1) The hospital's utilization review personnel will be responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

(2) The initial continued stay review should be performed on the date assigned by Medicaid. Subsequent reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record.

(3) If the facility's utilization review personnel determines the patient does not meet the criteria for continued stay, the case

should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed.

(4) If a final decision of denial is made, the hospital must notify the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within ten (10) days after the denial is made.

(5) The facility's utilization review personnel shall be responsible for phoning Medicaid with a report whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

Author:

Statutory Authority: 42 C.F.R. Section 441.102; Section 456.231 through 456.238.

History: New Rule: Filed September 6, 1995; effective October 12, 1995. **Amended:** Filed October 6, 1997; effective November 10, 1997.