Provider Alert

October 2019 Second Edition Alert No: 2019-2 **FFS Medi-Cal Inpatient Hospital**

A Publication of the Local Mental Health Plan (LMHP) of the County of Los Angeles Department of Mental Health

IN THIS ISSUE

ADMINISTRATIVE DAY SERVICES UPDATES: INCLUDES CONCURRENT REVIEW AND AUTHORIZATION OF ADMINISTRATIVE DAY SERVICES CLAIMS.

The purpose of this Provider Alert is to communicate the changes and provide updates on the requirements of claiming and authorizing Administrative Day Services in concurrent review process. This Provider Alert replaces the Provider Alert No: 2012-01, February 10, 2012.

Implementation of the Changes

Effective October 15, 2019, ALL of the following requirements regarding changes and updates noted in this Provider Alert must be in place when submitting Treatment Authorization Request (TARs) for reimbursement for Administrative Day Services.

Pursuant to California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.202, "Administrative Day Services" means psychiatric inpatient hospital services provided to a client who has been admitted to the hospital for acute psychiatric inpatient services; and the client's stay at the hospital must be continued beyond the client's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the client.

On May 31, 2019, the State Department of Health Care Services (DHCS) issued *Information Notice No: 19-026*, *Authorization of Specialty Mental Health Services,* (IN). The IN includes policy changes the DHCS has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule). The key goals of the Final Rule include improving quality of care and beneficiary experience, strengthening program integrity by improving accountability and transparency, and aligning key Medicaid and Children's Health Insurance Program (CHIP) managed care requirements with other health coverage programs.

The following is an excerpt from the IN regarding Administrative Days. In this Provider Alert, where Mental Health Plan (MHP) is mentioned, Los Angeles County Department of Mental Health (LACDMH) is the MHP.

Authorizing Administrative Days

A hospital may claim for Administrative Day Services when a beneficiary no longer meets Medical Necessity Criteria for acute psychiatric hospital services, but has not yet been accepted for placement at a non-acute residential treatment facility in a reasonable geographic area. In order to conduct concurrent review and authorization for Administrative Day Service claims, the (MHP) LACDMH shall review that the hospital documented having made at least one (1) contact to a non-acute residential

treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on Administrative Day status. Once five (5) contacts have been made and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on Administrative Day status can be authorized. A hospital may make more than one contact on any given day within the seven consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five (5) required contacts are completed and documented. Once the five contacts requirement is met, any remaining days within the seven day period can be authorized without a contact having been made and documented.

The MHP (LACDMH) may waive the requirements of five(5) contacts per week if there are fewer than five (5) appropriate, non-acute residential treatment facilities available as placement options for the beneficiary, per CCR, Title 9, (Chapter 11), Section 1820.230(d)(2)(B)(1). The lack of appropriate, non-acute treatment facilities and the contacts made at appropriate facilities shall be documented to include the status of the placement, date of contact, and the signature of the person making the contact.

Examples of appropriate placement status options include, but may not be limited to, the following:

- *The beneficiary's information packet is under review;*
- *An interview with the beneficiary has been scheduled for [date];*
- *No bed available at the non-acute treatment facility;*
- *The beneficiary has been put on a wait list;*
- *The beneficiary has been accepted and will be discharged to a facility on [date of discharge];*
- *The patient has been rejected from a facility due to [reason]; and/or,*
- *A conservator deems the facility to be inappropriate for placement.*

Guidelines and Recommendations

1. "Appropriate, non-acute residential treatment facilities" means facilities which offer treatment on premises to all beneficiaries. Assisted living facilities, Guest homes, non-augmented Board and Care facilities and Skilled Nursing Facilities without a Special Treatment Program (STP) for mental health do not qualify.

    - Mental health treatment must be provided to all beneficiaries for a significant period of time, Monday through Friday each week.
    - If a facility transports beneficiaries to treatment at an off-site location, that facility does not qualify as a residential treatment facility.
    - Case management does not count as "treatment."
    - For children and adolescents, "non-acute residential treatment facility" usually consists of a designation by LACDMH of certain Rate Classification Levels (RCLs).

2. Only Board and Care facilities that offer an array of treatment modalities can be considered as placement option billable to Medi-Cal Administrative Day Services. These augmented Board and Care facilities fall under the category of Community Residential Treatment System (CRTS) and provide rehabilitative Specialty Mental Health Services.
3. Facilities that offer solely Drug and Alcohol Program component are not acceptable.
4. The inpatient hospital staff must contact facilities that are appropriate for the specific beneficiary that they are attempting to refer. For example, if a beneficiary has a Dual Diagnosis, then facilities equipped to treat beneficiaries with Dual Diagnosis should be contacted. Conversely, beneficiaries

without substance/alcohol- related diagnosis should not be referred to Dual Diagnosis Programs. Another example would be an elderly beneficiary with extensive medical issues being referred to a placement that does not accept elderly beneficiaries and the placement is not equipped to handle the beneficiary's medical issues.

5. If there are no appropriate non-acute treatment facilities available and the inpatient hospital has documented only the minimum number of appropriate contacts (one contact a week), there must be documentation in the medical record of the justification/reason of less than the required five (5) contacts per week was made. The inpatient hospital must provide clear evidence "waiving" the required five (5) contacts every week due to unavailability of five (5) appropriate, non-acute residential treatment facilities.
6. When a patient who has been on Administrative Days is discharged home, or back to the facility from which he/she was admitted, there must be documentation to determine whether this abrupt change in the discharge plan was foreseeable. If the hospital was, in good faith, searching for a placement to which it fully intended to discharge the patient, but unforeseeable events outside of the hospital's control operated to abort its discharge plan, then credit maybe given for those Administrative Days which meet Title 9 criteria.
7. If a hospital deals with corporate entities which control multiple, non-acute residential treatment facilities, the hospital is expected to contact all facilities.

Requirements When Submitting Treatment Authorization Requests (TARs) for Administrative Day Services for Medi-Cal Reimbursement:

1. There must be at least one (1) approved acute day TAR.
2. There must be an MD order for an Administrative Day status (Day 1 Administrative Day starts on this date).
3. The inpatient hospital staff must make at least one contact to a non-acute residential treatment facility per day (except weekends and holidays), starting with the day the beneficiary is placed on Administrative Day status.
4. Once five(5) contacts have been made and documented, any remaining days within the seven (7) consecutive-day period from the day the beneficiary is placed on Administrative Day status can be authorized. A hospital may make more than one contact on any given day within the seven (7) consecutive-day period; however, the hospital will not receive authorization for the days in which a contact has not been made until and unless all five (5) required contacts are completed and documented. Once the five (5) contact requirement is met, any remaining days within the seven (7)-day period can be authorized without a contact having been made and documented.
5. Required documentation includes but not limited to:

    a. Date of placement contact;
    b. Facility staff name that was contacted (must make verbal contact);
    c. Name of facility/telephone number contacted;
    d. Status of referral (faxed packet, pending, mailed packet, etc., are not acceptable); and
    e. Provider staff name and signature of the person making the contact.
    (All telephone contacts must make verbal contact; leaving voicemail, etc., are not acceptable).

Although not required, it is recommended to have an Administrative Day Contact Log so that the required elements of contact documentation are captured and met.

The TAR Unit wishes to emphasize the importance of clear and accurate documentation in the medical records as required. Lack of accurate documentation will create problems at all phases of Administrative Day requests and could potentially put the provider at risk of unanticipated denials.

Administrative Days for Regional Center Beneficiaries

- Medi-Cal Fee-For-Service hospitals – For a Regional Center beneficiary, there is a limit of four (4) Administrative Days per episode.
- Pursuant to a Memorandum of Understanding (MOU) between the State's Local MHP (LACDMH) and six (6) Regional Centers (Lanterman, Westside, South Central, San Gabriel, North Los Angeles, and East Los Angeles) located within Los Angeles County, the MHP will be financially responsible only for the acute psychiatric inpatient days approved and the first four (4) approved Administrative Days for each acute psychiatric inpatient episode.
- The respective Regional Center will be financially responsible for all subsequent Administrative Days for their beneficiaries. Upon admission of a Regional Center Medi-Cal beneficiary to acute inpatient psychiatric services, the hospital is required to contact the appropriate local Regional Center to begin placement efforts and to obtain a written pre-authorization for any prospective reimbursement for Administrative Days.
- The Regional Center pre-authorization applies only to payment for Administrative Days in excess of the first four (4) approved days covered by the MOU.
- The hospital will also submit a written reimbursement claim/bill for Administrative Days to the respective Regional Center starting with day five (5).
- The TAR Unit will not authorize reimbursement for any Administrative Days when the beneficiary is a client of Los Angeles County Harbor Regional Center. This Center elected not to be a party to the MOU and subsequent Addendums.

References:

CCR, Title 9, Chapter 11, Section 1810.202; 1820.220(j)(B)(5)(A)(B)
CFR, Title 42, Part 456 Subpart D,§456.235(b)
LACDMH, Intensive Care Division, Intake Procedure for ICD Referrals
Title 9, Article 3.5 Community Residential Treatment System
State Department of Health Care Services, Information Notice No: 19-026, Authorization of Specialty Mental Health Services