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**PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL TRANSMITTAL
NO. 16-1**

ISSUED BY: Iowa Medicaid Enterprise

SUBJECT: **PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN**, Chapter III, *Provider-Specific Policies*, Contents (page 1), revised; and pages 1, 2, 5, 6, 11, and 20 through 26, revised.

Summary

The **PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL** is revised to align with current IA Health Link policies, procedures, and terminology.

Effective Date

January 1, 2016

Material Superseded

This material replaces the following pages from the **PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN MANUAL**:

<u>Page</u>	<u>Date</u>
Chapter III	
Contents (page 1)	May 1, 2014
1, 2, 5, 6, 11, 20-27	May 1, 2014

Additional Information

The updated provider manual containing the revised pages can be found at:

<http://dhs.iowa.gov/sites/default/files/PMIC.pdf>

If any portion of this manual is not clear, please contact the Iowa Medicaid Enterprise Provider Services Unit at 800-338-7909 or locally (in Des Moines) at 515-256-4609, or email at imeproviderservices@dhs.state.ia.us.



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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. FACILITIES ELIGIBLE TO PARTICIPATE

Psychiatric medical institutions for children (PMICs) are eligible to participate in the Medicaid program if they meet all of the following conditions.

- ◆ Be accredited by a federally recognized accrediting organization, such as:
 - The Joint Commission on the Accreditation of Health Care Organization
 - The Commission on Accreditation of Rehabilitation Facilities
 - The Council on Accreditation of Services for Families and Children
 - Any other organization with comparable standards
- ◆ Have been issued a license by the Department of Inspections and Appeals.
- ◆ Have been awarded a Certificate of Need from the Department of Public Health.
- ◆ Have received written approval of need from the Department of Human Services, Division of Adult, Children and Family Services.
- ◆ Be in compliance with all applicable state rules and standards regarding the operation of comprehensive residential facilities for children.

Facilities providing outpatient day treatment for children or adolescents require approval from the Department of Inspections and Appeals.

Once enrolled with the Iowa Medicaid Enterprise, psychiatric medical institutions for children (PMICs) may also enroll with the Department's contracted Managed Care Organizations (MCO).

B. COVERAGE OF SERVICES

1. Inpatient Services

Medicaid coverage is available for PMIC services when:

- ◆ The conditions for service to the child are met,
- ◆ The child is determined to meet the level of care criteria, and
- ◆ The child is eligible for Medicaid.

An emergency admission is one that is required because the health of the child is in immediate jeopardy.



a. Covered Services

All inpatient psychiatric services are covered services when the admission or continued stay is approved by the behavioral health contractor or Managed Care Organization (MCO). For members not enrolled with an MCO, facilities must request a PMIC authorization by:

- ◆ Contacting the IME Medical Services Unit at 888-424-2070 or locally in Des Moines at 256-4624,
- ◆ Emailing PMIC2@dhs.state.ia.us, or
- ◆ Faxing the request to 515-725-0931.

Facilities bill Medicaid separately for such services as prescription drugs, eyeglasses, and physician services. Psychological services are the responsibility of the facility. Other services in the plan of care that are not covered by the Medicaid program are also the responsibility of the facility.

Educational and vocational training are not reimbursable.

In order to receive Medicaid payment for a child entering a PMIC, the facility must have an assessment certifying all of the following:

- ◆ Ambulatory care resources available in the community do not meet the child's treatment needs,
- ◆ Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician, and
- ◆ Inpatient services can reasonably be expected to improve the child's condition or prevent further regression, so that the ongoing services will no longer be needed.

(1) Admission Facility Interventions

Admission facility interventions must meet all of the following:

- ◆ Treatment plan directed at admitting problem
- ◆ Level of intervention matches risk
- ◆ Discharge plan upon admission
- ◆ Psycho-educational services on assessment
- ◆ Family or significant other treatment and involvement



d. Children in Managed Health Care

Children enrolled in Managed Care Organizations require special procedures when they enter a PMIC.

Prior authorization is required for Medicaid payment of medical services. Contact the managed care organization provider to obtain any necessary authorization to ensure payment. Nonemergency services provided without a referral may not be paid.

Payment for services other than the facility (such as a psychiatrist's services) is subject to the authorization of the managed health care provider.

e. Independent Assessment

Children who are in foster care or have a Medicaid card before they go to the facility must be certified through an independent assessment performed by a team. None of the team members may have an employment or consultation relationship to the admitting facility.

The assessment team must include a physician and another professional. The physician should have competence in the diagnosis and treatment of mental illness and have knowledge of this child's situation. This may be accomplished through a community mental health center or a family physician with a Department social worker, a juvenile court officer, or another professional.

The assessment must be performed within 45 days before the proposed date for admission to the facility and be submitted to the facility on or before the date of the child's admission.



f. Interdisciplinary Team

An “interdisciplinary team” is a team of physicians and other personnel who are employed by the facility or who provide services to members in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are:

- ◆ Involved in the direct provision of treatment services, or
- ◆ Involved in the organization of the plan of care, or
- ◆ Involved in consulting with or supervising those professionals involved in the direct provision of care.

The team must include at a minimum either:

- ◆ A board-eligible or board-certified psychiatrist, or
- ◆ A clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or
- ◆ A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master’s degree in clinical psychology and has been licensed by the state.

The team must also include one of the following:

- ◆ A social worker with a master’s degree in social work and specialized training or one year’s experience in treating persons with mental illness.
- ◆ A registered nurse with specialized training, or one year of experience in treating persons with mental illness.
- ◆ A licensed occupational therapist that has specialized training or one year of experience in treating persons with mental illness.
- ◆ A psychologist who has a master’s degree in clinical psychology or who has been licensed by the state.

Based on education and experience, preferably including competency in child psychiatry, the team must be capable of:

- ◆ Assessing the child’s immediate and long-range therapeutic needs, developmental priorities, personal strengths, and liabilities.
- ◆ Assessing the potential resources of the child’s family.
- ◆ Setting treatment objectives.
- ◆ Prescribing therapeutic modalities to achieve the plan’s objectives.



The member has the capacity to benefit from the interventions provided.
Example:

- A member with a diagnosis of an intellectual disability may not be appropriate for a day treatment program if the member is unable to participate and benefit from group milieu therapy.
- A member exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.

b. Coordination of Services

Provide programming services in accordance with the individual treatment plan. Appropriate day treatment staff must develop the plan in collaboration with the member and the member's parent, guardian, or principal caretaker.

The services must be under the supervision of the program director, coordinator, or supervisor. Primary care staff of the PMIC must coordinate the program for each member.

A coordinated, consistent array of scheduled therapeutic services and activities must comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies.

"Active treatment" is defined as treatment in which the therapist assumes significant responsibility and often intervenes. At least 50 percent of scheduled therapeutic program hours for each member (exclusive of educational hours) must consist of active treatment components which:

- ◆ Are determined by the individual treatment plan based upon a comprehensive evaluation of member needs, and
- ◆ Specifically addressing the targeted problems of the population served.



h. Stable Milieu

The program must formally seek to provide a stable, consistent, and cohesive therapeutic milieu. Encourage this in part by scheduling attendance such that a stable core of patients exists as much as possible.

Consider the developmental and social stage of the participants, such that no member is significantly involved with other patients who are likely to contribute to intellectual disability or deterioration of the member's social and emotional functioning.

To help establish a sense of program identity, the array of therapeutic interventions must be specifically identified as the day treatment program. Program planning meetings must be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider must state how milieu stability will be provided.

C. BASIS OF PAYMENT

1. Inpatient Services

The basis of payment for PMIC services is the Fee Schedule.

a. Client Participation

Legal reference: 441 IAC 85.23(249A)

The member's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the member for payment of client participation.

Client participation is determined according to 441 IAC 75.16(249A).

Providers may verify a member's client participation by accessing the IME Eligibility and Verification System (ELVS). Click [here](#) to access the website.



b. Personal Needs Allowance

All income of the child in excess of \$50 per month for personal needs must be applied to the cost of care. In addition, if a child has earnings, a \$65 month allowance from earned income only is allowed for personal needs. The personal needs funds can be held by the child, by the facility for the child's use, or by the child's family.

Each foster care child who is in a PMIC and who has income assigned to the Department receives a state warrant for the child's personal needs. This represents the monthly personal allowance the child keeps from the child's unearned income or child support received from the parent.

Some children may have earned income that is to be used for personal needs. When children have income sent directly to them, the child is also allowed a personal needs allowance.

Determine whether the child can manage the child's own funds or whether the facility must handle the funds. Make this decision part of the child's case plan. Facilities do not have the option of refusing to handle a child's personal allowance funds if necessary and staff deems it appropriate. However, families may elect to handle their children's funds if they wish.

If the facility handles the funds, the facility must account for the funds. Purchase a surety bond or provide self-insurance to ensure the security of all personal funds of members deposited with the facility.

Establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each child's personal funds entrusted to the facility on the child's behalf. The system must preclude any commingling of member funds with facility funds or with the funds of any person other than another child.

Maintain two types of accounts to handle child personal allowance funds:

- ◆ A small "use" account to secure the first \$50 of each child's personal allowance funds. This can be a petty cash fund or a non-interest-bearing checking account.
- ◆ A larger interest-bearing checking account to handle all funds in excess of \$50 for each child. This may be a single joint account separate from any of the facility's operating accounts, an individual account for each child, or a pooled account of all members' funds.



The main function of the larger checking account is to act as a depository to generate interest and retain funds that later will be placed in the petty cash fund. If a single joint account is maintained, interest earned must be prorated periodically, normally upon receipt of the monthly bank statement, and credited to a separate ledger card for each member.

If an individual checking account is opened for each child, interest earned is automatically credited to each respective account. With this method, a second set of ledger cards is not necessary, as the individual check book register serves as a ledger card to record deposits and withdrawals.

Deposit all monthly personal allowance funds received into the larger account before being placed in the petty cash fund for member use. Under no circumstances should the monthly deposits be made directly into the petty cash fund.

Then deposit the first \$50 of each member's funds, or entire total if less than \$50, into a petty cash fund that consists solely of members' funds. Set up a new individual ledger card for each member that reflects the initial \$50 deposit into the petty cash fund. The individual financial record must be available on request to the member or the members' legal representatives.

Keep receipts for large purchases and vouchers for smaller items in individual envelopes for each member in the petty cash fund box. The receipts or vouchers must indicate the member's name, date, amount, and items purchased. Whenever possible, the member should sign a voucher for all cash received from the petty cash fund, regardless of its intended use. This is an adequate receipt for that type of withdrawal.

The total cash on hand plus vouchers should equal the total of all ledger cards for the petty cash fund. The ledger and receipts for each member must be made available for periodic audits by an accredited Department representative. The Department's representative must make an audit certification at the bottom of the ledger sheet. Supporting receipts may then be destroyed.



Make all purchases other than large items through the petty cash fund. Make large purchases directly through the individual checking account only.

When a member's account balance gets low in the petty cash fund, post the voucher to the ledger cards. As the petty cash fund amount for a member is used, draw an amount to replenish the fund to \$50 from the larger account and place it into the petty cash fund.

Notify each member who receives Medicaid benefits when the amount in the member's account reaches \$200 less than the SSI resource limit for one person. Notify the member's social worker that the member may lose eligibility for Medicaid or for SSI if the amount of the account, in addition to the member's other nonexempt resources, reaches the SSI resource limit for one person.

c. Hospital Leaves

Reserve bed payment must be made for days a member is absent from a PMIC and hospitalized in an acute care general hospital. The reserve bed day payments do not apply for an absence or transfer of a child to a sub-acute unit of the PMIC.

The following policies apply to all Medicaid-eligible members:

- ◆ Payment will not be authorized for over 10 days per calendar month and will not be authorized for over 10 days for any continuous stay.
- ◆ IME, depending on eligibility, review is required when the child returns to the facility after a 10-day absence.

Payment for reserve bed days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interest. In that case, payment must be canceled effective the day after the joint decision not to return the child.



d. Other Absences for Foster Children

Reserve bed payment must be made for days a foster care child is absent from a PMIC at the time of a nightly census for such reasons as detention, shelter care, or running away. The absence must be in accordance with the following policies:

- ◆ The facility must notify the Department social worker within 24 hours after the child is out of the facility for running away or other unplanned reason.
- ◆ The intent of the Department and the facility must be for the child to return to the facility after the absence.
- ◆ Payment for reserve bed days for other absences must not exceed 14 consecutive days or 30 days per year, except upon written approval of the Department's area administrator. In no case must payment exceed 60 days per year.

Payment for reserve bed days must be canceled and payments returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made by the court or by the parent, in a voluntary placement not to return the child to the facility.

Obtain IME review before the child's return to the facility if the child is away for 14 or more consecutive days. If it is determined that the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.

e. Reserve Bed Days

Reserve bed payment is not available until the child has been physically admitted to the facility. The reserve bed days are paid to the facility when the child is absent at the time of nightly census.



f. Visits

For visit days to be payable, the absence must be in accordance with the following conditions:

- ◆ For foster care children, the visits must be coordinated with the child's DHS social worker.
- ◆ The visits must be consistent with the child's case permanency plan and the facility's individual case plan.
- ◆ The intent of the Department and the facility must be for the child to return to the facility after the visitation.
- ◆ Staff from the psychiatric medical institution must be available to provide support to the child and family during the visit.
- ◆ Payment for reserve bed days cannot exceed 14 consecutive days or 30 days per year except upon approval from the member's Managed Care Organization or IME for children not enrolled with a Managed Care Organization. In no case must payment exceed 60 days per year.

Payment for reserve days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made not to return the child by the court or, involuntary placement, by the parent.

Upon return to the facility, IME review is required if the child's absence from the facility is greater than 30 consecutive days. If it is determined that the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.



2. Outpatient Services

Outpatient day treatment services are paid on a fixed-fee basis. Bill for day treatment in one-hour units:

H2012 Behavioral health day treatment, per hour

D. PROCEDURE CODES AND NOMENCLATURE

Revenue Code	HCPCS Code	Description	Valid DX. Codes
N/A	T2048	PMIC Bed Day	290.00-309.99, 311.00-314.99
0183	T2048	Therapeutic Leave Day (Use for home leave)	290.00-309.99, 311.00-314.99
0180	T2048	LOA General (Use of MH hospitalization)	290.00-309.99, 311.00-314.99
0189	T2048	LOA Other (Use for elopements)	290.00-309.99, 311.00-314.99

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Psychiatric Medical Institutions for Children are billed on federal form UB-04, *Health Insurance Claim Form**.

Click [here](#) to view a sample of the UB-04.

Click [here](#) to view billing instructions for the UB-04.

Refer to *Chapter IV. Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
<http://dhs.iowa.gov/sites/default/files/All-IV.pdf>