MaineCare Services
An Office of the
Department of Health and Human Services
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

Department of Health and Human Services
MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-2674; Fax: (207) 287-2675
TTY: 1-800-423-4331

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: Emergency Rule: MaineCare Benefits Manual, Section 46, Psychiatric Hospital Services, Chapter II

DATE: June 30, 2009

The Department of Health and Human Services (the "Department") is adopting Section 46, Chapter II rule changes on an emergency basis. These emergency rules clarify admission eligibility and continuing eligibility criteria for psychiatric hospital services.

The Department needs to ensure that MaineCare services are delivered only to individuals who are eligible for those services. Effective July 1, 2009, the Department is clarifying admission eligibility and continuing eligibility criteria for psychiatric hospital services for MaineCare members. These changes will assure the efficient operation of the MaineCare program by ensuring that only individuals who are eligible receive the service. Further, the administrative burden of utilization review will be lessened if the admission and continuing eligibility criteria are clear from the beginning. The Department estimates that these changes will not result in any expenditure changes for psychiatric hospitals. Because these rule changes are being established on an emergency basis, there will be no public comment period, but an opportunity to speak on these changes will happen in the proposed rule change that follows.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at
624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Section 46, Psychiatric Hospital Services, Chapter II

ADOPTED RULE NUMBER:

CONCISE SUMMARY: These emergency rules establish admission eligibility and continuing eligibility criteria for psychiatric hospitals. These changes will assure the efficient operation of the MaineCare program by ensuring that only individuals who are eligible receive the service. Further, the administrative burden of utilization review will be lessened if the admission and continuing eligibility criteria are clear from the beginning.

See http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: July 1, 2009

AGENCY CONTACT PERSON: Derrick Grant, Health Planner
AGENCY NAME: Division of Policy and Performance
ADDRESS: 442 Civic Center Drive
11 State House Station
Augusta, Maine 04333-0011
TELEPHONE: (207)-287-6427 FAX: (207) 287-9369
TTY: 1-800-423-4331 or 207-287-1828 (Deaf/Hard of Hearing)

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UPDATED 7/1/08

46.01 DEFINITIONS

46.01-1 Active Treatment

Active treatment means implementation of a professionally developed and supervised individual plan of care that is designed to achieve the member's discharge from inpatient services at the earliest time possible.

46.01-2 Authorized Agent

Authorized Agent means the organization authorized by the Department of Health and Human Services (DHHS) to perform specified functions including, but not limited, to prior authorization and/or utilization review pursuant to a signed contract or other approved signed agreement.

46.01-3 Community Care

Community Care means services not provided in a hospital setting and provided to a member in his/her place of residence, regardless of whether the member is residing with biological family, adoptive family, foster parents, therapeutic parents or in Intensive Temporary Out of Home Treatment.

46.01-4 Emergency Psychiatric Inpatient Admission

An emergency psychiatric inpatient admission means any admission of a patient who requires immediate psychiatric hospitalization due to the patient’s risk of harm to self and/or others and the patient’s inability to manage in a less restrictive environment without further regression.

46.01-5 Inpatient Services

Inpatient Services in this Section means services furnished in a psychiatric hospital for patients who have been admitted to the hospital for twenty four (24)-hour-a-day acute psychiatric care. MaineCare only covers inpatient psychiatric services for members under age twenty-one (21) or age sixty five (65) and older.

46.01 **DEFINITIONS (cont.)**

46.01-6 **Mental Health Clinician**

A Mental Health Clinician means a Physician, Psychiatrist, Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker, Licensed Master Social Worker Conditional Clinical (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), Licensed Professional Counselor (LPC), Licensed Marriage Family Therapist (LMFT), Advanced Practice Registered Nurse Psychiatric and Mental Health Practitioner (APRN-PMH-NP), or an Advanced Practice Registered Nurse Psychiatric and Mental Health Clinical Nurse Specialist (APRN-PMH-CNS) when practicing within their scope of licensure to make a diagnosis.

46.01-7 **Outpatient Services**

Outpatient services means a planned combination of diagnostic, treatment and rehabilitative services provided to mentally or emotionally disturbed members in the hospital setting on a less than twenty-four (24) hour a day basis. Outpatient services are intended to provide support and facilitate a more integrated and independent level of functioning in the community to members with psychiatric disorders.

46.01-8 **Partial Hospitalization Services**

Partial Hospitalization Services means a supervised rehabilitative-oriented treatment by a mental health clinician lasting more than two (2) hours but less than twelve (12) hours each day in a psychiatric hospital that provides a combination of evaluative, diagnostic, treatment and rehabilitative services to persons with psychiatric problems.

46.01-9 **Psychiatric Hospital**

Psychiatric Hospital means a hospital that is primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness. A psychiatric hospital must be licensed as a psychiatric hospital by the Department of Health and Human Services (DHHS).

46.01 DEFINITIONS (cont.)

46.01-10 Serious Emotional Disturbance

Serious Emotional Disturbance (SED) means when a member has a mental health, emotional or behavioral diagnosis, under the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), that has lasted for or can be expected to last for at least one (1) year, and is at risk for more restrictive placement, including but not limited to, psychiatric hospitalization, as a result of this condition for which other less intensive levels of service have not been effective (e.g. traditional outpatient services).

46.02 PROVIDER ELIGIBILITY

46.02-1 Psychiatric Hospitals Serving Individuals Age Sixty-five (65) or Older for Inpatient Services

In order to be enrolled as a MaineCare provider, and to receive reimbursement, the provider must be licensed as a psychiatric hospital by the Department of Health and Human Services and must be certified by Medicare.

46.02-2 Psychiatric Hospitals Serving Members Under Age Twenty one (21) for Inpatient Services

In order to be enrolled as a MaineCare provider, and to receive reimbursement, the provider must be licensed by the Department of Health and Human Services as a psychiatric hospital and must be accredited by the Joint Commission on Accreditation of Health Care Organizations.

46.02-3 Psychiatric Hospitals Providing Outpatient and Partial Hospitalization Services

In order to be enrolled as a MaineCare provider and to receive reimbursement, the provider must be licensed by DHHS as a psychiatric hospital and be accredited by the Joint Commission on Accreditation of Health Care Organizations.

ELIGIBILITY FOR CARE

46.03-1 General Eligibility

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (10-144 CMR Chapter 332). Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the responsibility of the provider to verify eligibility and benefit level. The following describes specific eligibility for the covered services set forth in this section.

The member's condition must be such that his or her needs cannot be met in a less restrictive setting.

46.03-2 **Age Requirement: For Inpatient Services**

An individual must be under age twenty-one (21) or age sixty-five (65) or older to be eligible to receive inpatient psychiatric hospital services, except that if a member receives inpatient services immediately before he or she reaches age twenty-one (21), the member is eligible for continued service until he or she reaches age twenty-two (22) or the date when service is no longer required, whichever comes first.

46.03-3 **Partial Hospitalization Services and Outpatient Services**

A. **Specific Eligibility – Outpatient and Partial Hospitalization**

To be eligible for partial hospitalization and outpatient services, the member's condition must be such that his or her needs cannot be met in a less intensive or less restrictive and available setting.

For outpatient services to be covered by MaineCare the member must need treatment similar to or more active or inclusive than is available through a weekly visit to a mental health agency, psychologist or psychiatrist, but not need partial or full-time hospitalization.

To be eligible for partial hospitalization services the member must need more active and inclusive treatment than is provided in an outpatient service, but not need full-time hospitalization or institutionalization.

46.03 ELIGIBLILITY FOR CARE (cont.)

46.03-4 "Katie Beckett" Eligibility

The Office of MaineCare Services will determine classification (or eligibility) for certain children with disabilities ("Katie Beckett" Eligibility Option) age eighteen (18) and under. "Katie Beckett" eligibility has medical criteria in addition to financial criteria. All of the following eligibility criteria must be met for a child to receive MaineCare services:

A. **Disability**

The child must be determined disabled by Supplemental Security Income standards. A disability determination is made by the Medical Review Team (MRT) at the Office of Integrated Access and Support as part of the MaineCare application process or by the disability determination unit at the Social Security Administration.

B. **Level of Care**

The child must require a level of care that is typically provided in a hospital, including psychiatric hospitals, ICF-MR, or a Nursing Facility, although the child does not have to be admitted, relocated nor have a history of admissions to such an institution.

If the child were in a medical institution, the child would be eligible for Medicaid.

C. **Psychiatric Hospital Level of Care**

The following describes the criteria for severely emotionally disturbed children to meet the Psychiatric Hospital Level of Care. These criteria are used for establishing levels of care for SED children living at home who otherwise would need to be admitted to a hospital or psychiatric hospital. NOTE: All of the criteria under 1, 2, 3, and 4 must be met.

1. The member must have a primary diagnosis of a Serious Emotional Disturbance as defined in Section 46.01 that has been diagnosed by a mental health clinician as defined in Section 46.01.

   This diagnosis must include information on all five axes from the most current version of The Diagnostic and Statistical Manual of Mental Disorders (DSM) that apply; and

46.03 **ELIGIBLILITY FOR CARE (cont.)**

2. Documentation by a mental health clinician must be entered in the medical record that evidences that the child has been diagnosed as defined in 46.03-4 C 1. and the disorder has persisted for a minimum of six (6) months and can be expected to persist for a year or longer: and

3. The child must have exhibited in the last three (3) months, as documented by a mental health clinician, at least one of the following symptoms and/or behaviors or would exhibit one of the following symptoms and/or behaviors without medical intervention (e.g. medication):

   a. **Psychotic symptoms** characterized by defective or lost contact with reality, often with hallucinations or delusions.

   b. **Suicidality -** The individual must have made one attempt within the last three months or have
   significant ideation about or have a plan for suicide within the past month.

   c. **Violence -** The individual must be at risk for causing injury to persons or significant damage to property as a result of a neurobiological, emotional and/or behavioral disorder.

   d. **Anorexia Nervosa -** (diagnosed by a physician) with a weight loss of at least 25% of original body weight, signs of electrolyte imbalance, cardiac arrhythmias or congestive heart failure.

   e. **Withdrawal -** Removal of one's physical and/or emotional self from activities of daily living (e.g. can't get out of bed or does not interact with others)

   f. **Severe Hyperactivity -** Hyperactive behavior, including mania, that interferes with the child's ability to participate in age-appropriate daily activities in a safe manner; and

46.03 **ELIGIBLILITY FOR CARE (cont.)**

4. The child must

a. demonstrate a serious functional impairment that substantially interferes with age-appropriate ability to function in family, school or community activities; or

b. evidence a persistent and pervasive anxiety and depression; or

c. present security risks; or

d. persistently or frequently exhibit inappropriate behavior such as: physical aggression, self-injurious behavior, hyperactive or impulsive behavior; or

e. be at risk for health problems due to inappropriate behavior, such as infections or other problems caused by functional impairments in activities of daily living.

D. **Appropriateness of Community-Based Care**

The child must be able to receive or currently be receiving appropriate care, in the least restrictive setting, outside a hospital or psychiatric inpatient setting. The parent and child will participate in making the decision as to where the child will receive care. The family home will be given first preference, if appropriate, as determined by the parent or guardian.

E. **Cost Limits of Community-Based Care**

The total annual cost to MaineCare for community-based care for children eligible for MaineCare in this category must be no greater than the amount MaineCare would pay for the child's care in an institution.

46.04 **DURATION OF CARE**

Each MaineCare member is eligible for those medically necessary covered services set forth in Section 46.05. See Utilization Review Requirements in Section 46.08.

Katie Beckett Eligibility will be reviewed annually by DHHS, which reserves the right to request additional information to evaluate medical necessity. Responses to requests for

46.04 **DURATION OF CARE (cont.)**

additional information must be made available to the Department within sixty (60) days in order to maintain eligibility. The Office of Integrated Access and Support is notified when members no longer meet eligibility as set forth in this Section, and reassesses continued MaineCare eligibility in another category using guidelines set forth in the MaineCare Eligibility Manual.

46.05 **COVERED SERVICES**

All covered services are subject to Utilization Review as set forth in Section 46.08.

46.05-1 **Inpatient Psychiatric Hospital Services**

Covered services include those services ordinarily provided in a psychiatric hospital for the twenty four (24) hour care and treatment of an inpatient under the supervision of a psychiatrist and in accordance with the member's plan of care.

46.05-2 **Partial Hospitalization Services**

Partial hospitalization services must be designed to meet the treatment and rehabilitative needs of the member as identified in a treatment plan. Services include, but need not be limited to, individual, group and activities components designed to develop members' emotional and physical capability in areas of daily living, community integration and interpersonal functioning. Outpatient services include but need not be limited to: diagnosis and assessment; individual, family and group therapy; medication evaluation, education and monitoring; stress management; and daily living skills training services.

46.05-3 **Outpatient Services**

Outpatient Services are professional assessment, counseling and therapeutic services provided to members to relieve excess stress and promote positive orientation and growth toward more integrated and independent levels of functioning. Services are delivered through planned interaction involving the use of physiological, psychological, and sociological concepts, techniques and processes of evaluation and intervention.

Services include diagnosis and assessment, psychometric evaluation, intervention services by psychological examiners, individual, group, and family therapy, specialized treatment for sexual abuse victims or offenders, medication review and chemotherapy, and similar professional therapeutic services. Services must include a direct encounter with the member. Services

46.05 **COVERED SERVICES (cont.)**

must focus on the special developmental and emotional needs and problems of the member where appropriate.

In order to be eligible for reimbursement the need for services must be documented in the treatment plan and is subject to approval and Utilization Review by the Department and its Authorized Agent according to guidelines set forth in Section 46.08.

46.06 **NON-COVERED SERVICES**

Services that are not reimbursable are:

1. outpatient meals
2. outpatient transportation
3. leave days

46.07 **DETERMINATION OF ELIGIBLITY**

All members requesting eligibility must be determined to be in need of the psychiatric hospital services provided by providers enrolled under this Section. The determination of medical eligibility is made concurrently with the determination of financial eligibility in order to expedite the determination of the member's overall eligibility for psychiatric hospital services.

46.07-1 **Financial Eligibility Determination Procedure**

Financial eligibility will be determined by the DHHS's Office of Integrated Access and Support.

46.07-2 **Medical Eligibility Determination Procedure**

Before authorization for reimbursement may be made, a complete evaluation of the member must be made, a plan of care established, a certification of need of service completed, and Central Enrollment as defined in Section 46.08 completed.

46.07 **DETERMINATION OF ELIGIBILITY (cont.)**

A. **Medical, Psychiatric, and Social Evaluations**

An attending physician or staff physician must make a medical evaluation of each member's need for care and appropriate professional personnel must make a psychiatric and social evaluation. This evaluation must include all requirements detailed in Hospital Licensing regulations. In addition, each medical evaluation must include:

1. Diagnosis
2. Summary of present medical findings
3. Medical history
4. Mental and physical functional capacity
5. Prognosis
6. Measurable short and long term goals
7. Specific treatment modalities to be utilized
8. The responsibilities of each team member
9. Treatment received by the member shall be documented to justify the diagnosis and the treatment and rehabilitation activities carried out; and
10. A physician's recommendation of inpatient, partial hospitalization or outpatient services for the member. In the case of an individual who applies for MaineCare while receiving inpatient, partial hospitalization or outpatient services, a recommendation by a physician for continued care must be made as part of the medical evaluation.

B. **Individual Written Plan of Care**

The attending staff physician must establish and sign a written plan of care for each member, which must at minimum include the items described at Section 46.10.

46.07 DETERMINATION OF ELIGIBILITY (cont.)

46.07-3 Coordination With Medicare

Medicare provides a lifetime limit of one hundred and ninety (190) inpatient days of care in a psychiatric hospital. In general, MaineCare benefits are limited to payment of the Medicare coinsurance and deductible for MaineCare-eligible Medicare beneficiaries as stated in Chapter I of the MaineCare Benefits Manual.

The following describes the additional requirements for authorization of MaineCare coverage in the event that a member applies for inpatient psychiatric hospital coverage after the one hundred and ninety (190) day lifetime limit or ninety (90) day spell-of-illness limit is exhausted or after the member's Medicare benefits are terminated for any other reason.

A. **If Medicare's Lifetime Limit of One Hundred and Ninety (190) Days or Spell-Of-Illness Limit of Ninety (90) Days is Exhausted**

A copy of the Medicare Exhaustion of Benefits notice must be included in the member's record.

B. **Termination of Medicare Coverage Before the One Hundred and Ninety (190th) Day of Benefits**

1. If the Department believes that a reasonable basis for appeal exists:

   a. The member must request reconsideration of the Medicare denial of benefit coverage.

   b. The provider must assist the member in requesting reconsideration of the Medicare denial and submit a copy of the reconsideration request.

46.08 DEPARTMENTAL UTILIZATION REVIEW

The Department requires utilization review (UR) for services reimbursed under this section. Utilization Review is performed by the Department or its Authorized Agent in coordination with the provider’s internal UR process.

Central Enrollment is a process of determining baseline eligibility for behavioral health treatment. DHHS or its Authorized Agent shall facilitate referrals to appropriate service providers, expedite delivery of service to members, and reliably

46.08 **DEPARTMENTAL UTILIZATION REVIEW (cont.)**

track the service status of members enrolled in the system and gather data that will inform DHHS of resource development needs. This is part of the UR process.

Utilization Review is a formal assessment of the medical necessity, efficiency and appropriateness of services and treatment plans on a prospective, concurrent or retrospective basis. The provider is required to notify the DHHS or its Authorized Agent upon initiation of all services in this Section in order for the Authorized Agent to begin utilization review.

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46.09 **~~DOCUMENTATION OF MEDICAL NECESSITY~~ ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA**

Providers must maintain a member record for each member documenting the medical necessity for these services. Documentation must be available to the Department and its Authorized Agent. Members must be determined eligible for admission to a psychiatric hospital. Members must meet all of the following four (4) criteria in order to be eligible for admission, and must continue to meet all four (4) of the following criteria in order to continue to be eligible for these services:

1. The member has a substantiated diagnosis found in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).

2. Treatment is medically necessary. Medical necessity must include one (1) or more of the following:

   a. The member exhibits an immediate or direct threat of serious harm to self or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour/day basis are required. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour day basis.

   b. The member is exhibiting an immediate or direct threat of serious harm to others or there is evidence for clear and reasonable inference of serious harm to others. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour/day basis.

   c. The member is exhibiting an extreme disabling condition such that one cannot take care of self in a developmentally appropriate level or requires assistance beyond the home or

46.09 **ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA**

Emerg. Effective

7/1/09 – 9/28/09

residential setting. The member's symptoms must be of such severity that they require 24-hour/day intensive medical, psychiatric, and nursing services. Outpatient treatment would be clearly unsafe or is unavailable. A lower level of care is not available or would not be adequate to successfully treat those symptoms.

3. Age specific criteria:

a. For members under the age of twenty one (21) or adults with a legal guardian:

i. The member's family / guardian(s), where applicable and clinically indicated, are willing to actively participate throughout the duration of treatment.

ii. The services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services will no longer be needed.

b. For members age sixty five (65) or older, services are the only alternative available to maintain or restore the member to the greatest possible degree of health and independent functioning.

~~46.09-1 **Criteria for Determining Need for Inpatient Services**~~

~~Documentation of the following must be present in the member's record:~~

~~1. The member has a substantiated diagnosis found in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).~~

~~2. In the case of members age sixty five (65) or older, substantiation that inpatient psychiatric hospital service is the only alternative available to maintain or restore the member to the greatest possible degree of health and independent functioning.~~

~~3. In the case of members under age twenty one (21), substantiation that:~~

~~a. Ambulatory care resources available in the community do not meet the treatment needs of the member;~~

~~b. Proper treatment of the member's psychiatric condition requires inpatient care under the direction of a physician; and~~

46.09 **ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA (cont.)**

Emerg. Effective 7/1/09 – 9/28/09

~~c. The services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services will no longer be needed.~~

4. A clear indication that the inpatient psychiatric services offered provide the member with active treatment.

46.10 **PLAN OF CARE REQUIREMENTS**

A written plan of care must be established for each member receiving psychiatric hospital services and must include at minimum items described under 46.10-1, General Contents. Plans of care for Inpatient Services and Partial Hospitalization/ Outpatient services are described in Sections 46.10-2 and 46.10-3, respectively. Plans of Care must be available to the Department and its Authorized Agent.

An interdisciplinary team of professionals must develop a plan of care for each such member within fourteen (14) days after the member's admission and must review the plan at least every thirty (30) days thereafter.

46.10-1 **General Contents of Plans of Care**

Plans of care shall at a minimum include the following:

A. Diagnosis, symptoms, complaints, and complications indicating the need for inpatient, partial hospitalization or outpatient services;

B. A description of the functional level of the member, including strengths and weaknesses;

C. Measurable short and long term goals;

D. Any orders for:

1. Medications,

2. Treatments,

3. Restorative and rehabilitative services,

4. Activities,

5. Therapies,

46.10 **PLAN OF CARE REQUIREMENTS (cont.)**

6. Social services,

7. Diet, or

8. Special procedures recommended for the health and safety of the member.

E. Plans for continuing care, including review and modification to the plan of care; and

F. Plans for discharge (see 46.12).

46.10-2 **Inpatient Services - Plans of Care**

A. **Plans of Care For Members Age Sixty-five (65) Or Older**

The plan of care must also include at minimum:

1. Periodic review of the member's medical, psychiatric, and social needs, and

2. A determination made sixty (60) days and one hundred and twenty (120) days after the initial certification, and every thirty (30) days after a one hundred and twenty (120) day period of continuous inpatient service, of the member's need for continued institutional care and for alternative care arrangements.

B. **Plans of Care For Members Under Age Twenty one (21)**

1. **Plan Specifications for Members Under twenty one (21)**

The plan of care for a member under twenty-one (21) must :

a. Be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and reflects the need for inpatient psychiatric care;

b. Be developed by a team of professionals, as specified below in consultation with the member, and his/her parents, legal

46.10 **PLAN OF CARE REQUIREMENTS (cont.)**

guardian, or others into whose care he/she will be released after discharge;

c. State treatment objectives;

d. Prescribe an integrated program of therapies, activities, and experiences designed to meet treatment objectives; and

e. Include ~~post-~~discharge plans and coordination of inpatient services with ~~partial~~ discharge plans and related community services to ensure continuity of care with the member's family, school, and community upon discharge; and

f. Be signed and credentialed, if applicable, by each member of the team providing services.

2. **Review of Plan of Care**

The plan must be reviewed at least every thirty (30) days by the team specified at (3), below, to:

a. Determine that services being provided are or were required on an inpatient basis, and

b. Recommend changes in the plan as indicated by the member's overall progress towards treatment goals.

3. **Team Developing Individual Plan of Care For Members Under Age Twenty one (21)**

The plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by the hospital or who provide services to members in the hospital. Qualification for participation on the team is based on education and experience, including competence in child psychiatry.

a. **Team Skills**

The team must be capable of:

i. Assessing the member's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

46.10 **PLAN OF CARE REQUIREMENTS (cont.)**

ii. Assessing the potential resources of the member's family;

iii. Setting treatment objectives; and

iv. Prescribing therapeutic modalities to achieve the plan's objectives.

b. **Team Composition**

The team must include either:

i. A Board-eligible or Board-certified psychiatrist; or

ii. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases paired with a clinical psychologist who is licensed by the state or province in which services are provided.

The team must also include at least one of the following:

iv. A psychiatric social worker.

v. A registered nurse with specialized training or one year's experience in treating mentally ill members.

vi. An occupational therapist who is licensed by the state or province in which services are provided and who has specialized training or at least one year of experience in treating mentally ill members.

vii. A clinical psychologist who is licensed by the state or province in which services are provided.

viii. A Licensed Alcohol and Drug Counselor (LADC) by the State or province in which services are provided.

46.10 PLAN OF CARE REQUIREMENTS (cont.)

46.10-3 Partial Hospitalization and Outpatient Services

A. **Diagnosis and Treatment Plan**

1. **Initial Assessment/Clinical Evaluation**

An initial assessment, which must include a direct encounter with the member, shall be performed by the interdisciplinary team and included in the member's clinical record. The assessment should include the member's medical and social history and the member's diagnosis.

2. **Individual Treatment/Service Plan**

Based on the initial assessment, a comprehensive plan of care shall be developed. This plan shall be in writing and shall identify all specific services to be provided, the frequency and duration of each service, the personnel who will provide the services and the goals and/or expected outcomes of each service.

For Partial Hospitalization Services, an initial written plan of care must be completed within three (3) treatment days.

A written comprehensive plan of care must be completed within ten (10) days of the initial plan of care. The comprehensive plan of care is to be updated within sixty (60) days and at least every ninety (90) days thereafter.

For Outpatient Services, a written plan of care must be completed by the third visit and be updated thereafter at least every ten (10) visits or every three (3) months, whichever comes first.

B. **Treatment Documentation**

1. Written treatment or progress notes shall be maintained in chronological order. Notes shall identify who provided the service, on what date the service was provided, its duration, and the progress the member is making toward attaining the goals or outcomes identified in the treatment plan. All entries shall be signed, credentialed, if applicable, and dated by the individual who performed the service.

46.10 PLAN OF CARE REQUIREMENTS (cont.)

C. Discharge/Closing Summary

A closing summary shall be signed, credentialed, if applicable, and dated and included in the clinical record of discharge treatment and outcome in relation to the Treatment Plan.

46.11 HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS

Each Psychiatric Hospital must have in effect a written Utilization Review Plan that provides for review of each member's need for inpatient, partial hospitalization or outpatient services furnished by the hospital and must meet the following requirements:

46.11-1 Utilization Review Committee

A. Utilization Review Plan

The Plan must:

1. Provide for a committee to perform the Utilization Review activities described in this manual;

2. Describe the organization, composition and functions of the committee; and

3. Specify the frequency of meetings of the committee.

B. Organization and Composition of the Utilization Review Committee

The Utilization Review Committee must be composed of two or more physicians, at least one of whom is knowledgeable in the diagnosis and treatment of mental diseases.

C. Disqualification From Committee Membership

The Utilization Review Committee must be constituted as a committee of the hospital staff and may not include any individual who:

1. Is directly responsible for the care of members whose care is being reviewed; or

2. Has a financial interest in any inpatient psychiatric hospital.

46.11 HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)

46.11-2 Information Requirements

A. **Member Information**

The Utilization Review Plan must provide that each member's record include information needed to perform Utilization Review under this manual. This information must include, at least, the following:

1. The member's name;

2. The name of the member's physician;

3. Date of initiation of service and, if application is made after initiation of service, dates of application for and authorization of MaineCare benefits;

4. The plan of care described in section 46.10, above;

5. Initial and subsequent continued service review dates described under Section 46.09;

6. Reasons and plan for continued service, if the attending physician believes continued service is necessary;

7. Other supporting material that the committee believes appropriate for inclusion in the record.

B. **Records and Reports**

The Utilization Review plan must describe:

1. The types of records that are kept by the committee and

2. The type and frequency of committee reports and arrangements for their distribution to appropriate members.

C. **Confidentiality**

The Utilization Review plan must provide that the identities of members in all Utilization Review records and reports are kept confidential.

46.11 HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)

46.11-3 Review of Need for Continued Stay for Inpatient Services

A. **Continued Stay Review Required**

The Utilization Review plan must provide for a review of each member's continued stay in the inpatient psychiatric hospital to decide whether it is needed, in accordance with the requirements of 46.11-3 (B) through (H).

B. **Evaluation Criteria for Continued Stay**

The Utilization Review plan must provide that:

1. The committee develops written medical care criteria to assess the need for continued stay.

2. The committee develops more extensive written criteria for cases that its experience shows are:

   a) Associated with high costs;

   b) Associated with the frequent furnishing of excessive services; or

   c) Attended by physicians whose patterns of care are frequently found to be questionable.

C. **Initial Continued Stay Review Date**

The Utilization Review Plan must provide that:

1. When a member is admitted to the inpatient psychiatric hospital under admission review requirements of this manual the committee assigns a specified date by which the need for his/her continued stay will be reviewed;

2. If an individual applies for MaineCare while in the hospital, the committee assigns the initial continued stay review date within one (1) working day after the hospital is notified of the application for MaineCare;

3. The committee bases its assignment of the initial continued stay review date on:

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

a. The methods and criteria required to be described under 46.11-3 (E) below,

b. The member's condition, and

c. The member's projected discharge date.

4. The committee uses any available appropriate regional medical care appraisal norms, such as those developed by abstracting services or third party payors, to assign the initial continued stay review date;

These norms are based on current and statistically valid data on duration of stay for inpatient psychiatric hospitals for members whose characteristics, such as age and diagnosis, are similar to those of the member whose need for continued stay is being reviewed;

If the committee uses norms to assign the initial continued stay review date, the number of days between the member's admission and the initial continued stay review date is no greater than the number of days reflected in the 50th percentile of the norms. However, the committee may assign a later review date if it documents that the later date is more appropriate;

5. The initial continued stay review date is not in any case later than thirty (30) days after admission of the member or thirty (30) days after notice to the inpatient psychiatric hospital of his application for MaineCare; and

6. The committee insures that the initial continued stay review date is recorded.

D. **Subsequent Continued Stay Review Dates**

The Utilization Review plan must provide that:

1. The committee assigns subsequent continued stay review dates in accordance with 46.11-3(C), above, and 46.11-3(E), below

2. The committee assigns a subsequent continued stay review date within sixty (60) days each time it decides under 46.11-3(F) below that the continued stay is needed, until one hundred and twenty (120) days of service has been provided, and within thirty (30)

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

days each time it decides under 46.11-3(F) below that a continued stay is needed after one hundred and twenty (120) days of service has been provided, and

3. The committee insures that each continued stay review date it assigns is recorded.

E. **Description of Methods and Criteria; Continued Stay Review Dates; Length of Stay Modification**

The Utilization Review plan must describe:

1. The methods and criteria, including norms if used, that the committee uses to assign initial and subsequent review dates under 46.11-3(C) and (D), above,

2. The methods that the committee uses to modify an approved length of stay when the member's condition or treatment schedule changes.

F. **Continued Stay Review Process**

The Utilization Review plan must provide that:

1. Review of continued stay cases is conducted by one of the following:

   a. The Utilization Review Committee;

   b. A subgroup of the Utilization Review Committee or

   c. A designee of the Utilization Review Committee;

2. The committee, subgroup, or designee reviews a member's need for continued stay on or before the expiration of each assigned continued stay review date;

3. For each continued stay of a member in the inpatient psychiatric hospital, the committee, subgroup or designee reviews and evaluates the documentation described under 46.11-2 against the criteria developed under 46.11-3(B) and applies close professional scrutiny to cases described under 46.11-3(B)(2).

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

4. If the committee, subgroup or designee finds that a member's continued stay in the inpatient psychiatric hospital is needed, the committee assigns a new continued stay review date in accordance with 46.11-3(D).

5. If the committee, subgroup, or designee finds that a continued stay case does not meet the criteria, the committee or a subgroup that includes at least one physician reviews the case to decide the need for continued stay;

6. If the committee or subgroups making the review under (5) of this Section finds that a continued stay is not needed, it notifies the member's attending or staff physician and gives him/her an opportunity to present his/her views before it makes a final decision on the need for the continued stay;

7. If the attending or staff physician does not present additional information to establish the need for the continued stay, the decision of the committee or subgroup is final; and

8. If the attending or staff physician presents additional information or clarification, at least two (2) physician members of the committee, one of whom is knowledgeable in the treatment of mental diseases, review the need for the continued stay. If they find that the member no longer needs inpatient psychiatric hospital services their decision is final.

G. **Notification of adverse decision**

The Utilization Review plan must provide that written notice of any adverse final decision, based on (1) through (8), above, disaffirming the need for continued stay above is sent to:

1. The hospital administrator;

2. The attending or staff physician;

3. The hospital reimbursement officer;

4. The member;

5. The next of kin, legal guardian, or sponsor;

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

6. The third party payor or MaineCare Office of Integrated Access and Support (OIAS); and

7. The Department and its Authorized Agent.

H. **Time limits for final decision and notification of adverse decision**

The Utilization Review plan must provide that the committee makes a final decision concerning a member's need for continued stay and gives notice of an adverse decision within two (2) working days after the assigned continued stay review date. If the committee makes a final decision denying a member's need for continued stay before the assigned review date, notice under (G) above, is given within two (2) working days after the date of the final decision.

46.11-4 **Medical Care Evaluation for Psychiatric Hospital Services**

A. **Purpose and General Description**

The purpose of medical care evaluations is to promote the most effective and efficient use of available health hospitals and services consistent with members' needs and professionally recognized standards of health care.

Medical care evaluations:

1. Emphasize identification and analysis of patterns of member care, and

2. Suggest appropriate changes needed to maintain consistently effective and efficient use of services.

B. **Utilization Review Plan Requirements for Medical Care Evaluation**

The Utilization Review plan must describe the methods that the committee uses to select and conduct medical care evaluations.

The Utilization Review plan must provide that the Utilization Review committee:

1. Determines the methods to be used in selecting and conducting medical care evaluations;

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

2. Documents the results of each evaluation and how the results have been used to make changes to improve the quality of care and promote more effective and efficient use of hospitals and services;

3. Analyzes the findings for each evaluation; and

4. Takes action as needed to correct or investigate further any deficiencies or problems in the review process and to recommend more effective and efficient hospital care procedures.

C. **Content of Medical Care Evaluations**

Each medical care evaluation must include the following:

1. Identification and analysis of medical or administrative factors related to member care;

2. Analysis of at least the following:

   a. Admissions;

   b. Duration of care;

   c. Ancillary services furnished, including drugs and biologicals; and

   d. Professional services performed.

3. If indicated, recommendations for change beneficial to members, staff, the hospital, and the community.

D. **Data Sources For Evaluations**

Data that the committee uses to perform evaluations must be obtained from one or more of the following sources:

1. Medical records or other appropriate hospital data;

2. External organizations that compile statistics, design profiles, and produce other comparative data; or

3. Cooperative endeavors with:

   a. PSROs/PROs,

46.11 **HOSPITAL UTILIZATION REVIEW PLAN REQUIREMENTS (cont.)**

b. Fiscal agents,

c. Other service providers, and

d. Other appropriate agencies.

E. **Numbers Of Evaluations Required To Be Performed**

The psychiatric hospital must have at least one (1) evaluation in progress at any time and complete one (1) evaluation each calendar year.

46.12 **DISCHARGE PLANNING**

Each hospital shall maintain a written record of discharge planning procedures, as required for licensure set forth in 10-144 CMR, Chapter 112, Regulations for the Licensure of General and Specialty Hospitals in the State of Maine.

46.13 **INSPECTIONS OF CARE**

A team, whose composition is specified at 46.13-1, will inspect at least annually the care and services provided to each member receiving inpatient services in the hospital. No hospital shall be notified of the time of inspection more than forty-eight (48) hours before the scheduled arrival of the team.

46.13-1 **Team Composition**

The Inspection Team shall consist of one or more psychiatric nurse consultants, a medical social work consultant, MSW level social worker and a psychiatrist or physician knowledgeable about inpatient services in psychiatric hospitals.

46.13-2 **Personal Contact With And Observation Of Members And Review Of Records**

The Team's inspections must include review of each member's record.

A. For members under age twenty one (21) receiving inpatient services, the inspections must also include personal contact with and observation of each member.

B. For members age sixty five (65) or older receiving inpatient services, if the record does not contain complete periodic assessments described at 46.10, or if the Team deems such reports inadequate, the inspection will also include personal contact with and observation of the member.

46.13 INSPECTIONS OF CARE (cont.)

46.13-3 Determination By Team

The team must determine in its inspection that:

A. The services available in the hospital are adequate to:

1. Meet the health needs of each member and

2. Promote each member's maximum physical, mental, and psychosocial functioning.

B. It is necessary and desirable for the member to continue to receive inpatient services within the hospital;

C. It is not feasible to meet the member's health needs through alternative institutional services; and

D. Each member under age twenty one (21) is receiving active treatment as defined at 46.01-3.

46.13-4 Basis for Determinations

In making the determinations on adequacy of services and related matters for each member under 46.13-3, above, the team may consider such items as whether or not:

A. The medical evaluation, social and psychological evaluation, and the plan of care are complete and current;

B. The plans of care are followed and all ordered services, including dietary orders, are provided and properly recorded;

C. The attending physician reviews prescribed medications at least every thirty (30) days;

D. Tests or observations of each member indicated by his medication regimen are made at appropriate times and properly recorded;

E. Physician, nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the member;

F. The member receives adequate services, based on observations such as

46.13 **INSPECTIONS OF CARE (cont.)**

1. Cleanliness;

2. Absence of bed sores;

3. Absence of signs of malnutrition or dehydration; and

4. Apparent maintenance of maximum physical, mental, and psychosocial functions;

G. The member needs any service that is not furnished by the hospital or through arrangements with others;

H. The member needs continued placement in the hospital or there is an appropriate plan to transfer the member to an alternate method of care.

I. Whether certification or recertification has been timely and properly documented.

46.14 **MEMBER APPEALS**

Member appeals are described in MaineCare Benefits Manual, (10-144 CMR, Chapter 101) Chapter I, Section 1.

46.15 **PROGRAM INTEGRITY**

Requirements for Program Integrity (formerly Surveillance and Utilization Review) are included in Chapter I of the MaineCare Benefits Manual (MBM).

46.16 **REIMBURSEMENT**

Reimbursement for psychiatric hospitals is made in accordance with the "Principles of Reimbursement for Hospital Services" as defined in Chapter III, Section 45 of this Manual.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of a rendered service prior to billing MaineCare.

To qualify for reimbursement of laboratory services provided in a psychiatric hospital those laboratory services must be in compliance with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA '88) and any amendments thereto. This information is available at **www.cms.hhs.gov/clia**.

46.17 BILLING INSTRUCTIONS

Billing must be accomplished in accordance with the Department's billing requirements set forth in the MaineCare Benefits Manual, Chapter III, Section 45, and "Billing Instructions for UB-04" available at
http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html