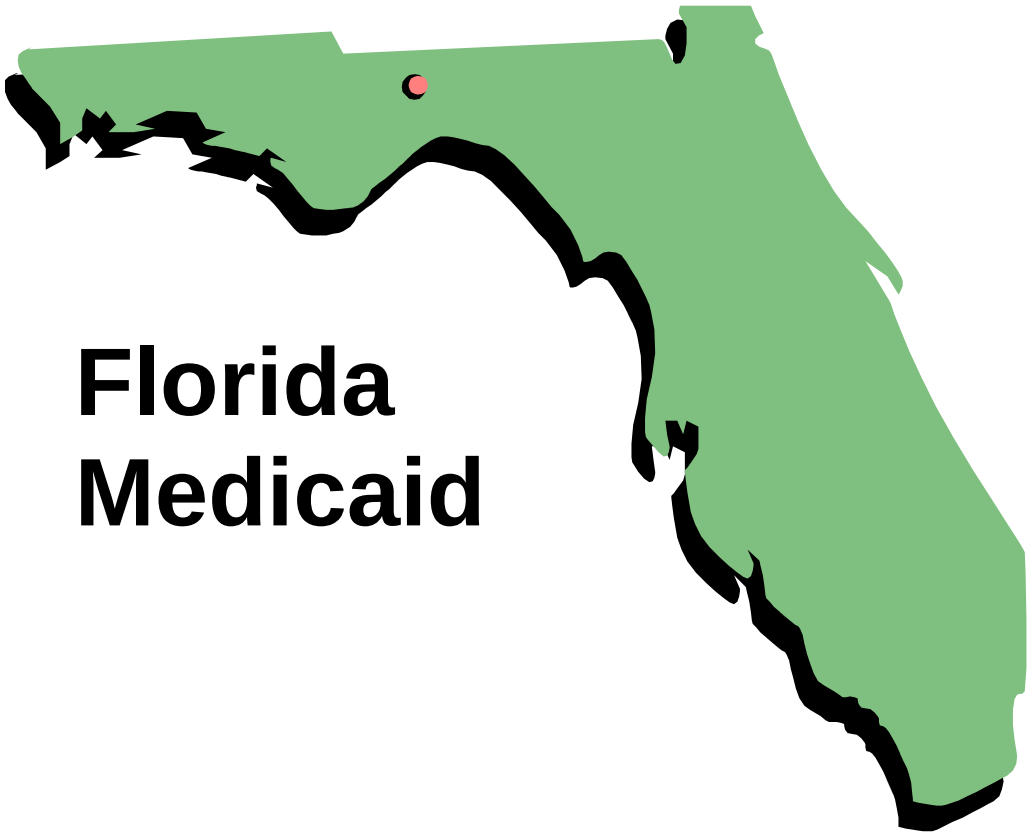

Florida Medicaid

Statewide Inpatient Psychiatric Program Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

1.1 Description

Florida Medicaid's Statewide Inpatient Psychiatric Program (SIPP) services provide extended residential psychiatric treatment, with the goal of facilitating successful return to treatment in a community-based setting.

1.1.1 Florida Medicaid Policies

This policy is intended for use by SIPP providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policy and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: Policies are available on the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/flpublic. All policies are incorporated by reference in Rule Division 59G, Florida Administrative Code (F.A.C.).

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum requirements for all providers of SIPP services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Medicaid managed care plan. The provision of services to recipients in a Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.

1.2 Legal Authority

Services are authorized by the following:

- Title 42 Code of Federal Regulations (CFR), section 441, Subpart D (for providers licensed under Rule Chapter 65E-9, F.A.C.), and 42 CFR 482 or 42 CFR 483 (as appropriate to the provider's licensure type)
- Chapters 394 and 395, Florida Statutes (F.S.)
- Section 409.906, F.S.
- Rule 59G-4.120, Rule Chapter 59A-3, and Rule 6A-6.0361, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Medicaid service.

1.3.2 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.3 General Policy

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.5 Peer Support Groups

A meeting of a group of individuals having similar challenges, to share experiences, offer mutual understanding and support, and learn recovery skills and coping strategies. Peer support groups are based on principles of empowerment, choice, mutual help, and recovery.

1.3.6 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.7 Psychiatric Residential Treatment Facility
A facility, other than a hospital, that provides psychiatric services as described in 42 CFR 441, Subpart D.

1.3.8 Quality Improvement Organization
The vendor contracted with AHCA to monitor the appropriateness, effectiveness, and quality of care provided to Florida Medicaid recipients. The vendor also performs prior authorization of services based on medical necessity determinations.

1.3.9 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.10 Suitability Assessment
A written determination developed in accordance with section 39.407, F.S. as to whether a child or adolescent meets the criteria for placement in a residential treatment center.

1.3.11 Therapeutic Home Assignment
Clinical interventions that allow a recipient to practice acquired skills in an identified discharge setting.

2.0 Eligible Recipients

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the coverage criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary SIPP services who meet the following criteria:

- Are under the age of 21 years with emotional disturbance or serious emotional disturbance otherwise defined in Chapter 394, F.S.
- Require treatment in a psychiatric residential setting due to a primary diagnosis of emotional disturbance or serious emotional disturbance

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

3.0 Eligible Providers

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Directly enrolled in Florida Medicaid if providing services through a fee-for-service arrangement
- Registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Hospitals licensed in accordance with Chapter 395, F.S., and Rule Chapter 59A-3, F.A.C.

- Residential treatment centers for children and adolescents licensed in accordance with Chapter 394, F.S., and Rule Chapter 65E-9, F.A.C., and that:
  - Qualify as a psychiatric residential treatment facility under 42 CFR 483, Subpart G.
  - Comply with 42 CFR 483.374 for attestation requirements and reporting serious occurrences to AHCA.

Providers must be accredited by a nationally recognized accrediting organization such as the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses services that:

- Are determined medically necessary.
- Do not duplicate another provider's service.
- Meet the criteria as specified in this policy.

4.2 Specific Criteria

4.2.1 Pre-admission Assessment Requirements

Recipients in the care and custody of the state must be assessed in accordance with section 39.407(6)(b), F.S.

Recipients not in the care and custody of the state must be assessed by a Florida-licensed psychologist or psychiatrist, with experience or training in childhood disorders. The assessment must result in a report with written findings as required by the Department of Children and Families in Rule 65E-9.008, F.A.C.

4.2.2 Treatment Planning

SIPP services must be supervised by a treatment team consistent with 42 CFR 441, Subpart G. Services include the following:

- An individual plan of care developed and implemented within 14 days after admission in accordance with 42 CFR 441, Subpart G
- Psychiatric or psychological assessment, and diagnosis
- Routine medical and dental treatment
- Clinical and therapy services
- Mandatory family or other caregiver involvement that supports the recipient in meeting treatment goals and returning to the community
- Peer support groups directed toward meeting the recipient's specific treatment goals
- A certified education program provided in accordance with Rule 6A-6.0361, F.A.C.
- Comprehensive discharge (aftercare and follow-up services) planning, developed and implemented in accordance with the SIPP provider's licensure
- Recreational, vocational (for recipients ages 16 and older), and behavior analysis services (when necessary)
- Time out in accordance with 42 CFR 483 (when necessary, regardless of licensure type)
- Seclusion and restraint in accordance with 42 CFR 482 or 42 CFR 483 (when necessary and as appropriate to the provider's licensure type)
- Therapeutic home assignment

5.0 Exclusions

5.1 General Non-Covered Criteria

Services related to this policy are not covered when:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid will not reimburse SIPP services, when the recipient is:

- Receiving any other 24-hour service.
- Eligible as medically needy.

Therapeutic home assignments are not reimbursable when no service has been provided on that day.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

The recipient's clinical record must contain informed consent signed by a parent or legal guardian or a medical affidavit and a court order prior to administering any psychotropic medications to recipients in the care and custody of the state, except as allowed by section 39.407, F.S. Any changes in medication, not covered on the original informed consent order, will require a new order or informed consent.

7.0 Authorization

7.1 General Criteria

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

For recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan. For recipients receiving services through the fee-for-service delivery system, providers should request authorization through the Quality Improvement Organization (QIO). For more information on general authorization submission requirements, please refer to Florida Medicaid's authorization policy.

7.2 Specific Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified.

Providers must obtain authorization from the QIO and must submit the following in addition to any general requirements:

- A current Diagnostic and Statistical Manual of Mental Disorders or International Classification Diagnosis code
- A description of the initial treatment plan relating to the admitting symptoms
- Current symptoms requiring SIPP treatment
- Medication history

- Prior psychiatric inpatient admissions, if applicable
- Documentation that the recipient is mentally competent, has age appropriate cognitive ability, and is sufficiently able to benefit from cognitive-based treatment
- Documentation of the recipient's physical health, as certified by a medical doctor, doctor of osteopathy, registered nurse, physician's assistant, or other professional who has the authority to perform physical examinations of a medical nature
- Prior alternative treatment
- Medical, social, and family histories
- Proposed placement and community-based treatments after discharge
- Suitability Assessment recommendation (for recipients in the custody of the state)

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

Florida Medicaid reimburses the per diem rate for up to 365 days per year for SIPP services excluding the day of discharge, delivered to a recipient who has been certified as meeting the eligibility criteria and when the service is prior authorized.

8.3 Claim Type

Institutional (837I/UB-04)

8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifiers(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C. Providers will be reimbursed for a unit of service for recipients present at the facility at 11:59 p.m., or for recipients on therapeutic home assignments.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.6 Rate

For per diem rates, see http://ahca.myflorida.com/medicaid/Finance/finance/index.shtml.