

# Chapter Five

## Inpatient Hospital Services

### Chapter Overview

**Introduction** This chapter describes covered services, restrictions, and exclusions in the inpatient hospital services category of the North Carolina Medicaid program.

**In This Chapter** This chapter contains:

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## Provision of Services

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**Inpatient Hospital Services** Inpatient hospital services are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients. These must be provided under the direction of either a physician with privileges or a dentist in an institution maintained primarily for treatment and care of patients with disorders other than mental disease.

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**Availability** Medically necessary and nonexperimental inpatient hospital services are available to all eligible Medicaid recipients without limitation on length of stay. Medical necessity is determined as generally accepted North Carolina community practice standards as verified by independent medical consultants. (NCAC T10: 26C.0005).

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**Referral for Medicaid Coverage** Patients who need financial assistance to pay for hospital services may be referred by the hospital business or insurance office to the county DSS in the patient’s county of residence for a determination of eligibility for Medicaid. The patient must consent to the referral.

For the convenience of hospitals, a state referral form, DMA-5020 “Referral for Inpatient Hospital Services,” may be used. This is a turnaround form that is initiated by the hospital and mailed to the county DSS.

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**Filing an Application** Patients, family members, or a patient representative need to go to the county DSS to file an application for Medicaid unless the hospital has an in-house county DSS representative who can take Medicaid applications on-site. The DMA-5020 referral form serves as notice that the patient has been referred and that a bill is owed and may be covered if eligibility is established.

The county DSS is instructed to respond to the hospital’s referral by completing the reverse of the DMA-5020 form within ten working days to notify the hospital of the status of the case.

If the individual has failed to file an application, hospital personnel may wish to contact him and encourage him to apply.

If the county DSS fails to return the DMA-5020, the hospital should call the county DSS and send a duplicate of the original referral annotated, “Duplicate Referral, Please Respond.”

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**Copayment** There is no copayment for hospital inpatient services. In some cases, however, a patient deductible or third party liability may apply. See *Chapter Eight, Reimbursement And Billing* for additional information.

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**Provision of Services, Continued**

**Inpatient Hospital Covered Services**

The Medicaid program will pay the cost of inpatient services that have been determined to be covered by the program and are medically necessary. Examples of covered services (not all inclusive) include:

- bed and board in semiprivate room except when private accommodations are medically necessary or when only private rooms are available
- nursing services and other related services that are ordinarily furnished by the hospital for the care and treatment of inpatients (Medicaid will not pay for the services of a private duty nurse or attendant.)
- use of hospital facilities
- drugs and biologicals for use in the hospital
- supplies, appliances, and equipment for use in the hospital
- other diagnostic or therapeutic items or services not specifically listed but which are ordinarily furnished to inpatients

**Transportation to Nursing Facilities and Adult Care Homes Upon Hospital Discharge**

Ambulance Transport: Ambulance transportation of a recipient from a hospital to a nursing facility or adult care home is covered when medical necessity criteria are met. Hospitals should not discharge patients by ambulance unless it is medically necessary. Medical necessity is when the recipient's condition requires ambulance transportation and any other means of transportation would endanger the recipient's health or life. Ambulance transportation is not considered medically necessary when any other means of transportation can be safely used.

Nonambulance Transport: The family is expected to transport the patient when nonambulance transport is required. This responsibility should always be assigned through hospital discharge planning. When family transportation is not an option, the hospital having physical control of the patient must address the issue as part of the discharge plan. During this process the hospital may use whatever resources are available at the time to arrange for transportation but the responsibility for arranging and assuring transportation ultimately rests with the hospital.

**Noncovered Services**

The following is a non-inclusive list of noncovered services. For an updated list of ICD-9-CM procedure codes that are no longer covered under North Carolina Medicaid, see Appendix D.

- screening mammography under age 35
- treatment and/or testing for infertility
- paternity blood testing
- magnetic resonance angiography
- cosmetic surgery
- experimental or unproved procedures
- telephone, television, newspapers, guests trays
- take-home supplies
- birth certificates, baby bracelets, layettes
- beauty shop, barber shop
- shrouds, morgue boxes

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**Provision of Services, Continued**

**Noncovered Services, (continued)**

- cots
  - sitters
  - private duty nurses
  - medical photography
  - leave days (overnight leave of absence)
  - late discharge for convenience of the patient or physician
  - private accommodations when the conditions listed under Inpatient Hospital Covered Services (above) are not applicable
  - prevocational evaluation
- Note:** Providers should call EDS if they have questions regarding the coverage of any procedures. See Appendix B for telephone numbers.

**Special Restrictions**

**Introduction**

Federal and state laws and regulations dictate strict guidelines for Medicaid reimbursement for sterilizations, abortions, and hysterectomies. The following sections provide detailed instructions for compliance.

**Sterilizations**

**Sterilization Procedures**

Federal regulations mandate that Medicaid reimbursement for elective sterilizations can be made only when the following conditions have been met:

1. The recipient is at least 21 years of age on the date the sterilization consent form is signed.
2. The recipient is not mentally incompetent.
3. The federally mandated Sterilization Consent Form (372-116) must be written in a language that the recipient understands. If an interpreter is used to translate the form to the recipient, the interpreter must sign and date the consent form along with the recipient. The date must match the witness date.
4. The recipient must be advised at least 30 days before the sterilization procedure of the expected benefits of the procedure, the discomforts and risks, alternative methods of family planning, and the steps in the procedure itself.
5. The recipient must be advised that a decision not to be sterilized will not affect his/her entitlements to benefits of any government assistance program.
6. The recipient must have voluntarily requested the procedure and signed a completed DMA 372-116 Sterilization Consent Form.
7. The consent form must be signed at least 30 days prior to the sterilization procedure. The sterilization procedure can be performed **no sooner than the 31st day** from the day the consent form is signed. If the procedure is performed sooner, Medicaid cannot pay for the services. The only exception will be in instances of premature delivery or emergency abdominal surgery. In the case of premature delivery, the informed consent form must be signed at least 30 days before the expected date of delivery. If 30 days has not passed, there must be at least 72 hours between signing of the consent form and the surgery. In the case of emergency abdominal surgery, there must be at least 72 hours between the signing of the informed consent form and the surgery.

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## Sterilizations, Continued

### Sterilization Procedures (continued)

It is most important that the recipient's signature and date, the witnesses' signatures and the date, and, if applicable, the interpreter's signature and date all have the same date. These dates and signatures cannot be accepted if altered, corrected, or added at a later date.

If the recipient name on the claim and the sterilization consent form is different, a signed name change statement that verifies that the recipient on the claim and consent are the same must be included. Acceptable documentation includes a letter from the provider's office or a letter from the DSS in the county in which the recipient is enrolled. The recipient's signature on the statement is not required.

The total responsibility for obtaining the properly completed consent form lies with the operating physician. The consent form must be reviewed by EDS to determine if the procedure meets federal regulations before any claim relating to a sterilization can be paid. EDS must have an approved form on file before payment can be made.

The consent form is effective for 180 days from the date the recipient signs the form. The consent for sterilization cannot be obtained if the recipient to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substances that affect the recipient's state of awareness.

**Note:** Medicaid will not reimburse providers for sterilization reversals. Medicaid will not pay for hysterectomies performed for the purpose of sterilization.

### Sterilization Consent Form

Sterilization consents may be submitted separately from your claim to allow electronic submission of claims.

- Write the recipient's Medicaid ID in the upper right corner of the consent form.
- Verify that all the information on the form is correct
- Mail the consent form to EDS, using appropriate address (see Appendix B). EDS reviews the consent form to ensure it adheres to federally mandated guidelines. The results are entered into the EDS system
- File claims electronically, or
- Mail paper claims without consent form to appropriate address (see Appendix B)
- When denial EOB's for sterilization claims request additional information (e.g., records to verify a procedure code or verification of a date of service), the verification attachments must be submitted with a claim

A sample copy of the sterilization consent form is on the next page. The following abbreviations are acceptable on the form:

BTF = Bilateral tubal fulguration  
 BTS = Bilateral tubal sterilization  
 BTC = Bilateral tubal cauterization  
 BTL = Bilateral tubal ligation

HCFA has also approved the use of the term "tubal banding."

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## **Sterilization Consent Form**

## Sterilization Consent Form Instructions

The following lists the fields for the Federal Consent Form for Sterilization. All fields must be completed except for field 9 (race). If an interpreter is used, fields 10, 11, and 12 must be completed.

1. Person or facility who provided information concerning sterilization
2. Type of sterilization procedure to be performed
3. Recipient date of birth (must be at least 21 years of age when the consent form is signed)
4. Name of recipient as it appears on the Medicaid ID card
5. The full name of the physician scheduled to do the surgery (abbreviations, initials, or “doctor on call” are unacceptable). May use “Physician on call of Jones OB GYN clinic”
6. Type of sterilization procedure to be performed
7. **Recipient’s signature**
8. **Date the consent form was signed (the date of the recipient’s signature must be at least 30 days prior to the date of the sterilization)**
9. Race and ethnicity (not required)
10. Language in which the form was read to the recipient if an interpreter was used
11. **Signature of the interpreter**
12. **Signature date of the interpreter (this date must be the same as the recipient signature date)**
13. Name of recipient
14. Name of sterilization procedure
15. **Signature of person witnessing consent (must be dated see # 16)**
16. **Signature date (this date must be the same as the recipient signature date)**
17. The full name and address of the facility, include street name and number, city, state, and zip code where the consent form was obtained and witnessed
18. Name of recipient
19. Actual date of sterilization
20. Type of sterilization procedure performed
21. Check this box if the delivery was premature (the recipient’s EDC must be provided)
22. Check this box if emergency abdominal surgery was performed
23. Physician signature (legible or printed name below signature. Signature stamp may be used)
24. Date must be on or after the date of service

**Note:** Items in **BOLD** cannot be altered or corrected.

## Abortions

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**Abortion Coverage**

Medicaid covers nontherapeutic and therapeutic abortions. Therapeutic abortion coverage is limited to termination of pregnancy for the following reasons:

1. the woman suffers from "a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed."
2. the pregnancy is the result of rape.
3. the pregnancy is the result of incest.

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**Definition of Nontherapeutic Abortion**

Any termination of pregnancy where there has been no manual or surgical interruption of the pregnancy is considered a nontherapeutic abortion. Missed, incomplete, and spontaneous abortions are examples.

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**Definition of Therapeutic Abortion**

Medicaid considers any termination of pregnancy where fetal heart tones are present at the time of the abortive procedure as a therapeutic abortion.

The termination of pregnancy may be induced medically (prostaglandin suppositories, etc.) or surgically (dilation and curettage, etc.). This includes the delivery of a nonviable (incapable of living outside the uterus ) but live fetus, if labor was augmented by pitocin drip, laminaria suppository, etc.

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## Abortions, Continued

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### Therapeutic Abortion Coverage

Medicaid will cover legal therapeutic abortions under the following circumstances:

1. In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by physician, place the woman in danger of death unless an abortion is performed. (Revised wording required by law.)
    - Medicaid must receive the physician's abortion statement "that the abortion be necessary in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would as certified by physician, place the woman in danger of death unless an abortion is performed." The statement must include the recipient's complete name and address.
    - The medical diagnosis and medical records must support the statement.
    - If the abortion was necessary as stated above, regardless of whether the pregnancy was a result of rape or incest, the diagnosis and medical records must support the medical situation.
    - A minor must have parental consent to an abortion unless a medical emergency exists that so complicates the pregnancy as to require an immediate abortion. See "Legal Guidelines for Minors".
  2. Incest
    - Medicaid must receive the physician's abortion statement that the recipient was a victim of incest. The statement must contain the recipient's complete name and address.
    - The diagnosis code V618 "other specified family circumstances" must be on the claim. The medical record documentation must support this diagnosis and the abortion statement.
    - A minor must have parental consent to an abortion. See "Legal Guidelines for Minors".
  3. Rape
    - Medicaid must receive the physician's abortion statement that the recipient was a victim of rape. The statement must include the recipient's complete name and address.
    - The diagnosis code V715, rape, must be on the claim. The medical record documentation must support this diagnosis and the abortion statement.
    - A minor must have parental consent to an abortion. See "Legal Guidelines for Minors".
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### Special note

In cases of rape or incest state law establishes when abortion is not unlawful.

- To advise, procure, or cause a miscarriage or abortion during the first 20 weeks of a pregnancy when the procedure is performed by a physician licensed to practice medicine in North Carolina in a hospital or clinic certified by the state to be a suitable facility for the performance of abortions.
- To advise, procure, or cause a miscarriage or abortion after the twentieth week of a pregnancy if there is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the woman.

For statistical purposes, the hospital is responsible for providing to the state annual samplings of statistical summary reports.

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**Abortions, Continued**

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**Coding for Therapeutic Abortions**

All therapeutic abortions must be coded to one of the following procedure codes:

- W8206     Legal therapeutic abortion, surgically completed
- W8207     Legal therapeutic abortion, medically completed

Note:     A diagnosis code of 635–635.92, 638–638.9 (Medical records required), must be on the claim.

Septic abortions can be considered either a nontherapeutic abortion or a therapeutic abortion depending on the diagnosis used.

The CPT code 59830, treatment of septic abortion, should be used when billing for a nontherapeutic septic abortion with a nontherapeutic abortion diagnosis. Documentation must be attached.

The CPT code W8206 or W8207 should be used when billing for a therapeutic septic abortion with a therapeutic abortion diagnosis. Documentation must be attached to determine if federal guidelines are met.

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**Legal Guidelines for Minors**

State law mandates parental or judicial consent for an unemancipated minor’s abortion. “Unemancipated minor” or “minor” is defined as any person under the age of 18 who has not been married or has not been emancipated pursuant to Article 56 of Chapter 7A of the General Statutes (N.C. House Bill 481, Chapter 462).

Before an abortion is performed on an unemancipated minor, the consent form must be signed by the minor **and**:

1. A parent with custody of the minor, **or**
2. The legal guardian or legal custodian of the minor, **or**
3. A parent with whom the minor is living, **or**
4. A grandparent with whom the minor has been living for at least six months immediately preceding the date of the minor’s written consent.

The pregnant minor may petition, on her own behalf or by guardian ad litem, the district court judge assigned to the juvenile proceedings in the district court where the minor resides or where she is physically present for a waiver of the parental consent requirement **if**:

1. None of the persons from whom consent must be obtained is available to the physician performing the abortion or the referring physician within a reasonable time or manner, **or**
2. All of the persons from whom consent must be obtained refuse to consent to the performance of an abortion; **or**
3. The minor elects not to seek consent of the person from whom consent is required.

The requirements of parental consent shall not apply when a medical emergency exists that so complicates the pregnancy as to require an immediate abortion.

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**Abortion Statement**

Medicaid must receive the physician’s statement prior to processing any claims related to abortions. The physician must submit the following abortion statement:

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### Abortions, Continued

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#### Abortion Statement

1. Recipient's Name: \_\_\_\_\_
2. Address: \_\_\_\_\_  
\_\_\_\_\_
3. Medicaid Identification Number: \_\_\_\_\_
4. Gestational Age: \_\_\_\_\_

On the basis of my professional judgment, I have performed an abortion on the above-named recipient for the following reason:

5. \_\_\_\_\_ The abortion was necessary due to a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed.
6. \_\_\_\_\_ Based on all the information available to me, I concluded that this pregnancy was the result of an act of rape.
7. \_\_\_\_\_ Based on all the information available to me, I concluded that this pregnancy was the result of an act of incest.

My signature on this statement is an attestation that the requirements were met and documentation is on file.

8. \_\_\_\_\_  
Physician's Name
9. \_\_\_\_\_  
Physician's Signature
10. \_\_\_\_\_  
Date

## Hysterectomies

### Coverage

Hysterectomies are covered when:

1. the recipient has been informed orally and in writing and signs a consent form that states that the procedure will render her permanently incapable of bearing children, and
2. the recipient has a diagnosis that indicates medical necessity for the surgery.

### Hysterectomy Statement Guidelines

Federally mandated regulations require a completed hysterectomy statement before payment can be made for claims. The following three statements are the only ones that Medicaid will process for payment.

Routine hospital consent for surgery forms or statements in any other form will be denied. A sterilization consent form will not be accepted in lieu of the federally mandated hysterectomy statement. The following guidelines also apply:

- if a recipient signs the statement with an “X,” the statement must be witnessed by two people
- when a hysterectomy is performed on a minor, the statement must be signed with the recipient’s name, followed with “by \_\_\_\_\_ (parent or legal guardian’s name).” A witness, other than the parent or guardian, also needs to sign the statement.
- if a hysterectomy is performed on a mentally retarded recipient, the recipient’s name must be on the form, and two witnesses must sign it. (One witness should be the parent or guardian.)

### Hysterectomy Statement Examples

#### Statement One

If the patient signs the hysterectomy statement prior to surgery, the statement is worded as follows:

**I have been informed orally and in writing that a hysterectomy will render me permanently incapable of bearing children.**

Patient’s Signature: \_\_\_\_\_

Patient’s Address: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Witness’s Signature: \_\_\_\_\_

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## Hysterectomies, Continued

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**Hysterectomy  
Statement  
Examples**  
(Continued)

**Statement Two**

If the provider fails to obtain the patient’s statement prior to surgery, the following statement must be used. (This is an exception, not a rule, and will be reviewed as such.)

**Prior to my surgery on date of surgery, I was informed orally and in writing that a hysterectomy will render me permanently incapable of bearing children.**

Patient’s Signature: \_\_\_\_\_

Patient’s Address: \_\_\_\_\_

Date Signed: \_\_\_\_\_ Witness’s Signature: \_\_\_\_\_

**Statement Three**

If the patient is sterile due to age, a congenital disorder, a previous sterilization, or if the hysterectomy was performed on an emergency basis because of life-threatening circumstances, the physician must state in writing which of the specific circumstances existed and include the patient’s name, complete address, physician’s signature, and date. Life-threatening should indicate that the patient is unable to respond to the information pertaining to the acknowledgment agreement. Federal regulations do not recognize metastasis of any kind as life-threatening or an emergency.

**Note:** If the hysterectomy is performed on an emergency basis, Statement #3 is used.

**Submitting  
Consent  
Forms and  
Statements**

Sterilization consent forms and hysterectomy statements submitted separately from the claims (i.e., electronic submissions) must have the recipient’s MID number written in the upper right corner of the consent forms or statements.

## Other Restrictions and Medical Policy

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**Cardiac  
Rehabilitation  
Instructions**

Many hospitals offer a program of instruction to assist the cardiac patient in recovery. These instructions for cardiac rehabilitation are usually provided by members of the physical therapy, dietary, and nursing staff. Medicaid covers these services on an inpatient basis only, and includes them in the appropriate Diagnosis Related Grouping (DRG) reimbursement or per diem rate.

**Routine  
Newborn Care**

Routine newborn care is limited to care while the infant is in the hospital and must be billed on a separate claim form, not the mother’s claim form.

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**Other Restrictions and Medical Policy, Continued**

**Inpatient Hospital Tests**

Payments for inpatient hospital tests are subject to recoupment unless the tests are specifically ordered by the attending physician or other licensed practitioner. Additionally, the physician is responsible for the diagnosis or treatment of a particular recipient’s condition. These tests must be medically necessary, and reimbursement is included in the DRG or per diem rate.

In a teaching situation, a test may initially be ordered by an intern, resident, or medical school student; however, the supervisory physician must certify the medical necessity for the test by countersigning the medical record in a timely manner

**Norplant insertion**

Payment for norplant insertion is made in addition to the DRG payment if the diagnosis code reported is V25.5. Payment is not made for claims qualifying for outlier or other reimbursement methods than DRG.

**Take-Home Supplies**

“Take-home” drugs, medical supplies, equipment, and appliances are not covered, except for small quantities of medical supplies, legend drugs, or insulin needed by the recipient until such time as he or she can reasonably obtain a continuing supply.

**Inpatient Hospital Services Requiring Prior Approval**

**Introduction**

Admitting office personnel must determine if the physician has completed the necessary prior approval (PA) forms before admitting recipients for procedures that require such authorization. The primary surgeon is responsible for obtaining written PA approval from the EDS Prior Approval Unit. This PA number must be on claims submitted by the primary surgeon, assistant surgeon, anesthesiologist, and hospital.

The PA number is granted when medical necessity is justified. The PA gives medical approval only; it does not guarantee payment. The recipient must be eligible for Medicaid on the date the service is rendered to qualify for payment. The individual provider is responsible for obtaining proof of eligibility prior to performing the service.

**Inpatient Hospital Services Requiring Prior Approval**

**This list is not all-inclusive, and Medicaid guidelines can change. Call EDS Prior Approval Unit if you have a question about a particular service.**

- removal of keloids and scars. Include location, description, size, and cause of lesion.
- breast reconstruction after breast cancer
- abrasion of skin for removal of scars, tattoos, or keratoses
- blepharoplasty
- mastectomy for gynecomastia

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## Inpatient Hospital Services Requiring Prior Approval, Continued

**Inpatient  
Hospital  
Services  
Requiring  
Prior  
Approval**  
(Continued)

- electrical stimulation to aid bone healing; percutaneous insertion of electrodes
- rhinoplasty
- donor cardiectomy, with preparation and maintenance of homograft
- reconstructive surgery—photographs may be requested to differentiate between cosmetic and reconstructive surgery. Cosmetic surgery is not considered medically necessary and is, therefore, not covered. Reconstructive surgery may have cosmetic effects, but is performed to enable the patient to function optimally
- sex transformation surgery—approved if (a) the anomaly is discovered prior to age two, or (b) during puberty, if the development of pronounced secondary sex characteristic occur
- breast reduction for hypertrophy—photographs may be requested. Mammoplasties performed for augmentation or prosthetic implants are not covered
- transplants (excluding bone, autologous tendon, skin, kidney and corneal)
- donor cardiectomy-pneumonectomy, with preparation and maintenance of homograft
- bone marrow harvesting for transplantation
- excision/incision of lingual frenum
- frenoplasty
- donor hepatectomy, with preparation and maintenance of homograft
- repair of blepharoptosis
- reduction of overcorrection of ptosis
- correction of lid retraction repair of ectropion
- chemonucleolysis
- implantation of dorsal column stimulators
- cranial-facial reconstruction
- hyperbaric oxygen therapy
- abdominal panniculectomy
- surgery for morbid obesity—stapling, binding, or bypass

**Note: DMA reviews all heart, lung, and liver transplant requests**

## Physician's Preadmission Certification

**Regulations**

Federal regulation 42 CFR 456.60 requires physicians to certify the need for inpatient hospital services for every Medicaid recipient or applicant. The certification must be made by a physician at the time of admission, or if an individual applies for assistance while in a hospital, before a Medicaid claim is submitted.

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**Physician’s Preadmission Certification, Continued**

**Example of Certification of Need**

Federal regulation 42 CFR 456.60 require that certification must appear in the recipient’s medical record at the time of admission as either a handwritten statement or a stamped statement, signed and dated by the physician. The following is an example of a certification of need that would meet the federal requirement:

I certify that inpatient services in a hospital are needed for this patient.

\_\_\_\_\_

Physician \_\_\_\_\_  
Date

**Note:** DMA’s Program Integrity postpayment review will monitor the inclusion of this certification statement in the recipient’s medical record.

**Recertification**

Federal regulation 42 CFR 456.60 requires recertification of need for inpatient acute care at least every 60 days by both general and psychiatric hospitals. A physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician, must sign and date a statement in the patient’s medical record that inpatient acute hospital care is needed.

**Out-of-State Medical Care**

**Emergency Services**

Care rendered for an **emergency** medical condition outside of North Carolina does not require prior approval. An emergency medical condition is one in which the sudden onset of a medical condition, surgical or psychiatric (including emergency labor and delivery), manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient’s health in serious jeopardy
- serious impairment to bodily functions, or
- serious dysfunction of any organ or body part

The provider must indicate that the service performed was a true emergency by using emergency codes on the UB-92 claim form.

**When Emergency Coverage Ends**

As soon as the recipient is stable, he should return to North Carolina. Medicaid will not pay for out-of-state services once the recipient is stable.

**Hospitals Within 40 Miles of NC Borders**

Medical care and services provided within 40 miles of the border of North Carolina in the adjoining states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as medical care and services provided in North Carolina.

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**Out-of-State Medical Care, Continued**

**Hospitals  
Beyond the 40  
Mile Limit**

Medical care and services provided beyond the 40-mile limit will not be covered without prior approval except in the following situations:

- where an emergency arises from an accident or illness
- where the health of the individual would be endangered if the care and services were postponed until return to North Carolina
- where the health of the individual would be endangered if travel were undertaken to return to North Carolina
- a foster child, who is a ward of the state, living in a foster home beyond the 40 mile radius is considered as a foster child living in North Carolina

**Requesting  
Out-of-State  
Services**

To receive services from an out-of-state provider, a North Carolina Medicaid recipient must have prior approval. The following information is needed to complete a request for out-of-state services:

- it must be determined that the procedure cannot be done in North Carolina
- a complete prior approval form with medical history is attached
- all out-of-state requests must first be submitted to the county DSS, involving the social worker assigned to the recipient

The referring or attending physician is responsible for obtaining prior approval from the EDS Prior Approval Unit. See Appendix B for contact numbers.

**Retroactive  
Eligibility**

Retroactive coverage is not granted for out-of-state services unless the recipient becomes eligible after the service is rendered and the county grants retroactive eligibility.

**Retroactive  
Prior  
Approval**

Retroactive prior approval will be considered only in cases of retroactive Medicaid eligibility. If retroactive eligibility is granted, a written prior approval form must be submitted to EDS following all the out-of-state guidelines.

**Transportation**

Prior approval is required for transportation by ground or air ambulance from North Carolina to another state, from one state to another, or from another state back to North Carolina. Prior approval for transportation is separate from prior approval for a medical procedure or treatment done out-of-state. Refer to the Ambulance Provider Manual for instructions on transportation or call the county DSS.

**Follow-Up  
Care**

Providers rendering out-of-state emergency treatment should refer recipients to a North Carolina physician for follow-up care. Certain situations which may require out-of-state follow-up care require prior approval by the out of state provider. The written prior approval request must be made to EDS and the guidelines for other out-of-state services must be followed. See Appendix B for EDS contact numbers.

## Psychiatric Admissions

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**Introduction** North Carolina Medicaid contracts with First Mental Health, Inc. (FMH) to help ensure psychiatric admissions for recipients through age 64 are appropriate. The FMH process includes preadmission review and certification, continued stay (concurrent ) reviews, post discharge reviews, and special team (on-site) reviews.

The FMH approval process is applicable to all psychiatric hospitals and those general hospitals with psychiatric units individually notified by DMA (Attachment D). Certification of length of stay is required. For specific questions refer to the First Mental Health “Provider Manual for North Carolina Psychiatric Utilization Review Services”, or see Appendix B, pre-admission review: First Mental Health, for a contact phone number.

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**Concurrent Review** FMH conducts continuous monitoring and concurrent reviews until discharge for all recipients under the age of 65 receiving in-patient psychiatric care in psychiatric hospitals and the psychiatric units of selected general hospitals. See Appendix B for a contact phone number.

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**Certification of Need** In addition to the FMH approval process, federal regulations require a certification of need (CON) for admission to a psychiatric hospital for Medicaid recipients or applicants under the age of 21 (42 CFR 441.152 and 441.153). This CON must meet all federal requirements, and a copy must be kept in the recipient’s medical record for federal or state audit. The CON form is needed for psychiatric hospitals only. There are no federal CON requirements for the adult population.

If correct procedures for admissions approval and CON are not followed, payments for inpatient hospital services will be denied.

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**Medicaid Status** Under federal regulations, CON procedures vary depending upon the patient’s Medicaid status at the time of admission. The hospital determines this status. If the proper procedures for admission approval are not followed, denial of Medicaid payment will be made as indicated in the information blocks. Current and accurate Medicaid status must be reported to FMH for each recipient.

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## Psychiatric Admissions, Continued

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### Elective Admissions for Medicaid Recipients

The CON for elective admissions is performed by an independent team, FMH at present. For patients under the age of 21 who are Medicaid recipients at the time of admission to a psychiatric hospital, the following procedures apply:

- A. For elective admissions the hospital must:
1. Contact FMH for admission approval on or before the date of admission. Medicaid payment for psychiatric hospitals cannot begin prior to the start date for admission approval and the date the CON is completed.
  2. Medicaid payment for psychiatric units of the notified general hospitals cannot begin prior to the date FMH preadmission approval is completed.
  3. Supply FMH with the recipient's current MID number. The claims payment system at EDS cannot accept an admission approval until the correct MID number is submitted to FMH.
- B. For elective admissions if FMH determines that they can approve the admission, FMH will:
1. Inform the hospital of the approval. The PA number will be computer-generated and faxed to an identified hospital contact person within one working day of the decision.
    - the admission approval is valid for 15 days
    - if the recipient is not admitted within this time frame, the hospital must obtain a new admission approval from FMH and have FMH perform a new CON
  2. FMH (the independent team) must complete the CON if the admission is to a psychiatric hospital and will forward a copy of the CON to the hospital to be maintained in the recipient's medical record.
    - approval for Medicaid payment cannot begin prior to the date the CON is completed for an approved admission
  3. Send the approval information to EDS.
- 

### Emergency Admissions for Medicaid Recipients

- A. For emergency admissions the hospital must:
1. Call FMH for admission approval within 2 working days of the admission.
    - delay in contacting FMH beyond 2 working days will result in denial of admission approval from the date of admission to the date the hospital contacts FMH to initiate admission approval
  2. Supply FMH with the recipient's current and accurate MID number. The claims payment system at EDS cannot accept an admission approval without a valid MID.
  3. In addition to the above, a psychiatric hospital must send FMH the original completed state-approved CON form legibly signed and clearly dated by appropriate interdisciplinary team members (See block).
    - a faxed copy of the CON is not acceptable
    - the hospital must keep a copy of the completed and signed CON in the recipient's medical record
- B. For emergency admissions, FMH will determine if the admission meets the criteria for emergency admissions:
- “Sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person by the individual.”
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**Psychiatric Admissions, Continued**

**Emergency Admissions for Medicaid Recipients**  
(Continued)

1. If the admission does not meet the criteria for emergency admission, FMH treats the admission as an elective admission. For elective admissions of Medicaid recipients, payment to psychiatric hospitals cannot begin prior to the date the CON is completed by FMH. When the patient is a Medicaid recipient on admission, Medicaid payment for psychiatric units of the notified general hospitals cannot begin prior to the date FMH prior approval is completed.
2. If the admission meets the criteria for an emergency admission, FMH can continue the admission approval process as follows:
  - C. For psychiatric hospitals, FMH will review the state-approved CON form submitted by the hospital to verify the signatures of the interdisciplinary team members (see that block) are individually dated within 14 days of the admission. Signatures and dates must be legible for verification.
    1. If both of the signatures are legible and clearly dated within 14 days of admission, FMH can enter the “start date” for admission approval as the admission date, if:
      - the admission is otherwise approvable, and
      - the hospital contacted FMH within 2 working days of admission. If the hospital did not contact FMH within the 2 working days, FMH will enter the “start date” for the admission approval no earlier than the first date the hospital contacted FMH to initiate the admission review
    2. If either of the signatures is dated beyond 14 days of admission, the earliest “start date” for admission approval entered by FMH is the latest date the CON was signed by either team member:
      - if the hospital also contacted FMH within 2 working days after admission (see bullet above for directions), and
      - if the admission is otherwise approvable

**Example:**

Date of admission: March 3, 1998  
 Date hospital called FMH: March 4, 1998  
 First CON signature date: March 13, 1998  
 Second CON signature date: March 20, 1998  
 Earliest “start date” for admission approval:  
 March 20, 1998, if otherwise approvable

Admission approval cannot be given until FMH has received a valid CON.

If FMH can approve the admission, FMH will:

3. Inform the contact at the hospital of the approval decision. A computer-generated prior approval number will be faxed to the hospital within one working day of the decision.
4. Submit admission approval information to EDS

If FMH is unable to approve the admission, they will notify the patient or patient’s guardian by certified mail, return receipt requested. Instructions on the appeal process will be included. Where DSS is the custodian, the notification is sent to the patient’s county DSS office. The hospital, physician, and DMA are notified by surface mail.

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## Psychiatric Admissions, Continued

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### Elective Admissions for Pending Medicaid Applications

The following guidelines must be followed for patients under 21 whose Medicaid was pending at the time of admission or who applied for Medicaid after admission:

- A. The hospital must:
1. Contact FMH for admission approval as soon as the hospital becomes aware of the Medicaid application. The hospital must supply FMH with the applicant's current MID number. This number is assigned at the time the application is taken. FMH cannot complete an admission approval and submit the approval to EDS without the MID number.
  2. Psychiatric hospitals, in addition to other required materials for admission approval, must send to FMH the original completed state-approved CON form legibly signed and clearly dated by appropriate interdisciplinary team members (See block label below). The interdisciplinary team members must certify the three admission criteria were met for the date the hospital is seeking to have Medicaid coverage begin. The hospital must maintain a copy of the completed and signed CON in the patient's record for federal or state audit.
- B. FMH will determine whether admission approval can be given.
1. FMH will verify the dates of application and approval for Medicaid eligibility through DMA.
    - if the patient was a Medicaid recipient at the time of admission, FMH must use the appropriate process for admission approval outlined in the previous section
    - if the patient was not a Medicaid recipient at the time of admission as reported, FMH can enter a "start date" for admission approval as early as the date the hospital is seeking to have Medicaid coverage begin, if the admission is otherwise approvable
  2. For psychiatric hospitals, FMH will review the state-approved CON form submitted by the hospital and will assure that it is legibly completed and signed. The interdisciplinary team members must certify the three admission criteria were met for the date the hospital is seeking to have Medicaid coverage begin.
  3. If FMH determines that they can approve the admission, FMH will:
    - inform the hospital contact of the approval. The PA number will be computer-generated at FMH and faxed to the hospital within one working day of the decision
    - send the approval information to EDS
  4. If FMH is unable to approve the admission, they will notify the patient or patient's guardian of the denial decision by certified mail, return receipt requested. Information on the appeal process will be included in case the provider wishes to contest this decision. Where DSS is the custodian notification is sent to the patient's county DSS office. The hospital, physician, and DMA are notified by surface mail.

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## Psychiatric Admissions, Continued

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### General Information

General information regarding admission approvals for under 65 psychiatric hospital care:

- FMH admission approval is not a guarantee of Medicaid eligibility. It is an approval for admission for necessary inpatient services. The hospital must separately verify the patient's period of eligibility for Medicaid.
- When submitting the request for admission approval, the hospital must provide FMH with the following information at a minimum. It is vital that the person contacting FMH have all this information available at the time of the initial contact:
  - the recipient's current and valid MID number. These are issued and available even on pending applications
  - ◆ recipient's name, date of birth, county of residence, and sex
  - ◆ hospital name, provider number, and (planned) date of admission
  - ◆ DSM IV diagnosis on Axis I through V (diagnoses) applicable for the patient at the time of admission. For requests for retroactive admission approval as allowed above, these diagnoses must be applicable for the date the hospital has requested Medicaid coverage to begin
  - ◆ a description of the initial treatment plan corresponding to the admitting symptoms and diagnoses
  - ◆ precipitating event/current symptoms requiring inpatient treatment
  - ◆ medication history
  - ◆ prior hospitalization
  - ◆ prior alternative treatment
  - ◆ appropriate medical, social and family histories
  - ◆ proposed aftercare placement/community-based treatment
- when the initial call to FMH does not result in an admission approval, the hospital or physician may provide any new or unreported information to FMH at any time up to the date of the denial by FMH. This information may be faxed to FMH. (See Appendix B for phone number.) This may avert the need for a peer-to-peer phone review between FMH and hospital physicians.
- although federal regulations do not require a CON form for general hospitals, the regulations do require admission approval certifying the need for acute care
- admission approval must be secured for all admissions. This includes admission on the same day as a previous discharge at either the same hospital or a different hospital. (This also includes situations where the patient never physically left the hospital, but the hospital record shows a discharge or readmission)

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## Psychiatric Admissions, Continued

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### **CON Inter-disciplinary Team**

Federal regulations require that the interdisciplinary team providing the CON form must include on the team, as 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 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 or who has been certified by the state or by the state psychological association

**and** one of the following:

- a psychiatric social worker
- a registered nurse with specialized training or one year of experience in treating mentally ill individuals
- an occupational therapist who is licensed and has specialized training or one year of experience treating mentally ill individuals
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association

For further details on the composition of the team, refer to 42 CFR 441.156

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### **Out-of-State Psychiatric Hospitals**

Any admission of a recipient under age 65 to an out-of-state psychiatric hospital requires review and approval from FMH. Out-of-state stays in psychiatric hospitals are subject to continued stay and postdischarge reviews by FMH.

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### **FMH Postdischarge Review**

Postdischarge reviews are conducted to ensure medical necessity for the admission and appropriate length of stay. FMH performs postdischarge reviews of a sample of cases designated by the state DMA. The purpose of the review is to identify days of an acute hospital stay that were not medically necessary. The hospital will be required to reimburse payment for any days determined not medically necessary as a result of the postdischarge review. Portions of and/or the entire medical record will be requested.

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### **Special Team Reviews**

FMH may be requested and authorized by the State to perform an onsite special team evaluation. A review may be requested to evaluate the needs of a patient experiencing a long length of stay or to monitor a specific program. The FMH onsite review team includes at a minimum a clinical psychologist and a psychiatric nurse.

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## Psychiatric Admissions, Continued

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**Length of Stay** Effective January 1, 1998, the North Carolina Criteria for Acute Stay in an Inpatient Psychiatric Facility (10 NCAC 26B 0.013) applies for all length of stay reviews.

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**Attachments** Attachment A is the North Carolina Medicaid Criteria for the Admission of Children and Adolescents Under Age 21 to Psychiatric Hospitals or Psychiatric Units of General Hospitals. These criteria are to be used for review of admissions.

Attachment B is the North Carolina state approved CON form to be used by the hospital interdisciplinary team. Photocopies can be made of this form.

Attachment C is the North Carolina Certification of Need form to be completed by FMH for admissions.

Attachment D is a list of hospitals subject to FMH preadmission review.

Attachment E is the North Carolina Criteria For Continued Acute Stay In An Inpatient Psychiatric Facility. **(Effective January 1, 1998).**

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*Continued on next page*

ATTACHMENT A

## North Carolina Medicaid Criteria for the Admission of Children and Adolescents Under Age 21 to Psychiatric Hospitals or Psychiatric Units of General Hospitals

To be approved for admission, the patient must meet criteria I, II, and III.

**Criteria I:** Client meets criteria for one or more DSM-IV diagnosis  
AND

**Criteria II:** At least one or more of the following criteria:  
Client is presently a danger to self (e.g., engages in self-injurious behavior, has a significant suicide potential, or is acutely manic)

*This usually would be indicated by one of the following:*

- Client has made a suicide attempt or serious gesture (e.g., overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on threat, and there is an absence of the appropriate supervision or structure to prevent suicide
- Client manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of the appropriate supervision or structure to prevent suicide
- Client has a history of affective disorder: a) with mood which has fluctuated to the manic phase, or b) has destabilized due to stressors or noncompliance with treatment
- Client is exhibiting self-injurious behavior (cutting oneself, burning oneself) or is threatening same with likelihood of acting on the threat

OR

Client engages in actively violent, aggressive, disruptive behavior or client exhibits homicidal ideation or other symptoms which indicate he/she is a probable danger to others

*This usually would be indicated by one of the following:*

- Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, severe oppositionalism, running away, severely disruptive behaviors at home or school, self-defeating and self-endangering activities, antisocial activity, and other behaviors which may occur in the context of a dysfunctional family and may also include physical, psychological, or sexual abuse
- Client exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocation of fights, gross aggressive over-reactivity to minor irritants, harming animals) or is threatening the same with likelihood of acting on the threat. This behavior should be attributable to the client's specific DSM-IV diagnosis and can be adequately treated only in a hospital setting.

OR

Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the client unmanageable and unable to cooperate in treatment

ATTACHMENT A (Page 2)

*This usually would be indicated by the following:*

- Client has recent onset or aggravated psychotic symptoms (e.g., disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speech, severely impaired judgment) and is resisting treatment or is in need of assessment in a safe and therapeutic setting

OR

Presence of medication needs, or a medical process or condition which is life-threatening (e.g., toxic drug level) or which requires the acute care setting for its treatment

*This usually would be indicated by one of the following:*

- Proposed treatments require close medical observation and monitoring to include, but not limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems
- Client has a severe eating disorder or substance abuse disorder which requires 24 hours-a-day medical observation, supervision, and intervention
- Client has Axis I and/or Axis II diagnosis, with a complicating or interacting Axis III diagnosis, the combination of which requires psychiatric hospitalization in keeping with any one of these criteria, and with the Axis III diagnosis treatable in a psychiatric setting (e.g., diabetes, malignancy, cystic fibrosis)

OR

Need for medication therapy or complex diagnostic evaluation where the client's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication

*This usually would be indicated by one of the following:*

- Client whose diagnosis and clinical picture is unclear and who requires 24 hour clinical observation and assessment by a multidisciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations
- Client is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts, or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs

AND

**Criteria III: To meet federal requirement at 42-CFR 441.152, all of the following must apply:**

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

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ATTACHMENT B

NC Department of Human Resources  
Division of Medical Assistance  
1985 Umstead Drive  
Raleigh, NC 27603

**Certification of Need For Medicaid Inpatient Psychiatric Services For Under Age 21**

Indicate type of admission:

- \_\_\_ Emergency admission of patient who was Medicaid recipient at time of admission.
- \_\_\_ Admission of patient whose Medicaid application was pending at time of admission or who applied for Medicaid after admission.

Recipient \_\_\_\_\_ Hospital \_\_\_\_\_  
 Medicaid ID# \_\_\_\_\_ Provider Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Admission Date \_\_\_\_\_

At the time of admission, the interdisciplinary team certifies the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

\_\_\_\_\_  
Printed Name of Physician Team Member

\_\_\_\_\_  
Signature of Physician Team Member \_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Other Team Member

\_\_\_\_\_  
Signature of Other Team Member \_\_\_\_\_  
Date

\*Dates must be legible.

DMA-3009  
03/92

ATTACHMENT C

N.C. Department of Human Resources  
Division of Medical Assistance  
1985 Umstead Drive  
Raleigh, NC 27603

**Certification of Need By Independent Team  
Psychiatric Preadmission Review**

**PATIENT INFORMATION:**

MID #: \_\_\_\_\_ NAME: \_\_\_\_\_  
LAST FIRST MI

DOB: \_\_\_\_\_ COUNTY OF RESIDENCE: \_\_\_\_\_

FACILITY NAME: \_\_\_\_\_ PLANNED ADMIT DATE: \_\_\_\_\_

**ATTENDING OR REFERRING PHYSICIAN INFORMATION:**

NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

ADDRESS \_\_\_\_\_

**CERTIFICATION:**

I hereby certify the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.
4. I have knowledge of the patient's situation and competence in diagnosis and treatment of mental illness.
5. I do not have an employment or consultant relationship with the admitting facility.

\_\_\_\_\_  
Signature of Physician Team Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Other Team Member

\_\_\_\_\_  
Date

DMA-3009 (A) **THIS FORM IS TO BE USED ONLY BY MEDICAID-APPROVED INDEPENDENT  
TEAM FOR ELECTIVE ADMISSION**

HOSPITAL INTERDISCIPLINARY TEAM MUST USE DMA-3009

*ATTACHMENT D*

**General Acute Care Hospitals Notified by DMA Who Are Subject to  
First Mental Health, Inc. Review for Psychiatric Admissions**

Alamance Regional Medical Center	Pitt County Memorial Hospital
Carolinas Medical Center	Rowan Memorial Hospital
Craven Regional Medical Center	Scotland County Memorial Hospital
Duke University Medical Center	Southeastern Regional Medical Center
Duplin General Hospital	St. Joseph's Hospital
Durham Regional Hospital	Transylvania Community Hospital
Elliott White Springs Memorial, South Carolina	UNC Hospitals
FirstHealth Moore Regional Hospital	Wayne Memorial Hospital
Frye Regional Medical Center	
Gaston Memorial Hospital	
Halifax Memorial Hospital	
High Point Memorial Hospital	
Kings Mountain Hospital	
Nash General Hospital	
New Hanover Regional Medical Center	
North Carolina Baptist Hospital	
Park Ridge Hospital	

## **Psychiatric Hospitals**

### **Behavioral Health Care of Cape Fear Valley health System**

Broughton Hospital

Brynn Marr Hospital

Charter Hospital of Asheville

Charter Hospital of Greensboro

Charter Hospital of Winston-Salem

Cherry Hospital

Dorothea Dix Hospital

### **Holly Hill/Charter Behavioral Health System**

John Umstead Hospital

Julian F. Keith Psychiatric Facility

Wake County Treatment Center

### **Walter B. Jones Alcohol and Drug Abuse Treatment Center**

Wilmington Treatment Center

## ATTACHMENT E

## NC Medicaid Criteria For Continued Acute Stay In an Inpatient Psychiatric Facility

The following criteria apply to individuals under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital. These criteria shall be applied after the initial admission period of up to three days. To qualify for Medicaid coverage for a continuation of an acute stay in an inpatient psychiatric facility, a patient must meet each of the conditions specified in Items (1) through (4) of this Rule. To qualify for Medicaid coverage for continued post-acute stay in an inpatient psychiatric facility a patient must meet all of the conditions specified in Item (5) of this Rule.

- (1) The patient has one of the following:
  - (a) A current DSM-IV, Axis I diagnosis; or
  - (b) A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:
    - (i) Symptoms/behaviors are likely to respond positively to acute inpatient treatment; and
    - (ii) Symptoms/behaviors are not characteristic of patient's baseline functioning; and
    - (iii) Presenting problems are an acute exacerbation of dysfunctional behavior patterns which are recurring and resistive to change.
- (2) Symptoms are not due solely to mental retardation.
- (3) The symptoms of the patient are characterized by:
  - (a) At least one of the following:
    - (i) Endangerment of self or others; or
    - (ii) Behaviors which are grossly bizarre, disruptive, and provocative (e.g. feces smearing, disrobing, pulling out of hair); or
    - (iii) Related to repetitive behavior disorders which present at least five times in a 24 hour period; or
    - (iv) Directly result in an inability to maintain age appropriate roles; and
  - (b) The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.
- (4) The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

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*Continued on next page*

*ATTACHMENT E (Page 2)*

(5) In the event that not all of the requirements specified in Items (1) through (4) of this Rule are met, reimbursement may be provided for patients through the age of 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at the High Risk Intervention Residential High (HRI-R High) rate if the facility and program services are appropriate for the patient's treatment needs and provided that all of the following conditions are met:

(a) The psychiatric facility has made a referral for case management and after care services to the area Mental Health, Developmental Disabilities, Substance Abuse (MH/DD/SA) program which serves the patient's county of eligibility.

(b) The area MH/DD/SA program has found that no appropriate services exist or are accessible within a clinically acceptable waiting time to treat the patient in a community setting.

(c) The area MH/DD/SA program has agreed that the patient has a history of sudden decompensation or significant regression and experiences weakness in his or her environmental support system which are likely to trigger a decompensation or regression. This history must be documented by the patient's attending physician.

(d) The inpatient facility must have a contract to provide HRI-R, High with the area MH/DD/SA program which serves the patient's county of eligibility, or the area program's agent.

(e) The Child and Family Services Section of the Division of Mental Health, Developmental Disabilities, Substance Abuse Services shall approve the use of extended HRI-R, High, based on criteria in (a)-(c) of this Paragraph.

(f) The area MH/DD/SA program shall approve the psychiatric facility for the provision of extended HRI-R High, receive claims from the inpatient facility, and provide reimbursement to the facility in accordance with the terms of its contract.