Elimination of the 254/257—effective July 1, 2014

Updates and Frequently Asked Questions

Updates

- Referrals for Rehabilitative Behavioral Health Services (RBHS)
  - Effective July 1, 2014, the 254 referral form is no longer in use for referrals to RBHS.
  - Referrals may be made among and between private providers enrolled in the SC Medicaid Program and State agencies.
  - Medicaid beneficiaries and /or their families may also self-refer for services.
  - Referrals (provider to provider or self-referred) can be done via phone, email, fax, and hard copy mail. **Note**: All information must be HIPAA compliant.
  - When referrals are made between providers, the referring provider may furnish the receiving provider the assessment, IPOC, list of services to render, and any other clinical documentation.

- Admission Process for Psychiatric Residential Treatment Facilities (PRTFs)
  - Effective July 1, 2014, the 257 referral form is no longer in use for referrals to PRTFs.
  - As is the current practice, admissions to PRTFs will require:
    - Certificate of Need (CON)—please reference the Forms section of the Provider Manual. The CON has been updated effective 7.1.14 with additional information that the signers must certify.
    - The Child and Adolescent Level of Care Utilization System (CALOCUS)
      - The CALOCUS can be completed by a referring state agency as part of admission to public or private PRTFs.
      - The pre-admission CALOCUS must be administered by a qualified clinical professional who is not associated with the receiving facility.
    - KEPRO Prior Authorization (PA)
      - Initial PA will be based on Interqual (initial stay criteria).
      - Initial PA will be for 21 days.
      - If a continued stay is needed, the first continued stay request will require a submission of the facility's individualized plan of care (IPOC) and progress summary submitted to KEPRO no later than the 14th day of stay.
      - Continued stay requests will be evaluated by KEPRO based on , the facility's IPOC, progress summary and adherence to manual service requirements.
      - Continued stays will be a maximum of 30 day in duration per continued stay episode.

- Transition:
  - ✓ All current PAs will be good through their original end date.
  - ✓ PA's that expire on or after July 1, 2014 will be held to the new continued stay request limit of 30 days

- Referring agencies/entities can choose from the list of approved private RBHS/PRTF providers who complete a comprehensive enrollment process and who must be accredited. This list is found at http://www1.scdhhs.gov/search4provider/Default.aspx.

- Private RBHS providers must sign the legally binding enrollment agreement as well as provide annual attestation that all policy requirements will be followed and staff credentialing is current and complete.

- Private PRTF providers must sign the legally binding service contract and are required by CMS to attest to the conditions of participation annually.

- Behavioral Health Quality Assurance auditors will be doing quality evaluations, trainings and consultations to RBHS providers on a scheduled and as-needed basis.

- KEPRO Quality Assurance auditors conducts both desk review and on-site visits of the PRTFs.

- DHEC conducts periodic certification reviews of the PRTFs.

- The list of private PRTF providers will be made available on line at the SCDHHS website soon.

FAQs

RBHS:

- How are referrals made from state agencies to private providers for RBHS services? **The state agency (SA) worker can discuss treatment options with the client. When the client decides which RBHS provider s/he prefers the SA worker can assist the client with making an appointment. Coordination of care should take place between originator of the referral and the provider of the service (including clinical documentation exchange; utilizing appropriate releases of information).**

- Who indicates to the private provider the amount and frequency of RBHS services? **It depends on point of entry. SA as referring agent could indicate suggested services and frequencies. If a self-referral, RBHS provider determines amount and frequency.**

- Who monitors the provision of RBHS services within the parameters provided in the referral? **SCDHHS QA will monitor for medical necessity, appropriateness of treatment and clinical quality of treatment. SCDHHS QA will monitor for service frequencies by provider and beneficiary.**

- Will private providers be required to send clinical notes to the referring state agency in order for the agency to monitor progress? **This is not a current requirement of SCDHHS. This should be negotiated between the referring SA and the private provider.**

- How will the state agency change providers if the client isn't making progress? **There should be collaboration amongst the providers to ensure appropriate service provision. SAs can withdraw the referral; if the client decides to remain with the provider that is the client's choice. SCDHHS QA will be monitoring appropriateness of care.**

- Who will complete the Medical Necessity Statement? **The specific Medical Necessity Form will no longer be required for RBHS. The Diagnostic Assessment or Individualized Plan of Care signed by an LPHA will confirm medical necessity.**

- Is a LMSW considered a LPHA? **Yes (per RBHS manual).**

- Per the RBHS Provider Manual, the RBHS services must be documented in an IPOC or service plan outlining planned frequencies with goals/outcomes/progress. Who will monitor/audit to ensure the RBHS service is being carried out per regulations and is effectively being administered if the referral and service is carried out by a non-state agency? Who gets recouped if service was not carried out per RBHS policy and procedures? **SCDHHS QA will monitor for medical necessity, appropriateness of**

treatment and progress in current treatment. Any determined recoupments would be the responsibility of the provider.

- How will state agencies know if a private practitioner is serving one of our clients if we don't make the referrals? **This should be covered at the initial assessment, follow-up assessments and as needed.**

- What if duplicate referrals for an RBHS service comes from a non-state agency and a state agency at the same time with differing frequencies/goals/outcomes? **This goes back to care coordination among all the providers involved. It behooves all providers to have a clear understanding of who is involved in treating their clients. If there is a designated care coordinator this should not be an issue.**

- How will Therapeutic Foster Care (TFC) providers know what level of TFC the child meets? **Medicaid does not reimburse for TFC but rather the discrete RBHS service, i.e., PRS, Behavior Modification and/or Family Support. Please note that RBHS must be determined medically necessary and individualized per Medicaid beneficiary.**

- What will be required for renewal/service extension? **No changes, still based on IPOC. There should be collaboration amongst the providers to ensure appropriate service provision.**

- If there are revisions to the IPOC does the LPHA have to sign off? **Yes, if the IPOC was used to establish medical necessity.**

- Will we send the Medical Necessity Statement in for the approval process? **There is no PA, so no need to send in the Diagnostic Assessment or IPOC to SCDHHS**

- Do current MN forms expire July 1st? **No. Medical Necessity should be reestablished upon the natural expiration of the 254 form or upon the 90 day review (whichever comes first).**

- Can an LPC-I sign for assessment or IPOC? **Currently an LPC-I is not recognized as an LPHA and cannot confirm medical necessity.**

- If new folks come into the provider on July 1 needing to be served, how much time does the provider have to get the Initial Assessment done? What services can be rendered? When does the clock start? **The provider has 14 calendar days to complete the initial assessment. Services can be rendered upon completion of the initial assessment.**

- How do the providers get all the assessments done prior to July 1? **Providers may complete a diagnostic assessment or follow-up assessment signed by an LPHA to confirm medical necessity.**

- Are LPES able to refer for RBHS? **Yes.**

- How does the provider determine how many units of service is needed? **The type and frequency of services is driven by the client's clinical need as determined by the diagnostic assessment. Service type and intensity must be individualized.**

- When does the current MNS expire? How long will it be good for? **The current MNS is valid until its expiration date.**

- When does the current 254 form expire? **The current 254 form is valid until its expiration date (does not automatically expire on June 30th).**

- Does an RBHS provider still need to put a PA # on the claim form after July 1? **As of July 1, 2014 a PA# is not required to be on the claim.**

- Can an LPHA complete a diagnostic assessment, confirm medical necessity, and provide the RBHS? **Yes, but ensure that services are medically necessary.**

- How would a LIP determine the correct party to bill for claims (i.e., KEPRO or MCO)? **As of April 1, 2012 behavioral health services are covered for beneficiaries enrolled in Medicaid Managed Care Organizations (MCO). If the service is covered by the MCO the provider must request prior authorization and claim reimbursement from the MCO directly. Medicaid fee for service beneficiaries must receive prior authorization from a Quality Improvement Organization (QIO) and reimbursement from Medicaid.**

- Will electronic signatures still be allowed? **Yes. All electronic health records must comply with HIPAA guidelines.**

- When the client becomes Non-Medicaid, how and when will we be notified to process state funding approval? **Nothing has changed: please refer to Section 1.**

- When a client becomes retroactively eligible, how will we recoup our state funding? **Nothing has changed: please refer to Section 1.**

PRTFs:

- What if a CON comes from a non-state agency for a PRTF when the state agency is providing the care coordination and is providing multiple community-based services to stabilize child in a lesser restrictive setting and considers the PRTF an inappropriate LOC? **If the beneficiary is being served by a state agency that agency remains the primary authority for the care of the beneficiary**. **If necessary, SCDHHS has an appeal process. Additionally, the Division of Behavioral Health has a psychiatrist and Medical Director for consultation.**

- If a CON is already established prior to 7.1.14, do I need to complete a new CON? **No, you may continue to use the current CON that has been established. After 7.1.14, if a CON is not established you will need to complete a CON.**

- What requirements have changed within the CON? **The reviewer must certify that prior treatments have not been successful, and comprehensive diagnostic assessment must be completed prior to completing a CON.**

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- Is a new CON required for the continued stay recertification? **No, a CON is not required every 90 days. Please refer to your Psychiatric Hospital Services Policy Manual for policy requirements.**

- Does a copy of the CON need to be submitted to KePro? **Yes, a copy of the CON should be a part of the package submitted to KePro.**

- If the state agency is referring to PRTF would they now be responsible for ensuring the CALOCUS is completed? **Yes.**

- Can the CALOCUS be done over the phone? **The CALOCUS must be done in a face to face meeting with the beneficiary.**

- If a private provider also works for a state agency may they carry out CALOCUS assessments independently for clients with no state agency involvement? **Yes, provided they have no association with the receiving facility. This includes but is not limited to:**
  - **No organizational affiliations (e.g. sharing a parent company)**

- **No personal affiliations (e.g. relatives or familial relationships)**
- **No financial affiliations (e.g. the receiving facility makes referrals to the clinician's business or practice)**

- How will the length of stay be determined ongoing and how will that be coordinated with all the other components of the recipient's life such as family, school, clinical services in the community, etc. if the original referral was from a non-state entity that does not participate in the entire service planning for a child (e.g. a pediatrician or the United Way)? **The initial length of stay will be limited to 21 days. Subsequent stays will be limited to 30 days per continued stay episode. If the beneficiary is being served by a state agency that agency remains an active participant in the facility's treatment and discharge planning.**

- How do we incentivize providers to attend meetings? **At this time there is not a mechanism of reimbursement for outpatient providers to attend SPD meetings. However, state agency providers can bill TCM up to 180 days prior to discharge for TCM related to discharge planning.**

- What happens if the approved 21 day stay by KEPRO expires before the client can be placed due to bed availability? **The 21 day approval begins upon admission to the PRTF.**

- How will this process relate to the new system of care? **It will support the new system of care since there will be increased freedom of choice and a designated Care Coordinator for children served by the Palmetto Coordinated System of Care (PCSC).**

- What effect will this have on the ability to coordinate wraparound services with children while they are in placement? **Current guidelines on billing for MTCM within 180 days prior to discharge remain in place. The child-serving state agency remains an active participant in the facility's treatment and discharge planning.**

- If the outpatient provider's treatment plan expires before the child is discharged from the PRTF, would you still meet with the family for SPD and have the IPOC signed? **The IPOC may expire since no services are being delivered by the outpatient provider; the outpatient provider should document the circumstances in the 90 day progress summary until child is discharged from either the PRTF or the outpatient treatment provider. The outpatient provider remains an active participant in the care of child.**

- What if the outpatient provider closes the case while the child is in the PRTF and the child is ready for discharge? **Child-serving state agencies should remain active in the care of a child in a PRTF. If it happens that this does not take place, PRTFs can get permission from parent/guardian to contact**

SCDHHS regarding a Medicaid Targeted Case Manager who can assist with treatment and discharge planning.

- If beneficiary is transitioning to lower level of care from Inpatient to PRTF at the same provider entity, who does the CALOCUS? **If the child is being treated by a state agency, that agency can administer the CALOCUS. Otherwise, an independent CALOCUS provider would need to complete the assessment.**

- If a beneficiary transfers from one PRTF to another PRTF, does the existing CON and CALOCUS hold? Is it still good? **The existing CON and CALOCUS would cover an administrative transfer; if the transfer is clinically indicated a new CON and CALOCUS should be administered. An independent CALOCUS provider would need to complete the assessment.**

- In the event there is a disagreement between the admitting provider and the provider doing the CALOCUS – how is this handled? **Given that the child has not been approved for admission, the PRTF would not have input into the decision.**

- In the event there is a disagreement between the referring provider and the provider doing the CALOCUS – **how is this handled? SCDHHS has an appeal process. Additionally, the agency's Medical Director and consulting psychiatrists are available.**

- Logistically, how does the admitting provider get the information/request to KePRO for continued stay after the first 14 day approval? **The initial stay has been extended to 21 days. Plan of Care and Progress Summary are due to KePro on the 14th day; Kepro will respond between two and four days.**

- Is the referring party responsible for the CALOCUS? **If the referring party is a state agency they may complete the CALOCUS. If a non-stat agency is the referring party an independent CALOCUS provider would need to complete the assessment.**

- How do you pay for CALOCUS? **If the CALOCUS administrator is a Medicaid provider they may bill for an assessment or follow-up assessment.**

- Will the annual CALOCUS need to be done by someone external to the facility? **Yes.**

RBHS and PRTFs:

- Do state agencies tell SCDHHS what services are needed and SCDHHS finds a provider? **State agencies will continue to be able to make referrals; their opportunities to do so will be expanded because they will not be responsible for covering the state match. As needed, PRTFs can contact SCDHHS for**

referral to a Targeted Case Management Provider, which includes freedom of choice by the beneficiary/guardian.

- Will SCDHHS create a database for us to have access to request a service? **There is a list of all private RBHS providers on the SCDHHS web site. The list of PRTF providers will be added to the SCDHHS website.**

- How will service changes be processed (e.g., modifier change, increased units, etc.)? **There are no planned service changes associated with the elimination of the 254/257 referrals.**

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