Statement of Work:
Psychiatric Inpatient Services

Target Geographical Area for Implementation:

☐ Arenac County ☐ Bay County ☐ Other:

Consumer Populations to be Served:

☐ Adults with Serious Mental Illnesses
☐ Children with Serious Emotional Disturbances
☐ Adults and/or Children with Developmental Disabilities
☐ Other:
☐ Persons with Substance Use Disorders
☐ Other:

Services to be Provided:

Provider is engaged to render the Services listed and defined below to the consumer populations in the geographic areas identified herein.

Service Definition Number	Service Title	HCPCS Code	Unit Type	Estimated Volume	Unit Rate	Estimated Total Value
1	Inpatient day – all inclusive	0100	Day			
2	Inpatient day	01XX	Day			
3	Physician services (list separate)	992XX	Event			
Estimated Total Annual Contract Value:						

Service Definitions:

Inpatient psychiatric care may be used to treat a mentally ill person who requires care in a 24-hour medically structured and supervised facility. The Severity of Illness (SI)/Intensity of Service (IS) criteria for admission are based upon the assumption that the recipient is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that either individual or collectively are of such severity that treatment in an alternative setting would be unsafe or ineffective. Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

Exceptions: N/A

Other Conditions:

Hospitals providing inpatient psychiatric services must obtain authorization and certification of the need for admission and continuing stay from BABH. A BABH reviewer determines authorization and certification by applying criteria outlined in the Michigan Department of Health and Human Services Medicaid Provider Manual.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the Michigan Department of Health and Human Services Medicaid Provider Manual. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that coexist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and BABH must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

CONTINUING STAY CRITERIA: ADULTS, ADOLESCENTS AND CHILDREN

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Continued Stay Reviews will be conducted by the Provider calling the BABH Access Center at 1-800-448-5495.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services. Discharge documentation shall include: Initial H&P, Discharge Summary, Discharge Instructions, copies of laboratory results, Social Work Assessment, List of Medications, and verification of Medicaid Application (when applicable)….

Discharge planning should be coordinated by the Provider with the BABH Hospital Liaison, Karen Heinrich at 989-895-2331.

A.1 Provider Specific Services Requirements.

In addition to the duties and obligations set forth in this Agreement, Provider shall comply with the following specific requirements for Services rendered by **Psychiatric Inpatient Providers**:

A.1.1 Provider agrees to maintain current licensure as an Inpatient Facility and Provider agrees to follow the credentialing procedures of its accreditation organization.

A.1.2 Provider will comply with the MDHHS/CMHSP Contract attachment C6.3.2.3A Continuing Education Requirements for Recipient Rights Staff Technical Advisory

A.2 Performance Requirements and Indicators.

A.2.1 Primary Healthcare Integration:

The Provider agrees to coordinate service delivery with the recipients' health care providers, including each recipient's primary health care provider. Providers are responsible for obtaining recipient consent to release and/or exchange information with the recipient's primary health care provider, or other providers, an with that consent, agrees to inform the primary health care provider of the initiation of services, to engage in discussion with the primary health care provider of any significant change in the course of treatment or care, including medication changes, and to integrate into the Providers' treatment plan input received from the primary care physician.

A.2.2 Consumer Satisfaction:

A.2.2.1 All CMHSP-sponsored consumers will be requested to participate in a standardized consumer satisfaction process that is adopted by the Provider.

A.2.2.2 The results of the consumer satisfaction measurement process will be available to BABH at least annually, or per the time frame specified in provider policies or procedures pertaining to consumer satisfaction reporting.

A.2.4 Billing and Claims:

a) Provider is encouraged to submit claims using the online billing module available to BABHA providers.
b) If submitting paper claims, at least 90% of submitted claims will be accurate for purposes of immediate processing and reimbursement.
c) All Coordination of Benefits (COB) claims shall be submitted using paper claims with a copy of the Explanation of Benefits (EOB) from the primary insurance(s) attached.
d) Standard practices shall be to submit claims as soon as practical after the delivery of service. All claims must be submitted within 365 days of the delivery of service.

A.3 Other Performance Requirements and Indicators:

A.3.1. The Provider agrees that all clinical documentation supporting the delivery of service will be completed within 24 hours of the actual provision of care. The Provider agrees to forward all appropriate clinical documentation necessary for continuity of care as soon as it's available but no later than 10 days within the request from BABHA.

A.3.2. All initial psychiatric assessments regarding Board-sponsored consumers will be completed within 48 hours of the admission.

A.3.3. All psychiatric assessments and subsequent follow-up care services will include clinical documentation in the medical record supporting provision of each service on the appropriate dates.

A.3.4. All Board-sponsored consumers will be requested to participate in a standardized customer satisfaction instrument adopted by the provider organization; at least 80% of respondents will report overall satisfaction with the provider services.

A.3.5. All Board-sponsored consumers who smoke will be encouraged to quit smoking.

A.3.6. All Board-sponsored consumers will be informed that they might need to be on antidepressant medication for at least six months to reduce the risk of relapse.

A.3.7. The average length of stay for Board-sponsored consumers will not exceed 10 calendar days from admission to discharge.

A.3.8. The average recidivism rate for Board-sponsored consumers will not exceed 15% readmission to a psychiatric hospital within 30 days.

A.3.9. All claims submitted for services contained in this contract will be forwarded to the Board 90 days of the delivery of service, or within 90 days of receipt of the EOB from the primary insurance..

A.3.10. At least 90% of submitted claims to the board will be accurate for purpose of immediate processing and reimbursement.