

PRIOR AUTHORIZATION CERTIFICATION: Inpatient Psychiatric Admissions

A Presentation for Providers

OAC 5160-2-40 - (D)(1)(a)

A “psychiatric admission” is an admission of an individual to a hospital with a primary diagnosis of mental illness and not a medical or surgical admission. A discharge from a medical/surgical unit and an admission to a distinct part psychiatric unit within the same facility is considered to be a psychiatric admission and is subject to pre-certification.

OAC 5160-2-40 - (D)(1)(b)

An “emergency psychiatric admission” is an admission where the attending psychiatrist believes that there is a likelihood of serious harm to the patient or others and that the patient requires both intervention and a protective environment immediately.

OAC 5160-2-40 - (D)(2)

All psychiatric admissions for individuals who are Medicaid eligible at the time of the admission must be certified by the reviewing agency (ODM or its contractual designee) prior to an admission to a hospital or within two (2) business days of the admission.

OAC 5130-2-40 - (D)(3)

The provider must request pre-certification for a psychiatric admission by contacting the reviewing agency. The reviewing agency is to make a decision on a pre-certification request within three working days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice.

OAC 5160-2-40 - (G)(1)

A certification that an inpatient stay is necessary for the provision of **care** and/or a procedure is medically necessary does not guarantee payment for that service. The individual must be a Medicaid recipient at the time the service is rendered and the service must be a covered service.

Medicare Primary

If a recipient has Medicare primary at the time of admission, providers do not need to request precertification for inpatient psychiatric admissions.

- If the Medicare benefit exhausts and the provider wishes to bill Medicaid, the case must be entered into MITS for retrospective review. The MITS eligibility screenshot must be uploaded into the MITS case. In the event the MITS screenshot is not available, date stamped documentation from the medical record that Medicaid eligibility AND Medicare benefits were checked within two (2) business days of admission must be uploaded into MITS. In this instance, the Permedion precertification form is not required. This also applies to QMB/QMB Plus and My Care Ohio recipients.

- Recipients in Managed Care Plans (MCP) should seek authorization from the MCP. Exception: If the provider is a freestanding psychiatric facility, precertification request must also be reviewed by Permedion via MITS.

Inpatient Precertification Form

1. Provider accesses Precertification form from Permedion website: hmspermedion.com
2. Click on the orange tab that reads, "Contract Information."
3. Click on "Ohio Medicaid: Mental Health."
4. Click on "Precertification Form: Inpatient Psychiatric Precertification Requests."
5. Provider completes Precertification Form and uploads it to MITS with any additional supporting information.

Documentation

- Permedion does not know the recipient and so relies solely upon provider documentation to support medical necessity and the appropriateness for inpatient psychiatric treatment.
- An adequate amount of information is needed in order to make determinations. Providers must provide complete, concise and pertinent clinical information to support medical necessity.

Two types of denials

- Medical necessity denial: A denial determined by physician review in which the patient does not meet medical necessity criteria as set forth in the Ohio Administrative Code.
- Technical denial: a denial due to a process not being properly followed (i.e. lack of precert, late precert or appeal).

Appeals: Medical necessity denials

The request for appeal must be received in writing within **60 calendar days** from the date on the denial letter.

- The request for appeal must include:
 - Cover letter explaining the nature of the request
 - Copy of the denial letter
 - Entire medical record (incomplete records will delay the appeal process and may result in late submission)

Appeals: Technical denial

The request for appeal for technical denials must be received in writing within **30 calendar days** from the date of the denial letter.

- The request for appeal must include:
 - Cover letter explaining the nature of the request
 - Copy of the denial letter.
 - Documentation to support the reason for the appeal

NOTE: Do not send the entire medical record for a technical denial appeal

Post-payment reviews

- The provider has 30 calendar days to submit an entire medical record for post-payment review upon written request from Permedion.
- Post-payment reviews are reviewed for medical necessity and quality.
- Determinations are for medical necessity only and rendered within 30 calendar days of receiving the medical record.
- Any denials are subject to the appropriate appeal process.
- The provider will receive a Findings Report for each medical record that contains areas of documentation that may not meet the Ohio Administrative Code (denials are not based on these areas of documentation).

Post-payment reviews with on-site visit

- Each facility is visited at least once every three (3) years.
- Provider will receive a medical record request and have 30 calendar days to submit to Permedion.
- Each medical record is reviewed by an RN, LISW and psychiatrist.
- The provider will be sent a Findings Report.
- All medical record reviews are subjected to medical record denials in which the appeals process applies.
- The provider contact will be notified by Permedion's clinical lead as to the date/time of the visit.
- Purpose of the visit: to discuss the Findings Report and educate staff on how to meet the Ohio Administrative Codes.
- Who should attend the visit conference? Social workers, nurses, utilization reviewers, managers, physicians (optional).

Recommendations

- Permedion recommends that you frequently check Permedion's website hmspermedion.com for updates and new information regarding inpatient precertification, appeals and community psychiatric supportive treatment services (CPST).
- For questions, please contact the nurse reviewer line at 855.974.5393.