Guidelines for Psychiatric Continued Stays and Admissions

Managed care organizations are responsible for all acute psychiatric admissions to a general care, stand-alone psychiatric or specialty care hospital. This includes admissions directly from a certified screening center. Acute care admissions are required for individuals presenting with unstable behavior requiring immediate professional intervention to monitor and diagnose, adjust and stabilize medications and develop a treatment plan beyond the acute episode of care. Acute care admissions from an emergency room or certified crisis center do not require prior authorization. However, admissions are subject to clinical review to determine medical necessity.

Rationale for an acute care admission include, but are not limited to:

- interventions to prevent self-harm such as self-mutilation, significant and severe risk taking or suicide attempt or ideation;
- interventions to prevent the harming of others such as homicidal ideation or assaultive behavior;
- medical management and adjustment of psychotropic medications when adjustment cannot be safely completed in an outpatient setting;
- assessment and treatment of an acute onset or exacerbation of psychotic symptoms such as command hallucinations prompting injury to self or others, flight of ideas, disordered or bizarre thinking, disorientation accompanied with severe agitation, severe psychomotor agitation or retardation, paranoia, grandiosity, or delusions of such severity as to endanger the welfare of the individual or others;
- assessment and treatment of severe depression with feelings of hopelessness or helplessness interfering with an individual's ability to complete activity of daily living and to maintain adequate nutrition;
- medical management of unpredictable and uncontrollable destructive behavior;
- when efforts to manage an individual's symptoms at a lower level of care were unsuccessful and/or resulted in an acute escalation of behavioral symptoms;
- Tapering of medication where previous attempts have resulted in an acute escalation of behavioral symptoms severe enough to meet inpatient admission criteria.

Admissions are not considered medically necessary when:

- the individual suffers from severe and persistent mental illness and the current episode is not an acute exacerbation of that illness;
- The individual can be safely maintained and effectively treated at a less intensive level of care;
- The individual is mentally stable and the primary reason for admission is social (homeless, family conflict, etc.)
- Symptoms are the result of a medical condition which should be treated in a medical-surgical setting.

Individuals shall require an acute level of care for as long as the individual continues with the behavioral and emotional symptoms and treatment needs initially requiring inpatient admission.

Treatment interventions shall continue to be consistent with the treatment plan and pharmacological treatment continues to need monitoring and/or adjustment. Active, individualized discharge planning shall be documented indicating anticipated post discharge care needs and coordination of care with those providers when appropriate. In situations where the Medicaid managed care organization is not contractually responsible for post discharge care, they are expected to actively participate in the discharge planning process to the extent possible. For those individuals with mental health coverage under their Medicaid managed care plan, the plan should be an active participant in the discharge planning and supportive of appropriate, available discharge options.

If a safe and appropriate discharge is available, the individual is expected to be discharged to the community for continued care. Primary responsibility for discharge planning continues to belong to the provider. However, the plan is responsible to participate to the extent possible and to fully understand the discharge plan and any barriers identified. If the individual requires connection to new services post discharge, the provider shall assume responsibility for compiling a list of available resources and should share that list with the individual, as well as any person or entity (case manager, group home, family member) acting on the individual's behalf and assisting with arrangement of these services. If the individual is being discharged to another level of care, the provider shall assume responsibility for connection of the individual with the new provider. If the plan is contractually responsible for coverage of the post discharge services, the plan should facilitate the discharge by sharing a list of "in plan providers" and shall provide authorization of those services when required.

When an individual no longer meets an acute level of care but requires continued hospitalization secondary to discharge or placement issues, an administrative payment may be required as long as skilled intervention continues. Examples of a less than an acute level of care appropriate for coverage at an administrative rate include, but are not limited to:

- Thoughts of serious harm to one's self or others is no longer considered an acute risk and is manageable at a lower level of care;
- the individual is able to perform activities of daily living with prompting and is manageable at a lower level of care;
- the need for medication monitoring and therapy continues, but can be met at a lower level of care;
- medical comorbidity is manageable at a lower level of care

If the individual has unmet discharge planning needs and cannot be safely discharged to an alternate level of care, an administrative level of reimbursement shall be offered. For those contracted utilizing a DRG payment, the administrative rate shall be no less than 50% of the calculated per diem rate based on the State's base Fee for Service (FFS) DRG payment. For those providers contracted under a per diem payment arrangement, the administrative rate shall be 50% of the Facility's State FFS per diem rate. There shall be no limits applied to the number of days the administrative rate may be paid. The appropriateness and efficacy of administrative days, including the rate, will be closely monitored by the State on an ongoing basis.

The plan should fully understand any rationale for a delayed discharge and apply that knowledge in coverage determinations. For those individuals experiencing a delay in discharge, an administrative level of care allows reimbursement for continued treatment and therapy by a multidisciplinary team in an acute care setting but at a less than acute level of care. Care is intended to continue services designed to prevent deterioration of the individual's condition while awaiting discharge to an alternate setting. Services that are provided must be within current medical standards and must continue to address the individual's symptoms, diagnoses and functional impairment. Services are expected to restore or maintain the individual's baseline level of function or to prevent deterioration of the individual's disorder/condition. Individuals shall be maintained at an administrative or SNF level of care for as long as the individual is receiving services designed to treat, maintain or prevent deterioration of the individual's condition and the individual cannot be safely discharged to an alternate level of care in the community.

Discharge Scenarios

Appropriate for discharge but awaiting placement with appropriate supports	Option of administrative rate is dependent on the care provided and reason(s) for delays
Awaiting placement in Long Term Psych (State or County psychiatric facility)	Acute rate
Court ordered but not meeting criteria	Acute rate
Child with DCP&P placement issues	SNF rate shall be paid after the determination is made that the individual no longer meets an acute level of care but is awaiting placement through DCP&P. This payment does not require an initial clinically acute day.
Pending nursing facility placement	SNF rate consistent with NJAC 10:52-1.9

General Requirements

- Notification of admission is required within 24 hours. Admission and ongoing stay is subject to subsequent authorization.
- At least one acute inpatient hospital day (24 hours) must immediately precede an administrative day. No direct admissions into administrative level of care (exception for DCP&P involved children).
- Hospitals are required to participate and cooperate with the MCO in comprehensive, appropriate discharge planning efforts, including documentation and timely submission of discharge planning information.
- Members, their families and their physicians are expected to cooperate with the MCO in discharge planning. Administrative days may not be covered if placement is refused in an appropriate and available alternative setting.
- Administrative days are for uncontrollable delays in discharge and are not approved for the convenience of the patient, their family or the hospital and their staff.

Calculated per diem based on base State FFS DRG rates:

DRG	Administrative rate
424	$616.60
425	$415.29
426	$357.30
427	$368.15
428	$408.98
429	$652.87
430	$405.11
431	$347.80
432	$547.22
743	$341.94
744	$305.86
745	$338.86
746	$339.67
747	$560.07
748	$389.91
749	$481.17
750	$553.99
751	$382.82

The rates for hospitals paid on a **per diem basis** for acute psychiatric care are posted on NJMMIS.com