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Vermont Medicaid
Mental Health Inpatient and Detoxification Services Supplement

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Table of Contents

Section 1 Introduction

This manual is designed as a supplement to and does not replace the Vermont Medicaid General Provider Manual which can be found at https://vtmedicaid.com/#/manuals.

This supplement describes processes to be followed by admitting facilities, the Department of Vermont Health Access (DVHA) and the Department of Mental Health (DMH) when Vermont Medicaid primary members are hospitalized for mental health or detoxification services. For information regarding the Applied Behavioral Analysis benefit please refer to the Applied Behavior Analysis Supplement, https://vtmedicaid.com/#/manuals.

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Medicaid Rule, 4.104, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition and must conform to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition.

1.1 Acute Inpatient Mental Health and Detoxification Treatment

Acute inpatient mental health treatment is the most intensive level of psychiatric care. Treatment is provided in a 24-hour secure and protected, medically staffed environment with a multimodal approach. The goal of the inpatient stay is to stabilize the individual who is experiencing an acute psychiatric condition with a relatively sudden onset, severe course, or a marked decompensation due to a more chronic condition in order to transfer the person to a less restrictive level of care.

"Detoxification" means the planned withdrawal of an individual from a state of acute or chronic intoxication, under qualified supervision and with or without the use of medication. Detoxification is monitoring and management of the physical and psychological effects of withdrawal, for the purpose of assuring safe and rapid return of the individual to normal bodily and mental function. (Vermont Statutes, Title 33 §702). Inpatient detoxification refers to the medically managed treatment regimen requiring the full services of an acute care hospital to support the withdrawal of the addictive substance.

1.2 Utilization Management

The DVHA and the DMH clinicians utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. The DVHA and the DMH conduct numerous utilization management and review activities to ensure quality services are being provided to members while increasing the likelihood of desired health outcomes. The DVHA and the DMH monitor if services being provided are consistent with prevailing professionally recognized standards of medical practice. DVHA conducts these measures to ensure appropriate, effective, and efficient use of the program.

Approved criteria for the services included in this supplement include the following:

- DVHA Clinical Guidelines: https://dvha.vermont.gov/providers/clinical-practice-guidelines
- Vermont State Medicaid Rules: https://humanservices.vermont.gov/rules-policies
- Change Healthcare, LLC InterQual® CriteriaChange Healthcare, LLC InterQual® Guidelines are available to providers on the Vermont Medicaid website by navigating to the Transactions Menu, https://vtmedicaid.com/secure/logon.do. After log-in, look for the link Change Healthcare Smart Sheets in Secure Options drop-down menu. InterQual® Guidelines are updated annually.

The goals for the utilization management system are as follows:

- Inpatient care is provided only as long as necessary for safety and/or other acute needs.
- There are standardized criteria for admission, continued stay, and discharge throughout the system of care.
- Care is continuous between the ongoing community treatment teams and episodes of inpatient or care. The hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and his/her family, beginning within 24 hours of admission.
- Resources of the public system are effectively and efficiently used.
- The care management system will ensure access to effective, appropriate, recovery-based services that promote health, wellness, resiliency, and successful integration into the community.

1.3 Prior Authorization

Prior authorization (PA) is a process used to ensure the appropriate use of health care services. The goal of PA is to ensure that the proposed health service, item or procedure meets the medical necessity criteria; that all appropriate, less expensive and/or less restrictive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. See the Vermont Medicaid General Billing and Forms Manual, Section 2, Prior Authorization for Medical Services for more information. https://vtmedicaid.com/#/manuals

1.4 Concurrent Review

Notification to the DVHA utilization reviewer (UR) within 24 business hours of the admission begins the concurrent review process. The provider is responsible for faxing the clinical documentation from the medical record to demonstrate the need for inpatient level of care to the DVHA for review. The UR will use the documentation provided to assess the member's acuity level using the InterQual® tool. The UR will assign authorization, typically in increments of 1 to 7 days.

Notification of the authorization decision will be provided within 24 business hours of receipt of the necessary clinical information required to complete a review.

It is the provider's responsibility to contact the UR on or before the last covered day to request authorization for **a specific number** of additional inpatient days. Notification via fax must include additional clinical documentation to support the need for continued inpatient level of care. Failure to notify the UR (and fax the supporting documentation supporting additional inpatient days) results in the end of authorization. **Should the situation arise outside of regular business hours in which the clinical presentation of a member changes and the provider believes additional authorized days are required, the provider must make the request for authorization and submit the clinical documentation via fax no later than 12:00 pm (noon) on the next business day.** Every effort will be made to render an authorization decision by the end of the business day.

Upon determination that clinical criteria for inpatient level of care are no longer met, the UR will inform the provider of the last covered day or the change in authorization status. If the provider disagrees with the decision, they may request a Reconsideration Review, please refer to Section 7 Reconsideration Process below.

The DVHA expects that members will discharge with scheduled follow-up appointments with mental health treatment providers within 7 days of the discharge date. The discharge plan will contain documentation of these appointments or if applicable, documentation of the member's refusal of appointments. The discharge plan will be faxed to the UR and upon receipt, a final payment will be authorized by the DVHA.

In order for the DVHA to make authorization determinations, the provider is responsible for:

- Notifying the DVHA of an inpatient admission within 24 business hours and providing via fax the clinical documentation from the medical record justifying the inpatient admission, and, if requesting additional inpatient days, clinical justification for continued stay. The clinical information provided must be sufficient to complete the review utilizing the InterQual ® tool.
- Initiating aftercare planning at the time of admission, including but not limited to, contact with family or guardian, primary care provider (PCP), all relevant outpatient behavioral health treatment providers, and if required, the appropriate state liaison from the DMH, the Department of Disability, Aging and Independent Living (DAIL), the Department for Children and Families (DCF), the Vermont Department of Health (VDH), Vermont Department of Health, Division of Substance Use Programs (DSU), and/or the Local Educational Agency (LEA). Discharge planning must include frequent coordination with team members, specific recommendations for aftercare **and identification of expected discharge date upon admission**.
- Documentation of the member's (or guardian's) refusal to sign releases for team members not covered by HIPPA.
- Daily active and ongoing discharge planning with all treatment team members. The discharge planning should be directly linked to the symptoms/behaviors that led to the admission and should identify appropriate post-hospitalization treatment and recovery resources.
- Prompt notification to the DVHA UR of barriers to active discharge planning including difficulties reaching the treatment team members. The DVHA expects that the provider will proactively communicate with the appropriate Departmental liaison (DCF, DMH, DAIL and/or VDH-DSU) to gain support in initiating and engaging in active discharge planning with the outpatient treatment providers.
- Contacting the UR on or before the last covered day to request authorization for a specific number of additional inpatient days. The provider is expected at this time to provide by fax the pertinent clinical information from the medical record justifying the need for continued inpatient level of care; including evidence that a continued inpatient stay can be reasonably expected to bring about significant improvement in the presenting psychiatric condition that led to inpatient hospitalization.

1.5 Retrospective Authorization Requests

It is the responsibility of the provider to notify the DVHA or the DMH of an inpatient admission and to initiate and complete the concurrent review process. As such, the DVHA and the DMH are under no obligation to perform retrospective authorization reviews due to lack of notification of admission or failure to request additional authorized days and provide the required clinical documentation via fax prior to the end of the previous authorization period (last covered day). **Requests for retrospective authorizations due to lack of notification or failure to request additional authorized days by the provider are considered solely at the discretion of the DVHA and the DMH.** In the instance of a member whose Vermont Medicaid eligibility becomes retroactive to the time of the inpatient hospitalization, but who at the time of admission was not eligible for Vermont Medicaid, the provider

may request that the DVHA or the DMH complete a retrospective review for authorization. The request for consideration of a retrospective authorization decision is made in writing to the DVHA or the DMH. The supporting clinical documentation demonstrating that the inpatient level of care criteria was met for the days requested must be submitted for review via fax or mail. The DVHA or the DMH UR will make every effort to render an authorization determination within 14 days of receipt of the necessary clinical documentation.

Requests for a retrospective authorization may be made to the DVHA Manager, Clinical Integrity Unit or DMH Manager by Toll-free fax at 1.855.275.1212 or in writing to:

The Department of Vermont Health Access
ATTN: Quality Improvement and Clinical Integrity Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671

The Department of Mental Health
ATTN: DMH Adult Care Managers
280 State Drive NOB 2 North
Waterbury, VT 05671

1.6 Contact Information

Admission Notifications
Fax toll-free: 855.275.1212

Department of Vermont Health Access (DVHA)
https://dvha.vermont.gov/department-vermont-health-access-contact-information

Department of Mental Health (DMH)
https://mentalhealth.vermont.gov/

DVHA and DMH Utilization Review staff are available from 7:45 am to 4 pm Monday through Friday (excluding State holidays)

Questions regarding claims and billing issues should be directed to the Provider Services Unit of Gainwell Technologies at 1.800.925.1706.

Section 2 Children and Adolescent Psychiatric Admissions

2.1 Criteria for Inpatient Hospitalization

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the DVHA has adopted the Change Healthcare InterQual ® Criteria. The InterQual tool provides resource efficient evidence- based clinical decision support across the levels of care.

2.2 Admission Process

Youth located in the State of Vermont whose primary insurance is Vermont Medicaid are expected to be assessed in person by designated Emergency Services (ES) staff from one of the Vermont Designated Agencies (DA) prior to being referred for admission to a psychiatric inpatient facility. The ES assessment, prior to an inpatient admission, allows for determination of whether a less intensive level of care is available that can meet the youth's clinical needs. It also assists in continuity of care with outpatient providers, identifies emergency intervention strategies (including utilization of existing crisis plans), and if necessary, demonstrates that the youth's clinical presentation meets the emergency examination criteria for involuntary hospitalization.

An inpatient psychiatric admission may be recommended or supported by the ES staff when:

1. The youth is in need of hospitalization based on clinical level of care criteria; **and**
2. Community and support system resources are not available; **and**
3. A less restrictive alternative is not available and/or is not able to meet the youth's clinical needs.

ES staff are provided with an admission notification form that includes a list of available resources that must be contacted to make decisions related to appropriate level of care recommendations and treatment options (Clinical Forms and Prior Authorization Forms). The ES staff must fax this admission notification form and supporting clinical documentation to the DVHA by the next business day following an admission. The documentation must reflect the clinical justification for the recommendation for, or support of inpatient admission. The documentation must specify the alternatives to inpatient admission that were considered and reasoning for ruling out the alternatives. The ES staff also arranges for transportation and makes the referral to a psychiatric inpatient facility.

Admitting facilities are expected to utilize clinical level of care criteria in determining whether a referred youth's clinical presentation meets medical necessity for inpatient admission. **Referrals for inpatient level of care based on assessments by designated ES staff are not meant to supersede a facility's use of the facility's admissions criteria when determining the medical necessity of an urgent/emergent admission.**

Children and adolescents who are primary Vermont Medicaid members and are physically located outside the State of Vermont but are referred or seeking admission to an in-state (located in Vermont) inpatient facility are not expected to be assessed by ES staff prior to admission when the assessment cannot be completed in-person. Admitting facilities are expected to utilize clinical level of care criteria in determining whether a youth's clinical presentation meets medical necessity criteria for inpatient admission. In lieu of the in-person assessment by an ES staff, the admitting facility is expected to notify the youth's home DA of the admission and begin coordination of care within 24 hours of the admission.

All emergent and urgent admissions will require notification to the DVHA within 24 business hours of the admission. The admitting facility will fax to the DVHA the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form.

All elective (planned) admissions require prior authorization. The provider will fax the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form with the supporting clinical information.

2.3 Concurrent Review

Visit the Concurrent Review section 1.4 above.

Section 3 Voluntary Adults (Non-Community Rehabilitation & Treatment) Psychiatric Admissions

3.1 Criteria for Inpatient Hospitalization

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the DVHA and the DMH have adopted the Change InterQual ® criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care.

3.2 Admission Process

Adults whose primary insurance is Vermont Medicaid admitted to a facility for psychiatric inpatient services will be assessed prior to admission by the admitting facility (provider) to determine medical necessity for inpatient level of care. All emergent and urgent admissions will require notification to the DVHA within 24 business hours of the admission. The admitting facility will fax to the DVHA the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form.

All elective (planned) admissions require prior authorization. The provider will fax the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form with the supporting clinical information.

3.3 Concurrent Review

Visit the Concurrent Review section 1.4 above.

Section 4 Medically Managed Detoxification

4.1 Criteria for Inpatient Hospitalization

To ensure that the medically managed detoxification services are provided at an appropriate level of care and with the appropriate utilization of resources, the DVHA has adopted the Change InterQual® Criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care.

4.2 Admission Process

All adults (ages 18 and over) whose primary insurance is Vermont Medicaid admitted to an inpatient facility for medically managed detoxification services will be assessed by staff at the admitting facility (provider) to determine the medical necessity for inpatient level of care, prior to admission. All emergent and urgent admissions will require notification to the DVHA within 24 business hours of admission. The admitting facility will fax to the DVHA all necessary clinical documentation from the medical record, including nationally recognized, standardized tools used to assess withdrawal symptoms (i.e. COWS ®, CIWA ®, CIWA-Ar®) as well as the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form.

All elective (planned) admissions will require prior authorization. The provider will fax the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form with the supporting clinical information.

4.3 Concurrent Review

Visit the Concurrent Review section 1.4 above.

Section 5 Community Rehabilitation & Treatment (CRT)

5.1 Criteria for Inpatient Hospitalization

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the DVHA and the DMH have adopted the Change InterQual® Behavioral Health criteria. The InterQual tool provides resource efficient evidence-based clinical decision support across the levels of care.

5.2 Admission Process

Initial interview and evaluation by Designated Agency screener

Staff from the Designated Agencies (DA) evaluate all proposed CRT psychiatric inpatient admissions. These staff are referred to as screeners.

The screener interviews and evaluates all individuals identified in need of psychiatric hospitalization for purposes of:

- Referrals to appropriate services and connection to follow-up care
- Recommendation of immediate intervention strategies
- Determination of appropriateness for hospitalization
- Determination of appropriateness for involuntary hospitalization

This encounter includes assessment for less restrictive alternatives and review of any existing crisis plan for the individual.

If an involuntary hospitalization is sought, an Emergency Examination Application must be completed.

If the admitting facility (provider) determines (through an emergency department or 'transfer' from a medical unit or another hospital) that an individual presenting for admission is a CRT enrollee, the individual's DA emergency services program must be contacted to begin the assessment process. All emergent and urgent admissions will require notification to the DMH within 24 business hours of the admission. Call DMH Admissions at 802-828-2799.

For CRT inpatient hospitalization, the payer source upon admission remains the same payer throughout the episode of care regardless of any changes that occur during the course of treatment. For example, if an individual is enrolled in a CRT program **after** being admitted to an inpatient facility for psychiatric services, the payer that covered the stay at the time of admission remains the payer for the entire episode of care. Conversely, if an individual is enrolled in a CRT program at the time of admission and is dis-enrolled prior to discharge from the inpatient facility, the original payer remains for the entire episode of care.

5.3 Concurrent Review

Visit the Concurrent Review section 1.4 above.

Section 6 Involuntary Admissions/Emergency Examinations

6.1 Admission Process

A Qualified Mental Health Professional (QMHP) must evaluate all individuals regardless of treatment provider, program, or payer source to determine whether criteria are met to pursue an involuntary hospitalization. By agreement with the Department of Mental Health and designated general hospitals, only QMHPs who are designated by the Department of Mental Health (DMH) and designated general hospitals, only QMHPs who are designated by the DMH Commissioner or designee and employed by a Designated Agency (DA) or by the Department of Corrections (DOC), can screen and serve as the applicant for involuntary psychiatric admissions.

The definition of mental health professional from Title 18 of the Vermont Statutes Annotated, Section 7101(13): "Mental health professional" means a person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, mental health counselor, nurse or other qualified person designated by the commissioner.

Visit the DMH Manuals website for more information on QMHPs.

The QMHP reports all admissions to the Vermont Psychiatric Care Hospital (VPCH) Admission's Office and completes the Emergency Examination Application.

6.2 Authorization Criteria for Continued Stay

To ensure that mental health services are provided at an appropriate level of care and within the appropriate utilization of resources, the DVHA and the DMH have adopted the Change InterQual® criteria. The InterQual® tool provides resource efficient evidence-based clinical decision support across the levels of care.

6.3 Concurrent Review

Visit the Concurrent Review section 1.4 above.

Section 7 Reconsideration Process

The DVHA and the DMH will conduct an internal review of the following types of decisions directly affecting providers in response to requests by providers:

- PA disapproval by the DVHA or its agents (other than medical necessity determinations)
- PA disapproval because documentation was inadequate
- Error in manual pricing

The DVHA and the DMH will not review any decision other than those listed above.

Although this process is not an appeals process, it is the DVHA's and the DMH's position that providing a "second look" for certain decisions may help improve accuracy. Any affected provider may ask that the DVHA or the DMH reconsider its decision.

Requests must be made no later than 14 days after the DVHA or the DMH UE clinician first gives notice, either written or oral, to the inpatient or residential facility of the authorization decision.

The DVHA or the DMH will base the reconsideration of authorization decision on the clinical documentation from the medical record and written documentation from the attending physician demonstrating why the provider believes the DVHA or the DMH should have found differently (based on the clinical presentation of the member). The fully completed REQUEST FOR RECONSIDERATION: FOR MENTAL HEALTH AND APPLIED BEHAVIOR ANALYSIS SERVICES form and all clinical documentation must be submitted via fax or mail to the reviewer. This form can be found at https://dvha.vermont.gov/forms-manuals/forms/clinical-prior-authorization-forms.

It is expected that the request will contain all supporting documents. Supplemental information submitted after the request for reconsideration of authorization is submitted, even if before the decision has been made, will not be considered by the DVHA or the DMH except when the DVHA or the DMH determines that extraordinary circumstances exist. Upon receipt of the request and supporting information, the DVHA or the DMH will review all information received.

The DVHA or the DMH will notify the inpatient or residential facility of its reconsideration of authorization decision within 14 days of receipt of notice of the request and the supporting clinical documentation from the medical record. There is a possible extension of up to 14 additional calendar days if the enrollee, residential or inpatient facility requests extension or the DVHA and/or the DMH justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

In the event that an inpatient or residential facility disagrees with the DVHA or the DMH regarding the reconsideration of authorization decision, the inpatient or residential facility's physician and/or Medical Director may request to speak with the DVHA or the DMH designated physician for a final review of the authorization decision (aka doc to doc review).

Such requests must be made in writing to the DVHA or the DMH utilization review clinician within 5 business days of the notification of the reconsideration of authorization decision. The request must include the service and or rate the provider is requesting be reviewed, the name and contact information for the provider who is requesting the review and the name and contact information for scheduling purposes.

- The provider is responsible for responding to the DVHA or the DMH proposed schedule of review times within 3 business days. Failure to respond to proposed times within 3 business days will result in the reconsideration of authorization decision being upheld.
- If a provider is unable to attend a scheduled physician to physician review, it is the provider's responsibility to contact the DVHA or the DMH utilization review clinician to request a rescheduled appointment within 3 business days. Failure of the provider to request a rescheduled appointment within 3 business days will result in the reconsideration of authorization decision being upheld.
- If a provider fails to attend 3 scheduled physician to physician reviews for a particular member and service, this will result in the reconsideration of authorization decision being upheld and no additional opportunities to schedule a doc to doc review for the service in question will be afforded.

There is no additional review or reconsideration after the DVHA or the DMH physician or the designee has made a decision on the reconsideration of authorization request.

7.1 Expedited Decisions

For cases in which the provider indicates or the DVHA and/or the DMH determines, that following the standard timeframe could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function, the DVHA and/or the DMH must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 3 business days after receipt of the request for this service.

Section 8 Interrupted Psychiatric Stays and Rapid Re-admission

Psychiatric inpatient admissions are considered "interrupted" when a patient is admitted to a psychiatric floor in a general hospital or transferred to a medical floor within the same facility and transferred back to the psychiatric floor. These stays are considered continuous for the purpose of applying the variable per diem adjustment and are considered one continuous stay for payment.

There are four types of rapid re-admissions described in this document. Rapid re-admissions are authorized and billed in different ways to account for the days a member may be on a medical floor during a stay, days spent out of the hospital, or if a member discharges and then re-admits on the same day. When a member re-admits to a psychiatric floor of a different hospital within 3 midnights, DVHA UR clinicians review documentation to determine if the second admission should start at day 1 (new episode) or should continue as an extension of the first admission. This affects the rate of reimbursement for the second admission.

8.1 Scenario 1: Rapid Re-admission – Interrupted Psychiatric Stay

For instances where a member is on a psychiatric floor, then is transferred to a medical floor, and then is transferred back to the psychiatric floor within the same hospital;

Example:

- Member is admitted to psychiatric floor on 02/05/23 and is transferred to medical floor on 02/07/23.
- Member is on medical floor from 02/07/23 - 02/09/23 and is transferred back to the psychiatric floor on 02/10/23.
- Member is discharged on 02/15/23.

Claim:

- Submit one claim using one detail line with a date span that encompasses the entire stay with an occurrence code 74 for the dates of the stay on the medical floor.
- Submit a separate claim for the stay on the medical floor using only the dates of service the member was on the medical floor.

Claim Example:

- Psychiatric Claim: 02/05/23 - 02/15/23 for 10 units of revenue code 124 with occurrence code 74 for 02/07/23 - 02/09/23.
- Medical Claim (submitted separately): 02/07/23 - 02/10/23 for 3 units of revenue code 120 (or other inpatient medical code as appropriate).

8.2 Scenario 2: Rapid Re-admission to a Different Hospital Within 3 Midnights

For instances where a member is discharged from a psychiatric floor in one hospital and readmitted to a psychiatric floor in a different hospital within 3 midnights;

Example:

- Member is admitted on 02/01/23 and discharged on 02/05/23.
- Member is out of the hospital 02/06/23.
- Member is readmitted on 02/07/23 and discharged on 02/12/23.

Claim:

- The first hospital submits a claim using the first admission and first discharge date.
- The second hospital submits a claim using the second admission date and second discharge date AND consults the final faxback to see if value code 75 & the number of units need to be entered for the first admission.

Claim Example:

- Psychiatric claim #1: 02/01/23 - 02/05/23 for 4 units of revenue code 124 by hospital 1.
- Psychiatric claim #2: 02/07/23 - 02/12/23 for 5 units of revenue code 124 AND 4 units of value code 75 by hospital 2.

8.3 Scenario 3: Rapid Re-admission to the Same Hospital Within 3 Midnights

For instances where a member is discharged from a psychiatric floor in a hospital and readmitted to a psychiatric floor in the same hospital within 3 midnights;

Example:

- Member is admitted on 02/05/23 and discharged on 02/07/23.
- Member is out of the hospital on 02/08/23.
- Member is readmitted on 02/09/23 and discharged on 02/14/23.

Claim:

- The hospital submits a claim using the first admission and first discharge date.
- The hospital submits a claim using the second admission date and second discharge date AND
- consults final faxback to see if value code 75 should be used.

Claim Example:

- Psychiatric claim #1: 02/05/23 - 02/07/23 for 2 units of revenue code 124.
- Psychiatric claim #2: 02/09/23 - 02/14/23 for 5 units of revenue code 124 AND 2 units of value code 75.

8.4 Scenario 4: Rapid Re-admission to the Same Hospital on the Day of Discharge

For instances where a member is discharged from a psychiatric floor in a hospital and readmitted to the same hospital's psychiatric floor on the same day;

Example:

- Member is admitted on 03/15/23 and discharged on 03/18/23.
- Member is readmitted on 03/18/23 and discharged on 03/22/23.

Claim:

- The hospital submits a claim using the first admission and second discharge date.

Claim Example:

- Psychiatric claim #1: 03/15/23 – 03/22/23 for 7 units of revenue code 124.

Section 9 Facility to Facility Transfer

During a psychiatric inpatient stay, the treating provider may determine that the member requires a higher level or alternate level of care. As an example, a member may be in an inpatient psychiatric facility, and it is determined there is a need for inpatient eating disorder treatment. In these situations, there may be a need for a facility-to-facility transfer. Below are the required steps for a facility-to-facility transfer:

- The treating facility determines that a higher or alternate level of care is required and medically necessary.
- The treating facility makes a referral to an appropriate admitting facility.
- The admitting facility reviews the referral and supporting clinical documentation and determines medical necessity and accepts the referral for admission.
- A Prior Authorization (PA) is **not** required prior to admission to the admitting facility. Admitting facilities are expected to utilize the clinical level of care criteria in determining whether a referred member's clinical presentation meets the medical necessity for inpatient admission. (Please refer to section 1.1 Utilization Management for clinical criteria).
- All psychiatric inpatient emergent and urgent admissions will require notification to the DVHA within 24 hours or the next business day of admission. The admitting facility will fax to the DVHA the Vermont Medicaid Admission Notification Form for Inpatient & Detoxification Services form
- Notification to the DVHA begins the concurrent review process (Please refer to section 1.4 Concurrent Review for more information).

If there are questions regarding ambulance transportation, please refer to the following page for more information: https://dvha.vermont.gov/providers/ambulance-services.

Section 10 Sub-Acute and Awaiting Placement Reimbursement Rates

10.1 Sub-Acute

To determine if an inpatient continued stay is eligible for authorization at the sub-acute inpatient rate the following criteria will be utilized:

- The clinical documentation provided by the facility demonstrates that criteria for inpatient level of care per the Change InterQual® criteria is not met and;
- The member no longer requires the intensity of services that can only be provided at the inpatient level of care and;
- The member requires a residential level of care and no discharge placement has been identified or a discharge placement has been identified but is not available, and;
- Active and appropriate aftercare planning has been ongoing from the time of admission and appropriate Agency of Human Services Department partners have been engaged by the facility if barriers to aftercare planning and/or discharge were identified (i.e. DCF central office, DMH Children's Unit, DAIL).

10.2 Awaiting Placement

The Awaiting Placement rate is applied when the acute level of care is no longer necessary, and the member is being discharged to a lower level of care (non-residential).

The UR clinician will notify the inpatient facility no later than 24 hours or one business day prior to the change to authorization at the Awaiting Placement rate.

Section 11 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

Section 12 Resources

- **Mental Health 24-Hour Emergency Services**

  https://mentalhealth.vermont.gov/individuals-and-families/designated-and-special-services-agencies
- **Adults Ages 18 & Over Psychiatric Crisis Beds in Vermont**

  https://bedboard.vermont.gov/
- **Substance Abuse Services**

  https://vthelplink.org/app/home