6.19. Mental Health – Nursing Home Psychiatric Consultation Services

DESCRIPTION OF SERVICES

Nursing home psychiatric consultations services are provided on a short-term basis to prevent psychiatric hospitalization. Maintenance mental health services for participants in nursing homes are expected to be covered by the nursing homes under the day rate paid by Medicaid. Nursing home psychiatric consultation services are not covered by the Medicaid day rate. These services will be paid for by the Maryland Public Behavioral Health System (PBHS) if pre-authorized by Beacon Health Options, Inc. (Beacon) and if medical necessity criteria are met. These psychiatric services are defined as mental health services or psychiatric consultation services which are necessary to avoid psychiatric hospitalization.

SERVICE RULES

Nursing home psychiatric consultations are provided on a short-term basis to prevent a psychiatric admission. An initial consultation in the nursing home will be authorized by Beacon to evaluate the severity of a participant’s psychiatric problem. Additional services (up to four visits per episode) by the psychiatrist will be approved only for participants with a mental illness severity level which puts them at-risk for hospitalization (i.e. the participant is exhibiting behavior that is threatening to him or herself or others or otherwise becoming increasingly at-risk for hospitalization). The participant must have a PBHS covered diagnosis.

The mental health service provider is expected to exchange information and coordinate care with the participant’s PCP and other treatment (i.e. substance use disorder treatment and/or mental health) providers when clinically appropriate.

PARTICIPANT ELIGIBILITY

Only participants with Medicaid and/or dual eligibility (Medicare and Medicaid) are eligible for nursing home psychiatric consultation services.

PROVIDER ELIGIBILITY

Psychiatrists and psychiatric nurse practitioners with an active Maryland Medicaid provider number may be providers of nursing home psychiatric consultation services.

AUTHORIZATION PROCESS

The provider must submit a pre-authorization request by phone. The Beacon Care Manager will review the clinical data to determine if medical necessity and severity of illness criteria are met in order to authorize nursing home consultation services.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW

Pre-Admission Screening and Resident Review (PASRR) determinations will be reviewed to ensure that participants with serious mental illness are not unnecessarily institutionalized, but can live in the least
restrictive environment where their needs may be met. If a nursing facility is the least restrictive environment that can meet their needs, then services will be identified for their optimal functioning.

Those participants with a positive Level I screening will then have a Level II evaluation to confirm a serious mental illness/major mental disorder diagnosis, level of impairment and duration of illness/recent treatment related to the serious mental illness.

Following the requirements of 42.CFR Part 483, COMAR 10.09.10.03 and Nursing Home Transmittals 159-239, a review of the Level II Evaluation will be completed by Beacon within three business days of a completed request. The Level II Evaluation will include specific and clear recommendations by the Adult Evaluation and Review Services (AERS) Reviewer for nursing facility services.

The Beacon RN MCO Liaison and PASRR licensed health care professionals will review all requests and communicate the determination to AERS and the requesting facility. If approved, the PASRR reviewer will sign and fax a copy of the determination PASRR Certificate to the AERS office. If a denial is rendered by a Beacon psychiatrist, then Beacon shall notify in writing the applicant of his/her right to appeal the determination. For participants referred from hospitals, every effort will be made to expedite this process to assure timely discharge.

**CLAIMS PROCESS**

Psychiatrists must obtain authorization for consultations and follow-up services for Medicaid participants. Claims must be submitted on a CMS 1500 form.

Claims for unauthorized services will be denied. If the services requested by the provider do not meet medical necessity criteria and are non-authorized, please refer to Chapter 10, Grievance and Appeals.