



# Florida Medicaid

## STATE MENTAL HEALTH HOSPITAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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Agency for Health Care Administration







CHARLIE CRIST  
GOVERNOR

*Better Health Care for all Floridians*

THOMAS W. ARNOLD  
SECRETARY

July 15, 2010

Dear Medicaid State Mental Health Hospital Provider:

The State Mental Health Hospital Coverage and Limitations Handbook, EDITION 2010, Section 59G- 4.300 is amended to implement changes to the handbook that include:

- The amendment updates fiscal agent contact information and Web sites;
- Clarifies services provided through the per diem rate;
- Updates and clarifies services included in the per diem rates;
- Updates and clarifies non-institutional services and excluded services;
- Adopts new AHCA-Med Serv Form 034, Jan 2008; and
- Updates references to Medicaid claim form UB 04.

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are listed on AHCA's website at [www.ahca.myflorida.com](http://www.ahca.myflorida.com). All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web site at [www.mymedicaid-florida.com](http://www.mymedicaid-florida.com). Select *Public Information for Providers*, then on *Provider Support*, and then on *Provider Handbooks*.

We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder, Chief  
Bureau of Medicaid Services





# UPDATE LOG

## STATE MENTAL HEALTH HOSPITAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

### **How to Use the Update Log**

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#### **Introduction**

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at [mymedicaid-florida.com](http://mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as a revised handbook or a completely new handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

#### **Explanation of the Update Log**

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

#### **Instructions**

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at [mymedicaid-florida.com](http://mymedicaid-florida.com). Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

<b><u>UPDATE</u></b>	<b><u>EFFECTIVE DATE</u></b>
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New Handbook	July 1997
Revised Handbook	September 2005
Revised Handbook	January 2010



# STATE MENTAL HEALTH HOSPITAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

### Overview

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#### Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

#### Background

There are three types of Florida Medicaid handbooks:  
Provider General Handbook describes the Florida Medicaid Program.

Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.

Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

#### Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes; and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each service-specific coverage and limitations handbook.

#### In This Chapter

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
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## **Handbook Use and Format**

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### **Purpose**

The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.

The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.

### **Provider**

The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.

### **Recipient**

The term “recipient” is used to describe an individual who is eligible for Medicaid.

### **General Handbook**

General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook.

### **Coverage and Limitations Handbook**

Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.

### **Reimbursement Handbook**

Each reimbursement handbook is named for the claim form that it describes.

### **Chapter Numbers**

The chapter number appears as the first digit before the page number at the bottom of each page.

### **Page Numbers**

Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.

### **White Space**

The "white space" found throughout a handbook enhances readability and allows space for writing Notes.

## **Characteristics of the Handbook**

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### **Format**

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

## **Information Block**

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Each block is identified or named with a label.

## **Label**

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

## **Note**

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

## **Topic Roster**

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

## **Handbook Updates**

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### **Update Log**

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log.

Each update will be designated by an “Update No.” and the “Effective Date.”

### **How Changes Are Updated**

The Medicaid handbooks will be updated as needed. Changes may consist of one of the following:

1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy.
2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.

### **Effective Date of New Material**

The month and year that the new material is effective will appear in the corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

## **Identifying New Information**

**New material will be indicated by yellow highlighting.** The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

### **New Label and New Information Block**

**A new label and a new information block will be identified with yellow highlight to the entire section.**

### **New Material in an Existing Information Block or Paragraph**

**New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence or paragraph affected by the change.**

# CHAPTER 1

## STATE MENTAL HEALTH HOSPITAL SERVICES

### PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

#### **Overview**

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##### **Introduction**

This chapter describes the Medicaid State Mental Health Hospital Program, the specific authority regulating state mental health hospital services, the program's purpose, provider qualifications and responsibilities, and facility staffing requirements.

##### **Legal Authority**

State mental health hospital services are governed by Title 42, Code of Federal Regulations (C.F.R.) Parts 405, 435, 440, 441, and 456.

The Florida Medicaid State Mental Health Services Program is authorized by Chapter 409.906(22), Florida Statutes (F.S.) and Chapter 59G-4.300, Florida Administrative Code (F.A.C.). The state authority for the licensing of hospitals is Chapter 395, Part I. State mental hospitals must also comply with the provisions of Chapter 394, Part I, F.S.

##### **In This Chapter**

This chapter contains:

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#### **Purpose and Definition**

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##### **Purpose**

The purpose of the Medicaid State Mental Health Hospital Program is to provide medically necessary, long term inpatient mental health services to recipients age 65 and older who meet the Medicaid Institutional Care Program (ICP) eligibility requirements.

##### **Definition**

State mental health hospital services are medical and mental health-related services provided by or under the direction of professional or technical personnel, in an institution that is owned by the state, licensed as a psychiatric hospital and certified or certifiable for participation in the Medicare program. Services provided must be medically necessary.

Note: See Appendix D, Glossary, in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

## **Medicaid Handbooks**

This handbook explains covered services, their limits and who is eligible to receive them. It is intended to be used with the Florida Medicaid Provider Reimbursement Handbook, UB-04, which describes how to complete and file claims for reimbursement, and the Florida Medicaid Provider General Handbook, which provides general information about the Florida Medicaid program.

## **Provider Qualifications and Responsibilities**

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### **State Mental Health Hospital Provider Qualifications**

A state mental health hospital must:

- Be owned by the state of Florida;
- Be licensed as a psychiatric hospital under Chapter 395, F.S.;
- Comply with the provisions of Title 42, C.F.R.; Title XIX of the Social Security Act; Chapters 395 and 409, F. S.; and Chapters 59A-3, 59G-4 and 59G-6, F.A.C., as determined through an annual survey conducted by the Agency for Health Care Administration (AHCA), Division of Health Quality Assurance;
- Provide services in Florida;
- Have a Medicaid reimbursement rate established by submitting a projected budget or a Medicaid cost report; and
- Be Medicare certified or certifiable.

### **Medicaid Decertification**

If AHCA determines that Medicaid participation requirements have not been met, AHCA has the option to cancel the facility from the Medicaid program.

A 30-day cancellation notice will be given before termination of the Medicaid program agreement without cause.

Medicaid will continue to pay the facility for up to 30 days after the termination date or until Medicaid recipients can be relocated, whichever comes first.

### **Federal Certification Sanctions**

The agency can impose the following sanctions for federal certification violations:

- Directed plans of correction;
- Appointment of a State Monitor;
- Directed in-service training;
- Denial of payment for new admissions;
- Denial of payment for all individuals;
- Appointment of a temporary manager; and
- Termination.

## Provider Responsibilities

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with the HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. The Coverage and Limitations Handbooks contain information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding changes to claims processing procedures in Florida Medicaid due to HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, UB-04.

Note: For more information regarding changes in the EDI requirements for Florida Medicaid because of HIPAA, contact call the Medicaid fiscal agent EDI Help Desk at 800-289-7799 and select Option 3 or call 866-586-0961.

## Staffing Requirements

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### Introduction

Services furnished in a state mental health hospital must be provided by qualified staff. If a state mental health hospital purchases services from a vendor, the vendor and his staff must meet all mandatory educational, licensing and certification requirements for the specific area of service furnished.

For information specific to staffing requirements, please contact the Agency for Health Care Administration, Health Quality Assurance, area office.

Note: The addresses and phone numbers of the area offices are available on the AHCA Internet site at [ahca.myflorida.com](http://ahca.myflorida.com).

### Physician Services

State mental hospitals must have a physician available (on call) at all times. A physician must approve in writing all admissions. A physician must examine residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The physician may delegate the required visits to a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNP).

### **Therapy and Supportive Services**

State mental health hospitals must have the appropriate number of staff to provide therapy and supportive services. Therapy/counseling services must be delivered at a minimum by a master's level practitioner. Supportive and therapeutic group services must be delivered at a minimum by a bachelor's level practitioner.

### **Nursing Services**

State mental health hospitals must have the appropriate number of staff to provide 24-hour nursing and related services to residents in order to maintain the highest levels of physical, mental and psychosocial well being of each resident, as determined by resident assessments and documented in individual plans of care.

### **Dietary Services**

State mental health hospitals are required to retain a qualified dietician who is registered with the American Dietetic Association on a full time, part time, or consultant basis. Sufficient support staff must be available to carry out the functions of the dietary service.

### **Pharmacy Services**

State mental health hospitals are required to make available the services of a licensed pharmacist on a full time or contractual basis to dispense routine and emergency prescription drugs.

## CHAPTER 2

# STATE MENTAL HEALTH HOSPITAL SERVICES COVERED SERVICES, LIMITATIONS & EXCLUSIONS

### **Overview**

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#### **Introduction**

This chapter describes the services covered under the Medicaid State Mental Health Hospital Program. It also describes the requirements to receive services, service limitations and exclusions, and the utilization review process.

#### **In This Chapter**

This chapter contains:

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### **Requirements To Receive Services**

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#### **Introduction**

Medicaid reimburses state mental health hospitals for Medicaid eligible recipients age 65 and older who meet the Medicaid Institutional Care Program (ICP) eligibility requirements, including state mental health hospital level-of-care criteria.

#### **Written Physician Orders**

In order to qualify for ICP services, a recipient must have a written order for state mental health hospital services from a licensed doctor of medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental illness.

#### **Eligibility Determination**

The determination of eligibility for ICP is made by the Department of Children and Families and must be completed for all individuals whose care will be paid for by Medicaid, including individuals who were eligible for Medicaid in the community when they were placed in the state mental health hospital.

Eligibility for ICP is determined using program-specific financial eligibility criteria and level-of-care criteria. To meet state mental health hospital level-of-care criteria, an individual must meet the medical and voluntary or involuntary commitment criteria. Level-of-care is determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services Program (CARES).

To begin the ICP application process, a state mental health hospital refers the resident to the Department of Children and Families.

Note: See Admissions and Discharges in this chapter for additional information on voluntary or involuntary commitment into a state mental facility.

### **Retroactive Recipient Eligibility**

Medicaid eligibility can be established retroactively for any of the three months prior to the date of application if the recipient meets all ICP eligibility criteria, including level-of-care.

### **Service Requirements**

Medicaid may reimburse for the state mental health hospital services described in this handbook. Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary.

## **Items and Services Included in the Per Diem**

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### **Introduction**

Medicaid pays a per diem (daily) rate for care in a state mental health hospital. The per diem includes all services, except for dental, hearing, optometric, podiatry, and visual services. These services may be rendered to the recipient and billed to Medicaid by Medicaid providers other than the state mental health hospital. (See Other Available Medicaid Services in this chapter for information on these services.) The per diem also includes the items described below. The provider cannot charge a recipient, a recipient's family or any other third party for the services and items included in the per diem.

The only exceptions are items requested by the recipient that are not stocked by the hospital. The hospital may charge the recipient only the difference in cost between the stocked and the requested item.

### **Room**

The per diem covers the recipient's room and basic room furnishings, such as a bed of proper size and height; a clean comfortable mattress; clean linens and bedding appropriate to the weather and climate: towels and washcloths; functional furniture appropriate to the resident's needs; and individual closet space with clothes racks and shelves.

### **Medical and Psychiatric Services**

The per diem covers psychiatrist, physician, and nursing services rendered according to an individualized plan of care.

### **Clinical Therapy Services**

The per diem covers individual and family therapy services based on the recipients' and families' needs as defined in the individual's plan of care. Therapy services provided to the families of recipients must address the ability to cope with condition of the recipient or otherwise must have direct benefit for the recipient.

### **Nutritional Services**

The per diem covers all nutritional services, including meals, snacks, food supplements, tube feedings, supplies and equipment required for tube feedings and food substitutes needed for special diets.

### **Personal Care Services**

The per diem covers personal care services rendered by nursing staff or nutritional services staff and assistance with activities of daily living rendered by any staff.

### Personal Care Supplies

The per diem covers personal care supplies including gowns, water pitcher, drinking glass, straws, wash pan, emesis basin, bedpan, urinal, oral and rectal thermometers, soap, shampoo, deodorant, razors and shaving supplies, toothbrush, toothpaste, toothpowder, mouthwash, denture cups, denture powder, denture adhesive, skin moisturizer, and nail care supplies.

### Incontinence Supplies

The per diem covers incontinence supplies including catheters, catheter irrigation trays, supplies needed to insert catheters, linen savers, waterproof pads, diapers, rubber pants, incontinence skin care products, and absorbent bladder control garments.

### Rehabilitative, Restorative, and Recovery Services

The per diem covers rehabilitative, restorative, and recovery services, ordered by the recipient's physician and interventions or programs designed to assist the resident to achieve individual recovery goals. Services are provided to facilitate the ability to live, learn, work, and socialize in the recipient's preferred community setting. Services provided will address issues in the following areas:

- Clinical treatment services focusing on assessing, diagnosing, and reducing the symptoms of mental illness and physical health needs;
- Rehabilitation services focusing on developing skills and resource supports to enable recipients to overcome the functional disabilities that result from mental illness;
- Quality of life enrichment services allowing the recipient to maintain activities that are personally enriching; and
- barriers to discharge.

### Medical Equipment

The per diem covers medical equipment including equipment that must be available for use by recipients, such as hospital beds, wheelchairs, walkers, Geri-chairs, crutches, canes, bedside commodes, traction equipment, blood pressure equipment, protective restraints, positioning devices, suction equipment, lifts, nebulizers and any other equipment included in the care plan and prescribed by the physician.

Medical equipment items included in the per diem belong to the hospital and are not to be taken home when the recipient leaves.

### Stock Medical Supplies

The per diem covers pharmacy items including:

- All prescribed over-the-counter medications except insulin;
- Syringes;
- Prescribed vitamins, minerals and iron;

- Sterile saline for wound irrigation and other wound care dressings;
- Durable and nondurable equipment and supplies;
- Dietary supplements, salt and sugar substitutes, tube feedings; and
- Laxatives and antidiarrheal medications.

These items cannot be reimbursed under the Medicaid Prescribed Drug Services Program, because they are included in the hospital's cost report.

### **Analgesics**

The per diem covers **prescribed** over-the-counter analgesics including aspirin, acetaminophen, and ibuprofen.

### **Antacids**

The per diem covers **prescribed** non-legend antacids including at least one product in each of the following categories:

- Magnesium hydroxide and aluminum hydroxide with or without simethicone;
- Aluminum hydroxide; or
- Calcium carbonate.

### **Laxatives**

The per diem covers **prescribed** laxatives including at least one product from each of the following categories: bulk, fecal softener, irritant, saline, emollient, or enema.

### **Vitamins**

The per diem covers **prescribed** over-the-counter vitamins including at least one product in each of the following categories:

- B-complex with vitamin C stress formula;
- Therapeutic multi-vitamin, multi-mineral combination;
- Ferrous sulfate;
- Ferrous gluconate, ferrous fumarate products;
- Oil and water soluble multiple vitamins with minerals; or
- Oil and water soluble multiple vitamins without minerals.

### **Wound Care Supplies**

The per diem covers prescribed over-the-counter wound care supplies including: sterile saline, hydrogen peroxide, astringent, tincture of benzoin, providone-iodine ointment and solution, topical anti-bacterial preparation, zinc, and specialty pressure ulcer treatments and dressings.

## **Non-Institutional Medical Services**

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### **Other Medical Services**

Medically necessary dental, hearing, optometric, podiatry, and visual services are available to Medicaid eligible state mental health hospital recipients. They are billed directly to Medicaid by the rendering provider. The recipient's physician must order these services and record the order in the recipient's chart. The service provider must maintain documentation in the recipient's medical record for services rendered. All other Medicaid services rendered by the state mental health hospital are included in the hospital's per diem.

For additional information about coverage of other medical services contact the area Medicaid office.

Note: See Appendix C in the Florida Medicaid Provider General Handbook for a listing of the Medicaid area offices. The addresses and phone numbers for the area Medicaid offices are also available on AHCA's Internet site at [ahca.myflorida.com](http://ahca.myflorida.com).

### Dental Services

Dental services may be reimbursed for a Medicaid eligible resident in a state mental health hospital if the resident exhibits the need for dental care. See the Florida Medicaid Dental Services Coverage and Limitations Handbook for the dental services that are covered by Medicaid. The attending physician must request the oral examination. The resident or the resident's guardian/representative must be informed, express an understanding, and consent to the procedures that will be performed. The state mental health hospital must assist residents in obtaining dental care by assisting in arrangements for transportation to the dental services.

The following information must be included in the resident's facility medical record as well as the recipient's dental record in the dentist's office:

- A statement identifying the rationale for the referral to the dentist;
- A statement regarding the resident's or the representative's knowledge, understanding, and concurrence with the referral; and
- The duration of the problem, and the anticipated impact on the resident's health if the problem is unresolved.

### Hearing Services

Hearing services may be reimbursed for a Medicaid eligible resident in a state mental health hospital if the resident exhibits the need for services. See the Florida Medicaid Hearing Services Coverage and Limitations Handbook for the hearing services that are covered by Medicaid. The attending physician must request the hearing evaluation. The resident or the resident's guardian/representative must be informed, express an understanding, and consent to the services that will be provided. The state mental health hospital must assist residents in obtaining hearing services by assisting in arrangements for transportation to the hearing services.

The following information must be included in the resident's medical record in the hearing provider's office and in the state mental health hospital's medical record:

- Documentation of the rationale for the referral;

- Documentation that the resident or the resident's representative has been informed, understands, and concurs with the referral;
- The duration of the problem; and
- The anticipated impact on the resident's health if the problem is unresolved.

### **Optometric Services**

Optometric services may be reimbursed for a Medicaid eligible resident in a state mental health hospital if the resident exhibits the need for services. See the Florida Medicaid Optometric Services Coverage and Limitations Handbook for the optometric services that are covered by Medicaid. The attending physician must request the optometric evaluation. The resident or the resident's guardian/representative must be informed, express an understanding, and consent to the services that will be provided. The state mental health hospital must assist residents in obtaining optometric services by assisting in arrangements for transportation to the optometrist's office.

The following information must be included in the resident's medical record in the hearing provider's office and in the state mental health hospital's medical record:

- Documentation of the rationale for the referral;
- Documentation that the resident or the resident's representative has been informed, understands, and concurs with the referral;
- The duration of the problem; and
- The anticipated impact on the resident's health if the problem is unresolved.

### **Podiatry Services**

Podiatry services may be reimbursed for a Medicaid eligible resident in a state mental health hospital if the resident exhibits the need for services. See the Florida Medicaid Podiatry Services Coverage and Limitations Handbook for the podiatry services that are covered by Medicaid. The attending physician must request the podiatry evaluation. The resident or the resident's guardian/representative must be informed, express an understanding, and consent to the services that will be provided. The state mental health hospital must assist residents in obtaining podiatry services by assisting in arrangements for transportation to the podiatrist's office.

The following information must be included in the resident's medical record in the hearing provider's office and in the state mental health hospital's medical record:

- Documentation of the rationale for the referral;
- Documentation that the resident or the resident's representative has been informed, understands, and concurs with the referral;
- The duration of the problem; and
- The anticipated impact on the resident's health if the problem is unresolved.

## Visual Services

Visual services may be reimbursed for a Medicaid eligible resident in a state mental health hospital if the resident exhibits the need for services. See the Florida Medicaid Visual Services Coverage and Limitations Handbook for the visual services that are covered by Medicaid. The attending physician must request the visual services. The resident or the resident's guardian/representative must be informed, express an understanding, and consent to the services that will be provided. The state mental health hospital must assist residents in obtaining visual services by assisting in arrangements for transportation to the location where the visual services are provided. The following information must be included in the resident's medical record in the hearing provider's office and in the state mental health hospital's medical record:

- Documentation of the rationale for the referral;
- Documentation that the resident or the resident's representative has been informed, understands, and concurs with the referral;
- The duration of the problem; and
- The anticipated impact on the resident's health if the problem is unresolved.

## Excluded Services

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### Non-medical Items

Non-medical items such as a radio, television and telephone are not included in the state mental health hospital per diem or reimbursed by Medicaid. If a recipient desires such items, they must be purchased directly by the recipient or a responsible party.

### Durable Medical Equipment

Medicaid does not cover durable medical equipment for recipients in state mental health hospitals. Medical equipment items utilized by recipients while in the hospital are included in the per diem and are not to be taken home when the recipient leaves.

## Admissions and Discharges

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### Introduction

Admission and discharge procedures for state mental health hospitals are contained in Chapter 394.4625 through 394.469, F.S.

### Voluntary Admission

An individual may be voluntarily admitted to a state mental health hospital under the conditions described in Chapter 394.4625, F.S. Any voluntarily admitted individual who

meets all the Medicaid eligibility criteria for the state mental health hospital program can be covered by Medicaid.

Note: See “Eligibility Determination” in this chapter for specific eligibility criteria for the state mental health hospital program.

### **Involuntary Admission**

An individual may be involuntarily placed in a state mental health hospital under the conditions described in Chapter 394.467, F.S. Any involuntarily admitted individual who meets all the Medicaid eligibility criteria for the state mental health hospital program can be covered by Medicaid.

Note: See “Eligibility Determination” in this chapter for specific eligibility criteria for the state mental health hospital program.

### **Right of Discharge**

At the time of his admission and each six months thereafter, a voluntarily admitted recipient and the recipient’s guardian or representatives must be notified in writing of the right to apply for discharge. A facility must discharge a voluntarily admitted recipient who has sufficiently improved so that retention in the facility is no longer desirable.

A voluntary patient who has been admitted to a facility and who refused to consent to or revokes consent to treatment shall be discharged within 24 hours after such refusal or revocation, unless transferred to involuntary status pursuant to section 394.4625, F.S. or unless the refusal or revocation is freely and voluntarily rescinded by the patient.

### **Transfer to Involuntary Status**

When a voluntary patient or an authorized person on the patient’s behalf makes a request for discharge, the request for discharge, unless freely and voluntarily rescinded, must be communicated to a physician, clinical psychologist, or psychiatrist as quickly as possible, but no later than 12 hours after the request is made. If the patient meets the criteria for involuntary placement, the administrator of the facility must file with the court, a petition for involuntary placement, within 2 court working days after the request for discharge is made. If the petition is not filed within 2 court working days, the patient shall be discharged. Once a petition has been timely filed, and pending a decision by the court, the patient may be held and emergency treatment rendered in the least restrictive manner appropriate for the recipient’s needs, upon the written order of the physician, if it is determined that such treatment is necessary for the safety of the patient or others.

## **Resident Rights**

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### **Introduction**

Unless declared incompetent, residents of state mental health hospitals have full rights as citizens. In addition, recipients entering a state mental health hospital gain special “residents’ rights” under federal regulations and state laws. Facilities must post a copy

of these rights in an area easily accessible to all residents, and must provide a copy to each resident upon admission.

Resident rights are found in Title 42 Code of Federal Regulations (C.F.R.), and are listed in Chapters 394, 395 and 381 Florida Statutes (F.S.).

### **Personal Needs Allowance**

A Medicaid recipient is allowed to keep a certain amount as specified by the Department of Children and Families from his income as a personal needs allowance. Veterans residing in a state mental health hospital, either single veterans or veterans' surviving spouses, may be allowed to keep more of their income. The recipient's personal needs funds must be given to the recipient; or if the recipient makes a written request, the hospital must maintain these funds in an account separate from the operating funds of the hospital. Each quarter the hospital must give the recipient or his designated representative a report of all activity in the recipient's account.

### **Treatment of Recipient Funds**

A state mental health hospital cannot use recipient funds to pay for items and services included in the per diem. If a recipient dies, all funds belonging to the recipient must be released to the recipient's designated representative if a prior request was made in writing by the recipient to the facility. If not, the funds must be deposited in an interest-bearing account. After two years, if the recipient's estate is not probated, the funds must be sent to the Agency for Health Care Administration (AHCA), Health Facility Regulation office for deposit in the Resident Protection Trust Fund.

### **Reporting Requirements for Supplemental Security Income (SSI) Recipients**

State mental health hospitals must report the admission of a Supplemental Security Income (SSI) recipient to the Social Security Administration within two weeks of admission. This is to prevent SSI overpayments caused by a recipient's inability or failure to make a timely report of changes. The facility must also refer the recipient to the Department of Children and Families for completion of ICP eligibility requirements.

## **Bed Reservations and Absences**

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### **Reserving a State Mental Health Hospital Bed**

Medicaid pays to reserve a bed in the state mental health hospital when a Medicaid recipient goes into a hospital or is on therapeutic leave. The hospitalization must be medically necessary. Hospitalization may be in an acute care hospital, specialty psychiatric hospital or inpatient psychiatric unit in an acute care hospital.

### **Absences**

Medicaid will not pay for absences when it is determined that the recipient no longer requires state mental health hospital services or will not be returning to the state hospital.

Medicaid will not pay for absences for:

- Residents who have applied, for but have not yet been found eligible for ICP;
- Retroactive approvals;
- Hospice recipients; or
- Recipients that are in the Medicare Part A coinsurance period because Medicare does not make payment for absences.

### **Days Reserved for Hospital Stays**

Medicaid pays to reserve a bed for up to 15 days for each hospital stay. One day is defined as an overnight stay away from the state mental health hospital. There is no limit on the number of hospital stays. Each admission to the hospital (even on the same day) begins a new hospital stay.

### **Exclusions**

Medicaid will not pay when a recipient does not plan to return to the state mental health hospital. The state mental health hospital must direct the hospital to send them notification when the recipient decides not to return. If the decision not to return to the state mental health hospital is made while the recipient is in the hospital but prior to the end of the 15-day allowable period, Medicaid will pay to reserve the bed up until the state mental health hospital is advised by the hospital or the recipient that the recipient will not return.

### **Days Reserved for Home Visits**

If the recipient's plan of care allows, Medicaid will reimburse state mental health hospitals for absences for home visits.

- Leave of absence visits cannot exceed 30 days per fiscal year (July 1 through June 30).
- A day is considered to be an overnight stay away from the state mental hospital.
- A home visit means the recipient leaves the facility to go to a family type setting.
- A family type-setting may include an adult family care home or assisted living facility (ALF).

### **Notice Requirements**

A recipient and the recipient's designated representative must be informed in writing about the facility's reserved bed policy before the facility transfers a recipient to the hospital or allows the recipient to go on therapeutic leave. This information must also be provided upon admission.

## Utilization Review

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### Introduction

Each state mental health hospital must ensure that Medicaid recipients receive quality care, while safeguarding against unnecessary or inappropriate utilization of institutional care services. The facility must have a written utilization review plan that provides for review of each recipient's need for the services being furnished.

### Certification of Need for Care

A physician who has knowledge of the case must certify in writing the recipient's need for institutional care. This certification must be signed and dated no more than 45 days before the day of admission or on or before the date of approval of institutional care program payments. Recipients must be recertified at least every 60 days after certification.

When a recipient is transferred from one type of facility to another, a new certification is required.

### Plan Of Care

The state mental health hospital is responsible for developing a comprehensive individualized plan of care for each recipient. The plan of care must contain measurable goals and objectives and timetables to meet a recipient's medical, nursing, and psychological needs.

The plan of care must include:

- Diagnoses, symptoms, complaints and complications indicating the need for admission;
- A description of the functional level of the individual;
- Measurable treatment goals and objectives;
- Any orders of medications, treatments, restorative and rehabilitative services, activities, therapies, social services, or diet;
- Special procedures recommended for the health and safety of the recipient;
- Plans for continuing care, including review and modification to the plan of care;
- Plans for discharge; and
- Documentation that the attending or staff physician and other personnel involved in the recipients care have reviewed each plan of care at least every 60 days.

### Seclusion and Restraints

State mental health hospitals must comply with seclusion and restraint regulations as specified in Chapter 65E-5.180 Florida Administrative Code.

In addition to state requirements, Title 42 Code of Federal Regulations 482.13 regulates the use of seclusion and restraints. These federal requirements may be accessed at [gpoaccess.gov/ecfr/](http://gpoaccess.gov/ecfr/).

### **Plan Of Care Timeframes**

The plan of care must be signed by a physician. It cannot be completed more than 45 days prior to an individual's admission, and must be completed no later than 14 days after an individual's admission. The plan of care must be reviewed by the attending or staff physician and other personnel involved in the recipient's care at least every 60 days.

### **Initial Resident Assessment**

Within 14 days of a recipient's admission to a state mental health hospital and every twelve months thereafter, the facility must conduct a complete, comprehensive, and accurate assessment of the recipient's functional capacity.

The assessment must be:

- Reviewed at least once every 90 days;
- Reviewed and revised promptly after a significant change in the resident's physical or mental condition;
- Revised as appropriate to assure the continued accuracy of the assessment; and
- Included in the plan of care.

### **Continued Stay Reviews**

Continued stay reviews are reviews of each recipient's need for continued placement and the specific level of services required. A state mental health hospital may not retain a recipient who requires a level-of-care or services that the facility is not certified or equipped to provide. ICP benefits are not available for individuals who do not meet level-of-care requirements. Continued stay reviews are conducted by CARES at least annually.

If the state mental health hospital or CARES determines that a recipient does not need state mental health hospital care, Medicaid can continue to pay for up to 30 days after the recipient receives written notification of the determination, to allow time to find another place for the recipient to live.

### **Annual Review and Evaluation of Services**

There is an annual review and evaluation of care and services provided to the recipient in an institutional care facility. AHCA, Health Quality Assurance is responsible for this review.



## CHAPTER 3

# STATE MENTAL HEALTH HOSPITAL SERVICES PER DIEM PAYMENTS

### **Overview**

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#### **Introduction**

This chapter describes the Medicaid State Mental Health Hospital Program per diem payment.

#### **In This Chapter**

This chapter contains:

<b>TOPIC</b>	<b>PAGE</b>
Per Diem Payment	3-1
Contributions To Facilities	3-1

### **Per Diem Payment**

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#### **Introduction**

Medicaid pays a daily rate for care in a state mental health hospital. This rate is called a per diem and is calculated based on the hospital's annual cost report.

#### **Per Diem**

The per diem includes all services and items necessary to ensure appropriate care. Items and services included in the per diem are listed in Chapter 2 of this handbook.

### **Contributions To Facilities**

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#### **Recipient Specific Contributions**

Contributions to a state mental health hospital on behalf of a specific resident are considered third party payments and must be reported to Medicaid Third Party Recovery as such contributions are considered "income" for the recipient.

#### **Contributions Cannot Be Required**

A state mental health hospital cannot require that contributions be made by or on behalf of a recipient in order for the recipient to be admitted to or remain in the facility.



APPENDIX A

AHCA-Med Serve Form 034, January 2008

Physician Certification



**PHYSICIAN CERTIFICATION  
STATE MENTAL HEALTH HOSPITAL SERVICES**

**To be completed by Comprehensive Assessment and Review for Long Term Care Services (CARES)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medicaid #: \_\_\_\_\_  
Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Current Location: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Date of Admission: \_\_\_\_\_  
Attending Physician (please print): \_\_\_\_\_  
Last State Mental Health Hospital Stay: From \_\_\_\_\_ To \_\_\_\_\_ N/A \_\_\_\_\_

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1. Diagnosis: \_\_\_\_\_

2. Summary of Current Medical Findings: \_\_\_\_\_

3. Medical History and Current Medications: \_\_\_\_\_

4. Mental and Physical Capacity: \_\_\_\_\_

5. Prognosis: \_\_\_\_\_

6. Meets the following clinical criteria: (42 CFR § 441.102, 42 CFR § 441.103, 409.966(22), Florida Statutes)
- \_\_\_\_\_ A. Ambulatory care resources available in the community do not meet the treatment needs of the individual.
  - \_\_\_\_\_ B. Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist.
  - \_\_\_\_\_ C. Services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.
- 

Recommended to receive State Mental Health Hospital Services      Effective Date: \_\_\_\_\_

Attending Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Consulting Psychiatrist Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Required if Attending Physician is not a Psychiatrist)

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**PHYSICIAN CERTIFICATION STATE MENTAL HEALTH HOSPITAL SERVICES INSTRUCTIONS**

**Name, Date of Birth, and Medicaid Number:** Should be filled out accurately and as completely as possible.

**Race, Sex, and Marital Status:** Should be filled out accurately and as completely as possible.

**Current Location and Telephone Number:** Where the individual is located during the time the level of care is requested and the contact telephone number.

**Date of Admission:** The date the individual was admitted into the current facility.

**Attending Physician:** The physician responsible for coordinating clinical care for the individual.

**Last State Mental Health Hospital Stay:** Dates the individual previously received state mental health hospital services, if known.

**Diagnosis:** All medical and psychiatric diagnoses for the individual.

**Summary of Current Medical Findings:** Any significant medical conditions that impact the individual (lab results, radiology reports, etc).

**Medical History and Current Medications:** All pertinent historical medical information and any medications currently prescribed for the individual. A copy of individual's medical history and current medications may be attached.

**Mental and Physical Capacity:** Current mental and physical capabilities and deficits of the individual.

**Prognosis:** Indicate poor, fair, or good.

**Meets the following criteria:** Individual meets each of the criteria as described in the 42 Code of Federal Regulations 441.152 (a), and detailed in the State Mental Health Hospital Services Handbook.

**Recommended to receive State Mental Health Hospital Services:** By checking this box, the attending physician and or consulting psychiatrist certifies placement is recommended in a state mental health hospital.

**Effective Date:** The date the attending physician and/or consulting psychiatrist certifies the individual meets the medical and psychiatric criteria for state mental health hospital services.

**Attending Physician Signature:** The original signature of the medical doctor (MD) or doctor of osteopath (DO) that is providing medical care to the individual, is required.

**Date:** The date the physician signs the form.

**Consulting Psychiatrist Signature:** The original signature of the psychiatrist providing care to the individual if the attending physician is not a psychiatrist, is required.

**Date:** The date the psychiatrist signs the form.

**Comments:** The attending physician or consulting psychiatrist may provide additional comments here relevant to the individual or level of care.

AHCA-Med Serv Form 034, Page 2, January 2008, incorporated by reference in 59G-4.300, F.A.C.



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