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Authority

The provisions of this Chapter 1151 issued under section 443.1 of the Public Welfare Code (62 P. S. § 443.1), unless otherwise noted.

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Source

The provisions of this Chapter 1151 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1150.59 (relating to PSR program); 55 Pa. Code § 1163.67 (relating to disproportionate share payments); and 55 Pa. Code § 1163.459 (relating to disproportionate share payments).

GENERAL PROVISIONS**§ 1151.1. Policy.**

- (a) This chapter applies to inpatient psychiatric facilities.
- (b) The MA Program provides payment for medically necessary inpatient services rendered to eligible recipients by enrolled inpatient psychiatric facilities. Payment is made subject to this chapter and Chapter 1101 (relating to general provisions).

Authority

The provisions of this § 1151.1 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.1 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150047).

§ 1151.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Acute psychiatric services—Psychiatric services rendered in response to a severe psychiatric condition requiring intervention to bring the patient's symptoms under control.

Certified day—A day of inpatient hospital care approved by the Department under this chapter.

Day of inpatient hospital care—Room, board and professional services furnished to a patient on a continuous 24-hour-a-day basis in a semiprivate room of a hospital. The term includes items and services ordinarily furnished by the hospital for the care and treatment of inpatients provided in an institution other than one maintained primarily for treatment and care of patients with tuberculosis.

Emergency admission—The unscheduled admission of a person with a severe mental disability who requires immediate treatment, to an inpatient psychiatric facility.

Fiscal year—A period of time beginning July 1 and ending June 30 of the following year.

General hospital—A facility licensed as a hospital under 28 Pa. Code Part IV, Subpart A (relating to general and special hospitals) which provides equipment and services primarily for inpatient care to persons who require treatment for injury, illness, disability or pregnancy. The term does not include public or private psychiatric hospitals, general nursing facilities, county-operated nursing facilities, intermediate care facilities for the mentally retarded or psychiatric transitional facilities.

Inpatient psychiatric facility—The term refers to private psychiatric hospitals and distinct part psychiatric units of general hospitals.

Patient pay amount—Income or assets that the CAO has determined to be available to a recipient to meet the cost of medical care. The recipient, not the MA Program, pays this amount toward the cost of care.

Private psychiatric hospital—An institution, other than a general hospital, not directly operated or controlled by the Department that is engaged in providing acute short-term psychiatric services on an inpatient basis.

Public psychiatric hospital—An institution, other than a general hospital, controlled, operated and funded directly by the Department and engaged in providing long-term and short-term inpatient psychiatric services for the diagnosis, treatment and care of individuals with mental diseases.

Recipient under 21 years of age—A recipient who is one of the following:

- (i) Under 21 years of age.
- (ii) Age 21 and was receiving inpatient psychiatric services in a psychiatric hospital the day preceding the date the recipient reached age 21. This recipient continues to be recognized as a recipient under 21 years of age until the earlier of the date the recipient either:
 - (A) No longer requires inpatient psychiatric facility services.
 - (B) Reaches age 22.

Therapeutic leave—A period of absence by a patient from the inpatient psychiatric facility directly related to the treatment of that patient's illness.

Authority

The provisions of this § 1151.2 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1151.2 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (259615) to (259616) and (293659).

Notes of Decisions

Private Psychiatric Hospital

The definition of “private psychiatric hospital” does not preclude a facility from providing other than acute short-term inpatient psychiatric care; rather, it must provide at least that type of services to qualify as a private psychiatric hospital. *Devereux Hospital Texas Treatment Network v. Department of Public Welfare*, 797 A.2d 1037 (Pa. Cmwlth. 2002), appeal granted, 827 A.2d 1202 (Pa. 2003) and affirmed in part, reversed in part, 855 A.2d 842 (Pa. 2004); remand 878 A.2d 967 (Pa. Cmwlth. 2005); appeal denied 918 A.2d 748 (Pa. 2007).

Cross References

This section cited in 55 Pa. Code § 1151.21 (relating to scope of benefits for the categorically ready); and 55 Pa. Code § 1151.22 (relating to scope of benefits for the medically needy).

SCOPE OF BENEFITS

§ 1151.21. Scope of benefits for the categorically needy.

Categorically needy recipients under 21 years of age as defined in § 1151.2 (relating to definitions) or 65 years of age or older are eligible for medically necessary inpatient psychiatric services provided by a participating inpatient psychiatric facility, subject to this chapter and Chapter 1101 (relating to general provisions).

Authority

The provisions of this § 1151.21 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1151.21 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5244; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (293659) to (293660).

Notes of Decisions

Petitioner’s challenge to a Department order denying her relief was dismissed as the petitioner did not prove she did not receive inpatient psychiatric hospital care from either a public or private psychiatric hospital for at least 60 days. *Campion v. Department of Public Welfare*, 545 A.2d 491 (Pa. Cmwlth. 1988).

§ 1151.22. Scope of benefits for the medically needy.

Medically needy recipients under 21 years of age as defined in § 1151.2 (relating to definitions) or age 65 or older are eligible for medically necessary inpatient psychiatric services provided by a participating inpatient psychiatric facility, subject to this chapter and Chapter 1101 (relating to general provisions).

Authority

The provisions of this § 1151.22 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1151.22 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial page (293660).

§ 1151.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for inpatient psychiatric services unless the recipient is also either categorically needy or medically needy.

Authority

The provisions of this § 1151.23 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.23 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (177171).

§ 1151.24. Scope of benefits for GA recipients.

(a) GA recipients, age 21 to 65, are eligible for medically necessary inpatient psychiatric services as described in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

(b) Inpatient psychiatric services are subject to this chapter and Chapter 1101.

Authority

The provisions of this § 1151.24 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1151.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (293661) and (259619).

PROVIDER PARTICIPATION**§ 1151.31. Participation requirements.**

(a) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), to participate in the MA Program, a private psychiatric hospital shall:

- (1) Be licensed by the Department's Office of Mental Health.
- (2) Be approved by the Department's Office of Mental Health under Chapter 5100 (relating to mental health procedures).
- (3) Have in effect a utilization review plan that meets the requirements at 42 CFR Part 456, Subpart D (relating to utilization control: mental hospitals) and 42 CFR 482.30 (relating to conditions of participation: utilization review) as certified by the Department's Office of MA Programs.
- (4) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- (5) Be certified by the Department of Health as being in substantial compliance with the Medicare requirements for participation for specialty hospitals at 42 CFR Part 482, Subpart E (relating to requirements for specialty hospitals).
- (6) Be enrolled in the MA Program as a private psychiatric hospital.

(b) In addition to the participation requirements established in Chapter 1101, to participate in the MA Program, a psychiatric unit of a general hospital shall:

- (1) Be a part of a general hospital enrolled in the MA Program.
- (2) Meet the criteria of a distinct part unit as set forth under subsection (c).
- (3) Be approved as a psychiatric unit by the Department's Office of Mental Health.
- (4) Be enrolled in the MA Program as a distinct part psychiatric unit.

(c) To qualify as a distinct part psychiatric unit for MA purposes, the unit shall:

- (1) Have written admission criteria that are applied uniformly to both MA patients and non-MA patients.
- (2) Have readily available admission and discharge records that are separately identified from those of the hospital in which the unit is located.
- (3) Have policies requiring that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit.
- (4) Have utilization review standards applicable for the type of care offered in the unit.
- (5) Have beds physically separate from (that is, not commingled with) the hospital's other beds.

- (6) Be treated as a separate cost center for cost finding and apportionment purposes.
- (7) Use an accounting system which properly allocates costs.
- (8) Maintain adequate statistical data to support the basis of the cost allocation.
- (9) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.

Authority

The provisions of this § 1151.31 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.31 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3665; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181769) to (181771).

§ 1151.32. Participation requirements for out-of-State private psychiatric hospitals.

Out-of-State private psychiatric hospitals furnishing care to Commonwealth recipients shall do the following:

- (1) Participate in the Medicaid Program of the state in which the hospital is located.
- (2) Enroll in the Commonwealth's MA Program.
- (3) Be Medicare certified.
- (4) Be certified by either the Joint Commission on Accreditation of Health-care Organizations (JCAHO) or the American Osteopathic Association (AOA).

Authority

The provisions of this § 1151.32 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.32 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181771).

§ 1151.33. Ongoing responsibilities of providers.

(a) In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions), and as a condition of continued participation in the MA Program, private psychiatric hospitals and general hospitals with distinct part psychiatric units that are reimbursed under this chapter shall:

- (1) Maintain transfer agreements with skilled nursing and intermediate care facilities, general hospitals and rehabilitation hospitals, for the prompt and appropriate transfer of patients who no longer require inpatient psychiatric services.
 - (2) Upon request, promptly furnish accurate copies of patient records and fiscal records to the Department or its agents or to Federal and State auditors.
 - (3) Retain complete, accurate and auditable medical and fiscal records for 4 years from the date of each admission for every MA recipient.
- (b) In addition to the ongoing responsibilities established in Chapter 1101 and as a condition of continued participation in the MA Program, psychiatric units of general hospitals that are reimbursed under this chapter shall also keep separate patient statistics and fiscal records on the cost of, and charges for, services provided to MA patients in the psychiatric unit.

Authority

The provisions of this § 1151.33 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.33 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181771) to (181772).

§ 1151.34. Changes of ownership or control.

- (a) An inpatient psychiatric facility is not entitled to additional reimbursement due solely to change of ownership or control.
- (b) If ownership changes, the Department will establish per diem payment rates as follows:
 - (1) If the change involves only one inpatient psychiatric facility, the Department will use the per diem payment rate assigned to the inpatient psychiatric facility before the change.
 - (2) If the change combines two or more inpatient psychiatric facilities into a single entity, such as a merger or consolidation, the Department will establish a new per diem payment rate for the new entity by averaging the rates of the previous entities on a days-weighted basis. To determine that days-weighted average, the Department will use the MA days of each previously enrolled inpatient psychiatric facility as reported in the most recent fiscal year for which all the previous entities filed acceptable Cost Reports (MA 336).
 - (3) If the change divides one enrolled inpatient psychiatric facility into two or more entities, the Department will use the per diem payment rate assigned to the inpatient psychiatric facility before the change, for all resulting entities.
 - (4) The Department will not rebase rates established under this subsection until it rebases rates Statewide.

- (5) If the Department rebases rates Statewide after a change in ownership has occurred, by using a base year which predates or corresponds to the year of the change, the Department will use the Cost Reports (MA 336) and the claims data for the base year regardless of who owned the entity in that base year.
- (c) If ownership changes, disproportionate share payment policy is as follows:
- (1) If the change involves only one inpatient psychiatric facility, the Department will use the disproportionate share status assigned to the inpatient psychiatric facility before the change, so long as the inpatient psychiatric facility maintains the nonemergency obstetric services by which it previously complied with section 1923(d) of the Social Security Act (42 U.S.C.A. § 1396r-4(d)).
 - (2) If the change combines two or more inpatient psychiatric facilities into a single entity, such as a merger or consolidation, the Department will establish the new entity as eligible for disproportionate share payments if one or more of the previous entities was eligible for disproportionate share payments, so long as the resulting entity maintains the nonemergency obstetric services by which one of the previous entities complied with section 1923(d) of the Social Security Act. To determine the monthly disproportionate share payment for the new entity, the Department will add the monthly disproportionate share payments of the previous entities.
 - (3) If the change divides one enrolled inpatient psychiatric facility into two or more entities, the Department will use the disproportionate share status assigned to the inpatient psychiatric facility before the change, as long as each of the resulting entities maintains the nonemergency obstetric services by which the previous entity complied with section 1923(d) of the Social Security Act. The Department will pro rate the monthly disproportionate share payment of the previous entity on the basis of ratio of utilization agreed upon by the entities.
 - (4) The Department will not recalculate disproportionate share status established under this subsection until it recalculates disproportionate share status Statewide.
 - (5) If the Department makes a Statewide redetermination of disproportionate share status after a change of ownership has occurred, and uses a base year which predates or corresponds to the year of the change, the Department will use the cost reports for the base year regardless of who owned the entity in that base year.
 - (6) For a Statewide redetermination of disproportionate share status, the determination of disproportionate share status for the entities resulting from a division will be made on the basis of ratio of utilization for the base year as agreed upon by the entities.

(d) A hospital that changes ownership or closes shall submit final Cost Reports (MA 336) to the Department within 45 days of the change of ownership or closure.

(e) This section applies only to inpatient psychiatric facilities which change ownership in the period July 1, 1993, through June 30, 1995.

Authority

The provisions of this § 1151.34 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.34 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181772) to (181775).

Cross References

This section cited in 55 Pa. Code § 1151.46 (relating to payment rate calculations for Fiscal Year 1993-94 and 1994-95).

PAYMENT FOR INPATIENT PSYCHIATRIC SERVICES

§ 1151.41. General payment policy.

(a) This chapter and Chapter 1101 (relating to general provisions) govern payment for inpatient psychiatric facility services.

(b) If a recipient is readmitted to an inpatient psychiatric facility within 24 hours of the recipient's discharge from the same facility, it will not be considered a new admission for MA purposes, but rather a continuation of the original admission.

(c) If a recipient is admitted to an inpatient psychiatric facility and discharged the same calendar day, the Department will do the following:

(1) Pay one-half of the per diem rate determined by the Department for the facility under § 1151.46 (relating to payment rate calculations for Fiscal Years 1993-94 and 1994-95).

(2) Count the stay as one-half of an inpatient day for cost settlement purposes, for facilities which are subject to cost settlement.

(d) Payment for preadmission laboratory tests, radiology services and other diagnostic services provided to patients admitted to an inpatient psychiatric facility will be included in the payment for inpatient services. If preadmission diagnostic services are provided to a patient who is scheduled to be admitted but who is not admitted to the inpatient psychiatric facility as expected, the diagnostic services shall be billed as outpatient services according to Chapter 1150 (relating to MA Program payment policies) and the MA Program fee schedule.

(e) An inpatient psychiatric facility may not seek reimbursement from an MA recipient if either the facility's utilization review committee or the Department, through its Concurrent Hospital Review process, denies certification for that recipient's days of care. If a patient who has been discharged by a physician refuses to leave the facility at the end of a certified stay, the facility may bill the recipient for days used beyond the length of stay certified by the Department or the facility's utilization review committee.

(f) The inpatient psychiatric facility may bill an MA recipient for days of care related to a noncovered service if the recipient was informed prior to receiving the service that the particular service and the inpatient care relating to the service were not covered under the MA Program.

(g) The inpatient psychiatric facility may not bill the MA Program for services provided to a person who has applied for MA benefits unless the CAO has notified the MA facility that the person is eligible for MA benefits.

(h) If a private psychiatric hospital, or the general hospital of which the psychiatric unit is a part, voluntarily terminates the provider agreement, payment for inpatient services continues for MA patients admitted prior to the date on which the facility announced its intent to withdraw from the program, until the effective date of the termination. The Department will not pay for services provided on or after the effective date of the termination of the provider agreement.

(i) The Department will continue to make payment to a facility affected by a strike for patients temporarily transferred to a facility licensed to provide the required care. If the facility to which the patient is transferred has a per diem rate which is different from that of the transferring facility, the transferring facility will be reimbursed the lower rate. The facility shall immediately notify the Office of Medical Assistance Programs in writing of an impending strike and follow with a listing of MA patients and the facility to which they are to be transferred.

(j) For payment to be made for laboratory tests and other diagnostic procedures, the studies shall be related to the patient's condition and be specifically ordered in writing for the particular patient by the attending physician or other licensed practitioner who is responsible for determining the diagnosis or treatment of that patient. In emergency situations, an exception will be made to the requirement that studies be specifically ordered in writing if the test or procedure is necessary to prevent the death or serious impairment of the health of the recipient. Payment will not be made for diagnostic services performed pursuant to a preprinted regimen.

(k) As part of the discharge planning process, the inpatient psychiatric facility shall refer the patient to the local mental health program in the patient's county of residence.

Authority

The provisions of this § 1151.41 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.41 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective October 30, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181775) to (181777).

Cross References

This section cited in 55 Pa. Code § 1151.41a (relating to clarification of the term “in writing”—statement of policy).

Notes of Decisions

Petitioner, who was denied medical assistance certification for days of care, did not suffer a pecuniary interest from the Department’s denial of payment to a provider and lacked standing to challenge the Department’s order as the provider could not seek reimbursement from a medical assistance recipient if certification for days of care is denied. *Campion v. Department of Public Welfare*, 545 A.2d 491 (Pa. Cmwlth. 1988).

§ 1151.41a. Clarification of the term “in writing”—statement of policy.

(a) The term “in writing” in § 1151.41(j) (relating to general payment policy) includes orders that are handwritten or transmitted by electronic means.

(b) Written orders transmitted by electronic means must be electronically encrypted or transmitted by other technological means designed to protect and prevent access, alteration, manipulation or use by any unauthorized person.

Source

The provisions of this § 1151.41a adopted July 16, 2010, effective July 17, 2010, 40 Pa.B. 3963.

§ 1151.42. Payment methods and rates.

(a) The Department will pay inpatient psychiatric facilities a payment rate based on cost items that are determined to be allowable under § 1151.44 (relating to allowable costs).

(b) The Auditor General will audit each inpatient psychiatric facility’s cost report to determine allowable costs under State and Federal regulations.

(c) Out-of-State private psychiatric hospitals are reimbursed under § 1151.50 (relating to payment for out-of-State private psychiatric hospital services).

(d) Payment for inpatient hospital services, including acute care general hospitals and their district part units, private psychiatric hospitals and freestanding rehabilitation hospitals, will not be made in excess of the amount which would be paid in the aggregate for those services under Medicare principles of reimbursement in 42 CFR Part 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services).

Authority

The provisions of this § 1151.42 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.42 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181778).

§ 1151.43. Limitations on payment.

(a) For adult recipients, payment for inpatient psychiatric hospital services in a private psychiatric hospital or a distinct part of a psychiatric unit of a general hospital is limited to 30 days per fiscal year.

(b) A recipient is limited to two periods of therapeutic leave per calendar month. Neither of these periods of therapeutic leave may exceed 12 hours in a calendar day.

(c) The Department is authorized to grant an exception to the limits specified in subsection (a) as described in § 1101.31(f) (relating to scope).

Authority

The provisions of this § 1151.43 amended under sections 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454 of the Public Welfare Code (62 P. S. §§ 201(2), 403(b), 443.1, 443.3, 443.6, 448 and 454).

Source

The provisions of this § 1151.43 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended July 12, 1985, effective July 13, 1985, and will apply to reimbursement for services for FY 1984-85 for each fiscal year thereafter, 15 Pa.B. 2572; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241; amended August 26, 2005, effective August 29, 2005, 35 Pa.B. 4811. Immediately preceding text appears at serial pages (259625) to (259626).

Cross References

This section cited in 55 Pa. Code § 1151.48 (relating to noncompensable services and items).

§ 1151.44. Allowable costs.

The Department uses Medicare principles as established by the Social Security Act (42 U.S.C.A. §§ 301—1399) and Federal regulations and instructions as a basis for determining what cost items are allowable for the purposes of MA reimbursement. In addition to the cost items allowable under 42 CFR Part 413 (relating to principles of reasonable cost reimbursement; payment for end-stage renal disease services), the Department recognizes costs for direct or indirect chaplaincy expenses related to patient care excluding training costs associated with the chaplaincy program.

Authority

The provisions of this § 1151.44 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.44 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2976; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 600; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150054).

Cross References

This section cited in 55 Pa. Code § 1151.42 (relating to payment methods and rates).

§ 1151.45. Nonallowable costs.

Costs not allowable under the MA Program are:

- (1) Costs exceeding the limits established by the Department of Health and Human Services under Medicare regulations at 42 CFR 413.30 (relating to limitations on reimbursable costs).
- (2) Costs related to the provision of a noncompensable service or item listed in § 1151.48 (relating to noncompensable services and items).
- (3) Inpatient costs related to preadmission laboratory tests, radiology services and other diagnostic services provided to recipients who are not admitted to the hospital as planned.
- (4) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is ultimately decided in favor of the Commonwealth.
- (5) Costs for relocating or housing employees.

(6) Costs for which Federal financial participation (FFP) is precluded by statute, except as may be expressly provided for otherwise in this chapter.

(7) Capital costs related to new or additional beds unless an application for a Certificate of Need for the new or additional beds has been approved by the Department of Health, with an effective date of June 30, 1991, or earlier. For the facility to receive payment, the project shall be substantially implemented as defined by applicable Department of Health regulations within the effective period of the Certificate of Need.

(8) Capital costs related to new or additional beds unless a letter of nonreviewability has been issued on or before June 30, 1991.

(9) Capital costs for replacement beds, unless the facility received a Certificate of Need as defined at section 701 of the Health Care Facilities Act (35 P. S. § 448.701) for replacement beds. To be recognized as allowable, the replacement beds shall physically replace beds in the same facility, capital costs related to the beds being replaced shall have been recognized as allowable and the project shall be substantially implemented as defined by applicable Department of Health regulations within the effective period of the original Section 1122 approval or the original Certificate of Need, plus one 6-month extension period.

Authority

The provisions of this § 1151.45 amended under sections 201 and 443.1(1) and (4) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1) and (4)).

Source

The provisions of this § 1151.45 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended February 28, 1986, effective March 1, 1986, 16 Pa.B. 660; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181779) to (181781).

§ 1151.46. Payment rate calculations for Fiscal Years 1993-94 and 1994-95.

(a) The amount of the Department's payment for services provided to an MA recipient is the inpatient psychiatric facility's per diem rate established under this section multiplied by the number of compensable days of service rendered minus payment made by a third-party payor, the recipient or a legally responsible relative. The Department will also deduct from the payment Medicare Part B payments and other resources available to the patient to meet the cost of the inpatient psychiatric care.

(b) The per diem rate includes payments for capital costs and for direct medical education costs, but does not include disproportionate share payments.

(c) The method for determining the per diem payment rates under this section depends upon the status of the inpatient psychiatric provider as being “existing” or “new,” as follows:

(1) An “existing” provider is an inpatient psychiatric facility that was enrolled in the MA Program for the entire period from July 1, 1989, to June 30, 1990, including each inpatient psychiatric facility which changed ownership after July 1, 1989, and elected to retain the rate of the prior entity, which had submitted a full cost report for Fiscal Year 1989-90.

(2) A “new” provider is an inpatient psychiatric facility that enrolled in the MA Program after July 1, 1989, including each inpatient psychiatric facility which changed ownership between July 1, 1989, and June 30, 1993, and elected to have its payment rate rebased.

(d) Subject to the limits specified in subsection (i), the per diem payment rate for an existing provider is the facility’s MA per diem cost as reported on the Fiscal Year 1989-90 MA Cost Report (MA 336) reduced by the over reporting factor of 1.69% and inflated by the appropriate inflation factors specified under subsection (h).

(e) The payment rates established for existing providers shall be considered final payment rates, without regard to audit, unless the facility is eligible for additional capital payment under § 1151.52 (relating to payment for capital costs not included in the base year).

(f) Subject to the limits specified under subsection (i), the interim and final per diem payment rates for new providers are determined as follows:

(1) The interim per diem payment rate is based on the MA per diem cost as reported on the MA Cost Report (MA 336) for the first full fiscal year of operation in the MA Program, or, until the first full cost report is available, a projected budget is submitted by the provider and approved by the Department.

(2) The interim per diem payment rate is the amount determined under paragraph (1), reduced by the over-reporting factor of 1.69% and inflated by the appropriate inflation factors specified under subsection (h).

(3) The final per diem payment rate is the audited MA per diem cost of the facility’s first full fiscal year of operation in the MA Program, inflated by the appropriate inflation factors specified under subsection (h).

(g) New providers will be subject to cost settlement for a difference between the interim and final payment rates determined under this section.

(h) To calculate per diem payment rates, the Department will use the following inflation factors, as applicable:

- (1) 5.3% to account for Fiscal Year 1990-91 inflation.
- (2) 5.2% to account for Fiscal Year 1991-92 inflation.
- (3) 4.6% to account for Fiscal Year 1992-93 inflation.
- (4) 4.3% to account for Fiscal Year 1993-94 inflation, to be applied as follows:

(i) Inpatient psychiatric facilities that received a Fiscal Year 1992-93 disproportionate share rate enhancement will receive the 4.3% inflation factor effective July 1, 1993.

(ii) Inpatient psychiatric facilities that did not receive a Fiscal Year 1992-93 disproportionate share rate enhancement will receive the 4.3% inflation factor effective January 1, 1994.

(5) For Fiscal Year 1994-95 effective January 1, 1995, inpatient psychiatric facilities will receive an inflation factor equal to the prospective payment system type hospital market basket moving average inflation factor, published by DRI/McGraw-Hill in the fourth quarter of 1993 for the second calendar quarter of 1995.

(i) The Department will limit per diem rates as follows:

(1) For Fiscal Year 1993-94, an inpatient psychiatric facility's per diem rate may not exceed \$950.

(2) For Fiscal Year 1994-95, an inpatient psychiatric facility's per diem rate may not exceed \$950 increased effective January 1, 1995, for inflation by the prospective payment system type hospital market basket moving average inflation factor, published by DRI/McGraw-Hill in the fourth calendar quarter of 1993 for the second calendar quarter of 1995.

(j) The Department will establish payment rates for inpatient psychiatric facilities which change ownership on or after July 1, 1993, under § 1151.34 (relating to changes of ownership or control).

Authority

The provisions of this § 1151.46 amended under sections 201 and 443.1(1) and (4) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1) and (4)).

Source

The provisions of this § 1151.46 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 3828; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181781) to (181782).

Cross References

This section cited in 55 Pa. Code § 1151.41 (relating to general payment policy); and 55 Pa. Code § 1151.52 (relating to payment for capital costs not included in the base year).

§ 1151.47. Annual cost reporting.

(a) An inpatient psychiatric facility shall complete Form MA 336 (Financial Report for Hospital and Hospital Health Care Complex Under the Medical Assistance Program of the Department of Human Services, Commonwealth of Penn-

sylvania) in accordance with Medicare principles at 42 CFR Part 405, Subpart D (relating to principles of reimbursement for services by hospital based physicians).

(b) The inpatient psychiatric facility shall submit Form MA 336 to the Department's Office of Medical Assistance Programs by September 30 of each year. The Department may grant a 30-day extension to the September 30 due date, upon receipt of a written request from a private psychiatric hospital or a general hospital with a distinct part psychiatric unit. If the inpatient psychiatric facility participates in Medicare, a completed copy of Form HCFA-2552—*Hospital, Hospital-Skilled Nursing Facility Complex and Skilled Nursing Facility Cost Report*—also shall be submitted to the Department as a supplement to Form MA 336.

(c) The hospital's cost report shall:

- (1) Be prepared using the accrual method of accounting.
- (2) Cover a fiscal period of 12-consecutive months, from July 1 to June 30, except as noted in paragraph (4).
- (3) Include information necessary for the proper determination of costs payable under the Program, including financial records and statistical data.
- (4) In the case of a hospital beginning operations after the start of the fiscal year, cover the period from the date of approval for participation in the MA Program to the end of that fiscal year.
- (5) Be adjusted to remove the costs of direct care by salaried physicians and other salaried practitioners.

(d) For inpatient psychiatric facilities subject to cost settlement, if the total amount of MA payment for interim claims for services during the fiscal year exceeds the total audited costs, the Department will recover the overpaid amount from the provider under § 1101.69(b) (relating to overpayment—underpayment).

(e) The inpatient psychiatric facility shall submit requests to retroactively review or alter the Auditor General's reimbursement certification to the Department of the Auditor General within 1 year of the date the reimbursement certification was made.

Authority

The provisions of this § 1151.47 amended under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

Source

The provisions of this § 1151.47 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended July 12, 1985, effective July 13, 1985, 15 Pa.B. 2572, and will apply to reimbursement for services for FY 1984-85 for each fiscal year thereafter; amended February 5, 1988, effective February 6, 1988, 18 Pa.B. 556; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181782) to (181784).

§ 1151.48. Noncompensable services and items.

- (a) The Department will not pay an inpatient psychiatric facility for:
- (1) Experimental procedures and services that are not in accordance with customary standards of medical practice or that are not commonly used.
 - (2) A day of inpatient care solely for the purpose of performing diagnostic tests that can be performed on an outpatient basis, or tests not related to the diagnoses that require the inpatient hospital care.
 - (3) A day of inpatient care if payment is available from another public agency or another insurance or health program.
 - (4) Services not ordinarily provided to the general public.
 - (5) Methadone maintenance.
 - (6) Days of care during which the patient was absent from the inpatient psychiatric facility to attend school, conferences or meetings, to participate in other activities outside the facility, or for employment except for therapeutic leave under § 1151.43 (relating to limitations on payment).
 - (7) Custodial care related or unrelated to court commitments. Payment for services provided to recipients confined to an inpatient psychiatric facility under a court commitment for any reason will be made only if medical necessity exists for psychiatric inpatient care.
 - (8) Diagnostic or therapeutic procedures for experimental research or educational purposes.
 - (9) Unnecessary admissions and days of care due to conditions which do not require psychiatric inpatient care, such as, rest cures and room and board for relatives during a recipient's hospitalization.
 - (10) Days of care for recipients who no longer require psychiatric inpatient care. The Department does make payment to an inpatient psychiatric facility for skilled nursing or intermediate care provided for a recipient in a certified bed in a certified and approved hospital-based skilled nursing or intermediate care unit in accordance with Chapter 1181 (relating to nursing facility care) or successor provisions.
 - (11) Days of care for recipients remaining in an inpatient psychiatric facility beyond the length of stay certified by the Department's Concurrent Hospital Review (CHR) unit, or, if the hospital has been granted an exemption to the CHR process, days of care beyond the length of stay certified by the hospital's utilization review committee.
 - (12) Grace periods, such as pending discharge of a recipient when inpatient hospital care is no longer needed.
 - (13) Days of care due to failure to promptly request or perform necessary diagnostic studies or consultations.
 - (14) Days of care on or after the effective date of a court commitment to another facility.
 - (15) Days of inpatient care provided to a recipient who is suitable for an alternate type or level of care, regardless of whether the recipient is under voluntary or involuntary commitment.

(16) Diagnostic procedures or laboratory tests not specifically ordered by the physician or practitioner responsible for the diagnosis or treatment of the patient unless the procedure or test is necessary to prevent the death or serious impairment of the patient's health.

(17) Diagnostic procedures or laboratory tests ordered by means of a stamped or preprinted regimen.

(18) The day of discharge unless it is also the day of admission.

(19) Days of care not certified in accordance with the Department's concurrent hospital review process unless the inpatient psychiatric facility has been granted an exemption by the Department.

(20) Days of care due to failure to promptly apply for a court-ordered commitment.

(b) The Department will not pay inpatient psychiatric facilities for services or items provided in conjunction with the provision of a service or item in subsection (a).

(c) The Department will not pay inpatient psychiatric facilities for services or items in subsection (a) even if the attending physician or hospital utilization review committee determines that the stay was medically necessary.

Authority

The provisions of this § 1151.48 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.48 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3665; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181784) to (181786).

Notes of Decisions

Unnecessary Admissions

The Department's determination that patient's admission was unnecessary was erroneous where the patient was admitted pursuant to a court commitment order. That order constituted a legal determination that commitment in the appellant's facility was appropriate and necessary. *Devereux Hospital Texas Treatment Network v. Department of Public Welfare*, 797 A.2d 1037 (Pa. Cmwlth. 2002); appeal granted 827 A.2d 1202 (Pa. 2003); affirmed in part; reversed in part 855 A.2d 842 (Pa. 2004); remand 878 A.2d 967 (Pa. Cmwlth. 2005); appeal denied 918 A.2d 748 (Pa. 2007).

Cross References

This section cited in 55 Pa. Code § 1151.45 (relating to nonallowable costs); and 55 Pa. Code § 1151.74 (relating to responsibilities of the inpatient psychiatric facility utilization review committee).

§ 1151.49. Third-party liability.

(a) Inpatient psychiatric facilities shall utilize the available third-party resources for services a recipient receives while in the inpatient psychiatric facility.

(b) If expected payment by a third-party resource is not realized, the inpatient psychiatric facility may bill the MA Program.

(c) If the psychiatric facility receives reimbursement from a third-party subsequent to payment from the Department, the facility shall repay the Department by submitting a claim adjustment.

(d) If a recipient or the legal representative of a recipient requests a copy of the facility's invoice, the facility shall submit a copy of the invoice and the request to the Department's Office of Administration at the address specified in the Provider Handbook. The Office of Administration will forward the requested copy to the requestor and take follow-up action necessary to ensure the repayment of MA expenditures.

(e) If a recipient is entitled to Medicare Part A benefits, the Department will pay the amount of the Medicare deductible and coinsurance minus other resources available to the recipient for the psychiatric inpatient care.

(f) Except as specified in subsection (g), if a recipient is entitled to hospital insurance benefits other than Medicare Part A, the Department will pay the lesser of the following:

(1) The inpatient psychiatric facility's per diem rate multiplied by the number of compensable inpatient psychiatric days of care rendered, minus resources available to the recipient for hospital care, including Medicare Part B payments.

(2) The amount of the insurance plan's deductible and coinsurance minus other resources available to the recipient for inpatient psychiatric care, including Medicare Part B payments.

(g) If the resources available to a recipient for inpatient psychiatric care equal or exceed the inpatient psychiatric facility's per diem rate multiplied by the number of compensable inpatient psychiatric days of care rendered, the Department will make no payment for the inpatient psychiatric facility care.

(h) The inpatient psychiatric facility shall utilize resources available through Medicare Part B for services provided in the facility that are covered and approved for payment by Medicare.

Authority

The provisions of this § 1151.49 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.49 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181786) to (181787).

§ 1151.50. Payment for out-of-State private psychiatric hospital services.

(a) The Department will pay for compensable services furnished by out-of-State private psychiatric hospitals to an eligible Pennsylvania recipient, if one of the following exists:

- (1) Residents in a given area generally receive their care in a particular out-of-State private psychiatric hospital; this would apply when the out-of-State private psychiatric hospital is closer to, or substantially more accessible from the residence of the recipient than, the nearest private psychiatric hospital within this Commonwealth which is adequately equipped and is available for the treatment of the individual's illness.
- (2) Documentation is provided verifying one of the following:
 - (i) The recipient required inpatient psychiatric hospital services on an emergency basis, while temporarily out of this Commonwealth.
 - (ii) An out-of-State private psychiatric hospital is the only facility equipped to provide the type of care that the individual requires.
- (b) The payment for inpatient hospital services provided by an out-of-State private psychiatric hospital is the lowest of:
 - (1) The payment the hospital would receive for the admission under the hospital's home state payment system.
 - (2) A Statewide days-weighted average per diem rate, times the number of compensable days of inpatient psychiatric care rendered.
 - (3) The amount of the charges billed by the hospital.
 - (4) The Medicare deductible or coinsurance, if applicable.
- (c) If a recipient is admitted to an out-of-State private psychiatric hospital and discharged within the same calendar day, the Department will pay one half of the per diem rate established under subsection (b)(2). If Medicare is involved, the entire allowable Medicare deductible and coinsurance will be paid.
- (d) The Department will pay the amount established in accordance with subsection (b) minus payments from the recipient, a legally responsible relative or a third-party resource for the services a recipient receives while in the hospital.
- (e) The Department's payment rate will not be based on costs which are precluded from recognition by the Social Security Act (42 U.S.C.A. §§ 301—1399).

Authority

The provisions of this § 1151.50 amended under sections 201 and 443.1 of the Public Welfare Code (62 P. S. §§ 201 and 443.1).

Source

The provisions of this § 1151.50 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended February 28, 1986 effective March 2, 1986, 16 Pa.B. 600; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181787) to (181788).

Notes of Decisions

Court Order Committing Juvenile Delinquents to Out-of-State Hospital Did Not Preclude In-State Placement

Court order committing juvenile delinquents to out-of-State hospital on grounds that such placement was "best suited" to their needs did not establish that hospital was the only facility equipped to provide the type of care the juveniles required, which would necessitate the Department of Public Welfare to pay the costs of the out-of-State placements. *Department of Public Welfare v. Devereux Hospital Texas Treatment Network (K.C.)*, 855 A.2d 842, 847 (Pa. 2004)

Cross References

This section cited in 55 Pa. Code § 1151.42 (relating to payment methods and rates).

1151-22

§ 1151.51. [Reserved].**Source**

The provisions of this § 1151.51 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 10, 1986, effective retroactively to July 1, 1984, 16 Pa.B. 4384; amended November 7, 1986, effective July 1, 1986, 16 Pa.B. 4384; amended June 16, 1989, effective immediately and applies retroactively to July 1, 1988, 19 Pa.B. 2563; amended June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150062).

§ 1151.52. Payment for capital costs not included in the base year.

(a) Inpatient psychiatric facilities which place a new capital project into service after the base year, as determined under § 1151.46 (relating to payment rate calculations for Fiscal Years 1993-94 and 1994-95), are entitled to payment for certain capital costs, if the qualifying criteria, outlined under this section, are met.

(b) This additional payment applies only to capital projects with an approval date of either a Certificate of Need or letter of nonreviewability on or before June 30, 1991.

(c) To apply for an additional capital payment, an inpatient psychiatric facility shall submit documentation sufficient to enable the Department to verify that the requirements of this section are met.

(d) To be eligible for an additional capital payment, the costs related to a capital project shall meet the following criteria:

(1) The costs shall represent increases in the inpatient psychiatric facility's allowable depreciation and interest costs for a fixed asset that was entered in the inpatient psychiatric facility's fixed asset ledger in the year being audited.

(2) The costs shall be attributable to a fixed asset that is both of the following:

(i) Approved for Certificate of Need on or before June 30, 1991, under 28 Pa. Code Chapter 301 or 401 (relating to limitations on Federal participation for capital expenditures; and Certificate of Need Program), or not subject to review for Certificate of Need as evidenced by a letter of nonreviewability dated on or before June 30, 1991.

(ii) Related to patient care in accordance with Medicare standards.

(e) For an inpatient psychiatric facility to qualify for an additional capital payment set forth in this section, the following criteria shall be met:

(1) The inpatient psychiatric facility's rate of increase in overall audited costs shall exceed 15%. The Department will establish this rate of increase by comparing the inpatient psychiatric facility's audited costs for the fiscal year to its audited costs for the preceding fiscal year.

(2) The inpatient psychiatric facility's rate of increase for allowable depreciation and interest shall exceed its rate of increase for net operating costs. The Department will determine the rate of increase in an inpatient psychiatric facility's net operating cost by comparing the inpatient psychiatric facility's audited

net operating costs for the fiscal year to its audited net operating costs for the preceding fiscal year. The Department will determine the rate of increase in an inpatient psychiatric facility's depreciation and interest costs by:

(i) Determining the inpatient psychiatric facility's allowable audited depreciation and interest costs for the preceding fiscal year, including costs excluded in the preceding fiscal year under subsection (b).

(ii) Adding the amount allowable under subsection (b) for the fiscal year being audited to the amount determined under subparagraph (i).

(iii) Comparing the amounts determined under subparagraphs (i) and (ii) to determine the rate of increase.

(f) For Fiscal Years 1993-94 and 1994-95, for each inpatient psychiatric facility which requests an additional capital payment, the Department will audit its MA Cost Reports for the fiscal year for which the request is made, the prior fiscal year and subsequent fiscal years for which additional capital payment is requested. To the extent that the facility is determined eligible to receive an additional capital payment under this section, the following applies:

(1) For each fiscal year the Department will compare the total MA payments for inpatient psychiatric services paid to the inpatient psychiatric facility for that fiscal year (the "total payment") with the inpatient psychiatric facility's actual MA costs for inpatient psychiatric services as determined at audit, including the allowable capital costs eligible under this section (the "actual costs").

(2) If the amount of actual costs exceeds the total payment, the Department will pay the inpatient psychiatric facility the difference between the actual costs and the total payment, not to exceed the amount of allowable capital costs.

(3) If the amount of actual costs does not exceed the total payment, the Department will not pay the inpatient psychiatric facility any additional capital payment.

(4) The Department will not recoup or offset any additional capital payment made under this section.

Source

The provisions of this § 1151.52 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3665; reserved June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181789).

Cross References

This section cited in 55 Pa. Code § 1151.46 (relating to payment rate calculations for Fiscal Years 1993-94 and 1994-95).

§ 1151.53. Billing requirements.

(a) The inpatient psychiatric facility shall submit invoices to the Department under the instructions in the Provider Handbook.

(b) The Department will not pay for inpatient psychiatric services if the facility submits the invoice for payment for those services later than 180 days following the last certified day of care unless the hospital is awaiting one of the following:

(1) Final determination of the patient's eligibility for a potential third-party payment.

(2) Final determination by the CAO of the patient's eligibility for MA.

(c) The Department will not pay for claims or claim adjustments, including pending claims and pending claim adjustments for services provided during Fiscal Year 1983-84, if they are not adjudicated by December 31, 1984. Beginning with Fiscal Year 1984-85, exception requests for prior fiscal year services will not be considered through the exception process, but may be appealed upon completion of the audit. This subsection applies whether or not the hospital was granted an extension under subsection (b).

(d) Except as specified in subsection (e), inpatient psychiatric facilities shall bill services and items provided to an inpatient as inpatient services.

(e) Inpatient psychiatric facilities may not bill for the following services and items provided to a patient of the facility:

(1) Services provided by a practitioner, unless the practitioner is under salary or contract with the inpatient psychiatric facility to provide services; or services provided by a practitioner who may bill directly under another chapter.

(2) Services provided by a midwife, as defined in § 1142.2 (relating to definitions), unless the midwife is under salary or contract with the inpatient psychiatric facility to provide services.

(3) Orthoses, prostheses and durable medical equipment.

(4) Ambulance services when one or more of the following applies:

(i) The ambulance is not owned and operated directly by the private psychiatric hospital, or general hospital of which the psychiatric unit is a part.

(ii) The patient is transferred from the emergency room or clinic of the private psychiatric hospital, or general hospital of which a psychiatric unit is a part, to another inpatient psychiatric facility for admission.

(iii) The patient is discharged from the inpatient psychiatric facility, transferred by ambulance to another inpatient psychiatric facility and then admitted to the second inpatient psychiatric facility.

(f) If a patient is admitted to the distinct part psychiatric unit of a general hospital from the emergency room, the psychiatric unit shall bill for the services provided in the emergency room on the inpatient invoice.

Authority

The provisions of this § 1151.53 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.53 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended July 12, 1985, effective July 13, 1985, 15 Pa.B. 2572, and will apply to reimbursement for services for FY 1984-85 for each fiscal year thereafter; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181789) to (181790).

§ 1151.54. Disproportionate share payments.

(a) The Department will annually determine the acute care general hospitals including their distinct part units, private psychiatric hospitals and freestanding rehabilitation hospitals that qualify for disproportionate share payments by the method in subsections (b)—(e). The Department will annually determine the amount of disproportionate share payments for eligible private psychiatric hospitals and distinct part psychiatric units of acute care general hospitals by the method in subsections (f)—(h).

(b) A hospital that meets at least one of the requirements in subsection (d) will qualify for disproportionate share payments if one of the following applies:

(1) The hospital's ratio of Title XIX inpatient days to total inpatient days is equal to or greater than one standard deviation above the mean of the ratios for hospitals in this Commonwealth. To determine the ratio for an acute care general hospital, the Department will include inpatient days covered under Chapter 1163, Subchapter A (relating to acute care general hospitals under the prospective payment system), and days covered under Chapter 1163, Subchapter B (relating to hospitals and units covered under cost reimbursement principles), as well as days covered under this chapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid Programs, MA health maintenance organizations (HMO) days and MA Health Insuring Organization (HIO) days.

(2) The hospital's low income utilization rate, as defined under section 1923(d) of the Social Security Act (42 U.S.C.A. § 1396r-4(b)(3)) exceeds 25% under one of the following methods:

(i) The hospital's low income utilization rate as reported on its cost report (MA 336) computation of low income utilization rate worksheet exceeds 25%.

(ii) The hospital's low income utilization rate as determined by its ratio of Title XIX and General Assistance inpatient days to total inpatient days exceeds 25%. To determine the ratio for an acute care general hospital, the Department will include inpatient days covered under Chapter 1163, Subchapter A, and days covered under Chapter 1163, Subchapter B, as well as days covered under this chapter. The Department will include in the database MA administrative days, days of care provided to recipients in other states' Medicaid Programs, MA HMO days and MA HIO days.

(3) The hospital is an acute care general hospital which qualifies as a rural hospital or sole community hospital under the Medicare Program, and its number of MA acute care inpatient cases to total acute care inpatient cases is equal to or greater than the 75th percentile of the ratios for acute care general hospitals in this Commonwealth. The Department will not include cases for a unit covered under Chapter 1163, Subchapter B, or under this chapter. The Department will include in the database discharges related to other states' Medicaid Programs.

(c) The Department will utilize the following data sources in making disproportionate share eligibility determinations:

(1) For Fiscal Year 1993-94, the Department will utilize data from Fiscal Year 1991-92 Cost Reports (MA 336) and from Fiscal Year 1991-92 for services provided to recipients enrolled in MA HMO programs and MA HIO programs. To determine the Title XIX percentage of total MA cases or days, the Department will utilize the most currently available data.

(2) For Fiscal Year 1994-95, the Department will utilize data from Fiscal Year 1992-93 Cost Reports (MA 336) and from Fiscal Year 1992-93 for services provided to recipients enrolled in MA HMO programs and MA HIO programs. To determine the Title XIX percentage of total MA cases or days, the Department will utilize the most currently available data.

(d) To qualify for disproportionate share payments, a hospital shall meet at least one of the following requirements:

(1) The hospital shall be identified as a children's hospital, as defined under § 1163.2 (relating to definitions).

(2) The hospital shall have at least two physicians with staff privileges who have agreed to provide obstetric services to individuals entitled to those services under the MA Program.

(3) The hospital has not offered nonemergency obstetric services to the general population since December 21, 1987.

(e) To determine hospitals that qualify for disproportionate share payments based on the ratio of Title XIX inpatient days to total inpatient days, the Department will:

(1) Identify the total number of MA inpatient days from the hospital's cost report (MA 336), including days of care provided to recipients in other states' Medicaid Programs, and to that number:

(i) Add the hospital's number of inpatient days for MA recipients enrolled in MA HMO programs and MA HIO programs.

(ii) Add the hospital's number of MA administrative days from the hospital's Cost Report (MA 336).

(iii) Subtract the hospital's number of days of care provided to General Assistance recipients.

- (2) Divide the days determined under paragraph (1) by the total number of inpatient days from the hospital's Cost Report (MA 336) to determine the hospital's ratio of Title XIX inpatient days to total inpatient days.
- (3) Array the hospitals, from high to low, according to the ratios determined under paragraph (2) and determine the mean and standard deviation of the array.
- (4) Identify as disproportionate share providers, hospitals with a ratio of Title XIX inpatient days to total inpatient days equal to or greater than one standard deviation above the mean.
- (f) Once the Department determines which hospitals qualify as disproportionate share providers under subsection (b)(1)—(3) for Fiscal Year 1993-94, the Department will calculate disproportionate share percentages for qualifying private psychiatric hospitals and distinct part psychiatric units of acute care general hospitals by:
 - (1) Arraying qualifying inpatient psychiatric facilities from high to low, according to each facility's ratio of Title XIX inpatient days to total inpatient days.
 - (2) Assigning a disproportionate share percentage of 10% to the qualifying inpatient psychiatric facility with the highest ratio of Title XIX inpatient days to total inpatient days.
 - (3) Obtaining for other inpatient psychiatric facilities in the array, the annual disproportionate share percentage, which is 1%, plus 8% multiplied by a fraction, the numerator of which is the ratio of Title XIX inpatient days to total inpatient days of the qualifying facility, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest facility in the array; and the denominator of which is the ratio of Title XIX inpatient days to total inpatient days of the second to highest facility in the array, minus the ratio of Title XIX inpatient days to total inpatient days of the lowest facility in the array.
- (g) The Department will determine prospectively the annual disproportionate share payment amount for each qualifying inpatient psychiatric facility by multiplying the following:
 - (1) The inpatient psychiatric facility's disproportionate share percentage determined under subsection (f).
 - (2) The inpatient psychiatric facility's per diem rate in effect on July 1 of the fiscal year, except that the Department will use the new base per diem rate for a facility whose rate changes during the fiscal year for any reason except for the annual inflationary increase.
 - (3) The inpatient psychiatric facility's projected number of MA inpatient psychiatric days, determined as follows:
 - (i) For Fiscal Year 1993-94, the number of inpatient psychiatric days for the inpatient psychiatric facility, as reported on the facility's Fiscal Year 1991-92 Cost Report (MA 336), increased by 3.52%, and then by 2.8%.

(ii) For Fiscal Year 1994-95, the number of inpatient psychiatric days for the inpatient psychiatric facility, as reported on the facility's Fiscal Year 1992-93 Cost Report (MA 336) increased by utilization factors consistent with the Governor's Fiscal Year 1994-95 budget proposal.

(4) For inpatient psychiatric facilities that do not receive an inflationary increase on July 1, the Department will inflate one-half of the amount calculated under subsection (g)(1)—(3) by the annual inflation increase.

(h) The Department will divide the annual disproportionate share payment amount into 12 monthly payments.

(i) The Department will publish annually, as a notice in the *Pennsylvania Bulletin*, a list of the qualifying inpatient psychiatric facilities and their annual disproportionate share payment percentages.

Authority

The provisions of this § 1151.54 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.54 adopted June 1, 1990, effective retroactively to July 1, 1988, 20 Pa.B. 2913; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181790) to (181793).

§ 1151.55. [Reserved].

Source

The provisions of this § 1151.55 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; reserved October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181793) to (181794).

§ 1151.56. [Reserved].

Source

The provisions of this § 1151.56 adopted June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; reserved October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181795) to (181797).

PAYMENT CONDITIONS FOR INPATIENT PSYCHIATRIC SERVICES

§ 1151.61. Payment conditions: general.

For payment to be authorized for inpatient psychiatric services:

(1) The recipient's need for admission shall be certified under § 1151.62 (relating to Certification of Need for admission).

(2) A medical and psychiatric evaluation shall be made by the attending physician or staff physician under § 1151.63 (relating to medical and psychiatric evaluation).

(3) A social evaluation must be made under § 1151.64 (relating to social evaluation) by one of the following:

(i) The social service staff of the CAO or its agent for recipients applying for admission to an inpatient psychiatric facility.

(ii) An appropriate member of the inpatient psychiatric facility's staff, if the individual applies for MA while in an inpatient psychiatric facility.

(4) A plan of care shall be established and implemented under § 1151.65 (relating to plan of care).

(5) The recipient's admission to the inpatient psychiatric facility shall be under State statutes and regulations governing admission to inpatient psychiatric facilities.

(6) The medical justification for the recipient's need for care on an inpatient basis shall be established under §§ 1151.70—1151.78 (relating to utilization control).

(7) The recipient's continued need for care, if applicable, shall meet § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

Authority

The provisions of this § 1151.61 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.61 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181798).

§ 1151.62. Certification of Need for admission.

(a) If a recipient is 21 years of age or older, the attending or staff physician shall certify in the medical record either at the time of admission or on the first day of a benefit period, when applicable, or upon application for MA, that acute psychiatric services in a private psychiatric hospital are needed.

(b) If a recipient under 21 years of age is being admitted, an independent team shall certify at the time of admission the need for acute psychiatric services in a private psychiatric hospital and document this in the medical record. The team shall:

(1) Include a physician.

(2) Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.

(3) Have knowledge of an individual's situation.

(c) For an individual under 21 years of age who applies for MA while in the private psychiatric hospital, the team responsible for the individual's plan of care under § 1151.66 (relating to team developing plan of care) shall:

(1) Certify the need for acute psychiatric services in a private psychiatric hospital.

(2) If claims are made, certify the need for acute psychiatric services in a private psychiatric hospital for a period before application.

(d) In the event of an emergency admission of a recipient under 21 years of age, the recipient's need for inpatient psychiatric services shall be certified under subsection (c).

(e) Subsections (a)—(d) apply only to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.60 (relating to certification and recertification of need for inpatient care).

Authority

The provisions of this § 1151.62 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.62 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181799).

Notes of Decisions

Psychiatric hospitals are entitled to Medicaid reimbursement when the services rendered are psychiatric and drug/alcohol detoxification treatments in nature. *University of Pittsburgh v. Department of Public Welfare*, 616 A.2d 149 (Pa. Cmwlth. 1992).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general).

§ 1151.63. Medical and psychiatric evaluation.

(a) The medical and psychiatric evaluation of each applicant's and recipient's need for inpatient psychiatric care shall include the following:

(1) Diagnoses.

(2) Summary of present medical findings.

(3) Medical history.

(4) Mental and physical functional capability.

(5) Prognoses.

(6) A recommendation by a physician concerning admission to an inpatient psychiatric facility or continued care in the inpatient psychiatric facility, whichever is applicable.

(b) The medical and psychiatric evaluation specified in subsection (a) shall be recorded in the recipients record and, for private psychiatric hospitals only, on the Department's form. Examples of the Department's reporting form appear in the Provider Handbook.

Authority

The provisions of this § 1151.63 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.63 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181800).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general).

§ 1151.64. Social evaluation.

(a) The social evaluation of an applicant or recipient shall include the following:

- (1) Reports of interviews with the patient.
- (2) Reports of interviews with family members or other individuals familiar with the patient, if applicable.
- (3) An assessment of home plans and family attitudes, if applicable.
- (4) Community resource contacts.
- (5) A social history.

(b) The social evaluation specified in subsection (a) shall be recorded in the recipient's medical record, and, for private psychiatric hospitals only, on the Department's reporting form. An example of the Department's reporting form appears in the Provider Handbook.

Authority

The provisions of this § 1151.64 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.64 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181800) to (181801).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general).

§ 1151.65. Plan of care.

(a) Before authorization for payment for care provided to a recipient 21 years of age or older, the attending or staff physician shall establish, and include in the

recipient's medical record, an individual written plan of care. The plan of care shall be designed to maintain the recipient at or restore the recipient to the greatest possible degree of health and independent functioning. The plan shall include:

- (1) Diagnoses, symptoms, complaints and complications indicating the need for admission.
 - (2) Treatment objectives.
 - (3) A description of the functional level of the individual.
 - (4) Orders for medications, treatments, restorative and rehabilitative services, activities, therapies, social services and diet.
 - (5) Special procedures recommended for the health and safety of the patient.
 - (6) Plans for continuing care, including review and modification to the plan of care.
 - (7) Plans for discharge.
- (b) If a recipient is under age 21, an individual written plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time shall be included in the recipient's medical record. The plan shall:
- (1) Be developed and implemented within 14 days after admission.
 - (2) Be based on the diagnostic evaluation of the recipient that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's condition and medical need for inpatient psychiatric care.
 - (3) Be developed by the interdisciplinary team of professionals under § 1151.66 (relating to team developing plan of care) in consultation with the recipient and those in whose care the recipient will be placed upon discharge.
 - (4) State treatment objectives.
 - (5) Prescribe an integrated program of therapies, activities and experiences designed to meet the objectives in paragraph (4).
 - (6) Include, at an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.
- (c) Subsections (a) and (b) apply only to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.80 (relating to individual written plan of care).

Authority

The provisions of this § 1151.65 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.65 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181801) to (181802).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); and 55 Pa. Code § 1151.74 (relating to responsibilities of the inpatient psychiatric facility utilization review committee).

§ 1151.66. Team developing plan of care.

(a) The team responsible for developing the plan of care for recipients under age 21 shall be capable of:

- (1) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities.
- (2) Assessing the potential resources of the recipient's family to care for and support the recipient.
- (3) Setting treatment objectives.
- (4) Prescribing therapeutic modalities to achieve the plan's objectives.

(b) In addition to the individuals specified in subsection (c), the team shall include one of the following:

- (1) A Board-eligible or Board-certified psychiatrist.
- (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy.
- (3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology or who has been certified by the State Board of Psychology or by the State Psychological Association.

(c) The team shall include at least one of the following:

- (1) A psychiatric social worker.
- (2) A registered nurse with specialized training or 1 year of experience in treating mentally ill individuals.
- (3) An occupational therapist who is licensed and who has specialized training or 1 year of experience in treating mentally ill individuals.
- (4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State Board of Psychology or by the State Psychological Association.

(d) Subsections (a)—(c) apply only to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.80 (relating to individual written plan of care).

Authority

The provisions of this § 1151.66 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.66 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181802) to (181803).

Cross References

This section cited in 55 Pa. Code § 1151.62 (relating to certification of need for admission); 55 Pa. Code § 1151.65 (relating to plan of care); and 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

§ 1151.67. Payment conditions related to the recipient's continued need for care.

(a) For MA payments to be made on behalf of a recipient for continuing care in a private psychiatric hospital:

(1) The plan of care at § 1151.65 (relating to plan of care) shall be reviewed within 14 days after admission to determine whether inpatient psychiatric services are or were needed and to make necessary changes in the plan. Review of the plan of care shall be carried out by:

(i) The team specified in § 1151.66 (relating to team developing plan of care), if the recipient is 20 years of age or younger.

(ii) The attending or staff physician and other personnel involved in the recipient's care, if the recipient is 21 years of age or older.

(2) The recipient's need for inpatient psychiatric care shall be recertified at least every 90 days by:

(i) The team specified in § 1151.66, if the recipient is 20 years of age or younger.

(ii) The attending or staff physician and the personnel involved in the recipient's care if the recipient is 21 years of age or older.

(3) The recertification of the recipient's need for inpatient psychiatric care as specified in paragraph (2) shall be substantiated by the medical, psychiatric and social information in the recipient's chart.

(4) The medical necessity for the recipient's care on an inpatient basis shall be established under §§ 1151.70—1151.78 (relating to utilization control).

(b) Subsection (a) applies only to private psychiatric hospitals. Distinct part psychiatric units of acute care general hospitals shall comply with 42 CFR 456.60 (relating to certification and recertification of need for inpatient care).

Authority

The provisions of this § 1151.67 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.67 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial page (181803).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general).

UTILIZATION CONTROL**§ 1151.70. Scope of claim review process.**

Inpatient psychiatric services provided to MA recipients are subject to the utilization review procedures in this chapter and in Chapter 1101 (relating to the general provisions).

Authority

The provisions of this § 1151.70 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.70 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150074).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); and 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

§ 1151.71. Concurrent hospital review.

(a) Each inpatient psychiatric facility shall conduct reviews of each MA recipient's need for admission and continued need for psychiatric inpatient services in accordance with the Department's Manual for Concurrent Hospital Review (CHR) unless granted an exemption by the Department.

(b) The Department will regularly monitor each inpatient psychiatric facility's utilization review program to determine whether it is operating in accordance with the CHR process and this section. Monitoring is carried out through review of admissions, continued stays, patient records and claims paid by the Department.

(c) The Department will approve or disapprove the recipient's need for admission and need for continued hospitalization through its CHR process unless an exemption is granted by the Department.

(d) If a discrepancy exists between a hospital's utilization review plan and the instructions in the Department's *Manual for Concurrent Review of Inpatient Hospital Services*, the Department's manual shall take precedence.

Authority

The provisions of this § 1151.71 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.71 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181804) to (181805).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); and 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

§ 1151.72. Inpatient psychiatric facility utilization review plan.

(a) Each inpatient psychiatric facility participating in the MA Program shall have in effect a written utilization review plan which provides for the review of each recipient's need for inpatient psychiatric services. Each provider's utilization review plan shall provide for a utilization review committee which meets the requirements under § 1151.73 (relating to requirements for inpatient psychiatric utilization review committees).

(b) Each utilization review plan shall describe the organization, composition and functions of the utilization review committee and specify the frequency of the meetings of the committee.

(c) Each utilization review plan shall provide for a review of each recipient's admission to the inpatient psychiatric facility under § 1151.75 (relating to admission review requirements).

(d) Each utilization review plan shall provide for a review of each recipient's continued stay in the inpatient psychiatric facility under § 1151.76 (relating to continued stay review requirements).

(e) Each utilization review plan shall describe the methods the utilization review committee uses to select and conduct medical care evaluation studies under § 1151.77 (relating to medical care evaluation studies).

Authority

The provisions of this § 1151.72 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.72 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended November 18, 1983, effective November 19, 1983, 13 Pa.B. 3665; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181805) to (181806).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); and 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

§ 1151.73. Requirements for inpatient psychiatric utilization review committees.

(a) Each inpatient psychiatric facility shall have a utilization review committee composed of two or more physicians knowledgeable in the diagnosis and treatment of mental diseases and other professional personnel as required under 42 CFR 456.206 (relating to organization and composition of UR committee; disqualification from UR committee membership). Committee members need not be members of the hospital medical staff.

(b) A member of the utilization review committee may not participate in the review of a patient's case if the member is or was directly responsible for the care of that patient.

(c) A member of the utilization review committee may not have a direct or indirect financial interest in a hospital.

Authority

The provisions of this § 1151.73 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.73 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (150075) to (150076).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); and 55 Pa. Code § 1151.72 (relating to inpatient psychiatric facility utilization review plan).

§ 1151.74. Responsibilities of the inpatient psychiatric facility utilization review committee.

The utilization review committee, or its representative, shall:

- (1) Conduct admission reviews in accordance with § 1151.75 (relating to admission review requirements).
- (2) Conduct continued stay reviews in accordance with § 1151.76 (relating to continued stay review requirements).
- (3) Conduct medical care evaluation studies in accordance with § 1151.77 (relating to medical care evaluation studies).
- (4) Notify the Department's Concurrent Hospital Review Section of a recipient's assigned initial or continued length of stay. This notification shall be done on the form specified and in accordance with the instructions in the Manual for Concurrent Review of Inpatient Hospital Services.
- (5) Provide that each recipient's record include:
 - (i) Identification of the recipient.

- (ii) Copies of the certification of days records.
 - (iii) The names of the recipient's physician.
 - (iv) The date of admission and date of application for and authorization of MA benefits if application is made after admission.
 - (v) The plan of care required under § 1151.65 (relating to plan of care).
 - (vi) Initial and subsequent review dates specified in accordance with this chapter.
 - (vii) Justification of the recipient's need for admission and need for continued inpatient hospital services as documented by the attending physician.
 - (viii) The reasons and plan for continued stay, if the physician believes continued stay is necessary.
 - (ix) Other supporting material the utilization review committee believes appropriate.
- (6) Notify the Department's Concurrent Hospital Review Section of a change in a recipient's diagnosis.
- (7) Maintain utilization review records for a minimum of 4 years from the date of submission of that year end cost report.
- (8) Submit copies of utilization review records and documents, medical records, psychiatric and social evaluation records, certification of days records and discharge planning information to the Department upon request.
- (9) Maintain copies of certification of days records with the patient's medical record and with the hospital copy of the invoice submitted for payment.
- (10) Review cases that the Department identifies as being a questionable utilization of inpatient psychiatric facilities or services or that contain noncompensable services or items as listed in § 1151.48 (relating to noncompensable services and items).
- (11) Initiate discharge planning during the admission review process to provide timely placement in an appropriate level of care for patients that may require posthospital care.

Authority

The provisions of this § 1151.74 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.74 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150076) to (150077).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); and 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care).

§ 1151.75. Admission review requirements.

(a) The utilization review committee or its representative shall review the need for admission of each recipient admitted to the inpatient psychiatric facility within 24 hours of the admission.

(b) The utilization review committee or its representative shall make a final determination of each recipient's need for admission within 2 working days after the admission.

(c) The utilization review committee shall establish written criteria on which it bases a recipient's need for admission. The criteria shall be more extensive for admissions known to be associated with high costs, associated with the frequent furnishing of excessive services, or authorized by a physician whose patterns of care are questionable.

(d) The utilization review committee or its representative shall assess the need for inpatient psychiatric services by comparing each admission to the written criteria established in accordance with subsection (c).

(e) Except as noted in subsection (f), the utilization review committee or its representative shall use the Hospital Utilization Project (HUP) 50th percentile length of stay guidelines in assigning an initial length of stay.

(f) If a recipient's diagnosis is unconfirmed upon admission, the utilization review committee or its representative shall assign an initial length of stay of no more than 2 days. If the utilization review committee is unable to confirm the recipient's diagnosis within 2 working days, the committee shall notify the Department's Concurrent Hospital Review Section and initiate continued stay review in accordance with § 1151.76 (relating to continued stay review requirements).

(g) The utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for admission.

(h) In the event of an adverse determination, the utilization review committee shall follow the procedures set forth in § 1151.78 (relating to adverse determinations).

(i) The utilization review committee shall conduct a review of cases identified by the Department as being a questionable utilization of inpatient psychiatric services and facilities.

Authority

The provisions of this § 1151.75 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.75 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150077) to (150078).

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Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); 55 Pa. Code § 1151.72 (relating to inpatient psychiatric facility utilization review plan); and 55 Pa. Code § 1151.74 (relating to responsibilities of the inpatient psychiatric facility utilization review committee).

§ 1151.76. Continued stay review requirements.

(a) The utilization review committee or its representative shall review the need for continued stay of each recipient admitted to the inpatient psychiatric facility.

(b) The utilization review committee shall establish written criteria on which it bases a recipient's need for continued stay. The criteria shall be based on the recipient's medical condition and shall be more extensive for admissions known to be associated with high costs, associated with the frequent furnishing of excessive services or authorized by a physician whose patterns of care are questionable.

(c) The utilization review committee or its representative shall assess the need for continued stay in an inpatient psychiatric facility by comparing each case to the written criteria established under subsection (b).

(d) The utilization review committee or its representative shall assign subsequent review dates based on the date continued hospitalization will no longer be necessary.

(e) The utilization review committee or its representative shall conduct the continued stay review and provide the Department's Concurrent Hospital Review Section with the medical justification for the continued stay on or before the expiration date of the initial length of stay. Subsequent reviews shall be completed before the expiration of the previously assigned length of stay.

(f) If an individual applies for MA while in an inpatient psychiatric facility, the committee shall:

(1) Assign the continued stay review date within 1 working day after the inpatient psychiatric facility is notified that the individual has applied for MA.

(2) Contact the Department's Concurrent Hospital Review section for approval of the assigned length of stay.

(g) The utilization review committee shall provide that the justification for the recipient's continued need for inpatient psychiatric services be documented in the patient's record.

(h) The utilization review committee shall allow the attending physician the opportunity to present his views before making a final decision on the need for continued stay.

(i) In the event of an adverse determination, the utilization review committee shall follow § 1151.78 (relating to adverse determinations).

Authority

The provisions of this § 1151.76 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.76 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150078) to (150079).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); 55 Pa. Code § 1151.72 (relating to inpatient psychiatric facility utilization review plan); 55 Pa. Code § 1151.74 (relating to responsibilities of the inpatient psychiatric facility utilization review committee); and 55 Pa. Code § 1151.75 (relating to admission review requirements).

§ 1151.77. Medical care evaluation studies.

(a) The utilization review committee shall conduct Medical Care Evaluation (MCE) studies in accordance with this section.

(b) MCE studies shall identify and analyze medical or administrative factors related to patient care rendered in the inpatient psychiatric facility and, when indicated, make recommendations for changes that would be beneficial to patients, staff, the facility and the community.

(c) MCE studies shall include analysis of at least the following:

- (1) Admissions.
- (2) Durations of stay.
- (3) Diagnostic categories.
- (4) Ancillary services, including drugs and biologicals.
- (5) Professional services performed in the facility.

(d) At least one MCE study shall be in progress at any time.

(e) At least one MCE study shall be completed each calendar year.

(f) The results of each MCE study shall be documented.

(g) Documentation shall be made describing how the MCE study results have been used to institute improvements in the quality of care and to promote the efficient and effective use of inpatient psychiatric facilities.

Authority

The provisions of this § 1151.77 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.77 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial pages (150079) to (150080).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); 55 Pa. Code § 1151.72 (relating to inpatient psychiatric facility utilization review plan); and 55 Pa. Code § 1151.74 (relating to responsibilities of the inpatient psychiatric facility utilization review committee).

§ 1151.78. Adverse determinations.

(a) The utilization review committee shall send an adverse determination letter on each case for which it denies admission or denies continued stay. The letter shall be sent to:

- (1) The recipient.
- (2) The recipient's next of kin or sponsor, if applicable.
- (3) The attending physician.
- (4) The inpatient psychiatric facility administrator.
- (5) The Office of MA Programs.

(b) The adverse determination letter shall include:

- (1) The recipient's name.
- (2) The recipient's age.
- (3) The recipient's full MA number.
- (4) The inpatient psychiatric facility's name.
- (5) The admission date.
- (6) The discharge date, if known.
- (7) The diagnoses required only on copy sent to the Office of MA Programs.

(c) The utilization review committee shall send the adverse determination letter no later than by the last day of the approved length of stay or the day after the determination, whichever is earlier.

(d) If a continued stay has been denied, the inpatient psychiatric facility shall attach a copy of the adverse determination letter to the invoice submitted for payment.

(e) Each month the utilization review committee shall complete and submit a summary report of adverse determinations in accordance with the instructions in the Department's *Manual for Concurrent Review of Inpatient Hospital Services*.

(f) The utilization review committee shall mail the monthly summary report specified in subsection (e) within 15 days after the end of the month.

Authority

The provisions of this § 1151.78 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.78 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181812) to (181813).

Cross References

This section cited in 55 Pa. Code § 1151.61 (relating to payment conditions: general); 55 Pa. Code § 1151.67 (relating to payment conditions related to the recipient's continued need for care); 55 Pa. Code § 1151.75 (relating to admission review requirements); and 55 Pa. Code § 1151.76 (relating to continued stay review requirements).

INSPECTIONS OF CARE**§ 1151.81. Inspections of care: general.**

(a) The Department's Federally required inspection of care team will evaluate the care and services provided to each recipient under 21 years of age or 65 years of age or older in a participating psychiatric hospital at least annually by making an onsite inspection. The hospital will be notified no earlier than 48 hours prior to the inspection and advised of the scheduled arrival of the team. The hospital shall make MA medical records readily available to the team. The team's inspection includes:

- (1) Personal contact with, and observation of, each recipient under 21 years of age.
 - (2) Review of a recipient's medical record.
 - (3) Personal contact with and observation of the recipient if the recipient is 65 years of age or older and the medical record contains incomplete reports.
- (b) The team will determine in its inspections whether:
- (1) Services are available and adequate to meet the recipient's health needs.
 - (2) It is medically necessary and desirable for the recipient to remain in the hospital.
 - (3) It is feasible for the hospital to meet the recipient's health needs and rehabilitative needs or whether the recipient's needs could be met through alternative institutional or noninstitutional services.
 - (4) A recipient under 21 years of age is receiving active treatment.
 - (5) The medical, social and psychological evaluations and the plan of care are complete and current and are being followed, and ordered services are provided and recorded.
 - (6) The recipient receives adequate services based on personal observations; that is, the recipient is clean; there are no bedsores; there are no signs of malnutrition or dehydration; and there is apparent maintenance of maximum physical, mental and psychosocial function.
 - (7) Service needs are met by the facility or by outside arrangements.

- (8) The recipient needs continued placement in the hospital or there is an appropriate plan to transfer the recipient to alternate care.
- (c) This section applies only to private psychiatric hospitals.

Authority

The provisions of this § 1151.81 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.81 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181813) to (181814).

§ 1151.82. Inspections of care reports.

- (a) The inspection of care team will submit reports on each inspection of care within 45 days following the inspection to:
 - (1) The hospital administrator along with a copy for the chairperson of the utilization review committee.
 - (2) The Office of Mental Health of the Department.
 - (3) The CAO, if recommendations are made for alternate placement.
- (b) If the report of the inspection of care team recommends alternate care for a recipient:
 - (1) The CAO shall notify the recipient or the recipient's representative and the hospital administrator of the intended denial of payment authorization.
 - (2) The recipient or the recipient's representative has 30 days from the date the notice is mailed to appeal the decision. The facility does not have the right to appeal unless it is acting as the recipient's representative.
 - (c) If the recipient or the recipient's representative appeals the decision within 10 days from the date the notice is mailed, payment for inpatient psychiatric care will continue pending the outcome of the hearing.
 - (d) If an appeal is entered after the tenth day, payment will be discontinued effective with the first day the inspection of care team recommended alternative care pending the outcome of the hearing.
 - (e) If the recipient or the recipient's representative appeals the Department's recommendation for an alternative level of care within the specified time period, the Department will continue to make payment for private psychiatric hospital inpatient care. If the Department is sustained in its action, the Department will recover from the facility a payment that would not have been made if the action of the Department had not been appealed. The period for which the Department will recover excess payment begins on the effective date specified on the notice and ends with the date that the appropriate change in the level of care is made.
 - (f) If the report of the inspection of care team cites deficiencies, the hospital shall submit a written response to the Department within 30 days of the control date on the summary report. The response shall outline the hospital's planned

course of action including acceptable time frames for correcting deficiencies. The inspection of care team will conduct follow-up visits to determine if the deficiencies have been corrected.

(g) This section applies only to private psychiatric hospitals.

Authority

The provisions of this § 1151.82 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.82 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181814) to (181815).

ADMINISTRATIVE SANCTIONS

§ 1151.91. Provider abuse.

If the Department determines that a provider has billed for services inconsistent with this part, provided services outside the scope of customary standards of medical practice, or otherwise violated the standards set forth in the provider agreement, the provider is subject to the sanctions in Chapter 1101 (relating to general provisions).

Source

The provisions of this § 1151.91 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796.

§ 1151.92. Administrative sanctions.

(a) If the Department identifies delays in assigning the initial or continued length of stay, the Department will deny payment for all or part of the stay.

(b) If the utilization review committee fails to conduct a continued stay review or fails to notify the Department on or before the expiration of the previously assigned length of stay, the Department will not certify facility days between the expiration of the previously assigned length of stay and the date the request for continued stay is made and approved.

(c) If the Department determines that services or items provided by the facility were not medically justified or were unnecessary, inappropriate or otherwise noncompensable, the Department will deny payment for those services as well as services and items related to the provision of that service or item. Payment will also be denied to the practitioner.

Authority

The provisions of this § 1151.92 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.92 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917; amended October 29, 1993, effective July 1, 1993, 23 Pa.B. 5241. Immediately preceding text appears at serial pages (181815) to (181816).

PROVIDER RIGHT OF APPEAL**§ 1151.101. Provider right of appeal.**

(a) Providers have the right to appeal adverse actions of the Department under Chapter 1101 (relating to general provisions).

(b) Inpatient psychiatric facilities and practitioners do not have the right to a separate appeal on the same case.

(c) If an inpatient psychiatric facility appeals a decision by the Department to fully or partially deny payment for a case, the Department will withhold the denied payments pending decision on the appeal.

Authority

The provisions of this § 1151.101 amended under sections 201 and 443.1(1) of the Public Welfare Code (62 P. S. §§ 201 and 443.1(1)).

Source

The provisions of this § 1151.101 adopted September 30, 1983, effective July 1, 1983, 13 Pa.B. 2796; amended June 18, 1993, effective July 1, 1993, 23 Pa.B. 2917. Immediately preceding text appears at serial page (150084).

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