Inpatient Psychiatric Facility (IPF) FAQ's

Updated July 29, 2014

Q1) Can licensed clinicians be employees of the IPF's? Will rates increase for IPF's?

R1) Licensed clinicians may be employees of the IPF's. Licensed clinicians who are either employed by an IPF or contracted with an IPF may bill Medicaid separately for their services. There will be no change to the per diem rates for either IPFs or for licensed clinicians.

Q2) Will these changes affect the way PRTF's work with pharmacies?

R2) No. Pharmacies will continue to be eligible for separate billing. From the Memo of June 9, 2014: "D. The prescribing provider must be employed or have a contract with the facility." "Pharmacies must have a contract with the IPF. DMAS will use the prescribing NPI as the referral NPI. The prescription can serve as the referral document. The prescribing provider must be an employee or contractor of the IPF."

Q3) What are considered ancillary services?

R3) Refer to list of services in the Medicaid Memo of June 9, 2014

Q4) RTC uses their own vans for routine type transportation. When there is emergency use of ambulances for sudden medical conditions (i.e. appendicitis, broken foot), is a contract needed?

R4) From the Medicaid Memo of June 9, 2014: "IPFs that use LogistiCare for medical transportation must have a contract with Logisticare which allows non emergency transportation to be provided as a service provided under arrangement. When the member residing in the IPF needs transportation, the IPF should contact the LogistiCare facility number (866-679-6330) or use the LogistiCare online request system (https://facility.logisticare.com) in order to arrange transportation services. This request for transportation will be considered the referral. RTC-Level C providers must 1) inform LogistiCare that they are an RTC-Level C provider; and 2) provide LogistiCare with the RTC-Level C NPI number to use as a referral NPI on the transportation encounter that is submitted to DMAS." *Emergency transport does not require a contract.*

LogistiCare Contact: 866.809.4620 x 6002

Q5) Would a contract be between the dentist and DentaQuest or the RTC and DentaQuest.

R5) From the Medicaid Memo of June 9, 2014: "Dental services for Medicaid members are provided through Smiles For Children (SFC) and are reimbursed by the Department's Dental Benefits Administrator (DBA), DentaQuest. IPFs that currently arrange for dental services should continue to do so based on the member's Plan of

Care. IPFs must have a contract with a SFC participating dentist and must provide a referral to that dentist's office when the appointment is made for one of their residents/patients. The IPF shall provide the name of its contracted dentist to the Department or DentaQuest upon request."

Q6) How to determine need ancillary services at admission? Glasses, braces, recent medical procedure, upcoming appts, etc…

R6) According to 12VAC 30-130-890 all service needs are identified at the time of admission and added to the Plan of Care. This requirement did not change.

"Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in an IPF, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. IPFs should begin preparations now to include routine or expected services provided under arrangement in each plan of care."

Q6) Freedom of choice?

R6) Once an individual is admitted, the IPF determines which providers may be chosen, by selecting the IPF the freedom of choice requirement is managed by the members caregivers. Because parents and caregivers may arrange to take members to appointments while on therapeutic leave passes, parents and caregivers should be instructed by the IPF not to take individuals to non-contracted providers. If services are provided when they are not contracted then the service providers will not be reimbursed.

Q7) What does a referral need to include?

R7) The referral must be documented in the medical record. That is, the person responsible for making the referral should document in their progress note when the referral was made and accepted on a specified date. Once the identified provider is known and becomes the responsible person for that particular ancillary service, the provider should be added to the Care Plan (s) for treatment team communication purposes. The prescribed frequency can also be added to the Care Plan at that time.

Q8) It says that the CIPOC has to have a frequency of the ancillary service. Is "as needed" or "as determined by the ancillary provider" an acceptable frequency?

R8) Yes, although if more detail is available, that should be included. For example, dental cleanings may be required every six months, while emergency services would be provided "as needed." If a member's service needs change then the frequency should be changed in the POC to reflect a changed number of needed services.

Q9) Do referrals to ancillary services need to be signed by a physician or can the referral be made by anyone on the team?

R9) Anyone on the team may issue a referral however the new service must be included in the POC, the POC is signed by the physician

Q10) Does the entire team have to sign off on the referral?

R10) No.

Q11) Since a script for meds counts as a referral can the physician just write a script for the other ancillary services and have that count as the referral?

R11) From the Medicaid Memo of June 9, 2014: "Each IPF must document a written referral for each service provided under arrangement, and must maintain a copy of the referral in the member's medical record at the facility. The provider of the service under arrangement must also maintain a copy of the referral in the member's medical record. The referral must be consistent with the plan of care. A physician order will meet the requirement for a referral. For pharmacy services, the referral is the prescription. The prescribing provider must be employed or have a contract with the facility. Referrals should not be documented unless the provider has accepted the referral."

Q12) How does a facility meet the requirement of maintaining medical records from the ancillary service provider such as any admission and discharge documents, treatment plans, progress notes, treatment summaries and documentation of medical results and findings) in the case of a pharmacy?

R12) The Medication Administration Records (MARs) will meet this requirement for Pharmacy services.

R12) The arranged provider should send a summary of the treatment as it relates to the referral reason documented in the referral.

Q13) Is there an example of a contract? What needs to be in the contract?

R13) DMAS will not provide an example of a contract. A letter of understanding will be accepted as a contract, as long as both the IPF and the ancillary provider sign the letter.

Q14) Client who also has private insurance for both medical and dental and wish to use those providers and not use Medicaid as a secondary payer for some medical treatment - is the referral process the same for the PRT? An example is a client who comes in with braces and their parents are handling the appointments and using private insurance – what is the process?

R14) As required by regulations already in existence (42 CFR 441.155; 12 VAC 30-130-890; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child's medical, psychological, social, behavioral and developmental needs. So you will still need to list this need in the Members CIPOC. The non DMAS/Dentaquest providers do not need to have a contract and therefore the service needs to only be identified in the CIPOC. But if the dental provider that the family is utilizing is an enrolled Medicaid provider although the family/dental provider does not intend to bill Medicaid, you will need to still have a contract in place to cover any possible billing issues that may result in Medicaid being billed.

Q15) We are experiencing delays in getting contracts back to our organization- what is the process in order to make sure the clients in PRT are able to continue with needed medical care?

R15) Providers are expected to have the contracts in place. If the Member is in need of services while you're in the middle of establishing a contract, document your efforts and continue to work to get the contract while making sure the Members need is met, the referral is in place and the need is in the CIPOC.

Q16) Transportation with Logisticare – the presentation referenced transportation for medical care – what about transportation for behavioral health care – families use Logisitcare for transportation to come to the facility for family therapy sessions. Many times the arrangements are made outside of the PRT by the family or agency – how is that to be handled? If the PRT makes the call for the family, what is required, if anything?

R16) The facility will have to make those arrangements and include the service in the CIPOC for all services. For kids already in treatment the provider would not be subject to the referral requirement if services were already initiated. Any subsequent service should be included in the CIPOC.

IPFs that use LogistiCare for medical transportation must have a contract with LogistiCare which allows non emergency transportation to be provided as a service provided under arrangement. When the member residing in the IPF needs transportation, the IPF should contact the LogistiCare facility number (866-679-6330) or use the LogistiCare online request system (https://facility.logisticare.com) in order to arrange transportation services. This request for transportation will be considered the referral. RTC-Level C providers must 1) inform LogistiCare that they are an RTC-Level C provider; and 2) provide LogistiCare with the RTC-Level C NPI number to use as a referral NPI on the transportation encounter that is submitted to DMAS.

Q17) Can emergent medical issues and medication changes be added to as an "addendum" to the Plan of Care as opposed to redoing the entire Plan of Care? My plan was to add an "addendum " to our current POC that we would use to address changes that were not added to the standard plan. Will this suffice for the requirement to update the POC within 24 hours? Of course the standard POC would include updates at the scheduled treatment time.

R17) An addendum to the plan of care may be used to document a new service that was ordered by a physician and which is being provided or arranged for the member. A physicians order must be present in the record and the service must be included in the members CIPOC within 30 calendar days.

R17) Cited from page 4 of the Medicaid Memo regarding the IPF regulations:

The IPF regulations already require that each Members **Initial** and **Comprehensive Plan of Care** be **specific** to meet each child's medical, psychological, social, behavioral and developmental needs. Therefore, an addendum is sufficient to update the plan of care within (1) calendar day and then signed by the physician as soon as possible but no later than the next 30-day plan review. Please refer to the attached Medicaid Memo and the following referenced regulations (42 CFR 441.155; 12 VAC 30-130-890; 42 CFR 456.180; and 12 VAC 30-50-130). I have also identified segments of the Medicaid Memo that you can quickly reference below.

Page 2 of the Medicaid Memo:

1. As required by regulations already in existence (42 CFR 441.155; 12 VAC 30-130-890; 42 CFR 456.180; and 12 VAC 30-50-130), each initial and comprehensive plan of care must be specific to meet each child's medical, psychological, social, behavioral and developmental needs.

2. Each initial and comprehensive plan of care must include, within one (1) calendar day of the initiation of the service provided under arrangement, any service that the individual needs while residing in an IPF, and that is furnished to the member by a provider of services under arrangement. Physicians may implement the change to the plan of care by telephone, provided that the documented change is signed by the physician as soon as possible, and not later than the next 30-day plan review. Services provided under arrangement must be included in the plan of care -- documentation in the assessment, progress notes, or elsewhere in the medical record will not meet this requirement. IPFs should begin preparations now to include routine or expected services provided under arrangement in each plan of care.

3) Each initial and comprehensive plan of care must document the prescribed frequency and circumstances under which the services provided under arrangement shall be sought.

Page 4 of the Medicaid Memo:

IPFs should include emergency services in the plan of care and contract in advance with the usual providers of emergency services. However, if the IPF uses a non-contracted provider for emergency services, the IPF may contract with the emergency services provider after the fact. The emergency services provider must have a contract in place with the IPF provider prior to billing DMAS. A referral is required for emergency services, and the emergency services provider must include the NPI of the IPF in the referring provider locator on the claim for payment.

Q18) A child from the local community is admitted to an IPF. The member has an existing relationship with the local Speech/Occupational Therapy/Physical Therapy provider to deliver services through an Individualized Education Program (IEP). The IPF has a contract with the local SLP/OT/PT provider, but in this specific case is not engaged in the billing payment process. The local school system pays for the services to the SLP/OT/PT provider, and then bills Medicaid for reimbursement of services. Will that continue to be able to happen?

> R18) Since the IPF is coordinating the services, the Speech, Occupational and or Physical Therapy service (s) will need to be documented in the CIPOC. The billing process can continue as is allowed currently. Since the member is enrolled in Medicaid the contract must be in place and a referral will still need to occur as is required via the new IPF regulations.