OVERVIEW OF STATE HOSPITAL ALLOCATION METHODOLOGY

KEY RESPONSIBILITIES FOR STATE HOSPITALS and LMHAS (FORMS and INSTRUCTIONS)

FISCAL YEAR 2008

STATE HOSPITAL SECTION
DEPARTMENT OF STATE HEALTH SERVICES
(DSHS)

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Section 1

Overview of State Hospital Allocation Methodology

Introduction

Several assumptions have been made in the methodology to determine the utilization of State Hospitals (SH) in FY 2008. These are:

1. State Hospitals in conjunction with Local Mental Health Authorities (LMHA's) will continue to serve as a "safety net" within a continuum of care for indigent patients in that they offer "Inpatient" services for persons without an ability to pay.
2. Stability of the State Hospital system is critical because of "public service" and "public safety" roles; therefore, a minimum level of service must be defined and maintained. The current projection for Average Daily Census (ADC) for FY 2008 for the entire hospital system, which includes General Revenue and Third Party Funds, is approximately 2484 (2477 plus 7 DFPS Contract Beds).
3. Services in hospitals must be responsive to local needs and priorities. This must take into account the variation across the LMHA's with respect to operational philosophies, organizational structures, program management, demands from local communities, resource availability and relationships with State Hospitals.
4. All current hospitals will remain at current sites.
5. Services provided by the State Hospital system must be of high quality as evidenced by continued Joint Commission accreditation, Medicare certification and adherence to State Hospital performance measure targets.
6. The state mental health hospital system is dependent on the amount of general revenue received from the legislature and the amount of 3rd party reimbursement earned.
7. With the implementation of Resiliency and Disease Management principles within the LMHA's, and with the current efforts to define the structure, organization and financing of the State's Mental Health delivery system, the State Hospitals will also be changing in response to these efforts.

These factors shape the contents of this document. That is, the model presented in this document represents an evolving business/clinical model between State Hospitals and LMHA's. The model presented here identifies critical functions that must be performed by the State Hospital or LMHA, but, does not dictate how they are to perform these functions or what staff must be involved. In running this "gauntlet" between system-wide requirements and local flexibility, there is a recognition that the model will be refined and its processes better defined as experience necessitates.

The flowchart in ***Attachment I*** contains an overview of the key functions for State Hospital reimbursement and Utilization Management (UM). This flowchart also identifies key areas of contact between State Hospital UM and LMHA UM. In doing so, it suggests ways the LMHA might structure and operate its' UM function.

The flowchart in conjunction with the narrative in this overview not only identifies the critical functions necessary for a State Hospital and LMHA to manage the activities inherent in this method but also suggests processes for accomplishing these functions efficiently and effectively. While the functions are critical and must be performed, how the State Hospital and LMHA develops processes or assigns functions to staff is at their discretion. This document identifies what must be done, i.e., critical functions, and suggests, but does not dictate, how these functions can be accomplished.

Philosophy

The general philosophy characterizing the relationship between the State Hospital and LMHA under this model is:

- Every patient in a State Hospital has a payer, who is either an insurance carrier for the insured patient; the LMHA for the uninsured patient; or the State Hospital in certain special circumstances.
- The LMHA, as the authority and as payer, approves inpatient treatment to the degree possible while enabling the State Hospital to maintain compliance with federal law governing inpatient admission, i.e. Emergency Medical Treatment and Labor Act (EMTALA).
- The mutual objective of both the payer and provider is appropriate and timely treatment and clinically appropriate patient discharge. Therefore, the discharge process, and the role of the State Hospital treatment team in it, is a central focus of this model as can be seen in the attached flowchart.
- Every point where there is a consideration of who the payer is for a patient, is equally a point of consideration for UM. Payer identification and UM are two sides of the same coin.
- The hospital cost of a bed for the uninsured, acute adult patient in a State Hospital is $323.00.
- Each LMHA must, to the best of its ability, perform its admission and discharge functions during the patient's stay in a State Hospital. This is an important feature of making this model work, and will ultimately be to the advantage of all LMHA's as they work to efficiently and effectively manage their resources.

- It is imperative that patients being admitted to the hospital are evaluated and assessed appropriately before admission and that the appropriate LMHA is immediately involved in each person's inpatient care, treatment and discharge. Because each LMHA has the responsibility to determine the appropriate LMHA for each patient seeking admission and because each LMHA has the ability to follow every patient's course of treatment (from admission to discharge); any request for a change in the designated LMHA will only be considered while the patient is in the hospital (except as noted below). This procedure only relates to the SHAM and the debiting of each LMHA's SHAM allocation. There will no longer be any "after the fact" changing of the responsible LMHA after the patient has been discharged. But, if the patient remains in the hospital for longer than 30 days, then the request for a LMHA change must have been made within the first 30 days of treatment.
- The more effectively the LMHA functions as the "front door" and "back door" for the State Hospital the greater its ability to control emergency admissions related to EMTALA and make sure continuity of Care and appropriate placement is provided to every patient.

Synopsis of Critical Current Functions:

Admission to State Hospital

- The LMHA is responsible for performing preadmission screenings. As such, admissions to a State Hospital are considered to be already approved by the LMHA unless the State Hospital and LMHA have developed an agreement where the LMHA is to formally approve each admission.

First 30 days are considered Acute

- In accordance with the procedures in the ***Example Utilization Management Agreement in Attachment 2*** of this document, the State Hospital will notify the LMHA about voluntary admissions that have not been pre-screened. This includes notifying the LMHA-payer for a patient admitted to an out-of-region State Hospital.
- Clarification of federal laws governing admissions to hospitals, i.e., EMTALA, has placed a strain on the LMHA's approval of voluntary and emergency admissions. In light of the State Hospital's need to comply with EMTALA, it is in the LMHA's best interest to work with law enforcement and the courts to screen all potential admissions to a State Hospital.
- It is necessary for LMHA's to coordinate with each other on out-of-region admissions.

- For NorthSTAR, acting in congruence with the LMHA requirements, authorization refers to the contracted providers in NORTHSTAR seeking authorization from the Behavioral Health Organization (BHO) to refer a patient to a State Hospital for admission. This includes potential court commitments, referral by law enforcement and voluntary referrals. As with LMHA's, since pre-screening is performed by a NorthSTAR agent, admissions are considered approved.

Continued Stay

- The LMHA can request discharge at any time and the State Hospital will promptly comply, (e.g., promptly means, the State Hospital will make a good faith and reasonable effort to discharge the patient the same day as requested by the LMHA), but, no later than the next day, the day after the request to discharge, as long as, an appropriately documented Continuity of Care Plan exits and transportation is readily available. The State Hospital will make a referral to the LMHA and will release the patient to an appropriate community placement. **This may include release to a specific LMHA physician.** Disagreements about discharge are subject to the appeals process described in the ***UM Agreement. (Attachment 2)***
- The State Hospital will work with the LMHA to develop all the appropriate clinical information necessary to enable the LMHA to make continued stay and placement decisions.

LOC Assignment

- Level of Care (LOC) assignment ***(See Attachment 3 for the Form and Instructions)*** is determined by the State Hospital. The LMHA can agree with this LOC or it can appeal using the procedures in the ***UM Agreement***.
- The LMHA can also request LOC assignment, at treatment team review, on any uninsured patient. The State Hospital shall ensure that the necessary clinical information is available to the LMHA.
- Determination of LOC is based on the criteria in the ***LOC Form*** in ***Attachment 3***.
- All uninsured patients will be considered "Acute" for the first 30 days of inpatient care. Changing the LOC assignments can only be considered on the 31st day of inpatient services.
- Disagreements regarding LOC assignment are resolved through the appeal procedures in the ***UM Agreement***.

Determining the Payer

- The LMHA will conduct a financial assessment of all referrals to the State Hospital. This will assist in identifying insured patients. This information should be provided to the State Hospital at admission.

- The State Hospital will also conduct a financial assessment to identify insured patients based on the definition of third-party coverage in Section 2 of this document on ***Instructions for Conducting Reimbursement Activity***.

- For insured patients the ***MH Bed Day Allocation Exception Form (Attachment 4)*** is completed and entered into AVATAR PM.

  The LMHA's hospital allocation is not charged for the inpatient days reimbursed by the third-party payer.

- The State Hospital will, as soon as possible, notify the LMHA regarding the number of days ***reimbursed*** by the insurer if this information has not already been determined by the LMHA.

Major Functions Detail Overview

Admission to State Hospital

- **LMHA UM:** Because the LMHA is responsible for performing certain functions, which includes pre-screening of commitments and admissions to the State Hospital, admissions to a State Hospital are considered approved by the LMHA.

  However, the LMHA and State Hospital, at their discretion, may develop an agreement that requires the LMHA to approve admissions by the courts, local law enforcement and voluntary admissions to the State Hospital and is responsive to the range of circumstances associated with State Hospital admissions. It is in the best interest of each LMHA, and the patient, and is required by the Admission, Continuity and Discharge rule for one LMHA to notify another LMHA regarding out-of-region admissions to State Hospitals.

- **STATE HOSPITAL UM:** The State Hospital will notify the LMHA regarding voluntary patients seeking admission who have not been prescreened by the LMHA. Because the LMHA's now have direct access to information regarding patients from their service area in any of the State Hospitals, notification of admission is considered given when the patient has been entered into CARE.

NOTE: The following CARE sources are the only valid source of state hospital allocation methodology ("SHAM") utilization data.

1. Daily report HC020030 gives the LMHA notice of a patient admission in their Local Service Area (LSA). The report shows bed exceptions and acute/subacute status only if these fields have been entered at the time of admission, generally they are not. It is best to use this report only as an initial notification of admission and to use other reports to determine assigned acute/subacute status and bed exception.
2. Daily report HC022837 is designed specifically for "SHAM" and lists all patients from a given LSA in the hospital, sorted by hospital, with the bed exception and acute/subacute status. Field Support can run special versions of HC022837, HOSFUND for any date range needed – for state hospitals by location and for MHA by state hospital(s).

3. Weekly report HC027630 displays all the patients from a LSA, their number of days in the hospital, bed exception and acute/subacute status. This report is also produced monthly. These reports are sent to each community center via VPS and are also available whenever desired from XPTR.
4. Monthly download HC022855 contains all the detail used to calculate the "SHAM" status.
5. Lastly, CARE Action Code 397 reports Hospital Acuity Level of Care Records.

Special EMTALA Issues:

It is in the LMHA's best interest to prescreen all referrals, both voluntary and involuntary, to the State Hospital to determine if the inpatient hospital is the least restrictive environment for the person to receive appropriate treatment. To facilitate prescreening of all potential State Hospital admissions the LMHA should establish a local screening location and communicate this information to the courts and law enforcement. In situations where the LMHA is unaware that a person is presenting for voluntary admission, the State Hospital Admissions Office will contact the designated LMHA UM staff to advise them of the prospective voluntary admission.

Prospective Involuntary Emergency Admissions:

If a person is brought to a State Hospital by a law enforcement officer via a warrantless detention for an emergency screening, the person presenting for admission will be screened by a physician as outlined in the ***Health and Safety Code, Subtitle C., Texas Mental Health Code, Subchapter C., Emergency Detention, Release and Rights.*** If the person is determined to be not appropriate for admission, the person will be transported back to the location of apprehension, to the person's residence in Texas, or to another suitable location at the cost of the county where the apprehension took place. (Sec. 573.025 – Health and Safety Code)

Prospective Voluntary Admissions:

If a person presents to a State Hospital for prospective admission on a voluntary basis without contact with the LMHA, the person presenting for admission will be screened by a physician on the State Hospital medical staff to determine the presence or absence of an emergency medical condition. If the medical screening evaluation (MSE) does not identify an emergency medical condition (EMC), the State Hospital will immediately confer with the LMHA for recommendations. The LMHA will have the opportunity to recommend admission or a lesser restrictive treatment setting, as appropriate.

If admission is not to occur, it is the LMHA's responsibility to transport the person to the identified treatment setting. This must occur within 60 minutes after the time a decision has been made that the LMHA will make an alternate placement.

If the medical screening evaluation (MSE) does identify an EMC and the State Hospital physician decides the State Hospital has the capacity to treat the EMC, under EMTALA, the State Hospital has no choice but to admit the person.

If it is determined that the person has an EMC and the State Hospital does not have the capacity to treat, the State Hospital will provide evaluation and treatment within its capacity to stabilize and will arrange appropriate transfer to a hospital that has the capability and capacity to treat the person's EMC. The State Hospital will comply with all requirements of an appropriate transfer as defined in current EMTALA rules and regulations.

Continued State Hospital Stay:

LMHA UM:

LMHA can request discharge at any time and the State Hospital will promptly comply as long as an appropriate Continuity of Care Plan exists and transportation is readily available, e.g., make a reasonable effort to discharge on the same day as requested but no later than the next day – the day after the request to discharge. Disagreements between the LMHA and State Hospital, around the appropriateness of the discharge, are subject to the appeals process in the ***UM Agreement***.

In general, the LMHA should work out how it intends to manage its allocation with the State Hospital. There are no requirements as to how an LMHA will do this. The best guidance is to understand the rules and then develop and implement strategies that are efficient and reasonable within the limited resources available to both the LMHA and the State Hospital. The flowchart (***Attachment 1***) provides a good guide for understanding the flow of work and information required.

STATE HOSPITAL UM:

The State Hospital is responsible for providing information necessary to enable the LMHA to make continued stay, discharge and placement decisions. The extent of this information should be determined between each hospital and their corresponding LMHA's.

LOC Assignment:

LMHA UM:

Patients, for whom the LMHA is the payer, must have a LOC assignment, which is determined by the State Hospital. The LMHA can agree with the State Hospital's assignment or it can appeal using the procedures in the UM Agreement. The LMHA can also request a LOC assignment, at treatment team review, on any uninsured patient whereupon, the State Hospital shall ensure that the necessary clinical information is available to the LMHA.

Any changes in a LOC assignment are valid from that point on. It cannot be applied retrospectively. By default, the first 30 days of inpatient care are considered acute.

While determination of LOC lies with the State Hospital treatment team, it is possible the LMHA will request a LOC determination for a particular patient. If the patient is found to be subacute and the LMHA decides to leave the patient in the State Hospital, the treatment team, or hospital designee, will enter the ***LOC Form*** into AVATAR PM. This will change the patient's LOC assignment to subacute, effective the date of the determination.

The State Hospital shall determine LOC based on the criteria in the ***LOC Form***. Disagreements regarding the LOC assignment are resolved through the appeal procedures in the ***UM Agreement***.

The State Hospital and LMHA may agree that a patient is acute, or subacute, based on clinical judgment without having to meet all the criteria on the ***LOC Form***. When such agreement occurs, the patient will be assigned to the agreed-to LOC.

The State Hospital treatment team would make this tentative determination, but would have to receive approval from the LMHA before the completed ***LOC Form*** would be entered into AVATAR PM. If there is a disagreement, the ***UM Agreement*** procedures would govern the final decision. If the acute phase of the patient's illness subsides and the patient is determined to be subacute, then the treatment team would complete the ***LOC Form*** and enter it into AVATAR PM. The LMHA, at its discretion as defined in its working agreement with the State Hospital, may want to be involved in approving this downward movement in LOC.

It is possible that a patient who is categorized as subacute can become acute during the course of his/her stay in the State Hospital. A specific example would be when a subacute patient must be transferred to a Medical/Surgical Hospital for services. In this situation, the patient has not been discharged from the State Hospital, and the State Hospital remains responsible for the cost of Medical Care. The patient will be determined "Acute" during this phase of their illness. No approval from the LMHA is necessary in this situation.

See ***Quick View: LOC Form Entry Guidelines in the LOC Form Section of Attachment 3*** for detail on how to determine the effective date for a change in LOC.

While there are certain critical functions regarding the performance of UM functions, e.g., see Synopsis of Critical Functions Section in this document, page 6, the specifics of the working relationship between the LMHA's UM activity and, that of, the State Hospital is itself, not dictated in this document but should be determined by the business relationship between the two parties.

STATE HOSPITAL UM:

If at admission the patient is determined to be uninsured, then the payer is the LMHA. Because all uninsured patients must have a LOC assignment, the LOC for newly admitted uninsured patients is always assumed to be acute for the first 30 days of service. Because this is the default condition, there is no need to complete the ***LOC Form***; AVATAR PM will do this automatically.

State Hospital UM must interface with LMHA UM in a manner that is agreed to by the LMHA and the State Hospital. The State Hospital must make available to the LMHA information required to enable the LMHA to function in its role as payer as this role has been defined in the business relationship between the LMHA and State Hospital.

STATE HOSPITAL TREATMENT TEAM:

Once a patient is assigned to a treatment team, it becomes the responsibility of the team to complete the ***LOC Form*** as appropriate. The following are guidelines for completing the form on all uninsured patients:

- The basic philosophy of treatment is to prepare the patient for discharge as quickly as clinically appropriate. With this in mind, determining if a patient is subacute is secondary to the discharge and placement decision.
- As the treatment team treats and evaluates the patient for improvement, it is moving towards discharge of the patient. When the treatment team, which includes the LMHA, determines the patient is ready for discharge, the discharge plan is in place, discharge occurs, which means that the ***LOC Form*** has no role and is not completed. However, it is possible, that for whatever reason, the patient is not discharged and remains in the hospital. This is a time in the patient's stay where the treatment team evaluates the patient to determine if his/her LOC has become subacute. If the patient is now subacute, then the ***LOC Form*** is entered into AVATAR PM with the date of the LOC determination. If the team determines that the LOC has not changed from acute to subacute, then there is no need to enter the determination, i.e., the ***LOC Form*** into AVATAR PM. This process of treatment, evaluation and LOC determination is repeated throughout the patient's stay as illustrated in the flowchart.
- LOC for a patient is determined by meeting the criteria identified on the LOC Form. This is applicable to any change in a patient's LOC that occurs during his/her stay. State Hospital and LMHA staff can agree that a patient is acute, or subacute based on clinical judgment without having to meet all the criteria on the ***LOC Form***. However, the subacute or acute box, as appropriate on the ***LOC Form*** **MUST** be checked. This is essential because it determines the amount to charge the LMHA. If a mutual agreement between the State Hospital and LMHA is not reached, then the criterion on the LOC Form strictly governs the acute or subacute designation.
  This is true if the appeal process in the ***UM Agreement*** is used but does not produce an agreement. **For any change in LOC during the patient's stay, the effective date, the Review Date on the *LOC Form,* is the date at which either the LMHA approves the change or if an appeal results in a change in LOC, the date that was identified when the LOC change was sought or a date determined as a result of the appeal.**
- It is within the purview of the LMHA, as payer, to request that the State Hospital, during treatment team review, determine if a particular patient is subacute. While the clinical aspects of determining LOC lie with the treatment team, it is possible that for a particular patient, the LMHA will request a LOC determination after the first 30 days of service. If the patient is found to be subacute and the LMHA decides to leave the patient

in the State Hospital, the treatment team will enter the LOC Form into AVATAR PM to change the patient's LOC assignment to subacute, effective the date of the determination.

Identifying Third Party Payers:

LMHA:

The LMHA will conduct a financial assessment of all referrals to the State Hospital. This will assist in identifying insured patients. This information should be provided to the State Hospital's Reimbursement Office at admission.

The LMHA should interface with the State Hospital to be knowledgeable of when, for patients with insurance, the insurer is terminating reimbursement, that there is a denial of initial and/or continued stay coverage. This is a point of risk for the LMHA since, if the patient remains in the State Hospital after the third-party insurer no longer issues authorization for payment, the LMHA will become the payer for the remaining days. Additionally, should actual reimbursed days be less than originally authorized days, the LMHA becomes the payer for remaining unreimbursed days. The LMHA might want to work with the State Hospital to see that, if clinically appropriate, the insured patient is discharged as soon as his/her third-party authorization for payment ends and there is an appropriate discharge and placement plan.

STATE HOSPTIAL:

Responsibility for the reimbursement functions identified in the attached flowchart belongs to the State Hospital. These responsibilities are identified in detail in Section 2 of this document: ***Instructions for Conducting Reimbursement Activities for Third-Party Payers Insured Inpatient Treatment.***

As illustrated in the flowchart, State Hospital Reimbursement will:

- Conduct financial assessment
- Determine payer
- Complete ***MH Bed Day Allocation Exception Form*** and enter into AVATAR PM
- Seek, as appropriate, continued stay authorization for payment
- Keep State Hospital Utilization Management (UM) staff informed regarding a patient's continued eligibility for third-party reimbursement

A major responsibility of the State Hospital is to communicate to the LMHA information pertinent to third-party authorizations for payment. For example:

- Insured patients, for the number of days reimbursed by the third-party payer, are not the financial responsibility of the LMHA. However, when continued stay authorization for payment is denied by the third-party payer, the LMHA needs to know that it may be at risk for paying for the remainder of the patients stay if he/she remains in the hospital. Therefore, State Hospital should communicate to the LMHA information regarding when third-party authorization for payment is scheduled or anticipated to end so the LMHA can plan accordingly.

- State Hospital reimbursement staff must coordinate with the State Hospital staff responsible for communicating with the LMHA so that the LMHA is informed of all third-party authorizations for payment received for its patients.

Section 2

Instruction for Conducting Reimbursement Activity for Third-Party Payers (Insured Inpatient Treatment)

Reimbursement Office Functions under Financing Methodology

Philosophy:

Every patient at a State Hospital has a payer. It is either the LMHA for uninsured patients or the third-party payer for insured patients.

Responsible Office for Managing the Third-Party Payer Process:

Reimbursement Office

Responsibilities Include:

- Receiving information from the LMHA in admissions and identifying whether the patient is insured or not
- Determining, at admission or as soon as possible thereafter, if the patient is insured according to the definition after completing the ***MH Bed Allocation Exception Form***
- Identifying the payer
- Determining the number of days authorized for payment for each patient with insurance , determining the "begin and end dates" with respect to authorization for payment received from each third-party payer
- Entering information from the ***MH Bed Allocation Exception Form,*** i.e., third-party payer and number of days authorized for payment into AVATAR PM
- Requesting, as appropriate, continued stay authorizations for payment and updating the ***MH Bed Day Exception Form*** as necessary
- Interfacing with the State Hospital UM function of the hospital. This UM function communicates with the LMHA to inform it of each insured patient's third-party days authorized for payment

General Guidelines:

1. Insurers to be classified as third-party payers, for the purpose of this methodology, are listed under the **Reasons Codes** shown in the table on page 17.
2. The cost of providing inpatient services for patients referred to State Hospitals with paying third-party coverage, as defined in the following table, are not charged to the LMHA. This cost is covered by the ***per diem reimbursement rate*** of the third-party payer.
3. The key factor is whether or not an authorized day becomes an actual reimbursed day. The amount of the per diem payment received for each third-party reimbursed day is not a consideration.

Therefore, the LMHA is not financially responsible for the stay of third-party insured patients up to the number of days reimbursed by the third-party payer(s). The LMHA, however, is financially responsible for the number of days that remain unreimbursed by the third-party payer(s).
Retroactive changes to the ***MH Bed Allocation Exception Form***, which would debit the GR allocation account, will be made, as permitted, in the following section entitled, **"Timeframes for Retroactive Debit to the GR Allocations"**, when the insurer does not reimburse all previously authorized days.

For Example: If the number of days authorized for payment by the third-party payer is five (5) and the third-party payer actually only reimburses three (3) days, the LMHA is responsible for the remaining two (2) days. This example assumes State Hospital compliance with the timeframes provided below, otherwise the State Hospital forfeits its ability to retroactively debit the LMHA's GR allocation.

4. For each third-party payer listed in the following table, there is a different way for determining the number of days authorized for payment. The rules for doing so are listed in the detailed section of this document.
5. Determining the number of days authorized for payment by the third-party payer(s) is the responsibility of the State Hospital Reimbursement Office. The State Hospital Reimbursement Office manages this process. Days authorized for payment include initial, as well as, continued stay requests.
6. Third-party payers will be tracked according to the specific period authorized for payment. Because benefit availability and authorization for payment are subject to expiration, **it will be necessary to confirm the patient's eligibility for a particular insurance upon admission, during the authorization process and periodically, thereafter**.

Timeframes for Retroactive Debit to the GR Allocation:

All authorized services will be claimed, (billed), to the applicable third-party payer(s) by the State Hospital Reimbursement Office on a monthly cycle, or more frequently when appropriate, no later than the 10th working day of the closed accounting period.

In the event, the third-party payer reimburses fewer days than those originally authorized; the timeframes for retroactively debiting the LMHA's allocation account, i.e., reversing the exemption "end date", are as follows:

- State Hospital Reimbursement Offices are allowed 90-days from the date the authorized service is claimed, (billed), to retroactively debit the LMHA's GR allocation. The LMHA's also have ninety (90) days after the date of discharge to reconcile with the hospital, any issues regarding payor sources or amounts debited for individual patients. This action will reduce the necessity of having large numbers of case disputes at the end of each fiscal year.
- Exemptions entered to the ***MH Bed Allocation Exemption Form,*** based on third-party payer authorization for dates of service occurring during the last quarter of each fiscal year, will **NOT** be subject to retroactive change to the "end date" and the consequent debiting of the LMHA's GR allocation account. This will insure that the LMHA's have the ability to manage their allocation accounts and plan accordingly.

- August 31, 2008 is the final date that State Hospital Reimbursement Staff **MAY** reconcile differences between exempted and paid days for services claimed, (billed), as prescribed, after the close of the May, 2008 accounting period.

Completing the MH Bed Allocation Exception Form:

The State Hospital Reimbursement Office, as soon as possible after admission, determines if the patient is covered by any of the third-party payers listed in the following table. (This table is excerpted from the AVATAR PM Menu Option, ***MH Bed Allocation Exception Form – Attachment 4***)

Begin Date	end date	Reason	Reason Codes
			04-Out of TX TDJC Commitment 05-VA Project 09-Medicare A 10-Medicaid THSTEPS* 11-Medicaid IMD 12-Health Insurance 13-Contract (Other) 15-Medicaid THSTEPS-Independent Child** 16-Consignment from State School 17-Hospital as Payer

* The NorthSTAR allocation is billed for Medicaid THSTEPS STAR enrolled recipients whose county of residence is within the NorthSTAR Region. Please note, children from the NorthSTAR service area who enter foster care placement through the Texas Department of Family and Protective Services, become eligible for Medicaid Program Types 8, 9, OR 10, which are exempted from the NorthSTAR Programs. When this occurs, they are disenrolled from NorthSTAR and the hospital stay is, therefore, not charged to the NorthSTAR allocation, but rather, is billed to Medicaid.

** Terrell State Hospital cannot facilitate or claim Medicaid eligibility for patients from the NorthSTAR Region. This means, the NorthSTAR allocation is billed. All other State Hospitals may facilitate Medicaid eligibility under the Independent Child option for non-Medicaid patients who are admitted from the NorthSTAR Region. In this event, NorthSTAR's allocation is not billed. However, if this same child is **already Medicaid eligible at the time of admission** to the State Hospital, i.e., he/she is STAR enrolled, the hospital may not claim these stays to Medicaid, in which case, the NorthSTAR allocation is billed.

SPECIAL NOTES:

- The State Hospital system contains a total Adult Forensic Maximum Security Capacity of 234 beds (229 GR plus 5 3rd party = 234). Request for admissions of 46.02, 46.03, 46B and 46C patients who are charged with crimes needing Maximum Security are made to the North Texas State Hospital Vernon Campus. These patients are NOT a part of the SHAM and are NOT counted against the LMHA's. In the event that all Exempt Maximum Security Beds are FULL, an estimate will be made regarding the earliest possible admission date. Requests for admission of 46.02, 46.03, 46B and 46C patients that are NOT charged with a crime needing Maximum Security are made to the **DSHS Forensic Admission Clearinghouse.** These patients ARE included in the SHAM and ARE debited against an LMHA unless they have a third party payor. In the event that all adult beds in the state hospitals are **FULL,** an estimate will be made regarding the earliest possible admission date.

GUIDELINES FOR ENTERING BEGIN and END DATES ON FORM

Notice that the "end date" is the day following the last authorized or covered day, and as such, is a GR-funded day. Please refer to **Section 2**, ***Instruction for Conducting Reimbursement Activity for the Third-Party Payers***, of this document for information regarding retroactively adjusting previously exempted days based upon authorization for payment to reflect actual reimbursed days.

1. In reference to exempting bed days from LMHA payer responsibility for patients with Medicare Part A coverage for inpatient psychiatric care, the "begin date" for exemption will be the **admission date, IF,** the patient is **certified for active care**. Though the "end date" will remain open until one of the following occurs, enter the ***MH Bed Day Allocation Exception Form*** into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient **IF**:

   The patient is decertified from active care
   The spell of illness is exhausted
   The psychiatric days are exhausted

2. In reference to exempting days from LMHA payer responsibility for patients Medicaid eligible upon admission, who are under age 21 or 65+, the "begin date" to exempt will be the admission date. The "end date" will be either the day after the last date authorized for payment or the day after the last day of eligibility, whichever comes first. Until the "end date" is known, it will remain open, however, the ***MH Bed Day Allocation Exception Form*** is entered into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient.

   For Example: NHIC gives authorization on a 90-day court commitment admitted on 09/15/07, but, the patient's eligibility closed effective 10/31/07. In this instance, the "end date" entered into the AVATAR PM Bed-Day Exception Screen would be 11/01/07 rather than 12/14/07 (day-91) of the hospital stay.

3. In reference to exempting Independent Child covered days from LMHA payer responsibility, the "begin date" for exemption will be the date of admission, or later if the patient was admitted on a voluntary and then committed during the hospital stay. The "end date" will be, either, the day after the last date authorized for payment, the day after the last day of the court-ordered period or the day after the last day of eligibility which will normally be the discharge date unless the client converts from court-ordered to voluntary status during the hospital stay. Though the "end date" will remain open until it is known based on the above, enter the ***MH Bed Day Allocation Form*** into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient.

4. If a patient, age 65 and over has both Medicare Part A, or health insurance benefits and Medicaid eligibility upon admission to the State Hospital, the "begin date" for exemption will be the admission date, assuming admission to a certified bed. The "end date" is the day following the last date that coverage is available.

A new exemption "begin date" is entered with the appropriate reason code when Medicaid eligibility becomes available. Enter the ***MH Bed Day Allocation Form*** into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient. For patients who do not have Medicaid eligibility, the Reimbursement Office is responsible for facilitating application for Medical Assistance Only (MAO) Coverage, or, SSI, when applicable, if there is a reasonable expectation that Medicaid reimbursement will be necessary for payment of the hospital stay. This will necessitate NOT only working closely with hospital UR Staff in determining if the patient will be long-term, but, also careful monitoring of benefit availability from Part A or other third-party coverage. Because the application process for MAO may take a number of months, and there is no certainty that a patient will meet the income/resource requirements of the program, the Reimbursement Office enters an "end date" in the AVATAR PM exception screen when benefits from the primary payer are no longer available. In the event MAO eligibility is awarded retroactive to the "end date" of the primary payer, so the client has no break in covered days, a "begin date" equal to the original "end date" exemption should be entered with the Medicaid IMD exemption code. Once processed, a credit to the LMHA's GR allocation will be generated retroactive to the "begin date" of the Medicaid IMD exemption. If the effective date of the Medicaid eligibility is not retroactive to the "end date" of the primary payer, then the original "end date" remains. The Reimbursement Office will then need to add a new "begin date" to match the Medicaid start date, which will again generate a credit for that part of the patient's stay for which retroactive Medicaid eligibility pays.

5. In reference to exempting Health Insurance covered days from LMHA payer responsibility, the "begin date" for exemption will be the admission date. The "end date" will be the earlier of either the day after the last date authorized for payment or the day after the last day of coverage under the insurance plan, should the client's coverage under the plan terminate during his hospital stay. Though the "end date" will remain open until the final day of authorization for payment is known, enter the MH Bed Day Allocation Form into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient.

6. Patients who enter the hospital under the contract that Big Spring State Hospital has with the VA are NOT the financial responsibility of the LMHA. Even if these patients remain in the hospital after the VA no longer reimburses the hospital for their stay, there is NO cost to the LMHA.

7. For patients admitted to a State Hospital under a "contract", this refers to other than performance contract between the State Hospital and LMHA, the LMHA is NOT charged the admission and bed day costs during their inpatient episode. It is as though this contract represents a third-party payer. Contractual agreements are for specialty services provided by State Hospitals and are above the bed day levels that have been purchased through the Performance Contract. The State Hospital must know which patients enter the hospital on this contract so as to exempt the LMHA from having to pay for the stay out of its hospital allocation.

8. When a patient in a State Hospital is on "consignment" from a State School, the LMHA will be notified by the referring State School when the consignment occurs. After 30 days, the patient on consignment should either be committed by the appropriate LMHA to the State Hospital or returned to the State School. If the patient is committed, then the LMHA will become financially responsible for the patient's inpatient treatment. The

Department of Aging and Disability Services (DADS) will reimburse Department of State Health Services (DSHS) for this service (consignment).

9. Patients in North Texas State Hospital – Vernon Campus, are NOT the financial responsibility of the LMHA and there is NO cost for these patients to the LMHA for the duration of the patient's stay. They include:

    - Adult Forensic Maximum Security patients
    - Civil Maximum Security Patients
    - Adolescent Forensic patients

Brief Guidelines for Entering the MH Bed Day Exception Form into AVATAR PM:

- The "begin date" associated with a particular third-party payer needs to be determined according to the rules in this Section. The "begin date" is entered on the ***MH Bed Day Allocation Exception Form*** as soon as it is known, but, always within 24-48 hours. This is important because the form provides UM information to the LMHA regarding the fact, that for a particular patient, there is a third-party payer.

- The ***MH Bed Day Allocation Exception Form*** is to be entered into AVATAR PM as soon as the "begin date" is known. The "end date" always remains open until Reimbursement Staff have verified that authorization for payment or third-party coverage is no longer available.
  The "end date" is subject to adjustment based upon actual reimbursed days. Please refer to **Section 2 – Instruction for Conducting Reimbursement Activity for Third-Party Payers**, of this document for information regarding retroactively adjusting previously exempted days.
- When the rules for entering the "begin date" for the authorization from a particular third-party payer requires that the "begin date" be the same as the patient's admission date to the State Hospital, it is critical that these dates be the same. If they are not, there may be an inappropriate charge to the LMHA's hospital allocation. A standing exception to the rule that the "begin date" of a primary payer be the same as the admission date is, **IF** neither the LMHA nor the patient informed the State Hospital of third-party coverage and the State Hospital does not discover this coverage until after the date of admission, which results in unreimbursed days.
- Unless there is a mistake, e.g., data entry error, once the "begin date" has been entered into AVATAR PM, it may be changed **ONLY** if that change is to move the date closer to the admission end of the patient's stay. For Example: IMD, where there may be retroactive reimbursement. It cannot be moved forward in time, that is, to the discharge end of the patient's stay.
- The "end date" is the day after the last day of third-party authorization for payment and/or the day after the last third-party reimbursed day. The "end date" is then the first day of GR-funded coverage "paid by" the LMHA.

Detailed Guidelines

Reimbursement Guidelines for Allocation Methodology FY2008

Overview: The Department's allocation methodology for State Hospitals was implemented in Fiscal Year 2001. In this system patient bed days are paid for by either the LMHA, through its allocation of general revenue from DSHS, or by per diem reimbursement received from third-party payers.

Pricing Schedule: Uninsured Patients in State Hospitals

The cost of providing inpatient services to patients referred to State Hospitals without third-party payer insurance coverage is charged to the LMHA.

The Department of State Health Services allocates to each LMHA a prepaid account to pay for the treatment of the uninsured patient in a State Hospital. The amount of this equitable allocation to each LMHA is listed in ***Attachment 5.*** This "account" can only be used in the State Hospital System. If the LMHA does not use the full amount of funding in its "account" it cannot carry this over to the next contract year.
These accounts should be used in the Regional State Hospital Service Area that has been established by Department of State Health Services.

Charges to the LMHA's allocation for its use of the State Hospital for the uninsured patient will be determined by the pricing schedule listed below.

Uninsured patients while in the State Hospital who are transferred to a medical hospital for physical healthcare will continue to be the responsibility of the LMHA and these allocations will continue to be charged, at an acute care rate, for the days the patient is physically not present on the State Hospital campus. AVATAR PM Action Code 305, from AVATAR PM-CAM1 has a code-AHN that will be used to capture the appropriate billing information. There is no need for State Hospital Reimbursement Offices to do anything different in their role of these codes; the AVATAR PM System will identify the changes, if any, to the LMHA's allocation. This charging for patient absences applies to any patient not receiving paying third-party benefits. These days should also be coordinated between the State Hospital Reimbursement Office and State Hospital Medical Records to make use of appropriate coding of absence to off ground hospitals.

The LMHA is responsible for paying the bed day costs for uninsured patients and an admission cost for ALL admissions, insured or uninsured, (except for most Forensic admissions) that have been admitted to the following State Hospitals:

- Austin State Hospital
- Big Spring State Hospital
- El Paso Psychiatric Center
- North Texas State Hospital
- Kerrville State Hospital
- Rusk State Hospital
- San Antonio State Hospital
- Terrell State Hospital
- Rio Grande State Center

The LMHA's prepaid (GR) account for uninsured patients will be charged the following rates:

- Each admission to the State Hospital 325.

(Inter-hospital transfers excluded and certain forensic patients excluded)

- Adult Acute Bed Day 323.
- Acute Child/Adolescent Bed Day 358.
- Adult Subacute Bed Day 285.

The AVATAR PM system will track the LMHA's GR account by assessing the admission surcharge and charging any non-exempted days according to the prices associated with the patient's LOC.

Definitions:

Admissions – are currently defined:

Hospital-to-hospital transfer of patients is not considered an admission.
Patients returning from a furlough of less than 30 days are not considered an admission.
Patients returning from a furlough of over 30 days are considered an admission.

Acute Bed Day – is determined through:

The application of the LOC criteria.
The first 30 days are considered acute.

Subacute Bed Day – is defined as:

Non-Acute Bed Day

Insured Patient – is defined as:

A patient with paying coverage, a per diem reimbursement from one of the following third-party payers:

- Medicare Part A
- Medicaid THSTEP*
- Medicaid Independent Child
- Medicaid IMD
- Health Insurance

1. Commercial
2. Tricare
3. VA fee basis
4. BHO

*NorthSTAR is the exception. Refer to the ***MH Bed Day Allocation Exception Form*** detailed on page 16 for information regarding NorthSTAR and Medicaid.

Third-Party Payer Insured Patients in State Hospitals:

The cost of providing inpatient services for patients referred to State Hospitals with paying insurance coverage is NOT charged to the LMHA. This cost is covered by the per diem reimbursement received from the third-party payer.

In instances where the number of days reimbursed is less than the number of days originally authorized by the third-party payer, the reimbursed number of days will be considered as the number of insured days. The LMHA will be responsible for paying for the difference between authorized days and reimbursed days. In all instances where a patient's authorization expires and he/she remains in the State Hospital, the patient is considered uninsured and the cost becomes the responsibility of the LMHA.

In those instances where the per diem reimbursement paid to the State Hospital by the patient's third-party payer is less than the hospital cost, there will be no charge to the LMHA for the difference between the charge billed and the payment received for each reimbursed day.

Patients served at the following hospitals are excluded from having the LMHA pay for uninsured treatment:

- Vernon Campus of North Texas State Hospital
- Waco Center for Youth

In addition to the above stated exemptions, the following categories are also excluded from having the LMHA pay the State Hospital for bed day costs:

- VA project beds

- Direct-contracted beds with LMHA and/or other parties, e.g., LMHA contacts directly with a State Hospital out of their service area for child/adolescent service.
  Attachment 6 provides estimates of Funded Average Daily Census in each of the State Hospitals by General Revenue and Third-Party Revenues.

Over Utilization by LMHA:

Payment to State Hospitals Section of the Department of State Health Services

When the LMHA's have used all of their allocations, as determined according to ***Attachment V,*** the LMHA's will reimburse the State Hospital Section of the Department of State Health Services for costs of inpatient mental health services provided by State Hospital's according to the following methodology:

Statewide Overuse:

a. A LMHA will not be required to reimburse the DSHS State Hospital Section for costs of inpatient mental health services exceeding the LMHA's allocation, unless the total allocation for all LMHA's listed in ***Attachment V***, is exceeded by the end of the fiscal year, except for the 110% level as indicated on page 26.

b. Over utilization will be calculated on a statewide basis. If the total allocation for all LMHA's has been exceeded by the end of this fiscal year, a LMHA will reimburse the DSHS State Hospital Section for its proportional share of the total allocations overage as described in section "d" below.

c. The LMHA's proportional share for the total allocations overage is calculated by dividing the amount the LMHA exceeded its allocation by the amount that exceeds the allocation for all LMHA's who have exceeded their allocation, multiplied by the amount that the total allocation, as listed in ***Attachment V***, is exceeded.

d. Payment for overuse will be made within 45 days after the receipt of the LMHA of its Over Utilization Statements.

Payment for Overuse above the 110% Level:

If an individual community center exceeds their annual State Hospital allocation by more than 110%, the community center shall be assessed a sanction in the form of a penalty and required to settle-up the 110% level.

EXAMPLE: This is NOT dependent on the Statewide Utilization

Center X has an annual State Hospital allocation of $1,000,000.
At the end of the fiscal year, Center X has used 130% of their annual allocation ($1,300,000.).
Center X will be required to settle-up to the 110% ($1,100,000.) level.
Center X will be required to pay DSHS for the 20% or $200,000. for it's annual State Hospital over utilization.

Payment for overuse will be made within 45 days after the receipt of the LMHA of its Over utilization Statements.

Individual community center State Hospital utilization will be monitored on a monthly basis.

If a community center's quarterly use of the State Hospital allocation exceeds more than one-fourth of the YTD allocation, the center will be required to submit a plan of correction.

INSTRUCTIONS FOR COMPLETING THE MH BED ALLOCATION EXCEPTION FORM

Overview

All authorized or covered third-party days will be exempted prospectively but will be subject to change if the State Hospital does not receive payment for days previously authorized or identified as covered. Retroactive changes to days initially exempted based upon authorization for payment will be allowed in order to reflect actual reimbursed days. The State Hospital is responsible for making these retroactive changes within the 90-day timeframe detailed below. The LMHA's are responsible for communicating third-party insurance information to the State Hospital at the time of admission.

The LMHA also has ninety (90) days after the date of discharge to reconcile with the hospital any issues regarding payor sources or amounts debited for individual patients. This action will reduce the necessity of having large numbers of case disputes at the end of each fiscal year.

Begin and end dates – Principle:

- The "begin date" associated with a particular third-party payer needs to be determined according to the rules in this section and then entered on the ***MH Bed Day Allocation Exception Form*** as soon as it is known, but, always within 24-48 hours. This is important because the form provides UM information to the LMHA regarding the fact that for a particular patient, there is a third-party payer.
- The initial "end date" always remains open until reimbursement staff has verified that authorization for payment or third-party payer coverage is no longer available. The "end date" is subject to adjustment based upon actual third-party payer reimbursed days.
- When reimbursed days are less than authorized days, the State Hospital Reimbursement Office is allowed 90-days from the date the authorized service is claimed, (billed) to retroactively debit the LMHA's GR Hospital Account. All authorized services will be claimed, (billed) to the applicable third-party payer(s) by the State Hospital Reimbursement Office on a monthly cycle, or more frequently when appropriate, but, no later than the 10th working day of the closed accounting period.

NOTE: ***Dates of service occurring during the last quarter of each fiscal year will not be subject to retroactive change to the "end date" and the subsequent debiting of the LMHA's GR allocation. Additionally, August 31, 2008 is the final date the State Hospital Reimbursement Staff may reconcile differences between exempted and paid days for services claimed,(billed), as prescribed, after the close of the May, 2008 accounting period. This will insure that the LMHA's have the ability to manage their hospital accounts and plan accordingly.***

Third-party payers will be tracked according to the specific reimbursed period applicable to each unique third-party program. Third-party payers are to be tracked as delineated in the following sections.

MEDICARE PART A

Medicare Part A eligibility is determined using the on-line GPNet system, administered by the fiscal intermediary. This system reports the number of psychiatric days and the inpatient spell of illness available to the patient, as per the last billing processed by Medicare. Because another inpatient provider may file a claim after the patient's admission to the State Hospital resulting in a reduction of benefit availability, the hospital Reimbursement Office should check the on-line data weekly, or prior to each claim filing, until such time as the active care period ends or benefits are not otherwise available.

In reference to exempting bed days from LMHA payer responsibility for patients with Medicare Part A coverage for inpatient psychiatric care, the "begin date" for exemption will be the admission date IF the patient is certified for active care. Though the initial "end date" will remain open until the first of the following occurs, the ***MH Bed Day Allocation Exception Form*** should be entered into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient.

- The patient is decertified from "active care".
- The spell of illness is exhausted.
- The psychiatric days are exhausted.

The initial "end date" may be subject to adjustment based upon actual third-party payer reimbursed days, as appropriate, and IF reconciliation is done within the 90-day timeframe. Therefore, the final "end date" may precede the initial one, resulting in a retroactive debit to the LMHA's hospital account.

MEDICAID THSTEPS – Regular: (Eligible at the time of admission)

Medicaid eligibility for individuals under age 21 may be verified using the following sources:

- CARE SYSTEM 193 screen
- TDH CONNECT SYSTEM
- DHS's CEI/TIERS DATABASE
- TMHP – phone call to CCP prior authorization department
- CARE MEDICAID REPORTS, HC024 80 / HC024085

The most reliable source, of the above list, is TMHP. In contacting TMHP, one is able to inquire as to whether or not the patient's eligibility is scheduled to close or suspend. Monthly eligibility checks are recommended in the event a patient's Medicaid eligibility terminates during his/her hospital stay. This is especially important when prior authorization has been received for a 90-day court commitment, as the State Hospital may not be aware that the patient's eligibility has closed until after such time as the claim (bill) has been filed.

The initial authorization request is submitted the day of the admission, if the admission occurs during normal working hours, or the next business day if applicable due to holiday, weekend and/or after working hours admission. The continued stay authorization request is submitted on the last day of the currently authorized period. Voluntary stays, authorized for very limited periods of time, must be monitored closely to ensure that the initial "end date" for exempted days is entered into AVATAR PM as soon as they stay is no longer authorized.

Court ordered stays are typically authorized for the entire duration of the court commitment for up to 90 days with 30 day increments thereafter. The initial "end date" remains open until authorization has been denied, which includes continued stay authorizations, at which time the "end date" is entered into the AVATAR PM as soon as the stay is no longer authorized. Court ordered stays are typically authorized for the entire duration of the court commitment for up to 90 days with 30 day increments thereafter. The initial "end date" remains open until authorization has been denied. This includes continued stay authorizations, at which time the "end date" is entered.

In reference to exempting days from LMHA payer responsibility for patients Medicaid eligible upon admission, the "begin date" to exempt will be the admission date. The initial "end date" will be either the day after the last authorized date or the day after the last day of eligibility, whichever comes first. Until the initial "end date" is known, it will remain open, however, the ***MH Bed Day Allocation Exception Form*** is entered into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient.

FOR EXAMPLE:

> TMHP gives authorization on a 90 day court commitment admitted on 09/15/06, but, the patient's eligibility closed effective 10/31/06. In this instance, the "end date" entered into the AVATAR PM Bed-Day Exception Screen would be 11/01/06 rather than 12/14/06 (day 91) of the hospital stay. The initial "end date", which is entered based upon days authorized for payment, is subject to adjustment based upon actual third-party payer reimbursed days, as appropriate and if reconciliation is done within the 90 day timeframe. When this occurs, the final "end date" may precede the initial one.

MEDICAID THSTEPS – Eligibility facilitated under Independent Child

Under the Independent Child Program, Medicaid coverage is obtained by the State Hospital through an application process for individuals under the age of 19 who are admitted under a court commitment. Applications for Medicaid benefits will be initiated for every applicable patient served. The Medicaid coverage will be effective from the initial court ordered day, typically the date of admission, throughout the court ordered period. Therefore, monthly eligibility checks should not be an issue, as is the case for recipients who have accessed Medicaid prior to admission to the state hospital.

In reference to exempting Independent Child covered days from LMHA payer responsibility, the "begin date" for exemption will be the date of admission, or later if the patient was admitted on a voluntary, then committed during the hospital stay. The initial "end date" will be, either the day after the last authorized date, the day after the last day of the court-ordered period, or, the day after the court-ordered to voluntary status during the hospital stay. Though the initial "end date" will remain open until it is known, based on the above, enter the form into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient. The initial "end date", which is determined based upon the criteria noted above, is subject to adjustment based upon reimbursed days, as appropriate and if reconciliation is done within the 90 day timeframe. Again, the final "end date" may predate the initial one.

HEALTH INSURANCE

For the purpose of exempting bed days, all health insurance payers, other than Part A, Medicaid THSTEPS and Medicaid IMD, will be grouped together as one Exception Reason Code in AVATAR PM and CARE.

This category includes:

- COMMERCIAL
- TRICARE
- VA FEE BASIS (excludes the BSSH contract)
- MEDICARE HMO
- MEDICAID HMO

****NOTE:** Excluded from this Health Insurance Category is the following:

- Cash Policies – which are not per diem payers, but, rather offer a very limited benefit to supplement, but, not reimburse the cost of the inpatient stay.

Procedures for verifying health insurance benefit availability may vary among the different insurers, but eligibility determinations and available benefits inquiries are usually made directly with the health insurance plan by telephone contact. Typically, health insurance companies will quote the number of benefit days available per calendar year, or the lifetime maximum the plan will cover. This is only preliminary information in accurately determining the number of potential ***payable*** benefit days for the hospital stay. The State Hospital will need to specifically request the number of benefit days available during the ***current*** calendar year. In the event that behavioral health services are managed by an entity other than the health insurance carrier, this inquiry should be made of both the carrier and the contracted BHO, as each entity may maintain separate records.

The State Hospital should intermittently check the number of benefit days available and the eligibility of the patient, since both may be subject to change. Subsequent to the initial inquiry made at the time of admission, these periodic inquiries can be scheduled to coincide with the dates of the clinical reviews conducted by the Utilization Review Coordinator.

In reference to exempting Health Insurance (HI) covered days from LMHA payer responsibility, the "begin date" for exemption will be the admission date. The initial "end date" will be the earlier of either the day after the last date authorized for payment or the day after the last day of coverage under the insurance plan, should the client's coverage under the plan terminate during his/her hospital stay. Though the "end date" will remain open until the final day of authorization is known, enter the form into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient. The initial "end date", which is entered based upon days authorized for payment, is subject to adjustment based upon reimbursed days, as appropriate, and when discrepancies are identified within the 90 day timeframe. When paid days are less than authorized days, the final "end date" is prior to the initial one.

State Hospitals should receive written confirmation from the HI/BHO of all paid days in the form of an Explanation of Benefits (EOB), which traditionally, accompanies all payments issued by the HI/BHO. This written confirmation of all paid days becomes the source for determining the "final" "end date". Therefore, should the State Hospital Reimbursement Office have questions regarding the actual paid dates, they should contact the insurer to verify this information.

All State Hospitals need to make a "good faith effort" to become an in-network provider with various managed care organizations. Because State Hospitals are considered traditional providers for both Medicaid-CCP Managed Care and CHIP, the administering HMO should initiate a sincere effort to contract with the State Hospital as a network provider. All insurers are required to accept State Hospitals as a provider of emergency services, regardless of contractual status.

MEDICAID IMD

Medicaid eligibility for age 65 and over in State Hospitals is usually facilitated by the Reimbursement Office. Although, patients may be eligible at the time of admission if they have transferred from a Title XIX hospital, or are SSI eligible in the community. Because this Medicaid Program is the payer of last resort for the geriatric population, nearly all admissions will have days initially exempted as a result of their Part A, and/or, occasionally commercial insurance coverage.

If a patient, age 65 and over has both Medicare Part A, (or health insurance) benefits and Medicaid eligibility upon admission to the State Hospital, the "begin date" for exemption will be the admission date, assuming admission to a certified bed. Enter the ***MH Bed Day Allocation Exception Form*** into AVATAR PM within 24-48 hours of identifying the "begin date" for the patient**.**

For patients who do not have Medicaid eligibility, the Reimbursement Office is responsible for facilitating application for MAO coverage, or SSI, when applicable, if there is a reasonable expectation that Medicaid reimbursement will be necessary for payment of the hospital stay. This will necessitate, not only, working closely with hospital UR Staff to determine if the patient will be long-term, but, also careful monitoring of benefit availability from Part A or other third-party coverage.

Because the application process for MAO may take a number of months and there is no certainty that a patient will meet the income/resource requirements of the program, the hospital Reimbursement Office will enter an "end date" in the AVATAR PM Exception Screen when benefits from the primary payer are no longer available. In the event MAO eligibility is awarded retroactive to the "end date" of the primary insurer, so that the client has no break in covered days, the new "begin date" for the IMD Exemption Code will be the same as the "end date" of the primary insurer. The addition of the new exemption will reverse the prior charges to the LMHA's GR allocation account.

If the effective date of Medicaid eligibility is not retroactive to the "end date" of the primary payer, then the original "end date" remains. The Reimbursement Office will need to add a new "begin date" to match the Medicaid start date. This will generate a "credit" to the LMHA's GR allocation account for that part of the patient's stay, for which, retroactive Medicaid eligibility pays.

Applications for SSI are filed by the State Hospital Reimbursement Office when a patient, illegal aliens excepted, is completely indigent and expected to need Medicaid eligibility for reimbursement of the hospital stay. The Reimbursement Office should ensure the SSI effective date is processed retroactive to the first unreimbursed day of the State Hospital stay, which could be the date of admission, the date the client reaches age 65, or the date that coverage from the primary payer ends. Once the "begin date" for the IMD Exemption Code is entered into the system, a credit to the LMHA's trust fund will be generated.

__NOTE:__ **ONCE A DATE IS ENTERED IN AVATAR PM AS BEING IMD THIRD-PARTY COVERED OR EXEMPT FROM LMHA PAYER RESONSIBILITY, THE HOSPITAL __MAY NOT__ REVERSE THIS INFORMATION, WITH THE EXCEPTION OF A DATA ENTRY ERROR.

THIS INCLUDES ANY OF THE FOLLOWING SITUATIONS:

- Prior authorization requests submitted past the deadline
- Delayed submission of the MAO or SSI Applications
- Claims filed past the deadline
- Eligibility terminates for excess resources, as a result of conserved benefits in the patient's trust fund paid to the hospital as rep payee

Any excess income or resources, aside from conserved benefits in the patient's trust fund paid to the hospital as representative payee, which result in denial or loss of Medicaid eligibility will be considered outside the hospital's control and will, therefore, be a GR funded day. When this occurs, the "end date", if not already entered, will be keyed into AVATAR PM so the days are no longer exempted and the LMHA becomes the responsible payer.

OTHER SOURCES OF FUNDS

Because all sources of funds do not adequately reimburse the cost of the hospital stay, only payments from per diem third-party payers will be used to exempt bed days from GR funding. Monies received from non third-party sources of funds and other payers as identified will not be applied toward bed day exception:

__NON-THIRD PARTY__

- GOVERNMENTAL BENEFITS
- SPOUSAL AND/OR OTHER INCOME
- REAL OR PERSONAL PROPERTY

__SUPPLEMENTAL OR FEE-FOR-SERVICE COVERAGE SOURCE OF FUNDS__

- MEDIGAP
- CASH POLICIES
- QMB (AGE 65 AND OVER)
- PART B PROFESSIONAL AND ANCILLARY
- MEDICAID PROFESSIONAL AND ANCILLARY, WHEN APPLICABLE
- MEDICARE PART D

Quick Overview: State Hospital and LMHA Responsibilities

Admission to State Hospital

LMHA	▪ The LMHA is responsible for performing preadmission screenings, as such, commitments and admissions to a State Hospital are considered to be already approved by the LMHA unless the State Hospital and LMHA have developed an agreement where the LMHA is to approve each admission. ▪ It is necessary for LMHA's to coordinate with each other on out-of-region admissions.
STATE HOSPITAL	▪ The State Hospital will notify the LMHA about voluntary admissions that have not been pre-screened. Because the LMHA's now have direct access to information regarding patients from their service area in any of the State Hospital's, notification is considered given once the patient is entered into CARE. ▪ The State Hospital will operate in compliance with the EMTALA Regulations.

Continued Stay

LMHA	▪ LMHA can request discharge at any time and the State Hospital will promptly comply, e.g., make a reasonable effort to discharge on the same day as requested, as long as an appropriate Continuity of Care plan exists. The State Hospital will make a referral to the LMHA and will release the patient to an appropriate community placement. Disagreements are subject to the appeals process in the ***UM Agreement.***
STATE HOSPITAL	▪ The State Hospital will work with the LMHA to develop the appropriate clinical information necessary to enable the LMHA to make continued stay and placement decisions.

LOC Assignment

LMHA	▪ The LMHA can request LOC assignment, at treatment team reviews on any patient after the first 30 days of care. The State Hospital shall ensure that the necessary clinical information is available to the LMHA. ▪ The LMHA can approve the request by State hospital LOC or it can appeal using the procedures in the ***UM Agreement***
STATE HOSPITAL	▪ Level of care (LOC) assignment is determined by the State Hospital treatment team. ▪ Determination of LOC is based on the criteria in the ***LOC Form*** in the ***Attachment.*** ▪ Disagreements regarding LOC assignment are resolved through the appeal procedures in the ***UM Agreement***.

Determining the Third-Party Payer

LMHA	▪ The LMHA will conduct a financial assessment of all referrals to the State Hospital. This will assist in identifying insured patients. This information will be provided the State Hospital Admission Office at admission.
STATE HOSPITAL	▪ The State Hospital will conduct a financial assessment to identify insured patients based on the definition of third-party coverage in the Section on ***Instructions for Conducting Reimbursement Activity***. ▪ For insured patients, the **M*H Bed Day Allocation Exception Form*** is completed and entered into AVATAR PM by the State Hospital. The LMHA's allocation is not charged for the inpatient days reimbursed by the third-party payer. ▪ The State Hospital will, as soon as possible, notify the LMHA regarding the number of days reimbursed by the insurer.

Future Relationships Between State Hospitals and Local Mental Health Authorities

This methodology presents significant evidence of an evolution in the way of doing business for state hospitals and LMHA's. Analyses of this evolution suggest strategies at three levels:

1. Clarification of the role and mission of state hospitals, based in part on the pattern of actual utilization and the identified needs of the local community mental health authorities;

2. Reinforcement of the Department of State Health Services (DSHS) service philosophy that local community mental health needs drive the service system; and,

3. Recognition of the importance of the distinction between insured and uninsured Texans and, within this distinction, clearly identifying the size and scope of the general revenue funded inpatient services available for uninsured Texans.

State Hospitals will continue to be a component of integrated mental health service delivery system providing necessary inpatient services to patients who do not have any other access to such service because of their indigent status or because psychiatric beds have disappeared in the local community.

Within the context of a comprehensive continuum of care, the role of State Hospitals is to help Local Mental Health Authorities meet the needs of persons with mental illness which are not being met in community settings. Key to this role is the need for a stable, minimum amount of resources for the State Hospital system and a resource allocation strategy that is equitable across the state. The primary role of the State Hospital system is to ensure the presence of general revenue funded inpatient services for uninsured Texans. This function is not expected to change in size in the near future, but with the implementation of Resiliency and Disease Management principles within the LMHA's, with the current efforts to define the structure, organization and financing of the State's Mental Health Service delivery system; and with the increased use of the State Hospitals for Criminal Code Commitments, the State Hospitals will also be changing in response to these efforts.

State Hospitals will continue to offer services on a contractual basis to local mental health authorities and third party payers. The overall size of State Hospitals will vary according to local market conditions and available funding levels.

The State Hospital system will continue to provide statewide services, including forensic services and services for children and adolescents. At the same time, the system will continue to explore administrative efficiencies through the consolidation of administrative and support functions.

A commitment to maintaining the role of inpatient services includes the commitment to maintaining the quality of those services. Two key aspects of this are:

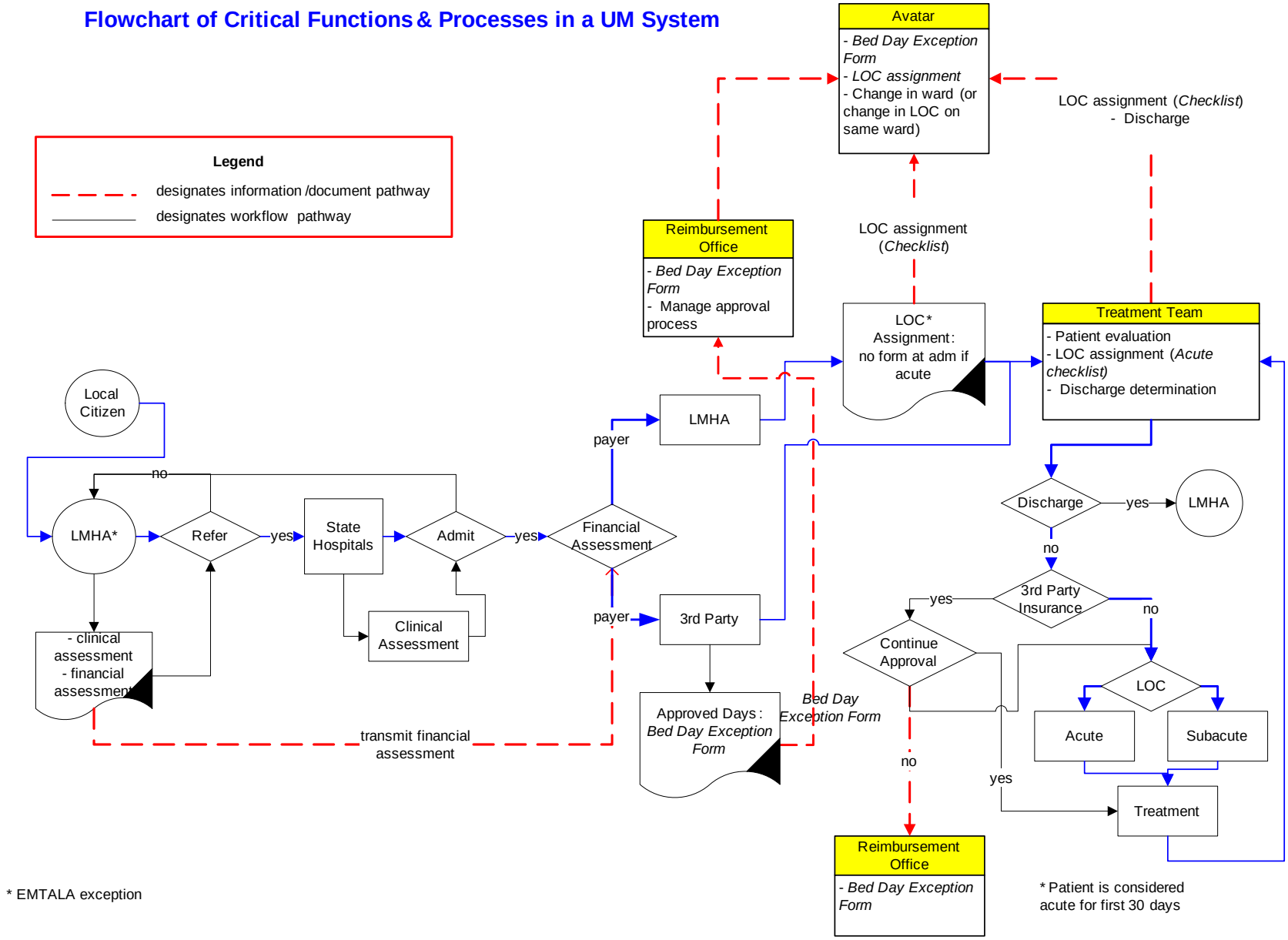
1. Ensure an appropriate number of qualified professional and support staff, and,
2. Ensure that the infrastructure, especially the infrastructure in which persons live and work, is maintained at an adequate level of safety and quality.

ATTACHMENT 1

WORKFLOW AND INFORMATION FLOW PATHWAYS:

IMPLICATIONS FOR REIMBURSEMENT AND UM

Flowchart of Critical Functions & Processes in a UM System



ATTACHMENT 2

UTILIZATION MANAGEMENT AGREEMENT

(EXAMPLE FOR)

LOCAL MENTAL HEALTH AUTHORITIES AND

STATE HOSPITALS

EXAMPLE

Utilization Management Agreement

Local Mental Health Authority and State Hospital

PURPOSE AND INTENT:

Utilization Management

The intent of this agreement is to establish guidelines that operationalize the utilization management (UM) functions of Local Mental Health Authority (LMHA) and State Hospitals. In general, both parties agree that the UM function is to evaluate the need for services, approve and arrange needed services in the least restrictive environment, and to certify the most appropriate service and level of care needed for each person requiring services.

LMHA, desires to enter into this agreement with the State Hospital, for the purposes of implementing its UM procedures relative to use of inpatient psychiatric services, for approval of admissions, continued stays, discharges and appropriate community placement.

State Hospital desires to enter into this agreement with LMHA, for the purposes of implementing its UM procedures, to determine appropriateness of admissions, denied admissions, continued care, and discharge readiness, and to acquire the services of discharge planning, aftercare and follow-along services provided by the LMHA.

I. LMHA Utilization Management Function

Initial Care:

Using the criteria listed in Section II, below, the UM staff of the LMHA will pre-screen and approve each person prior to the proposed commitment and admission.

Continuation of Care:

LMHA UM staff will participate in the treatment team activities and, based upon this information, decide if it wants to request discharge or approve continued stay. For new admissions, this initial decision will come within the first 3 days after admission. Should continued stay be approved, a review schedule will be established by the LMHA UM staff and communicated to State Hospital UM staff. Should discharge be requested, State Hospital will promptly discharge the patient as long as an appropriate discharge plan is in place, which will include a referral to the LMHA and release of the patient to an appropriate community placement, which may include release to a "specific" LMHA physician.

Persons who are approved for more extended terms of care will be reviewed by LMHA as clinically indicated.

Continued Stay Process:

The LMHA UM staff will perform scheduled reviews in order to achieve the following:

1. determination of discharge readiness, according to criteria referenced in Section II. Admission Criteria
2. re-evaluation of the level of care, after the first 30 days of service
3. determination of review schedule through extension of bed days

If there are disagreements about level of care determinations, the State Hospital Medical Director will promptly notify the LMHA Medical Director for a review of the case. If agreement can't be reached, it is the final responsibility of the State Hospital Medical Director for a decision.

Discharge is expected upon request of the LMHA and the presence of an appropriate discharge plan jointly developed by the LMHA and the State Hospital.

Notification:

LMHA UM staff will provide to State Hospital UM staff written notification of all requests for action. Such notifications would include approval of acute initial/admission bed days, continuing bed days, sub-acute bed days, third-party payer follow-up, and any requests for transfer to another hospital and request for discharge from State Hospital.

II. Admission Criteria

Only persons meeting the established criteria for acute inpatient psychiatric treatment, as outlined in this agreement, will be admitted to the State Hospital for inpatient psychiatric care.

The LMHA will approve or refer only those persons for inpatient psychiatric treatment that:

- are exhibiting symptoms/characteristics, which are related to the established admission criteria of DSHS.
- and for whom appropriate services are not available locally.

Those characteristics are inclusive of but not limited to:

- Suicide attempt
- Current suicide ideation with plan
- Current homicidal ideation with plan

- Self mutilating behavior with poor impulse control and **at least one of the following two:**

    - Thought disorder/delusions/hallucinations.
    - Unavailable / inadequate support system.

- Psychotic symptoms and **at least one of the following four:**

    - Assaultive behavior or destruction of property.
    - Medication noncompliance and unavailable/inadequate support system.
    - Comorbid depression (psychotic depression).
    - Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.

- Manic/depressed mood with impaired judgment and **at least one of the following five.**

    - Assaultive behavior or destruction of property.
    - Medication noncompliance and unavailable/inadequate support system.
    - Psychotic symptoms to depression and absent or inadequate support system preclude treatment adherence at a less intensive level of care.
    - Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.
    - Vegetative signs and symptoms to depression and absent or inadequate support system preclude treatment adherence at a less intensive level of care.

- Dementia and **at least one of the following three:**

    - Assaultive behavior or destruction of property.
    - Medication noncompliance and unavailability/inadequate support system.
    - Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.

Medical Exclusionary Criteria:

Each hospital will include the Medical Exclusionary criteria approved by their hospital medical staff.

Persons presenting for inpatient admission at State Hospital without community-based screening:

It is the LMHA's intention to prescreen all referrals, both voluntary and involuntary, to the State Hospital to determine if the inpatient hospital is the least restrictive environment for the person to receive appropriate treatment. The LMHA will designate local screening location(s) for the

purpose of screening for a least restrictive treatment environment. In situations where the LMHA is unaware that a person is presenting for voluntary admission, the State Hospital Admissions Office will contact the designated LMHA UM staff to advise of the prospective admission.

Prospective Involuntary Emergency Admissions:

If a person is brought to a State Hospital by law enforcement officers via a warrantless detention for an emergency screening, the person presenting for admission will be screened by a physician as outlined in the ***Health and Safety code, Subtitle C. Texas Mental Health Code, Subchapter C. Emergency Detention, Release and Rights.*** If the person is determined not appropriate for admission, the person will be transported back to the location of apprehension, to the person's residence in Texas, or to another suitable location at the cost to the county where the apprehension took place.

Prospective Voluntary Admissions:

If a person presents to a State Hospital for prospective admission on a voluntary basis without contact with the LMHA, the person presenting for admission will be screened by a physician on the State Hospital Medical Staff to determine the presence or absence of an emergency medical condition (EMC). If the medical screening evaluation (MSE) does not identify an EMC, the State Hospital will confer with the LMHA for recommendations. The LMHA will have the opportunity to recommend admission or a lesser restrictive treatment setting, as appropriate. If admission does not occur it is the LMHA's responsibility to take into custody and transport the person to an identified treatment setting. This must occur in 60 minutes after the time a decision has been made that the LMHA will make an alternate placement.

If the MSE does identify an EMC, the State Hospital physician decides whether the State Hospital has the capacity to treat the EMC. If it is, determined, the State Hospital has the capacity to treat the EMC, under EMTALA, the State Hospital has no choice but to admit the person.

If it is determined that the person has an EMC and the State Hospital does not have the capacity to treat, the State Hospital will provide evaluation and treatment within its capacity to stabilize and will arrange appropriate transfer to a hospital that has the capability and capacity to treat the person's EMC. The State Hospital will comply with all requirements of an appropriate transfer as defined in current EMTALA rules and regulations.

Payer Transition

The LMHA will conduct a financial assessment of all referrals to the State Hospital. This will assist in identifying insured patients. This information will be provided the State Hospital's Admission Office at admission.

Should a person be admitted to State Hospital with a third party pay source, the full number of actual per diem days reimbursed by that pay source will be communicated to LMHA as soon as it is known by the State Hospital. LMHA UM staff will provide ongoing review as indicated in Section II Continued Stay Process.

III. Discharge Readiness Determination Process

General Provisions

During the course of treatment, a reasonable and appropriate discharge plan will be jointly developed by LMHA and State Hospital that will be in compliance with requirements of the Admission, Continuity, and Discharge rule. LMHA UM staff will communicate with State Hospital UM staff to monitor the patient's response to treatment and to determine if the patient meets the criteria for continued stay.
Should the UM staff determine that the patient no longer meets the criteria for inpatient treatment, according to Section II of this agreement, the UM staff will contact the designated State Hospital UM liaison staff to request discharge. LMHA will notify the State Hospital as soon as possible regarding a determination to request discharge. State Hospital is expected to make good faith and reasonable efforts to discharge the patient the same day as requested by LMHA. For patients with an appropriate discharge plan, discharge will occur within a maximum of 48 hours of LMHA requested discharge. When requested, the State Hospital will discharge the patient, refer them to the LMHA, which accepts responsibility for the patient and the implementation of the discharge plan and release the patient to an appropriate community placement, which may include release to a specific LMHA physician. The LMHA UM staff and the State Hospital UM liaison staff will establish prompt communication to facilitate the LMHAs placement of the patient into the least restrictive, aftercare services.

IV. Utilization Management Communication

Both parties will establish processes and protocols of communication that will facilitate the exchange of information needed to accomplish the activities stated in this UM Agreement. This will include but not be limited to:

- Identification of UM staff for both parties
- State Hospital prompt updates to AVATAR PM Screen 397
- LMHA conducting financial assessment prior to admission, referral and making information available to State Hospital admission staff
- State Hospital prompt communication of insurance status and period of third party authorization and actual reimbursement for treatment
- LMHA participation and leadership in joint discharge planning
- LMHA prompt notification of discharge request

V. Resolution of Disputed Discharge Readiness Decisions

A. If an LMHA is requesting discharge, but in the attending physician's clinical judgment there is still a medical necessity for continued inpatient treatment, then the State Hospital's attending physician will immediately convey that assessment to the Medical Director of the Hospital and to the Superintendent.

Hospital staff will notify the LMHA of the attending physician's clinical assessment and decision.

If the LMHA disagrees with this decision, then the Superintendent and the Executive Director will contact the Director of State Hospitals and a decision will be made immediately by the Director of State Hospitals as to who the payer for services will be (LMHA Allocation patient or Hospital Pay Patient). The basis for making this decision will be on the existence of an appropriate Continuity of Care Plan and/or the willingness of a physician to physician transfer of responsibility for care.

B. In cases where the patient does not agree with the LMHA's request for discharge or transfer to another hospital, the patient will be advised of the appeal process, as outlined by the LMHA, but will be promptly discharged or transferred.

VI. Term

This UM Agreement is effective **September 1, 2007 and expires on August 31, 2008**.

This UM Agreement may be terminated without cause by either party upon thirty (30) days written notice to the respective party of its intent to terminate. Additionally, this UM Agreement may be terminated by mutual agreement of both parties.

VII. Authority to Bind the Parties

This agreement is not binding on any participating organization unless it is executed by the appropriate persons as defined in each organization's local policies and procedures. By signing below, each organization is agreeing to and signifying cooperation with the procedures as outlined in this agreement.

ATTACHMENT 3

MH ACUTE LEVEL OF CARE DETERMINATION

FORM

CARE

Client Assignment and Registration System
Department of State Health Services – State Hospital Section

Entered in AVATAR PM Menu Option

CARE - ACUTE

MH Acute Level of Care Determination (Action Code 343)

7/1/00

Last Name/ Suffix

First Name

Middle Name

CARE ID

Local Case Number

Component/Location

Review Date MM DD YY

Action Add: ☐ Change: ☐ Delete: ☐

Criteria

A. Check each clinical finding that applies:

☐ 1. Suicide attempt.
☐ 2. Current suicide ideation with plan.
☐ 3. Current homicidal ideation with plan.
☐ 4. Self mutilating behavior with poor impulse control and **at least one of the following two:**
  ☐ a. Thought disorder/delusions/hallucinations.
  ☐ b. Unavailable/inadequate support system.
5. Psychotic symptoms and **at least one of the following four:**
  ☐ a. Assaultive behavior or destruction of property.
  ☐ b. Medication noncompliance and unavailable/inadequate support system.
  ☐ c. Comorbid depression (psychotic depression).
  ☐ d. Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.
6. Manic/depressed mood with impaired judgment and **at least one of the following five.**
  ☐ a. Assaultive behavior or destruction of property.
  ☐ b. Medication noncompliance and unavailable/inadequate support system.
  ☐ c. Psychotic symptoms to depression and absent or inadequate support system preclude treatment adherence at a less intensive level of Care.
  ☐ d. Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.
  ☐ e. Vegetative signs and symptoms to depression and absent or inadequate support system preclude treatment adherence at a less intensive level of Care.
7. Dementia or delirium and **at least one of the following three:**
  ☐ a. Assaultive behavior or destruction of property.
  ☐ b. Medication noncompliance and unavailability/inadequate support system.
  ☐ c. Complicated psychiatric condition(s) that make treatment at a less intensive level (sub-acute/community) unsafe.
☐ 8. **Medical Acuity** – Patient does not meet the above criteria but has medical and/or other complicating conditions/factors, which require an intensive level of treatment/Care.

You *must* check B and C to meet Acute criteria.

B. Active, ongoing observation on each shift with accompanying documentation, (e.g. summary shift note, description of activities provided, patient status during shift, level of participation, etc.) ☐

C. Physician rounds at least **3** days per week with accompanying documentation. (Any entry by a physician that addresses treatment plan, medical necessity, progress and/or status.) ☐

Criteria Met (One selection *must* be made in section A, and sections B and C *must* be marked to meet the Acute criteria.)

☐ Acute

☐ Sub-acute

Criteria Not Met

Completed By: _____ Date: _____

MH Acute Level of Care Determination (CARE-ACUTE)

Field Name	Type	Contents
LAST NAME	R	Person's last name.
SUFFIX	O	Person's last name suffix. (e.g., Jr., Sr., II)
FIRST NAME	R	Person's first name.
MIDDLE NAME	O	Person's middle name.
CARE ID	O	Person's statewide identification number.
LOCAL CASE NUMBER	R	Person's local case number.
COMPONENT/LOCATION	R	Component code/Location code.
REVIEW DATE		Date at which LOC change is effective.
ACTION ADD	O/R	You must check this box if data is to be added to AVATAR PM.
ACTION CHANGE	O/R	You must check this box if data is a change to data already in AVATAR PM.
ACTION DELETE	O/R	You must check this box if data is to be deleted from AVATAR PM.

Instructions for Completing Criteria Form

General Instructions

- Uninsured patients are defined in the ***Instructions for Conducting Reimbursement Activity for Third-Party Payers (Insured Inpatient Treatment)*** document. It is assumed that all admissions to a State Hospital are acute for the first 30 days of service and as such, this form does not have to be completed for newly admitted patients.
- The form is normally completed only when the State Hospital Treatment Team, which includes the LMHA for the patient, determines that there has been a change in the severity of the patient's clinical condition, or medical condition that results in changes in the patient's LOC in either direction and the LMHA has agreed to and authorized this change. There can be an appeal. If the appeal results in a change in LOC, the Form is entered into AVATAR PM when the appeal process ends using as the "Review Date" the date the treatment team evaluated the patient for the change, or a date determined in the appeal process if such was the case.
- The form does not have to be completed if there is no change in the patient's LOC.
- Children/adolescent patients in a State Hospital cannot be subacute. At any time in their inpatient stay, an adult, uninsured patient will be either acute or subacute. Clinical judgment of the patient's treatment team makes this determination, which is captured on this form.
- If a patient has been determined to be subacute, but because of a medical condition, they have to be admitted to a medical/surgical hospital then their condition will be changed to "acute" while in the medical hospital.

Specific Instructions

SECTION A	R	Check all conditions that apply to the patient. In determining the timeframe for which a condition(s) is applicable, the guide should be: that clinical judgment determines that condition (symptom) is relevant to the current focus of treatment. Checking the **Medical Acuity** box is based solely on the patient's medical condition and is not contingent upon the patient's mental illness being acute. Even when only the Medical Acuity condition is present, in order for the patient to be considered acute, boxes B and C must also be checked.
SECTION B	R	This criteria is general and includes summary shift note, description of activities provided to the patient, patient status during the shift, patient's level of participation, etc and can be entered by any clinical/direct care staff.
SECTION C	R	Any entry by a physician that addresses the patient's treatment plan, medical necessity, patient progress, and/or patient status.
CRITERIA MET	R	Check this box if Acute criteria are met. To meet this criteria, there must be at least one check mark for Sections A, B and C. If one of these sections is not checked, then the patient is not acute.
CRITERIA NOT MET	R	Check this box if Acute criteria are not met. If there is not at least one check mark in each of the three Sections (A-B-C), then the criteria for being acute has not been met. **If the patient is not acute, then he/she is subacute**.
COMPLETED BY	R	Signature of person completing form. The form can be completed by any clinical staff.
DATE	R	Date LOC Form is completed.

Quick View: LOC Form Entry Guidelines

LOC at Admission

1. LOC does not apply to insured patients.

2. It is assumed that all admissions to a State Hospital are acute for the first 30 days of service and as such, this form does not have to be completed for newly admitted patients.

3. Children/Adolescents can only be acute. They cannot be subacute.

Changing Patient's LOC During Stay

1. The form does not have to be completed if there is no change in patient LOC.

2. Adult patients remaining in the State Hospital without insurance after they had been admitted with insurance need to have an LOC assignment. All uninsured patients must have a LOC.

3. The form is normally completed only when the State Hospital Treatment Team (which includes the LMHA) for the patient determines that there has been a change in the severity of the patient's clinical condition, or medical condition that results in changes in the patient's LOC in either direction and the LMHA has approved this change. There can be an appeal. If the appeal results in a change in LOC, the Form is entered into AVATAR PM when the appeal process ends using as the "Review Date" the date the treatment team evaluated the patient for the change, or a date determined in the appeal process if such was the case.

    - If there is no appeal, and the LMHA approved the LOC change, the REVIEW DATE is the date the LOC change was determined. As a general guideline, it is important to keep in mind that the requirement of 3 physician documentations in a 7 day period influences the date at which a patient can be considered acute. For example, if the State Hospital wants to request a change in LOC of a patient from subacute to acute, it will have to see that the patient has 3 physician documented entries in the medical record in the previous 7 days as required by the definition of acute. This means that the <u>effective date</u> of the LOC change, Review Date on AVATAR PM form is the date that the State Hospital has determined that the conditions for acute have been met, e.g., 3 physician documentations. The reason for this is because when the State Hospital says that a patient is acute, it is using the definition of acute in the *LOC Form*, which requires that the patient's record have 3 physician documentations in a 7 day period.

    - Newly admitted patients are assumed to be acute for the first 30 days of Care. It is expected that the patient, in the first 7 days after admission, would have 3 physician documented entries in his/her record. There is <u>no</u> appeal during this first 30 day period.

- If there are disagreements about level of Care determinations, the State Hospital Medical Director will promptly notify the LMHA Medical Director for a review of the case. If agreement can't be reached, it is the final responsibility of the State Hospital Medical Director for a decision.

- State Hospital and LMHA staff can agree that a patient is acute or subacute based on clinical judgment, without having to meet all the criteria on the *LOC Form*. As appropriate, the subacute or acute box on the LOC form must be checked. The REVIEW DATE is the date the LOC change was determined unless otherwise agreed to.

- LMHA can request a LOC assignment on any patient and if they do, the requirements of #3 above apply.

ATTACHMENT 4

MH BED ALLOCATION EXCEPTION

FORM

Entered Into AVATAR PM Menu Option

Client Assignment and Registration System
Department of State Health Services – State Hospital Section

CARE - BEDEX **MH Bed Allocation Exception** (Action Code 345) Rev. 8/10/05

Last Name/ Suffix ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Client ID ☐☐☐☐☐☐☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐ Local Case Number ☐☐☐☐☐☐☐☐☐☐

Middle Name ☐☐☐☐☐☐☐☐☐☐ Component ☐☐☐

Action Add: ☐ Change: ☐ Delete: ☐

Begin Date	End Date	Reason

Reason Codes

04-Out of TX TDJC Commitment
05-VA Project
09-Medicare A
10-Medicaid THSTEPS*
11-Medicaid IMD
12-Health Insurance
13-Contract (Other)
15-Medicaid THSTEPS-Independent Child*
16-Consignment from State School
17-Hospital as Payer

* The NorthSTAR allocation is billed as specified within the body of the document for NorthSTAR enrollees.

Completed By: _____ Date: _____

MH Bed Allocation Exception **(CARE-BEDEX)**

Field Name	Type	Contents
LAST NAME	R	Person's last name.
SUFFIX	O	Person's last name suffix. (e.g., Jr, Sr)
FIRST NAME	R	Person's first name.
MIDDLE NAME	O	Person's middle name.
CLIENT ID	O	Person's statewide identification number.
LOCAL CASE NUMBER	R	Person's local case number.
COMPONENT	R	Three-digit code of the component to which the person is assigned.
ACTION ADD	O/R	You must check this box if data is to be added to AVATAR PM.
ACTION CHANGE	O/R	You must check this box if data is to be changed in AVATAR PM.
ACTION DELETE	O/R	You must check this box if data is to be deleted from AVATAR PM.
BEGIN DATE	R	Beginning date of the exception period MMDDYYYY format.
END DATE	O/R	End date of the exception period. MMDDYYYY format.
REASON	R	Reason code for the exception. 04-Out of TX TDJC Commitment 05-VA Project 09-Medicare A 10-Medicaid THSTEPS* 11-Medicaid IMD 12-Health Insurance 13-Contract (Other) 15-Medicaid THSTEPS-Independent Child* 16-Consignment from State School 17-Hospital as Payer
COMPLETED BY	R	Signature of person completing form.
DATE	R	Date form is completed

ATTACHMENT 5

ALLOCATION FOR UNINSURED STATE HOSPITAL SERVICES*

*Allocations may have to be adjusted during the year as a result of funding changes to the State Hospitals.

FY 2008 Population Data

Hospital	MHA	FY08 Population
ASH	Austin-Travis County	891,353
	Bluebonnet Trails	587,688
	Central Counties	405,335
	Central Texas MHMR Center	20,517
	Gulf Coast	576,229
	Heart of Texas	348,415
	Hill Country	163,248
	MHMR Authority of Brazos Valley	300,259
	Texana	692,817
ASH Total		**3,985,861**
BSSH	Betty Hardwick Center	175,696
	Central Plains	99,967
	Concho Valley	126,231
	El Paso MHMR Center	777,961
	Lubbock Regional	302,494
	Permain Basin Community Center	295,427
	West Texas	215,696
BSSH Total		**1,993,472**
KSH	Hill Country	293,213
KSH Total		**293,213**
NTSH	Central Texas MHMR Center	82,417
	Denton County	657,941
	Helen Farabee Center	314,241
	Pecan Valley	409,598
	Tarrant County	1,706,338
	Texas Panhandle	395,735
	Texoma	161,171
NTSH Total		**3,727,441**
RSH	Access	109,515
	Andrews Center	196,409
	Burke Center	383,011
	Harris County	3,921,132
	Sabine Valley	446,058
	Spindletop	432,992
	Tri-County	572,373
RSH Total		**6,061,490**
SASH	Bluebonnet Trails	133,408
	Border Region	337,476
	Camino Real	206,899
	Center for Health Care	1,553,059
	Costal Plains	248,300
	Gulf Bend	186,029
	Hill Country	101,418
	Nueces County	330,751
	Tropical Texas	1,184,800
SASH Total		**4,282,140**
TSH	Andrews Center	191,881
	North Star	3,690,990
	Texoma	34,312
	The Lakes Regional	156,478
TSH Total		**4,073,661**
Grand Total		24,417,278

Local Mental Health Authorities
FY 2008 State Hospital Allocations

LMHA	FY08 Allocation
Access	1,037,532
Andrews Center	3,678,615
Austin-Travis County	8,444,574
Betty Hardwick Center	1,664,524
Bluebonnet Trails	6,831,579
Border Region	3,197,207
Burke Center	3,628,603
Camino Real	1,960,136
Center for Health Care	14,713,499
Central Counties	3,840,096
Central Plains	947,076
Central Texas MHMR Center	975,185
Concho Valley	1,195,898
Costal Plains	2,352,365
Denton County	6,233,256
El Paso MHMR Center	7,370,311
Gulf Bend	1,762,418
Gulf Coast *	3,434,226
Harris County *	18,951,139
Heart of Texas	3,300,843
Helen Farabee Center	2,977,082
Hill Country	5,285,280
Lubbock Regional *	564,278
MHMR Authority of Brazos Valley	2,844,618
North Star	34,968,007
Nueces County	3,133,496
Pecan Valley	3,880,483
Permain Basin Community Center	2,798,842
Sabine Valley	4,225,901
Spindletop	4,102,116
Tarrant County	16,165,647
Texana	6,563,667
Texas Panhandle	3,749,148
Texoma	1,851,983
The Lakes Regional	1,482,454
Tri-County	5,422,595
Tropical Texas	11,224,656
West Texas	2,043,480
Grand Total	208,802,815

* Community Hospital Allocations	
Gulf Coast	2,024,900
Lubbock Regional	2,301,515
Harris County	18,197,207

ATTACHMENT 6

STATE HOSPITALS

AVERAGE DAILY CENSUS

ESTIMATES

State Hospitals
Estimated Average Daily Census
FY 2008

Facility	Statewide GR ADC	Statewide 3rd ADC	Non Statewide GR ADC	Non Statewide 3rd ADC	Subtotal ADC	Facility ADC Totals
ASH			240	59		299
BSSH	115	3	57	25		200
EPPC			64	10		74
KSH	181	3	18			202
NTSH- Wichita Falls			238	35		273
NTSH- Vernon						343
Forensic	229	5			234	
Adol Forensic	35	42			77	
Civil Max Security	32				32	
RSH	107	3	197	28		335
RGSC			52	3		55
SASH			229	73		302
TSH			272	44		316
WCY	77	8				85
Subtotal	776	64	1,367	277		
Subtotal	840		1,644			
Grand Total						2,484

GR Safety Net and Projected Third Party Estimated ADC
FY2008

Projected FY2008 ADC

	Statewide	Non Statewide	Total Beds
GR Average Daily Census	776	1367	2143
Projected 3rd Party Average Daily Census	64	277	341
Total Average Daily Census	840	1644	2484

Statewide General Revenue

Waco Center for Youth	77
Big Spring State Hospital – Forensic	115
North Texas State Hospital - Vernon Campus	
Adult	229
Adolescent	35
Manifest Dangerous	32
Kerrville State Hospital – Forensic	181
Rusk State Hospital – Forensic	107
Subtotal	776

Statewide Third Party

North Texas State Hospital-Vernon Campus	
Adult - Forensic	5
Adolescent	42
Big Spring Sate Hospital – Forensic	3
Kerrville State Hospital – Forensic	3
Rusk State Hospital – Forensic	3
Waco Center for Youth	8
	64
Subtotal	
Statewide Total	840