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425.401: Introduction

130 CMR 425.000 contains regulations governing psychiatric inpatient hospital services under MassHealth. All psychiatric inpatient hospitals participating in MassHealth must comply with the MassHealth regulations, including, but not limited to, MassHealth regulations at 130 CMR 425.000 and 130 CMR 450.000.

425.402: Definitions

The following terms used in 130 CMR 425.000 will have the meanings given in 130 CMR 425.402 unless the context clearly requires a different meaning.

Activities of Daily Living — the quality or process of accomplishing everyday needs, including bathing, dressing and grooming, eating, transferring, ambulation, and toileting.

Administrative Day — a day of inpatient hospitalization on which a member's care needs can be met in a less intensive setting than a psychiatric inpatient hospital, as defined in 130 CMR 425.402, and on which a member is clinically ready for discharge, but an appropriate institutional or noninstitutional setting is not readily available.

Case Manager — an area-based coordinator of services employed by the Department of Mental Health (DMH) or, where appropriate, the Department of Children and Families (DCF), the Department of Youth Services (DYS), or the Department of Mental Retardation (DMR).

Child and Adolescent Needs and Strengths (CANS) — a tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members under the age of 21.

Conversion Case — a case where an individual under age 21 was not eligible for MassHealth when admitted to a psychiatric inpatient hospital, but then applied for and received MassHealth while in the psychiatric inpatient hospital. A conversion case is treated as a new admission for purposes of screening and certification by the screening team.

Medical Leave of Absence — an inpatient hospital stay of a member who is a resident of a nursing facility for up to 10 consecutive days in a hospital at a Medicare hospital level of care. The day on which a member is transferred from a nursing facility to a hospital for an inpatient stay is the first day of the medical leave of absence from the nursing facility. The day on which a member is transferred from a hospital back to a nursing facility or is otherwise discharged to a noninstitutional setting is not a medical leave-of-absence day.

Mental Illness — mental and emotional disorders as defined in the current American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV).

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Multidisciplinary Treatment Team— a team of mental-health professionals employed by or under contract with a psychiatric inpatient hospital that provides services to members in the facility. The team must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- (1) a licensed psychiatric social worker;
- (2) a licensed registered nurse with specialized psychiatric training or at least one year's experience treating mentally ill individuals;
- (3) an occupational therapist who is licensed and who has specialized psychiatric training or at least one year's experience treating mentally ill individuals; or
- (4) a psychologist who has a master's degree in clinical psychology, or a closely related field such as counseling psychology, or who has been certified either by the state in which the psychiatric inpatient hospital is located or by that state's psychological association.

Periodic Medical Review (PMR) Team — a team authorized by the MassHealth agency to perform periodic inspections of the care and services provided to MassHealth members in psychiatric inpatient hospitals.

Psychiatric Inpatient Hospital — any psychiatric facility or inpatient program in a licensed psychiatric facility that has six beds or more for inpatient use, is certified by the Massachusetts Department of Public Health for participation in Medicare, and primarily treats patients whose principal diagnosis is based on the DSM-IV. For out-of-state psychiatric inpatient hospital providers, certification for participation in MassHealth by the appropriate state agency may be substituted. "Primarily treats" means that, over a six-month period, inpatient care has been provided to a patient population of which 51 percent or more consistently have a principal diagnosis that is psychiatric.

Psychiatric Inpatient Hospital Services — psychiatric treatment provided under the direction of a psychiatrist in a psychiatric inpatient hospital.

Psychiatric Treatment — treatment that encompasses multidisciplinary assessments and multimodal interventions. Twenty-four-hour skilled nursing care, daily medical care, and a structured treatment milieu are required. Special treatment may include physical and mechanical restraint, isolation, and a locked unit.

Screening Team — an independent team that certifies the need for services for members under the age of 21. The team includes, but may not be limited to, a physician, and must

- (1) be competent in diagnosing and treating mental illness in children; and
- (2) have knowledge of the member's condition.

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Treatment Plan — a documented written plan developed for each member by the hospital multidisciplinary treatment team with the goal of improving the member's condition to the extent that inpatient care is no longer necessary. The treatment plan must include

- (1) specifications of all services required during the psychiatric inpatient hospital stay;
- (2) identified discharge plans;
- (3) when appropriate, indications of the need for DMH Continuing Care Services or for services from other state agencies, or both; and
- (4) written documentation in the member's record that the member, his or her legal guardian, and family members are given the opportunity to participate in the development and modification of the treatment plan and the psychiatric treatment itself, and to attend all treatment plan meetings according to the bounds of consent.

Working Days — Monday through Friday, except for holidays.

425.403: Eligible Members

- (A) (1) MassHealth Members. MassHealth covers psychiatric inpatient hospital services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105 specifically states, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
- (2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.
- (B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

425.404: Exclusion of MassHealth Managed Care Members

130 CMR 425.000 does not apply to members participating in a MassHealth managed care plan. Participation in a MassHealth managed care plan is subject to change. Providers are responsible to verify member status on a daily basis. For more information, see 130 CMR 450.117.

425.405: Provider Eligibility

Payment for the services described in 130 CMR 425.000 will be made only to psychiatric inpatient hospitals participating in MassHealth on the date of service.

- (A) In State. To participate in MassHealth, an in-state psychiatric inpatient hospital must
 - (1) be a MassHealth provider;
 - (2) be licensed as a hospital by or be operated by the Massachusetts Department of Mental Health (DMH);
 - (3) be accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO) or be certified by the Massachusetts Department of Public Health; and
 - (4) participate in the Medicare program.

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- (B) Out of State. To participate in MassHealth, an out-of-state psychiatric inpatient hospital must
- (1) be a MassHealth provider;
 - (2) be approved as a psychiatric inpatient hospital by the governing or licensing agency in its state;
 - (3) be accredited by the JCAHO or be certified by the public health agency in the state in which the psychiatric inpatient hospital is located;
 - (4) participate in its state's medical assistance program; and
 - (5) participate in the Medicare program.

425.406: Admission Criteria for Members under Age 21

(A) A screening team must screen a member under age 21 prior to admission to a psychiatric inpatient hospital or prior to conversion to MassHealth, as defined in 130 CMR 425.402. The screening team will determine and certify whether the admission is medically necessary.

(B) To demonstrate the necessity of a psychiatric inpatient hospital admission for a member under age 21, the following conditions must be met:

- (1) the member must have mental illness, as defined in DMH regulations at 104 CMR 3.01(a);
- (2) the member must meet one or more of the following criteria:
 - (a) be dangerous to himself or herself;
 - (b) be dangerous to others; or
 - (c) be unable to care for himself or herself; and
- (3) the moment-to-moment medical observation or clinical management required cannot be provided in a less restrictive setting.

(C) A psychiatrist appointed by the MassHealth agency will evaluate disputes between the screening team and the psychiatric inpatient hospital concerning medical necessity and the need for continued hospitalization of a child or adolescent requesting conversion to MassHealth from other third-party insurance coverage. The psychiatrist will interview the child or adolescent and review his or her medical record within three working days of receipt of the psychiatric inpatient hospital's written request and will make an independent determination of medical necessity and the need for continued hospitalization. This determination will constitute a final action of the MassHealth agency. A member or a provider on behalf of a member who disagrees with the determination may file an appeal, as set forth in 130 CMR 425.415.

(D) Court-ordered admissions are exempt from the admission criteria stated in 130 CMR 425.406(A) and (B).

425.407: Admission Criteria for Members Aged 21 or Over

A member aged 21 or over must meet all of the following conditions of medical necessity:

- (A) demonstrate symptomatology consistent with DSM-IV (AXES 1-V) diagnosis, which requires and will respond to therapeutic intervention;

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(B) be free from any physical conditions that require primary medical care and cleared for treatment in a nonmedical, nonsurgical treatment environment;

(C) require 24-hour medical, psychiatric, and nursing services that can appropriately be provided only at an acute level of hospital care;

(D) have a psychiatric condition that results in serious dysfunction, such as increased suicidal gestures, assaultiveness, or sudden inability to provide self-care, that endangers the member or others; and

(E) present conditions that can reasonably be expected to improve to the extent that psychiatric inpatient hospital services will no longer be needed or further regression of the member's condition will be prevented.

425.408: Payment Methodology

(A) In State. Payments to in-state psychiatric inpatient hospitals for services furnished to MassHealth members will equal the rate established in the signed provider contract with the MassHealth agency.

(B) Out of State. Payment to out-of-state psychiatric inpatient hospitals will be the Massachusetts state-wide average per diem rate or administrative day rate established by the MassHealth agency for in-state psychiatric inpatient hospitals.

425.409: Nonreimbursable Services

The following services are not reimbursable:

(A) drugs and durable medical equipment prescribed for take-home use that are readily available from pharmacies or medical providers;

(B) the cost of any treatment or testing of a member or of a specimen from a member who is not an inpatient in the psychiatric inpatient hospital where the treatment or testing occurs;

(C) room-and-board services on the day of discharge (unless the day of discharge is also the day of admission). The day of discharge is the day on which a member leaves the hospital for any reason, including death or the start of a leave of absence, whether medical or nonmedical, regardless of the hour of discharge;

(D) leave-of-absence days;

(E) research or the provision of experimental or unproven procedures;

(F) private hospital rooms, except when medically necessary; and

(G) services furnished by the emergency room or outpatient department on the day of admission, during the inpatient stay, or on the day of discharge.

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425.410: Service Limitations

(A) For members under age 21, MassHealth covers psychiatric inpatient hospital services until the earlier of the following:

- (1) the date the member no longer requires the services; or
- (2) the date the member reaches the age of 21.

(B) For members aged 21 through 64, MassHealth covers psychiatric inpatient hospital services up to a maximum of 30 consecutive days per admission. MassHealth covers no more than 60 days of psychiatric inpatient hospital services per year per member. For the purposes of 130 CMR 425.410(B), the MassHealth agency does not count toward these length-of-stay limitations any day for which it has paid only the Medicare Part A coinsurance, deductible, or both. Once a MassHealth member's Medicare Part A psychiatric inpatient hospital benefits have been exhausted, all other days for which the MassHealth agency makes payment will be counted toward these service limitations. A year is defined as the calendar year in which the psychiatric inpatient hospital services were provided.

(C) Members under age 21 must be prescreened by a screening team or be admitted under court order, pursuant to M.G.L. c. 123, §§ 7, 8, 12a, and 12b.

425.411: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary psychiatric inpatient hospital services for EPSDT-eligible members in accordance with 130 CMR 450.140 et seq., without regard to service limitations described in 130 CMR 425.000, and with prior authorization.

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425.412: Child and Adolescent Needs and Strengths (CANS) Certification

The following clinicians are eligible to administer the Child and Adolescent Needs and Strengths (CANS) in psychiatric inpatient hospitals and must be certified every two years, according to the process established by the Executive Office of Health and Human Services (EOHHS):

- (A) psychiatrists and psychiatric residents;
- (B) psychiatric nurse mental-health clinical specialists;
- (C) psychologists who have a specialization in clinical or counseling psychology;
- (D) social workers who have a master's degree in social work from an accredited educational institution; and
- (E) counselors who have a master's degree in counseling education, counseling psychology, or rehabilitation psychology from an accredited educational institution.

425.413: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted, the hospital must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

(130 CMR 425.414 Reserved)

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425.415: Notification and Right of Appeal

(A) The MassHealth agency or its agent will send a written notification of approval or denial to the member and to the medical practitioner or facility who submitted the request for psychiatric inpatient hospital services. If authorization for psychiatric inpatient hospital services is denied, the notification will inform the member and the medical practitioner or facility of the reason for the denial, the member's right to appeal, and the appeal process.

(B) Following the decision of the MassHealth agency or its agent to deny services in a psychiatric inpatient hospital, a member may appeal by requesting a fair hearing from the MassHealth agency. The request for a fair hearing must be made, in writing, within 30 days after receipt of the notice of the denial. The appeal procedure and fair hearing will be administered and conducted by the Board of Hearings in accordance with the regulations set forth in 130 CMR 610.000.

425.416: Treatment Plan

(A) The hospital multidisciplinary treatment team must develop and implement a written treatment plan for each member. For members under age 21, the treatment plan must be developed in conjunction with any case managers the member may have from DMH, DCF, DYS, or DMR. The treatment plan must

- (1) be developed and reviewed with the fullest possible participation of the member, his or her designated representative or guardian, if any, and individuals in whose care the member will be released after discharge;
- (2) be based on the findings of an initial assessment;
- (3) be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the member's situation and that reflects the need for psychiatric inpatient hospital care;
- (4) state long- and short-range goals;
- (5) state, with specific and measurable terms and time frames, treatment objectives that include changes that must occur in order to discharge the patient;
- (6) prescribe an integrated program of therapies, activities, and experiences designed to meet the treatment objectives;
- (7) specifically identify the psychiatric symptoms that require psychiatric inpatient hospital care rather than treatment in a less-restrictive setting;
- (8) be developed and implemented within three calendar days of admission; and
- (9) include an initial determination of the member's expected length of stay in the facility and the anticipated discharge plan, that is coordinated with outpatient and community providers.

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(B) The treatment plan for each member must be reviewed, and revised if necessary, by the hospital interdisciplinary review team every seven days from the date of admission to determine that psychiatric services being provided are required on an inpatient basis. If the member's length of stay is less than seven days, the review must be performed at the time of discharge.

(C) The treatment plan must be documented in the member's medical record, as set forth in 130 CMR 425.423.

425.417: Conditions for Continuing Care

(A) To continue to qualify for psychiatric inpatient hospital services, members must continue to meet the admission criteria described in 130 CMR 425.406 or 425.407, whichever is applicable, or meet one of the conditions in 130 CMR 425.417(B). Members who are under age 21 must also be reviewed by a screening team prior to the 30th day after admission and every 30 days thereafter.

(B) Additional Conditions. The following additional conditions qualify a member age 21 or over to continue to receive psychiatric inpatient hospital services, even if the member does not qualify under 130 CMR 425.417(A):

- (1) the persistence of conditions that necessitated admission, despite therapeutic efforts, or the emergence of additional problems consistent with the admissions criteria in 130 CMR 425.406 or 425.407;
- (2) a severe reaction to medication; or
- (3) a need for stabilization of psychiatric conditions, integration of gains, or preparation for transition to outpatient care or a residential setting.

425.418: Discharge Planning

(A) The psychiatric inpatient hospital must assign, in writing, the responsibility for all member discharge planning to one department (such as social services or continuing care).

(B) Admission data, including but not limited to age and diagnosis, must be screened by discharge-planning staff within 24 hours of admission in accordance with written criteria that identify pertinent patient characteristics and any high-risk diagnoses. Discharge-planning activities must then commence within three working days of admission for every member expected to require post-hospital care or services. Admission data must be noted in the member's record by the discharge-planning department. The written criteria used to screen members must be available to the MassHealth agency.

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(C) The hospital's discharge-planning staff and interdisciplinary review team must coordinate and document, in writing, a plan for each member who requires post-hospital care. Such plan must be prepared by the hospital's interdisciplinary review team, in conjunction with any primary care provider, DMH, DCF, DYS, or DMR case managers, and must ensure continuity of care with the member's family, school, and community upon discharge. The plan must also specify the services and care required by the member and the frequency, intensity, and duration of such services, including available family and community support. The plan must be updated if the member's condition changes significantly. The hospital must ensure that a clinician certified in accordance with 130 CMR 425.412 completes a CANS during the discharge planning process for members under the age of 21.

(D) The hospital must have a written policy that allows discharge-planning staff access to all members and their medical records. If such access is clinically contraindicated, the member's psychiatrist must sign a statement specifying the reason for the contraindication and the hospital must maintain the statement in the member's medical and discharge-planning records.

(E) Unless clinically contraindicated, the hospital's discharge-planning staff or interdisciplinary review team must contact the member's family to involve them in planning the member's discharge. To this end, family members must be informed of the discharge options and community resources available to the member and provided with lists of community resources in the area.

(F) Each visit to a member or meeting with the family by a member of the discharge-planning staff must be noted in the member's discharge-planning record. The notation must include the date of the meeting, all discharge options discussed, any problems raised and plans for addressing them, all agreements reached with the member, and additional steps required for the discharge-planning staff to prepare the member for discharge.

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425.419: Utilization Review

(A) The MassHealth agency or its agent will conduct reviews of the necessity and appropriateness of psychiatric inpatient hospital services provided to a member. These reviews may be conducted concurrently with the member's hospital admission or stay or retrospectively following the member's discharge from the hospital.

(B) If, as the result of a concurrent review, the MassHealth agency or its agent determines that a member's stay is no longer necessary due to the availability of appropriate resources outside of an institutional setting, the MassHealth agency will not pay for any part of the psychiatric inpatient hospital stay following the 10th day after the date of notice to the hospital and to the member that the stay is no longer necessary.

(C) The MassHealth agency or its agent will perform utilization review in accordance with 130 CMR 425.415 and 450.000.

(D) If, as the result of a review, the MassHealth agency or its agent denies an admission to a psychiatric inpatient hospital or determines that there was no medical necessity for an admission, a stay, or any part of a stay, the MassHealth agency will not pay for that admission, stay, or part of a stay.

(E) If, as the result of a review, the MassHealth agency or its agent determines that any psychiatric inpatient hospital admission, stay, or service provided to a member was subject to a service limitation (see 130 CMR 425.410 and 450.106), the MassHealth agency will not pay for that admission, stay, or service.

(F) If a psychiatric inpatient hospital stay or service is reviewed by the MassHealth agency or its agent concurrently with the member's hospital admission or stay and the admission, service, or stay, or any part thereof, is certified at the time of review as medically or administratively necessary and appropriate, the MassHealth agency will treat that certification as binding for payment purposes.

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425.420: Reimbursable Administrative Days

(A) The MassHealth agency pays a psychiatric inpatient hospital for a continued length of stay of up to 30 administrative days, as defined in 130 CMR 425.402. For members under age 21 and members aged 65 and over, the MassHealth agency may pay a hospital for administrative days exceeding the 30-day limit where the hospital can demonstrate, to the satisfaction of the MassHealth agency or its agent, that the hospital has

- (1) experienced extraordinary difficulty in placing the member, including the specific reasons for such extraordinary difficulty; and
- (2) exhaustively explored all potential appropriate placements.

(B) An administrative day, as defined in 130 CMR 425.402, is reimbursable only if a hospital is making regular efforts to move the member to a less intensive level of care. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 425.418 must be followed, but they do not preclude additional, effective discharge-planning activities.

(C) Examples of situations that may require hospital stays at an administrative-day level include, but are not limited to, the following.

- (1) A member is awaiting transfer to a nursing facility or any other institutional placement, and no appropriate nursing-facility bed is available.
- (2) A member is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.
- (3) A member is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.
- (4) A member in the custody of the Department of Children and Families is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.
- (5) A member cannot be treated or maintained at home because the primary caregiver is absent due to a medical or psychiatric crisis, and a substitute caregiver is not available.

425.421: Nonreimbursable Administrative Days

Administrative days are not reimbursable when

(A) an appropriate placement is currently available, but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays;

(B) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and the member, the member's family, or any person legally responsible for the member refuses the placement or services; or

(C) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the member.

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425.422: Periodic Medical Review

(A) In compliance with 42 CFR 456.600 through 456.614, the Department of Public Health (by agreement with the MassHealth agency) or the appropriate state survey agency of the psychiatric inpatient hospital's jurisdiction performs periodic medical reviews (PMRs) of the care and services provided to members in psychiatric inpatient hospitals. These inspections take place at least annually, and no psychiatric inpatient hospital may be notified of the inspection time more than 48 hours before the scheduled arrival of the PMR team.

(B) The team's review includes

- (1) personal contact with and observation of each member; and
- (2) a review of each member's medical record.

(C) The team determines whether

- (1) the services available in the psychiatric inpatient hospital are adequate;
- (2) it is necessary and desirable for the member to remain in the psychiatric inpatient hospital;
- (3) it is feasible to meet the member's needs through alternative institutional or noninstitutional services; and
- (4) each member is receiving active treatment as defined in 42 CFR 441.154.

(D) The MassHealth agency sends copies of the PMR report to appropriate state agencies, to the psychiatric inpatient hospital, and to the psychiatric inpatient hospital's utilization review committee.

425.423: Recordkeeping Requirements

(A) A record must be established and maintained for each member that is consistent with current professional standards. The record must include the following documents, if applicable:

- (1) the screening certification from a screening team, as described in 130 CMR 425.406, or appropriate court documentation for court-ordered admissions, pursuant to M.G.L. c. 123, §§ 7, 8, 12a, and 12b;
- (2) the treatment plan, as described in 130 CMR 425.416;
- (3) documentation from the hospital interdisciplinary review team supporting the need for continuing care, as described in 130 CMR 425.417;
- (4) the discharge plan, as described in 130 CMR 425.418; and
- (5) for members under the age of 21, a copy of the CANS completed during the discharge planning process.

(B) No information from the medical record may be released to other providers without a signed authorization form from the member, or his or her legal guardian.

(C) Psychiatric inpatient hospitals must adhere to all laws and regulations relating to recordkeeping requirements, including but not limited to the confidentiality regulations in 130 CMR 425.424 and the recordkeeping and disclosure requirements of 130 CMR 450.205.

(D) A member's records must be maintained by the psychiatric inpatient hospital for a period of six years following the date of discharge.

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(E) If any litigation, claim, negotiation, audit, or other action involving the records is commenced prior to the expiration of the applicable retention period, all records must be retained until completion of the action and resolution of all issues resulting therefrom, or until the end of the applicable retention period, whichever is later.

425.424: Confidentiality

(A) Psychiatric inpatient hospitals must comply with all state and federal laws and regulations relating to confidentiality and privacy.

(B) At all times, psychiatric inpatient hospitals must recognize the MassHealth agency's ownership of personal data (as defined in M.G.L. c. 66A, § 1 and regulations at 106 CMR 101.060) and other information deemed confidential by the Commonwealth.

(C) If any employee or subcontractor of a psychiatric inpatient hospital is involved with a member's personal data or other confidential information, the psychiatric inpatient hospital must inform the employee or subcontractor of the laws and regulations relating to confidentiality.

REGULATORY AUTHORITY

130 CMR 425.000: M.G.L. c. 118E, §§ 7 and 12

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456.601: Personal Needs Allowance Account

MassHealth members have the right to manage their own financial affairs and the nursing facility must not require residents to deposit their personal funds with the facility. However, upon written request by a member, the facility must hold, safeguard, manage, and account for the member's personal funds deposited with the facility as specified in 130 CMR 456.601 through 456.615.

456.602: Management of the PNA Account

If requested by the member, a facility must assume responsibility for the PNA funds of a member. To do so, the facility must obtain and maintain on file a statement of authorization signed by the member or the member's authorized representative, such as a guardian, conservator, relative, or other responsible person acting on the member's behalf. The "other responsible person" must not be an employee of the facility or related to an employee of the facility in any way. Once a facility is trustee of a member's PNA account, it is responsible for the safekeeping of this money and must repay the member for any lost or stolen funds or for any money that cannot be accurately accounted for.

456.603: Autonomy of PNA Accounts

(A) If the facility assumes responsibility for a member's funds, the facility must deposit funds in excess of \$50 into a PNA account, that is, an interest-bearing trustee account separate from any of the facility's operating accounts.

(B) The facility must ensure that PNA accounts are not available for any purpose except the personal needs of the member. The funds must not be lent or be used as collateral for a loan for anyone including the facility.

456.604: PNA Recordkeeping Requirements

(A) The facility must establish and maintain a system of recordkeeping that ensures a complete and separate accounting of the PNA funds according to generally accepted accounting principles. The system must prevent any commingling of the members' PNA funds with facility funds or with the funds of any other person other than another resident of the facility. If the facility does not manage the PNA funds for any member, it is not required to maintain such records.

- (B) (1) The facility must ensure a separate accounting of each member's PNA funds, maintain a written record of all financial transactions involving the PNA funds, and allow the member or the member's authorized representative access to the accounting record.
- (2) The bank-account statements and the general ledger must be in agreement and reconcilable at all times. All bank statements, canceled checks, and supporting documentation relating to the PNA account must be kept in the facility for at least four years from the date of the transaction.

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- (3) All checks or cash received on behalf of the member must be deposited into the PNA account no later than 30 days after the receipt of the money by the facility.
- (4) The facility must maintain for each member with a PNA account a record of receipts and disbursements separate from other members' records. The facility must clearly label all PNA receipts and disbursements in the general ledger.
- (5) At a minimum, all receipts and disbursements must be recorded in the ledger as follows:

Receipts	Disbursements
1. Date of entry 2. Amount 3. Source 4. Balance	1. Date of entry 2. Specific description (Avoid "misc.," "personal needs," etc.) 3. Amount 4. Signature of member or person receiving disbursement 5. Invoice number or date

- (6) General ledger records must be updated at least once a month.
- (7) The facility must ensure that funds are available to members in the form of actual cash or check for no less than 10 hours a week and on no less than three days a week. The facility must inform the members of the times when they may receive their money.
- (8) All money disbursed to or on behalf of a member must be at the request of the member or the member's representative. The nursing facility may not make any disbursements on behalf of a member for a service that is covered by either Medicare or MassHealth.
- (9) If a facility disburses money to a member by means of a check, or if the member signs petty cash vouchers, the facility does not need to obtain a signature in the ledger.
- (10) The facility does not need to itemize cash disbursements to members.
- (11) The facility must provide the member or the member's representative every three months and upon the member's request with an accounting of all financial transactions made on the member's behalf.

456.605: Petty Cash in the Facility

The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to residents. The total of this petty-cash fund must not exceed an amount equal to \$5 per member for whom the facility manages a PNA account; however, a maximum of \$250 is allowable regardless of the number of members.

456.606: Assurance of Financial Security

The facility must purchase a surety bond to assure the security of all personal funds of members deposited with the facility. The facility must keep this bond at the facility.

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456.607: Availability of PNA Records to Division Personnel

All PNA records, including the accompanying bank statements, canceled checks, and supporting documentation, must be kept in the facility at all times and must be available to Division of Medical Assistance personnel upon request. The request may be made by telephone, in person, or by mail.

456.608: Member Signature

If the member cannot sign his or her own name, a staff member or business employee of the facility may sign as witness that the member has received cash from his or her PNA account.

456.609: Notification of Account Balance

(A) The facility must notify each member for whom it has established a PNA account when the balance reaches a total of \$1800, which is \$200 less than the maximum countable assets allowed per member. The notification must state that, if the member's countable assets exceed the maximum allowable amount of \$2000, the member may lose MassHealth eligibility.

(B) If the member's balance exceeds the maximum allowable amount, the member may apply the excess to the cost of care in the facility.

456.610: Availability of PNA Records to Members

The facility must, within one working day of a request, allow the member or the member's authorized representative to examine the PNA records of the member.

456.611: PNA Funds of a Member Transferred to Another Facility

If a member is transferred to another facility, all of the member's funds held in trust by the facility must be sent to the new facility within 10 days of the transfer date.

456.612: PNA Funds of a Member Discharged to the Community

If a member has been discharged from the facility to the community, he or she must receive his or her bank book back from the facility or receive a check for the balance of his or her PNA account. The amount of the check must reflect the cash held on behalf of the member by the facility plus the bank balance.

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456.613: Member Is Transferred to a Hospital and Does Not Return to the Facility

If a member is transferred to a hospital and does not return to the facility, the balance of the PNA account must be sent to the member at his or her new address within 10 days after he or she leaves the facility.

456.614: Death of a Member

(A) Upon the death of a MassHealth member, the facility must:

- (1) render an accounting of the member's PNA funds. The funds must remain at the facility for 30 days after the death of a member to allow for the appointment of an administrator or executor of the estate and for the payment of burial expenses; and
- (2) notify the next of kin or the person who served as the member's representative in official business with the facility of any remaining funds, determine whether or not an executor or administrator has been or will be appointed, and explain to the next of kin or the member's representative how to obtain the funds from the facility.

(a) If there is an outstanding balance due on a funeral bill, the funeral home may submit an itemized funeral bill to the facility and the facility may pay the bill from the PNA funds.

(b) If an executor or administrator is appointed within 30 days after the death of a member, the facility must send the balance of the PNA account and a final accounting of the member's account to the administrator or executor of the member's estate. If any payment has been made to the funeral home under 130 CMR 456.414(A)(2)(a), the final accounting must reflect that payment.

(B) If any funds still remain in the PNA account after 30 days, the facility must

- (1) send a check for the balance and a final accounting of the member's account to the Division of Medical Assistance; and
- (2) notify the next of kin or the member's representative of the amount of the funds and the address to which they are being sent and tell them they may apply for the funds, if they are appointed executor or administrator of the member's estate.

(C) A final accounting of the PNA funds must include any transactions that occurred during the previous three months and for the 30 days following the member's death. If there are no PNA funds, the facility is not required to submit the final accounting; however, the facility must maintain all member records according to 130 CMR 456.604.

(D) The facility must include with the returned PNA balance and the accounting the following information:

- (1) the member's name and social security number;
- (2) the member's date of birth and date of death;
- (3) the name, address, and relationship of the next of kin or the member's representative ;
- (4) the name, address, and MassHealth provider number of the facility; and
- (5) the name and address of the funeral director.

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456.615: Annual Accounting to the Division of the PNA Balance

(A) Annually, at least by each June 1, an accounting must be made to the Division of the balance of each PNA account. If the facility is not a trustee for any member's money, it must report this fact by each June 1 to the Division. The accounting to the Division must be submitted on the Statement of MassHealth Member's Personal Needs Account (PNA-1) and must be dated and signed under the pains and penalty of perjury by the administrator of the facility and mailed to the Division.

(B) The accounting must consist of the following:

- (1) the member's name;
- (2) the member's social security number;
- (3) the amount of petty cash held in the facility for the member;
- (4) the balance held in any individual bank account for the member;
- (5) the balance held in the trustee account for the member;
- (6) any other money being held by the facility for the member; and
- (7) if funds are held in an aggregate trustee bank account, then a copy of the bank statement for that account must be submitted with the accounting.

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