Psychiatric Medical Institutions for Children (PMIC)

Provider Manual

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. FACILITIES ELIGIBLE TO PARTICIPATE

Psychiatric medical institutions for children (PMICs) are eligible to participate in the Medicaid program if they meet all of the following conditions.

- Be accredited by a federally recognized accrediting organization, such as:
  - The Joint Commission on the Accreditation of Health Care Organization
  - The Commission on Accreditation of Rehabilitation Facilities
  - The Council on Accreditation of Services for Families and Children
  - Any other organization with comparable standards
- Have been issued a license by the Department of Inspections and Appeals.
- Have been awarded a Certificate of Need from the Department of Public Health.
- Have received written approval of need from the Department of Human Services, Division of Adult, Children and Family Services.
- Be in compliance with all applicable state rules and standards regarding the operation of comprehensive residential facilities for children.

Facilities providing outpatient day treatment for children or adolescents require approval from the Department of Inspections and Appeals.

Once enrolled with the Iowa Medicaid Enterprise, psychiatric medical institutions for children (PMICs) may also enroll with the Department's contracted Managed Care Organizations (MCO).

B. COVERAGE OF SERVICES

1. Inpatient Services

Medicaid coverage is available for PMIC services when:

- The conditions for service to the child are met,
- The child is determined to meet the level of care criteria, and
- The child is eligible for Medicaid.

An emergency admission is one that is required because the health of the child is in immediate jeopardy.

a. Covered Services

All inpatient psychiatric services are covered services when the admission or continued stay is approved by the behavioral health contractor or Managed Care Organization (MCO). For members not enrolled with an MCO, facilities must request a PMIC authorization by:

- Contacting the IME Medical Services Unit at 888-424-2070 or locally in Des Moines at 256-4624,
- Emailing PMIC2@dhs.state.ia.us, or
- Faxing the request to 515-725-0931.

Facilities bill Medicaid separately for such services as prescription drugs, eyeglasses, and physician services. Psychological services are the responsibility of the facility. Other services in the plan of care that are not covered by the Medicaid program are also the responsibility of the facility.

Educational and vocational training are not reimbursable.

In order to receive Medicaid payment for a child entering a PMIC, the facility must have an assessment certifying all of the following:

- Ambulatory care resources available in the community do not meet the child's treatment needs,
- Proper treatment of the child's psychiatric condition requires services on an inpatient basis under the direction of a physician, and
- Inpatient services can reasonably be expected to improve the child's condition or prevent further regression, so that the ongoing services will no longer be needed.

(1) Admission Facility Interventions

Admission facility interventions must meet all of the following:

- Treatment plan directed at admitting problem
- Level of intervention matches risk
- Discharge plan upon admission
- Psycho-educational services on assessment
- Family or significant other treatment and involvement

(2) Concurrent Facility Interventions

Concurrent facility interventions must meet all of the following:

- Discharge plan implemented
- Treatment plan directed at admitting problem
- Level of intervention matches risk
- Treatment plan modified with progress or new information
- Family or significant other treatment and involvement

(3) Admission Criteria

Admission criteria must meet all of the following:

- Symptoms consistent with diagnosis in DSM-IV, and
- Treatment at a lower level of care considered or failed in last three months, and
- Level of stability. Must meet **two** of the following:
  - Danger to self or others without 24 hours of care,
  - Lacks support for age appropriate development, or
  - Needs occasional medical observation and care.
- Degree of impairment from psychiatric condition requiring 24 hours of care. Must meet the following:
  - Judgment, impulse control, cognitive or perception,
  - Social, interpersonal, family, failed treatment with family, or
  - Educational, occupational, or failed treatment with family.

(4) Continued Treatment Criteria

Continued treatment criteria must meet all of the following:

- Validation of principal DSM-IV diagnosis, and
- Likelihood of benefit from active intervention, and
- Progress toward goals, cooperation with plan.

Continued treatment criteria must also meet the following:

- Continued symptoms, current behaviors requiring admission, or
- New problems with admission guidelines.

b. Medicaid Member Eligibility

To be financially eligible for payments for the cost of inpatient care provided by a PMIC, a person must be under the age of 21 and be eligible for Medicaid. **Exception:** No payment is made at all if the child is eligible under the Medically Needy coverage group.

The facility should require that a Medicaid application be filed for every foster child who is not already eligible for Medicaid. The local Department of Human Services' income maintenance worker determines eligibility.

Both Department income maintenance and service workers and also juvenile court officers have responsibilities when a child is court-ordered into foster care in a PMIC. A Medicaid card may not be issued until all bases of eligibility are established to determine the availability of federal funding.

An eligible child is considered to be an inpatient until the child is unconditionally discharged or the child attains age 21. When inpatient treatment is provided immediately before the child's twenty-first birthday, coverage continues to be available until the twenty-second birthday or until service is no longer required, whichever is earlier. Coverage extends until the last day of the month of the discharge or the twenty-second birthday.

The Department must conduct a six-month review of eligibility to redetermine if the child remains eligible for federally paid Medicaid. While eligible for Medicaid, the child is entitled to the full scope of Medicaid benefits.

c. *Certification of Need for Inpatient Psychiatric Services*, Form 470-2780

Form 470-2780, *Certification of Need for Inpatient Psychiatric Services*, can be used to ensure the admission assessment is performed and meets the required criteria. Click here to view this form on line.

d. Children in Managed Health Care

Children enrolled in Managed Care Organizations require special procedures when they enter a PMIC.

Prior authorization is required for Medicaid payment of medical services. Contact the managed care organization provider to obtain any necessary authorization to ensure payment. Nonemergency services provided without a referral may not be paid.

Payment for services other than the facility (such as a psychiatrist's services) is subject to the authorization of the managed health care provider.

e. Independent Assessment

Children who are in foster care or have a Medicaid card before they go to the facility must be certified through an independent assessment performed by a team. None of the team members may have an employment or consultation relationship to the admitting facility.

The assessment team must include a physician and another professional. The physician should have competence in the diagnosis and treatment of mental illness and have knowledge of this child's situation. This may be accomplished through a community mental health center or a family physician with a Department social worker, a juvenile court officer, or another professional.

The assessment must be performed within 45 days before the proposed date for admission to the facility and be submitted to the facility on or before the date of the child's admission.

f. Interdisciplinary Team

An "interdisciplinary team" is a team of physicians and other personnel who are employed by the facility or who provide services to members in the facility. Membership in the interdisciplinary plan of care team includes those physicians and other professionals who are:

- Involved in the direct provision of treatment services, or
- Involved in the organization of the plan of care, or
- Involved in consulting with or supervising those professionals involved in the direct provision of care.

The team must include at a minimum either:

- A board-eligible or board-certified psychiatrist, or
- A clinical psychologist who has a doctoral degree and a physician licensed to practice in medicine or osteopathy, or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist who has a master's degree in clinical psychology and has been licensed by the state.

The team must also include one of the following:

- A social worker with a master's degree in social work and specialized training or one year's experience in treating persons with mental illness.
- A registered nurse with specialized training, or one year of experience in treating persons with mental illness.
- A licensed occupational therapist that has specialized training or one year of experience in treating persons with mental illness.
- A psychologist who has a master's degree in clinical psychology or who has been licensed by the state.

Based on education and experience, preferably including competency in child psychiatry, the team must be capable of:

- Assessing the child's immediate and long-range therapeutic needs, developmental priorities, personal strengths, and liabilities.
- Assessing the potential resources of the child's family.
- Setting treatment objectives.
- Prescribing therapeutic modalities to achieve the plan's objectives.

g. Plan of Care

Inpatient psychiatric services must include active treatment. "Active treatment" means implementation of a professionally developed and supervised individual plan of care that is developed and implemented by an interdisciplinary team.

A team of professionals, as specified below, must develop the plan of care no later than 14 days after admission. If possible, develop the plan in consultation with the child and the child's parents, legal guardians, or others in whose care the child will be released after discharge. The plan of care must:

- Be based on a diagnostic evaluation and include examination of the medical, psychological, social, behavioral and developmental aspects of the child's situation and reflect the need for inpatient psychiatric care.
- Be designed to achieve the child's discharge from inpatient status at the earliest possible time.
- State treatment objectives.
- Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives.
- Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the child's family, school, and community upon discharge.

The interdisciplinary team must review the plan every 30 days to:

- Determine that services being provided are or were required on an inpatient basis.
- Recommend changes in the plan as indicated by the child's overall adjustment as an inpatient.

h. *Case Activity Report*, Form 470-0042

The *Case Activity Report (CAR)*, form 470-0042, is a report of new members and changes in the status of current members. Click here to view the form online.

When a resident applies for Medicaid, a CAR must be submitted to the income maintenance worker in the Department's county office.

Any changes associated with Medicaid members must also be reported to the Department's county office, including any change in level of care decisions by the IME, hospital admissions, visits out of the facility, runaways, and discharges or death.

For foster care children, the service worker may require more specific information to be reported.

(1) Instructions for Preparing the *Case Activity Report*

When a current resident applies for Medicaid, complete sections 1 through 3. Enter the first name, middle initial, and last name of the member as they appear on the *Medical Assistance Eligibility Card*. The state identification number is assigned by the Iowa Department of Human Services and consists of seven digits plus one letter, e.g. 0000000X.

When a Medicaid applicant or member enters the facility, complete sections 1 through 3 and section 4, if applicable.

When there is Medicare coverage and the Medicaid rate is higher than the Medicare rate, complete sections 1, 2, and 4.

When a Medicaid applicant or member dies or is discharged, complete sections 1, 2, and 5.

This form must be completed within two business days of the action.

The administrator or designee responsible for the accuracy of this information should sign in section 2.

The date is the date the form is completed and sent to the Department of Human Services.

(2) Distribution Instructions for PMICs

Mail or fax a copy of the CAR to the DHS Centralized Facility Eligibility Unit:

Centralized Facility Eligibility Unit – PMIC
Imaging Center 1
Iowa Department of Human Services
417 E. Kanesville Blvd.
Council Bluffs, IA 51503-4470
Fax: 515-564-4040
Email: CSAPMIC@dhs.state.ia.us

Keep a copy of the form for the institution's records.

2. Outpatient Services (Day Treatment)

Day treatment services for persons aged 20 or under are outpatient services provided to persons who are not inpatients in a medical institution or residents of a licensed group care facility. Payment is made for day treatment services provided in an approved site. Day treatment coverage is limited to a maximum of 15 hours per week.

PMICs with day treatment programs for persons aged 20 or under must address:

- Documented need for day treatment services for children in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.
- Goals and objectives of the program that meet the guidelines below.
- Organization and staffing, including how the program fits with the PMIC, the number of staff, staff credentials, and the staff's relationship to the program (employee, contractual, or consultant).
- Policies and procedures for the program, including admission criteria, patient-assessment, treatment plan, discharge plan, and post-discharge services, and the scope of services provided.

a. Admission Criteria

The admission criteria for day treatment for people aged 20 or under are:

- The member is at risk for exclusion from normative community activities or residence due to factors such as:
  - Behavioral disturbance
  - Chemical dependence
  - Depression
- The member exhibits some of the following symptoms:
  - Psychiatric symptoms
  - Disturbances of conduct
  - Decompensating conditions affecting mental health
  - Severe developmental delays
  - Psychological symptoms
  - Chemical dependency issues

  These symptoms are sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate. This includes individual or group therapy services provided by:

- A physician or psychologist in the provider's office.
- Auxiliary staff of a physician in the physician's office.
- A mental health professional employed by a community mental health center.

The member's principle caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the member, and to enable adequate control of the member's behavior. The caretaker must be involved in the member's treatment.

If the principle caretaker is unable or unwilling to participate in the provision of services, the day treatment program must document how services will benefit the child without caretaker involvement. People who have reached majority, either by age or emancipation, are exempt from family therapy involvement.

The member has the capacity to benefit from the interventions provided. Example:

- A member with a diagnosis of an intellectual disability may not be appropriate for a day treatment program if the member is unable to participate and benefit from group milieu therapy.
- A member exhibiting acute psychiatric symptoms (e.g., hallucinations) may be too ill to participate in the day treatment program.

b. Coordination of Services

Provide programming services in accordance with the individual treatment plan. Appropriate day treatment staff must develop the plan in collaboration with the member and the member's parent, guardian, or principal caretaker.

The services must be under the supervision of the program director, coordinator, or supervisor. Primary care staff of the PMIC must coordinate the program for each member.

A coordinated, consistent array of scheduled therapeutic services and activities must comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies.

"Active treatment" is defined as treatment in which the therapist assumes significant responsibility and often intervenes. At least 50 percent of scheduled therapeutic program hours for each member (exclusive of educational hours) must consist of active treatment components which:

- Are determined by the individual treatment plan based upon a comprehensive evaluation of member needs, and
- Specifically addressing the targeted problems of the population served.

Scheduled therapeutic activities, which may include other program components as described above, must be provided at least 3 hours per week, up to a maximum of 15 hours per week. Therapeutic activities should be scheduled according to the needs of the members, both individually and as a group.

The member's family, guardian, or principal caretaker must be involved with the program through family therapy sessions or scheduled family components of the program. Encourage them to adopt an active role in treatment. **Exception:** People who have reached majority, either by age or emancipation, are exempt from family therapy involvement. Medicaid does not make separate payment for family therapy services.

c. Discharge Criteria

The length of stay in a day treatment program for children must not exceed 180 treatment days per episode of care. If the member's condition requires a longer stay, document the rationale for continued stay in the member's case record and in the treatment plan every 30 calendar days after the first 180 treatment days.

Discharge criteria for the day treatment program for children must incorporate at least the following indicators:

- If the patient improves:
  - The member's clinical condition has improved, as shown by symptom relief, behavioral control, or indication of mastery of skills at the member's developmental level.
  - Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
  - Treatment goals in the individualized treatment plan have been achieved.
  - An aftercare plan has been developed that is appropriate to the member's needs, and the member and the family, custodian, or guardian has agreed to it.

- If the member does not improve:
  - The member's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
  - The member, the family, or the custodian has not complied with treatment or with program rules.
  - Post-discharge services must include a plan for discharge that provides appropriate continuity of care.

d. Documentation

The program must maintain a distinct clinical record for each member admitted. At a minimum, documentation must include:

- The specific services rendered,
- The date and actual time services were rendered,
- Who rendered the services,
- The setting in which the services were rendered,
- The amount of time it took to deliver the services,
- The relationship of the services to the treatment regimen in the plan of care, and
- Updates describing the member's progress.

Example:

John Doe's Clinical Record

Day treatment services provided June 1, 1999, from 9:00 a.m. to 11:00 a.m. at Main Street PMIC.

Objective: Will develop and maintain a relapse prevention plan including action steps to take in order to stop his offense cycle.

Treatment Note: Arrives late looking very disheveled. Begins with making a lot of excuses with rapid speech and flushed cheeks. Give feedback regarding observing his anxiety at "not being perfect" (trigger for cycle). Went over his thinking ("I'm too busy"), what self-talk would put him back into control (positively). Also informed "my family is moving." Another trigger - discussed strategies for dealing with this to prevent relapse. Jane Doe, MSW

Objective: Increase the use of "I statements" in communications.

Treatment Note: Reports being more open with Mom when Mom makes hurtful comments. States he uses "I statements." He said his Mom often responds saying "you take things too personally." This was discussed and he acknowledged Mom's response intensifies his hurt and anger...but he doesn't continue to express himself. He states he will talk to Mom and continue using "I statements." Jay Doe, RN

e. Individual Treatment Plan

Prepare a treatment plan for each member receiving day treatment services. The treatment plan must be developed or approved by one of the following:

- A board-eligible or board-certified psychiatrist
- A staff psychiatrist
- A physician
- A psychologist registered on:
  - The National Register of Health Service Providers in Psychology, or
  - The Iowa National Register of Health Service Providers in Psychology.

Evidence of approval must be acknowledged by a signature of the physician or health service provider in psychology.

Formulate a preliminary treatment plan within three days of program participation after admission. Replace it within 30 calendar days by a comprehensive, formalized plan using the comprehensive assessment.

This individual treatment plan should reflect the member's diagnosis, identify the member's strengths and weaknesses, and identify areas of therapeutic focus. Relate the treatment goals (general statements of member outcomes) to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives such as:

- The hours and frequency the member will participate in the program
- The type of services the member will receive
- The expected duration of the program

Objectives must be related to the goal and have specific anticipated outcomes. State the methods that will be used to pursue the objectives. Review and revise the plan as needed, but review it at least every 30 calendar days.

f. Program Requirements

Day treatment programs must be a separate program from the inpatient program and must meet the following criteria:

- Staffing must be sufficient to deliver program services and provide stable, consistent, and cohesive milieu. Staffing plans must reflect how program continuity will be provided.
- Staffing must reflect an interdisciplinary team of professionals and paraprofessionals.
- Staffing must include a designated director who is a mental health professional. The director must be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.
- The program must have a staff-to-patient ratio of no less than one staff for each six participants. Clinical, professional, educational, and paraprofessional staff may be counted in determining the staff-to-patient ratio.
- Professionals or clinical staff are those staff who are either mental health professionals as defined in 441 Iowa Administrative Code (IAC) 24.1(225C) or persons employed for the purpose of providing offered services under the supervision of a mental health professional.
- All other staff must not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. This includes administrative, adjunctive, support, nonclinical, clerical, and consulting staff and professional or clinical staff when engaged in administrative, clerical, or support activities.

- Services must be provided by or under the general supervision of a mental health professional. When services are provided by an employee or consultant of the PMIC who is not a mental health professional, the employee or consultant must be supervised by a mental health professional. The employee or consultant must:
  - Have a minimum of a bachelor's degree in a human services related field from an accredited college or university, or
  - Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

  The supervising mental health professional must give direct professional direction and active guidance to the employee or consultant and retain responsibility for member care. The supervision must be timely, regular, and documented.
- The program must have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.
- Programming must meet the individual needs of the member. A description of services provided for members must be documented along with a schedule of when service activities are available including the days and hours of program availability.
- There must be a written plan for accessing emergency services 24 hours a day, seven days a week.
- The program must maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships must exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships must also exist with appropriate school districts and educational cooperatives.

  Relationships with other entities, such as physicians, hospitals, private practitioners, halfway houses, the Department, juvenile justice system, community support groups, and child advocacy groups, are encouraged. The provider's program description must describe how community links will be established and maintained.
- Psychotherapeutic treatment services and psychosocial rehabilitation services must be available. A description of the services must accompany the application for certification.

The provider must meet the PMIC license requirements, except that a staff-to-patient ratio of one-to-six is acceptable.

g. Programming

Day treatment services for children must be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. "Time-limited" means that:

- The member is not expected to need services indefinitely or life long, and
- The primary goal of the program is to improve the behavioral functioning or emotional adjustment of the member in order that the service is no longer necessary.

Day treatment services must be provided within the least restrictive therapeutically appropriate context and must be community-based and family-focused. The overall expected outcome is clinically adaptive behavior on the part of the member and the family. At a minimum, day treatment services are expected to:

- Improve the member's condition,
- Restore the condition to the level of functioning before the onset of illness,
- Control symptoms, or
- Establish and maintain a functional level to avoid further deterioration or hospitalization.

Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs must use an integrated, comprehensive and complimentary schedule of therapeutic activities, and must have the capacity to treat a wide array of clinical conditions. The following services must be available as components of the day treatment program:

- **Psychotherapeutic treatment services** (such as individual, group, and family therapy).
- **Psychosocial rehabilitation services**. Active treatment examples include, but are not limited to:
  - Individual and group therapy,
  - Medication evaluation and management,
  - Expressive therapies, and
  - Theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional or physical abuse issues).

  Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.
- **Evaluation services**. Evaluation services must determine need for day treatment before program admission. An evaluation service may be performed when clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria.

  Evaluation services must be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional.

  An evaluation from another source performed within the previous 12 months may be substituted if there has not been a change. Medicaid will not make separate payment for these services under the day treatment program.

- **Assessment services**. All day treatment members must receive a formal, comprehensive bio-psycho-social assessment of day treatment needs, including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. The assessment must address whether medical causes for the child's behavior have been ruled out.

  An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same. If not, parts of the assessment that reflect current functioning may be used as an update.

  Using the assessment, produce a comprehensive summation, including the findings of all assessments performed. Use this summary in forming a treatment plan including treatment goals.

  Also consider and consistently monitor indicators for discharge planning, including recommended follow-up goals and provision for future services.

- **Educational component**. The member's educational needs must be served without conflict from the day treatment program. The day treatment program may include an educational component as an additional service.

  Hours in which the member is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid. The day treatment program may wish to pursue funding of educational hours from local school districts.

  Example:

  > The member attends the day treatment program from 9:00 a.m. to 3:00 p.m. The member attends the educational component from 9:00 a.m. to noon.
  >
  > The hours the member attends the educational component are deducted from the day treatment hours. The billable day treatment hours for Medicaid are three hours (noon to 3:00 p.m.).

These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

h. Stable Milieu

The program must formally seek to provide a stable, consistent, and cohesive therapeutic milieu. Encourage this in part by scheduling attendance such that a stable core of patients exists as much as possible.

Consider the developmental and social stage of the participants, such that no member is significantly involved with other patients who are likely to contribute to intellectual disability or deterioration of the member's social and emotional functioning.

To help establish a sense of program identity, the array of therapeutic interventions must be specifically identified as the day treatment program. Program planning meetings must be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider must state how milieu stability will be provided.

C. BASIS OF PAYMENT

1. Inpatient Services

The basis of payment for PMIC services is the Fee Schedule.

a. Client Participation

Legal reference: 441 IAC 85.23(249A)

The member's client participation and medical payments from a third party shall be paid toward the total cost of care on a monthly basis. The state will pay the balance of the cost of care for the month. The facility shall make arrangements directly with the member for payment of client participation.

Client participation is determined according to 441 IAC 75.16(249A).

Providers may verify a member's client participation by accessing the IME Eligibility and Verification System (ELVS). Click here to access the website.

b. Personal Needs Allowance

All income of the child in excess of $50 per month for personal needs must be applied to the cost of care. In addition, if a child has earnings, a $65 month allowance from earned income only is allowed for personal needs. The personal needs funds can be held by the child, by the facility for the child's use, or by the child's family.

Each foster care child who is in a PMIC and who has income assigned to the Department receives a state warrant for the child's personal needs. This represents the monthly personal allowance the child keeps from the child's unearned income or child support received from the parent.

Some children may have earned income that is to be used for personal needs. When children have income sent directly to them, the child is also allowed a personal needs allowance.

Determine whether the child can manage the child's own funds or whether the facility must handle the funds. Make this decision part of the child's case plan. Facilities do not have the option of refusing to handle a child's personal allowance funds if necessary and staff deems it appropriate. However, families may elect to handle their children's funds if they wish.

If the facility handles the funds, the facility must account for the funds. Purchase a surety bond or provide self-insurance to ensure the security of all personal funds of members deposited with the facility.

Establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each child's personal funds entrusted to the facility on the child's behalf. The system must preclude any commingling of member funds with facility funds or with the funds of any person other than another child.

Maintain two types of accounts to handle child personal allowance funds:

- A small "use" account to secure the first $50 of each child's personal allowance funds. This can be a petty cash fund or a non-interest-bearing checking account.
- A larger interest-bearing checking account to handle all funds in excess of $50 for each child. This may be a single joint account separate from any of the facility's operating accounts, an individual account for each child, or a pooled account of all members' funds.

The main function of the larger checking account is to act as a depository to generate interest and retain funds that later will be placed in the petty cash fund. If a single joint account is maintained, interest earned must be prorated periodically, normally upon receipt of the monthly bank statement, and credited to a separate ledger card for each member.

If an individual checking account is opened for each child, interest earned is automatically credited to each respective account. With this method, a second set of ledger cards is not necessary, as the individual check book register serves as a ledger card to record deposits and withdrawals.

Deposit all monthly personal allowance funds received into the larger account before being placed in the petty cash fund for member use. Under no circumstances should the monthly deposits be made directly into the petty cash fund.

Then deposit the first $50 of each member's funds, or entire total if less than $50, into a petty cash fund that consists solely of members' funds. Set up a new individual ledger card for each member that reflects the initial $50 deposit into the petty cash fund. The individual financial record must be available on request to the member or the members' legal representatives.

Keep receipts for large purchases and vouchers for smaller items in individual envelopes for each member in the petty cash fund box. The receipts or vouchers must indicate the member's name, date, amount, and items purchased. Whenever possible, the member should sign a voucher for all cash received from the petty cash fund, regardless of its intended use. This is an adequate receipt for that type of withdrawal.

The total cash on hand plus vouchers should equal the total of all ledger cards for the petty cash fund. The ledger and receipts for each member must be made available for periodic audits by an accredited Department representative. The Department's representative must make an audit certification at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

Make all purchases other than large items through the petty cash fund. Make large purchases directly through the individual checking account only.

When a member's account balance gets low in the petty cash fund, post the voucher to the ledger cards. As the petty cash fund amount for a member is used, draw an amount to replenish the fund to $50 from the larger account and place it into the petty cash fund.

Notify each member who receives Medicaid benefits when the amount in the member's account reaches $200 less than the SSI resource limit for one person. Notify the member's social worker that the member may lose eligibility for Medicaid or for SSI if the amount of the account, in addition to the member's other nonexempt resources, reaches the SSI resource limit for one person.

c. Hospital Leaves

Reserve bed payment must be made for days a member is absent from a PMIC and hospitalized in an acute care general hospital. The reserve bed day payments do not apply for an absence or transfer of a child to a sub-acute unit of the PMIC.

The following policies apply to all Medicaid-eligible members:

- Payment will not be authorized for over 10 days per calendar month and will not be authorized for over 10 days for any continuous stay.
- IME, depending on eligibility, review is required when the child returns to the facility after a 10-day absence.

Payment for reserve bed days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interest. In that case, payment must be canceled effective the day after the joint decision not to return the child.

d. Other Absences for Foster Children

Reserve bed payment must be made for days a foster care child is absent from a PMIC at the time of a nightly census for such reasons as detention, shelter care, or running away. The absence must be in accordance with the following policies:

- The facility must notify the Department social worker within 24 hours after the child is out of the facility for running away or other unplanned reason.
- The intent of the Department and the facility must be for the child to return to the facility after the absence.
- Payment for reserve bed days for other absences must not exceed 14 consecutive days or 30 days per year, except upon written approval of the Department's area administrator. In no case must payment exceed 60 days per year.

Payment for reserve bed days must be canceled and payments returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made by the court or by the parent, in a voluntary placement not to return the child to the facility.

Obtain IME review before the child's return to the facility if the child is away for 14 or more consecutive days. If it is determined that the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.

e. Reserve Bed Days

Reserve bed payment is not available until the child has been physically admitted to the facility. The reserve bed days are paid to the facility when the child is absent at the time of nightly census.

f. Visits

For visit days to be payable, the absence must be in accordance with the following conditions:

- For foster care children, the visits must be coordinated with the child's DHS social worker.
- The visits must be consistent with the child's case permanency plan and the facility's individual case plan.
- The intent of the Department and the facility must be for the child to return to the facility after the visitation.
- Staff from the psychiatric medical institution must be available to provide support to the child and family during the visit.
- Payment for reserve bed days cannot exceed 14 consecutive days or 30 days per year except upon approval from the member's Managed Care Organization or IME for children not enrolled with a Managed Care Organization. In no case must payment exceed 60 days per year.

Payment for reserve days must be canceled and payment returned if the facility refuses to accept the child back, except when the Department and the facility agree that the return would not be in the child's best interests. In that case, payment must be canceled effective the day after the joint decision not to return the child.

Payment for reserve bed days must be canceled effective the day after a decision is made not to return the child by the court or, involuntary placement, by the parent.

Upon return to the facility, IME review is required if the child's absence from the facility is greater than 30 consecutive days. If it is determined that the child's care in the facility is no longer appropriate, then Medicaid payment is discontinued.

2. Outpatient Services

Outpatient day treatment services are paid on a fixed-fee basis. Bill for day treatment in one-hour units:

H2012 Behavioral health day treatment, per hour

D. PROCEDURE CODES AND NOMENCLATURE

Revenue Code	HCPCS Code	Description	Valid DX. Codes
N/A	T2048	PMIC Bed Day	290.00-309.99, 311.00-314.99
0183	T2048	Therapeutic Leave Day (Use for home leave)	290.00-309.99, 311.00-314.99
0180	T2048	LOA General (Use of MH hospitalization)	290.00-309.99, 311.00-314.99
0189	T2048	LOA Other (Use for elopements)	290.00-309.99, 311.00-314.99

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Psychiatric Medical Institutions for Children are billed on federal form UB-04, *Health Insurance Claim Form**.

Click here to view a sample of the UB-04.

Click here to view billing instructions for the UB-04.

Refer to *Chapter IV. Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf