Indiana Title XIX

**M E D I C A I D  B U L L E T I N**

B T 1 9 9 9 2 3  A U G U S T  2 4 ,  1 9 9 9

**To:** **All Indiana Medicaid Providers**

**Subject:** **Appropriate Procedures for Submitting the Certification of Need (Form 1261A) for Inpatient Psychiatric Services**

## Overview

This message is to clarify appropriate procedures for submitting the **Certificate of Need [Form 1261A]** for Medicaid eligible recipients who require emergency/non-emergency inpatient psychiatric services. This form must be submitted for all psychiatric admissions, regardless of setting.

To assist providers with the completion of the 1261A, the following guidelines should be followed. The provider should review all information prior to submission of the form to insure its completeness.

## *405 IAC 5-20-5* Certification of Need for Admission

Sec. 5. Medicaid reimbursement is available for services in an inpatient psychiatric facility only when the recipient's need for admission has been certified. The certification of need must be completed as follows:

1. By the attending physician or staff physician for a Medicaid recipient between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a Medicaid recipient sixty-five (65) years of age and over.
2. In accordance with *42 CFR 441.152*(a), effective October 1, 1995, (not including secondary Code of Federal Regulations citation therein) and *42 CFR 441.153*, effective October 1, 1995, (not including tertiary Code of Federal Regulation citations resulting

therefrom) for an individual twenty-one (21) years of age and under.

3. By telephone pre-certification review prior to admission for an individual who is a recipient of Medicaid when admitted to the facility as a non-emergency admission, to be followed by a written certification of need within ten (10) working days of admission.
4. By telephone pre-certification review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays and legal holidays, to be followed by a written certification of need within fourteen (14) working days of admission. If the provider fails to call within forty-eight (48) of an emergency admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement shall be denied for the period from admission to the actual dates of notification.
5. In writing within ten (10) working days after receiving notification of an eligibility determination for an individual applying for Medicaid while in the facility and covering the entire period for which Medicaid reimbursement is being sought.
6. In writing at least every sixty (60) days after admission, or as requested by the office or its designee, to re-certify that the patient continues to require inpatient psychiatric hospital services.

## *405 IAC 5-20-6* Emergency admissions

Sec. 6. Medicaid reimbursement is available for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

1. Danger to the individual
2. Danger to others
3. Death of the individual

## *405 IAC 5-20-7* Unnecessary services

Sec. 7. Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization is found not to have been medically necessary. Telephone pre-certifications of medical necessity will provide a basis for Medical reimbursement only if adequately supported by the written **Certification of Need [Form 1261A]** submitted in accordance with Section 5 of this rule. If the

required documentation is not submitted within the specified time frame, Medicaid reimbursement will be denied.

## Please Note:

1. It is the responsibility of the provider to submit correctly completed documentation. *Medical records are not to be submitted in lieu of the appropriate form.* All 1261A forms must be completed **in full** prior to submission. Each section is to be filled **with the requested information.** Incomplete 1261A forms will be returned to the provider. If the form is re-submitted to HCE after fourteen (14) business days, the request will be determined "untimely" and the "pending" days will be "denied."
2. **Timeliness** of submission is critical to the acceptance of the form.
3. Your information **must** reflect the following, and should be as specific as possible:

    (a) How is the patient a danger to self, a danger to others, or gravely disabled? Be specific in describing the behaviors.

    (b) If there is a known plan, please describe.
4. 1261A forms for Risk Based Managed Care (RBMC) patients are the responsibility of the admitting facility.

### *Persons available to answer your questions:*

Health Care Excel
Prior Authorization
PO Box 531520
Indianapolis, IN 46253-1520
1(800) 475-4518 or (317) 347-4500
Attention: Hearings and Appeals
Medicaid Prior Authorization