Billing Tips – Inpatient Hospital Psychiatric Admissions

How to determine which Medicaid entity is responsible for payment of services. Due to the complex reimbursement system, it is imperative for providers to work closely with the Medicaid Health Plans (MHP), Medicaid Fee for Service (FFS) and the Prepaid Inpatient Health Plans (PIHP) when planning to admit any patient to an inpatient status.

Policy: Medicaid Provider Manual (MPM) Chapter "Behavioral Health and Intellectual and Developmental Disability" Section 7 Inpatient Psychiatric Hospital Admissions, Chapter "Hospital" Section 3.21 Mental Health and Substance Abuse Services and Chapter "Medicaid Health Plans" Section 2.9 Substance Abuse.

Beneficiaries may seek services through the hospital emergency department (ED) for medical complications due to substance abuse/misuse and mental health emergencies with complications due to multiple medical issues. Prior to admitting the patient to an inpatient status, the hospital must work with the patient's PIHP authorizing authority for proper placement. It is not appropriate to place a patient in a medical/surgical unit to primarily treat the patient's psychiatric condition. To ensure that FFS CHAMPS does not pay claims that are the responsibility of the PIHP or the MHP, editing looks to the diagnosis coding within the claim. Please be advised that the Centers for Medicare/Medicaid Services (CMS) defines the form locators used when billing the admission diagnosis as well as the principle diagnosis. This is to ensure that provider's code claims correctly as the diagnosis coding, and the order in which they are reported on the claim, are used to develop the DRG assigned to certain inpatient hospital claims. CMS defines the use of the admitting diagnosis code form locator as: The admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. CMS defines the use of the principal diagnosis form locator as: The condition established after study to be chiefly responsible for the admission. Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. See this web site for additional information: https://www.cms.gov/manuals/downloads/clm104c23.pdf

Please see the below grid of billing scenarios.

Scenario#1. Patient has coverage through FFS. This patient fell, had broken bones and was admitted to have surgery on the fractures. The trauma may have caused the patient with underlying mental health issues to become briefly psychotic. The admission diagnosis should be coded with the reason the patient is being admitted to this medical/surgical hospital. The principal diagnosis should be coded with the main diagnosis for which the patient received care during this confinement. The hospital must work with the patients Community Mental Health (CMH) authorizing authority regarding proper placement while the patient is in the ED due to the presentation of the underlying mental health issues. In this case, the patient was admitted to inpatient status, received surgery, was medically stabilized and then discharged/transferred to another psychiatric hospital. This patient's PIHP authorized the transfer and paid for the psychiatric care. In this scenario, the provider has coded their claim with a mental health diagnosis in either the admitting or principal form locator, billed the claim to FFS and FFS is

denying the claim. This claim is the responsibility of FFS and again should be properly coded for the medical condition for which this facility is treating the patient.

Scenario#2. Patient has coverage through a MHP. This patient has a UTI and also has a diagnosis of schizophrenia. Everywhere the patient goes they carry the mental health diagnosis of schizophrenia with them. In this case, the patient is being admitted with a high fever, dehydration and an altered mental status. The hospital must work with the patients CMH authorizing authority regarding proper placement while the patient is in the ED due to the presentation of the underlying mental health issues. Because the patient has coverage through a MHP, the provider must also work with the MHP regarding authorization for this care. In this case, the patient was admitted to inpatient status, received IV antibiotic therapy to reduce the fever and to treat the infection, was medically stabilized and then discharged/transferred to another psychiatric hospital. This patient's PIHP authorized the transfer and paid for the psychiatric care. In this scenario the provider has coded their claim with a mental health diagnosis in either the admitting or principal form locator, billed the claim to FFS and FFS is denying the claim. This claim is the responsibility of MHP and again should be properly coded for the medical condition for which this facility is treating the patient.

Scenario#3. Patient has coverage through a MHP. This patient presented to the ED with delirium tremens, a blood alcohol level 350mg/dl and has congestive heart disease. Patient was admitted to inpatient status and treated for acute medical detoxification. Although the beneficiary is in a MHP, the claim is billed to FFS and payment is approved.

Scenario#4. Patient has coverage through a MHP. This patient has attempted to commit suicide by medication overdose and was taken to the ED. Although the patient has a history of substance abuse and other mental health issues, the patient is being admitted to treat the medication overdose. The hospital must work with the patients CMH authorizing authority regarding proper placement while the patient is in the ED due to the mental health issues that may have caused the suicide attempt. Because the patient has coverage through a MHP, the provider must also work with the MHP regarding authorization for this care. In this case, the patient was admitted to inpatient status, received gastric lavage, IV therapy, was also intubated and once medically stabilized was discharged/transferred to another psychiatric hospital. Claim is coded with overdose diagnosis in both the admitting and the principal form locator and therefore the MHP has approved the claim.

Commonly seen billing examples:

Scenario	Inpatient Hospital Claim Admitting Diagnosis	Inpatient Hospital Claim Principal Diagnosis	Admitted to Medical/ Surgical Unit	Surgical Codes or other codes on the claim	Patient has coverage through	Claim issue
#1	F23=Brief psychotic disorder	F23=Brief psychotic disorder	Revenue Code 0120	E-Code W1830XA = Fall And surgical code S32511A= Fracture	FFS	Claim needs coding corrections
#2	F200= Paranoid schizophrenia	R4182 = Altered Mental Status unspecified	Revenue Code 0120	Diagnosis Code G9340= Encephalopathy unspecified	MHP	Claim needs coding corrections
#3	F10239= Alcohol Dependence with withdrawal	F1020= Alcohol Dependence	Revenue Code 0120	Surgical Code HZ2ZZZZ= Detoxification services substance abuse treatment	MHP	FFS-DETOX paid this claim appropriately
#4	T450X4A= Poisoning by anti-allergic and antiemetic	T50904A= poisoning by unspecified drugs	Revenue Code 0203		MHP	MHP paid this claim appropriately

Beneficiaries may seek services through the hospital emergency department (ED) for medical illness, accident, substance abuse/misuse and mental health emergencies and if the patient is not admitted to inpatient status the following coverage guidelines apply:

Beneficiaries covered by a MHP claim is the responsibility of the MHP.

Beneficiaries covered by FFS claim is the responsibility of FFS.

If the patient is admitted to inpatient status to the same facilities psychiatric unit (same tax ID#) under the authority and authorization of the patients PIHP, the ED services must be included on the inpatient hospital claim and are the responsibility of the PIHP.