Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2012-61**
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TO: **Psychiatric Hospitals and Psychiatric Residential Treatment Facilities**

RE: Certificate of Need Requirement for Inpatient Admissions for Individuals Under the Age of 21

The purpose of this bulletin is to remind public and private psychiatric hospitals and psychiatric residential treatment facilities (PRTFs) of the requirement to conduct a certification of need for care (CON) for individuals under the age of twenty-one who are admitted to these facilities. This requirement is identified in federal regulations at 42 CFR Part 441, Subpart D. Written documentation that the CON has been performed in accordance with this regulation must be maintained in the recipient's record.

Facilities are advised to review the regulation carefully to be sure that they are in compliance. A brief summary of the requirements indicates that:
For non-emergency admissions for existing Medicaid recipients, an independent team must perform the certification of need. DSS or its agent fulfills this requirement.

For non-emergency admissions for an individual who does not have Medicaid at admission but who applies for Medicaid while in the facility, the interdisciplinary team that is developing the plan of care at the inpatient facility must perform the CON. The CON must be confirmed by the independent team (DSS or its agent).
For emergency admissions of existing Medicaid recipients or of individuals who apply for Medicaid while in the facility, the interdisciplinary team that is developing the plan of care at the facility must perform the CON. The CON must be confirmed by the independent team (DSS or its agent).

As indicated above, it is the interdisciplinary team at the admitting facility that must perform the CON for emergency admissions and for individuals who apply for Medicaid while in the facility. It is not sufficient to have a CON done by the referring provider or facility.

For emergency admissions, the CON should be done at the time of admission; a copy of the CON form completed by the interdisciplinary team must be in the patient's record no later than 14 days after the admission or else the authorization for payment will be void.
In all cases, the CON must be in writing and certify the three elements of need in 42 CFR 441.152(a) and must include documented clinical evidence that serves as the basis for the CON. A copy of the CON must be maintained in the recipient's record at the facility.

Composition of the independent interdisciplinary team and the independent team
Per federal regulations (42 CFR 441.153(a)) the independent team (DSS or its agent) certifying the need for services must:
- include a physician;
- have competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- have knowledge of the individual's situation.

Per federal regulations (42 CFR 441.156) the interdisciplinary team (at the admitting facility) must be composed of physicians and other personnel who are employed by or provide services to patients in the facility and must also be the team that develops the plan of care.
- The team must include, at a minimum, either: (1) A Board-eligible or Board-certified psychiatrist; (2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or (3) 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 or who has been certified by the state or by the state psychological association.
- The team must also include one of the following:

1. a psychiatric social worker

2. a registered nurse with specialized training or one year's experience in treating mentally ill individuals;
3. an occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals;
4. a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

Attached is a prototype of a Certification of Need form for the Interdisciplinary Team.

When the Independent Team performs the CON, a letter attesting to their finding will be securely e-mailed to an address chosen by the facility within two business days. A copy of this letter must be maintained in the patient's medical record.

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

MEDICAID CERTIFICATION FOR ADMISSION
OF AN INDIVIDUAL UNDER 21 YEARS OF AGE TO AN INPATIENT PSYCHIATRIC FACILITY-
INTERDISCIPLINARY TEAM

PLEASE TYPE OR PRINT ALL ENTRIES (Except Signatures).

Today's Date (MM/DD/YY):_____ Admission Date:_____

I. FACILITY INFORMATION

Facility Name: _____ Facility Telephone:_____

Address: Number and Street:_____ City, State, Zip Code:_____

Person Requesting Certification:_____ Facility NPI Number:_____

II. PATIENT INFORMATION

Patient Medicaid Number: _____

Name, Last:_____ First:_____ Initial:___ Date of Birth:_____

Address: Number and Street:_____

City:_____ State:_____ Zip Code:_____

Responsible Relative/Guardian:_____

Address:_____

III. REASON FOR CERTIFICATION – To be completed by Certifying Physician and team; each statement must be affirmed for inpatient care coverage.

1. The patient is under age 21 and must begin treatment before his or her 21st birthday. ☐ Yes ☐ No

2. Ambulatory care resources available in the community do not meet this patient's treatment needs. ☐ Yes ☐ No

3. Proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
☐ Yes ☐ No

4. The services can reasonably be expected to improve the patient's condition or prevent further regression so that services will no longer be needed.
☐ Yes ☐ No

IV. CERTIFICATION OF EMERGENCY ADMISSION (When Applicable)

Reason for Emergency Admission – check all that apply. Substantiating information, including pertinent history (prior inpatient treatment, medication, etc.) MUST be provided.
Indicate location of substantiating information: ☐ back of this form ☐ attached sheets

☐ The patient is dangerous to himself or herself, and there is substantial risk that the individual may inflict physical harm upon his or her own person.

☐ The patient is dangerous to others, and there is substantial risk that he or she may inflict physical harm upon other persons.

☐ The patient is gravely disabled as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her basic human needs.

Reason for finding of grave disability and impaired judgment due to mental illness:
☐ Please check here if continued on attached sheet(s).

Diagnosis (reason for which admission is necessary): DSM-IV Code:_____
☐ Please check here if continued on attached sheet(s).

Pertinent history (previous hospitalization, treatment, medication):
☐ Please check here if continued on attached sheet(s).

In our opinion, this patient requires immediate inpatient admission for treatment.

Physician name:_____ Physician Signature:_____

CT Medical License No.:_____ Date of examination:_____

Other team member:_____ Signature:_____

Title _____

Other team member:_____ Signature:_____

Title _____

THIS FORM MUST BE COMPLETED BY THE FACILITY'S INTERDISCIPLINARY TEAM RESPONSIBLE FOR THE PATIENT'S PLAN OF CARE. A COPY OF THIS FORM MUST BE KEPT IN THE PATIENT'S RECORD.