



Bulletin

NUMBER

#15-76-02

DATE

July 1, 2015

OF INTEREST TO

County Directors
Social Services Supervisors
and Staff

ACTION/DUE DATE

Please read information
and prepare for
implementation

EXPIRATION DATE

July 1, 2017

County Portion of Cost of Care at State Operated Services Regional Treatment Centers

TOPIC

Cost of care for adult mental health programs at the State Operated Services (SOS) Regional Treatment Centers. This bulletin replaces bulletin #13-76-03.

PURPOSE

identify changes made by the 2015 legislative session
review the changes made by the 2013 legislative session
define criteria used to determine length of stay
define criteria used to determine medical necessity
outline client appeal process

CONTACT

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SIGNED

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Deputy Commission
Direct Care & Treatment

TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of “People First” language.

I. Background

This bulletin is intended to provide information on the billing practices for the adult mental health inpatient services provided at State Operated Regional Treatment Centers as directed by Minnesota Statutes, section 246.54, subdivision 1, and amended by the 2015 Legislative Session by Laws of Minnesota 2015, chapter 71, article 4, section 2 as follows:

Subdivision 1. County portion for cost of care.

(a) EXCEPT for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall equal a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility according to the following schedule:

- 1) zero percent for the first 30 days;
- 2) 20 percent for days 31 and over if the stay is determined to be clinically appropriate for the client;
- 3) 100 percent for each day during the stay, including the day of admission, when the facility determines that it is clinically appropriate for the client to be discharged.

(b) IF payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days over 31 for clients who meet the criteria in paragraph (a), clause (2), the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

The percent change made during the 2015 Legislative Session for individuals who meet paragraph (a), clause (3), will be effective for all patients in-house or admitted on or after July 1, 2015.

II. Length of stay determination

In accordance with the law, the following methods will be used to determine length of stay:

- DATE of admission to the program after release of any hold order will be counted as day one for the county cost of care determination

- DISCHARGE from the inpatient episode will end the length of stay calculation for the episode unless a client is re-admitted to the program within 72 hours. If the client is readmitted within 72 hours from the discharge (provisional or full), the length of stay will continue from the previous episode

III. SOS – Hospital Level Medical Necessity Criteria – Determination Process

Minnesota Statutes, section 246.54, subdivision 1(b) requires the treatment facility determines the clinical appropriateness of discharge is as follows:

Step 1 - Utilization management reviewer identifies a client treatment episode that may no longer meet hospital level medical necessity criteria using LOCUS (Levels of Care Utilization System).

Step 2 - Utilization management reviewer reviews the client case with attending clinician to determine if clinical data supports hospital level medical necessity criteria, or “does not meet criteria” (DNMC).

Step 3 – Utilization management supervisor reviews case with the utilization management reviewer to assure appropriate justification for DNMC and writes DNMC letter.

Step 4 – SOS chief medical officer (CMO) reviews the case with the utilization management supervisor and if SOS CMO is in agreement, signs the DNMC letter.

Step 5 – DNMC letter is sent to the client (or designee) and to the county case manager.

IV. Process for appealing medical necessity determination

Clients have the right to appeal this determination. Clients may file an appeal with the Appeals Unit of the Minnesota Department Human Services. The address is below. Clients must submit their appeal within 30 days of when they receive notice. If the client can show good cause for failing to appeal within 30 days, the client might be able to appeal within 60 days. The human services judge decides if the client has good cause.

Representation: If the client requests an appeal, they may represent themselves or ask a lawyer, a friend or others to help them.

Appeals Units
Minnesota Department of Human Services
PO Box 64941
St. Paul, MN 55164-0941
(651) 431-3600

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-3676 (voice) or toll free at (800) 627-3529 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.