DRAFT

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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1.0 Description of the Procedure, Product, or Service

Psychiatric Residential Treatment Facilities (PRTFs) provide non-acute inpatient facility care for NC Medicaid (Medicaid) beneficiaries under 21 years of age who have a mental illness or a substance use disorder and need 24-hour supervision and specialized interventions.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. <u>Medicaid</u>

PRTF services are available to Medicaid beneficiaries under 21 years of age. Continued treatment can be provided until the beneficiary's 22nd birthday when medically necessary.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible,

compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

   EPSDT provider page: https://medicaid.ncdhhs.gov/

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

Medicaid shall cover admission to Psychiatric Residential Treatment Facilities when the beneficiary meets **all** of the following criteria:

a. The beneficiary demonstrates symptomatology consistent with a DSM-5, or any subsequent editions of this reference material, diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
b. The beneficiary is experiencing emotional or behavioral problems in the home, community or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.
c. The beneficiary demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.
d. The beneficiary has a history of multiple hospitalizations or other treatment episodes or recent inpatient stay with a history of poor treatment adherence or outcome.
e. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.
f. The family situation and functioning levels are such that the beneficiary cannot currently remain in the home environment and receive community-based treatment.

3.2.2 Continued Stay Criteria

All of the following criteria are necessary for continuing treatment at this level of care:

a. The beneficiary's condition continues to meet admission criteria at this level of care.
b. The beneficiary's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
c. Treatment planning is individualized and appropriate to the beneficiary's changing condition with realistic and specific goals and objectives stated. Treatment planning shall include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.
d. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

e. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress.
f. Care is rendered in a clinically appropriate manner and focused on the beneficiary's behavioral and functional outcomes.
g. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.
h. Beneficiary is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the beneficiary's engagement in treatment.
i. Unless contraindicated, family, guardian, or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
j. When medically necessary, appropriate psychopharmacological intervention has been prescribed or evaluated.
k. There is documented active discharge planning from the beginning of treatment.
l. There is a documented active attempt at coordination of care with relevant outpatient providers when appropriate.

3.2.3 Discharge Criteria

The following two criteria must both be met:

a. The beneficiary can be safely treated at an alternative level of care.
b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

In addition to "a" and "b" above, one or more of the criteria in "c" through "g" must be met:

a. The beneficiary's documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at an alternate level of care.
b. The beneficiary no longer meets admission criteria or meets criteria for a less or more intensive level of care.
c. The beneficiary, or family member, guardian, or custodian are competent but non-participatory in treatment or in following the program rules and regulations. There is non-participation to such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.
d. Consent for treatment is withdrawn, and it is determined that the beneficiary, parent, or guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.
e. The beneficiary is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care; nor is the level of care required to maintain the current level of function.

3.2.4 Medicaid Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover PRTF services that are ordered by the court when medical necessity criteria are not met.

Medicaid shall not cover PRTF when the primary issues are social or economic, such as placement issues.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for Psychiatric Residential Treatment Facilities services. The provider shall obtain prior approval before rendering Psychiatric Residential Treatment Facilities services.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available

5.2.2 Specific

None Apply

5.3 Additional Limitations or Requirements

5.3.1 Utilization Management

Utilization management of covered services is a part of the assurance of medically necessary service provision. Authorization, which is an aspect of utilization management, validates approval to provide a medically necessary covered service to an eligible beneficiary.

Services are based upon a finding of medical necessity, must be directly related to the beneficiary's diagnostic and clinical needs, and are expected to achieve the specific rehabilitative goals detailed in the beneficiary's service plan. Medical necessity is determined by North Carolina community practice standards, by 10A NCAC 25A .0201, and as verified by the utilization management contractor who evaluates the request to determine if medical necessity supports intensive services.

Medically necessary services are authorized in the most cost-effective modes, if the treatment that is made available is similarly effective as services requested by the beneficiary's physician, therapist, or another licensed practitioner. The medically necessary service must be recognized as an accepted method of medical practice or treatment.

To request an initial authorization, the Certification of Need (CON) (refer to Subsection 5.3.2), the Comprehensive Clinical Assessment (CCA) or Diagnostic Assessment (DA), the Person-Centered Plan (PCP), and the required NC Medicaid authorization request form must be submitted to the utilization management contractor.

Concurrent reviews will determine the ongoing medical necessity for the service. Providers shall submit an updated PCP, and any authorization or reauthorization forms required by the utilization management contractor.

5.3.2 Certification of Need

Federal regulations require a Certification of Need (CON) to be completed on or prior to admission to a PRTF facility when the beneficiary is Medicaid-eligible or Medicaid is pending. The CON must:

a. be done concurrently with the Medicaid application, when the application is done during the stay. The independent utilization reviewer must be contacted immediately to begin the review process.
b. be completed by an independent medical team, including a qualified physician.
c. not be retroactive.

d. meet all federal requirements.
e. certify that:
    1. ambulatory care resources within the community are insufficient to meet the treatment needs of the beneficiary;
    2. the beneficiary requires services on an inpatient basis under the direction of a qualified physician; and
    3. services can reasonably be expected to improve the beneficiary condition or prevent regression.

The last dated signature on the CON form determines authorization for payment.

A copy of the CON must be maintained in the beneficiary's medical record.

5.3.3 Therapeutic Leave

Each Medicaid eligible beneficiary who is occupying a psychiatric residential treatment facility bed for which the North Carolina Medicaid Program is then paying reimbursement shall be entitled to take up to 45 (non-consecutive) days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave is also limited to no more than 15 days within one calendar quarter (three months).

a. The taking of such leave must be for therapeutic purposes only and must be agreed upon by the beneficiary's treatment team. The necessity for such leave and the expectations involved in such leave shall be documented in the beneficiary's treatment/habilitation plan and the therapeutic justification for each instance of such leave entered into the beneficiary's record maintained at the Residential Facility's site.
b. Therapeutic leave shall be defined as the absence of a beneficiary from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the treatment/habilitation plan.
c. Facilities must reserve a therapeutically absent beneficiary's bed for him and are prohibited from deriving any Medicaid revenue for that beneficiary other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.
d. No more than five consecutive days may be taken without the approval of the beneficiary's treatment team.
e. Facilities must keep a cumulative record of therapeutic leave days taken by each beneficiary for reference and audit purposes. In addition, beneficiaries on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid for approved therapeutic leave days as regular residence days.
f. The official record of therapeutic leave days taken for each beneficiary shall be maintained by the State or its agent.
g. Therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving inpatient services or any other Medicaid covered service in the facility of current residence or in another facility. Therapeutic leave cannot be paid when Medicaid is paying for any other 24-hour service.

h. Medicaid benefits do not include non-emergency medical transportation. Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

PRTF programs:

a. Must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children.

b. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.

Hospital licensure is required if the treatment is hospital-based.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Medicaid Requirements

Documentation of PRTF services must meet both the requirements of the accrediting body and Medicaid guidelines.

~~For Medicaid, utilization reviews, including initial and continuing stay authorizations, are performed by an independent utilization review contractor. The utilization review contractor notifies the fiscal agent of the number of approved certified days.~~

8.0 Policy Implementation/Revision Information

Original Effective Date: December 1, 2001

Revision Information:

Date	Section Revised	Change
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Section 3.1	The section was revised to clarify the criteria for admissions.
01/01/2006	Section 3.2	The section was revised to clarify the criteria for continuing treatment.
01/01/2006	Section 3.3	The section was revised to clarify the criteria for discharge.
05/01/2006	Attachment A	The level of care and initial and continuing authorization criteria for Level D services was deleted from the policy.
09/01/2006	Section 5.2	Requirements and limitations related to therapeutic leave were added to the policy, effective with CMS date of approval, 8/19/2004.
12/01/2006	Section 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Section 8.1	Added UB-04 as an accepted claims form.
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/01/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 8D-1 under Session Law 2011-145, § 10.41.(b)
08/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy, but neither policy substantially changed.
8/1/2014	All Sections and Attachments	Updated: DSM-IV to DSM-5 language, 2013 CPT codes, as well as other technical, nonsubstantive, and clarifying changes including grammar, readability, typographical accuracy, and formatting.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

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Date	Section Revised	Change
11/15/2018	Subsection 6.1	Removed the term “board eligible” and replaced with “board-certified.” Effective 2012, the Board of Psychiatry and Neurology stopped using the term "board eligible".
10/01/2015	Subsection 6.1	Reverted wording to 10/01/2015 version. “Board-certified” changed back to “board-eligible or certified.” Policy posted on 12/05/2018 with an Amended/Effective Date of October 1, 2015.
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
12/15/2019	Throughout	Corrected an error by removing the word “Rehabilitation” and replacing it with “Residential”
12/15/2019	Attachment A	Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.
12/15/2019	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP
12/15/2019	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
12/15/2019	Attachment A	Added: Note: North Carolina Medicaid and North Carolina Health Choice will not reimburse for conversion therapy.
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program’s move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.
	Subsection 5.3.3	Policy revised as a part of NC Medicaid’s mental health and substance use disorder Parity analysis work related to Mental Health Parity and Addiction Equity Act and the Code of Federal Regulations Title 42 Chapter IV Subchapter C Part 438 Subpart K, § 438.900. Added utilization of language management to clarify service requirements.
	Section 7.2	Removed: “For Medicaid, utilization reviews, including initial and continuing stay authorizations, are performed by an independent utilization review contractor. The utilization review contractor notifies the fiscal agent of the number of approved certified days.”

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Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

A. Claim Type

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Providers shall code service in form locator 42 with the revenue code (RCC) 911 billed as one unit per day. A beneficiary is permitted up to 45 (non-consecutive) days of therapeutic leave per calendar year from the facility without the facility losing reimbursement.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Inpatient Hospital, Residential Treatment Facility

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

Psychologists, addictionologists or other behavioral health practitioners may at times need to see a beneficiary who has been hospitalized under the care of an admitting psychiatrist. When it is necessary for the outpatient provider to see an inpatient to facilitate treatment or facilitate transition back to the outpatient setting, that provider may be reimbursed when prior authorization is obtained from NC Medicaid's Utilization Review vendor.

Note: North Carolina Medicaid will not reimburse for conversion therapy.