

Legislative Regulation Review Committee

2008-027b

Department of Social Services

**REQUIREMENTS FOR PAYMENT OF
SERVICES PROVIDED BY PSYCHIATRIC
RESIDENTIAL TREATMENT FACILITY
PROVIDERS**

IMPORTANT: Read instructions on bottom of Certification Page before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations.

REGULATION

OF

NAME OF AGENCY

Department of Social Services

Concerning

SUBJECT MATTER OF REGULATION

Psychiatric Residential Treatment Facilities

SECTION _____

Statement of Purpose: (A) The purpose of the regulation is to establish the requirements under which Psychiatric Residential Treatment Facility (PRTF) providers enrolled in the Connecticut Medical Assistance Program (Medicaid) are to provide services in order to receive reimbursement pursuant to section 17b-262 of the Connecticut General Statutes. Currently, these requirements are set forth in policy only.

(B) The main provisions of the regulation: (1) establish the requirements under which a provider can enroll in Medicaid; (2) indicate that reimbursement for provider services are limited to those services that are provided to Medicaid eligible persons under the age of 21 years; (3) define services covered and limitations; (4) specify services that are not covered by Medicaid; (5) establish requirements pertaining to Certification of Need and prior authorization; (6) outline billing procedures; (7) indicate payment procedures, rates and limitations; and (8) reference necessary documentation and audit requirements.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: Adoption of the proposed regulations will formalize the requirements for payment to PRTFs previously set forth in policy only.

CERTIFICATION

R-39 REV. 1/77

Be it known that the foregoing:

Regulations Emergency Regulations

Are:

Adopted Amended as hereinabove stated Repealed

By the aforesaid agency pursuant to:

Sections 17b-262 of the General Statutes.

Section _____ of the General Statutes, as amended by Public Act No. _____ of the _____ Public Acts.

Public Act No. _____ of the Public Acts.

After publication in the Connecticut Law Journal on _____, of the notice of the proposal to:

Adopt Amend Repeal such regulations

(If applicable): And the holding of an advertised public hearing on 23 day of March, 2008

WHEREFORE, the foregoing regulations are hereby:

Adopted Amended as hereinabove stated Repealed

Effective:

When filed with the Secretary of the State.

(OR)

The _____ day of _____.

In Witness Whereof:	Date	SIGNED (Head of Board, Agency or Commission)	OFFICIAL TITLE, DULY AUTHORIZED
	<u>4-23-09</u>	<i>Frances A. Freer</i>	<i>Acting Deputy Commissioner</i>
Approved by the Attorney General as to legal sufficiency in accordance with sec. 4-169, as amended C.G.S.	SIGNED	<i>Bill B. Aik</i> <u>6/18/09</u>	OFFICIAL TITLE, DULY AUTHORIZED ASSOC. ATTY. GENERAL

- Approved
- Disapproved
- Disapproved in part, (Indicate Section Numbers disapproved only)
- Rejected without prejudice

By the Legislative Regulation Review Committee in accordance with Sec. 4-170, as amended, of the General Statutes.	Date	SIGNED (Clerk of the Legislative Regulation Review Committee)
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Two certified copies received and filed, and one such copy forwarded to the Commission in Official Legal Publications in accordance with Section 4-172, as amended, of the General Statutes.

DATE	SIGNED (Secretary of the State.)	BY
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INSTRUCTIONS

- One copy of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the Attorney General for his determination of legal sufficiency. Section 4-169 of the General Statutes.
- Seventeen copies of all regulations for adoption, amendment or repeal, except emergency regulations, must be presented to the standing Legislative Regulation Review Committee for its approval. Section 4-170 of the General Statutes.
- Each regulation must be in the form intended for publication and must include the appropriate regulation section number and section heading. Section 4-172 of the General Statutes.
- Indicate by "(NEW)" in heading if new regulation. Amended regulations must contain new language in capital letters and deleted language in brackets. Section 4-170 of the General Statutes.

R-39 REV. 04/04
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**STATE OF CONNECTICUT
 REGULATION
 OF**

Name of Agency

Department of Social Services

Subject Matter of Regulation

Requirements for Payment of Services Provided
 by Psychiatric Residential Treatment Facility Providers

The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-804 to 17b-262-816, inclusive, as follows:

(NEW) Section 17b-262-804. Scope

Sections 17b-262-804 to 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services' requirements for payment for Psychiatric Residential Treatment Facilities (PRTF) services provided to clients who are determined eligible for Connecticut's Medicaid Program pursuant to section 17b-261 of the Connecticut General Statutes.

(NEW) Sec. 17b-262-805. Definitions

As used in section 17b-262-804 to section 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies:

- (1) "Active treatment" means "active treatment" as defined in 42 CFR, Part 441, section 441.154;
- (2) "Acute" means having rapid onset, severe symptoms and a short course;
- (3) "Allied Health Professional" or "AHP" means a licensed individual who is qualified by special training, education, skills and experience in behavioral health care and treatment and shall include, but shall not be limited to: psychologists, social workers, psychiatric nurses, professional counselors and other qualified therapists as defined in Title 20 of the Connecticut General Statutes;
- (4) "Authorization" means the approval of payment for services or goods by the department based on a determination of medical necessity and appropriateness. For elective admissions, authorization also serves as the certification of need as defined in this section;
- (5) "CMS" means the Centers for Medicare and Medicaid Services;
- (6) "Certification of need" means an evaluation process for clients who are under consideration for admission to a PRTF;
- (7) "Client" means a person eligible for goods or services under Medicaid who is under age twenty-one at the time services are received. If a client received services immediately before reaching age twenty-one, payment shall be available for services received before the earlier of the date that the client no longer requires the services or the date that the client reaches age twenty-two;
- (8) "Department" means the Department of Social Services or its agent;
- (9) "Elective admission" means any admission to a PRTF that is non-emergent, including, but not limited to, transfers from one PRTF to another;
- (10) "Independent team" means a team that meets the requirements set forth in 42 CFR, Part 441, section 441.153(a). The independent team may not include anyone who is related, in any way, to the admitting facility, or who is directly responsible for the care

of patients whose care is being reviewed or has a financial interest in the admitting facility. The department performs the functions of the independent team;

- (11) "Individual plan of care" or "plan of care" means a written plan that meets the criteria set forth in 42 CFR, Part 441, Section 441.155;
- (12) "Inpatient" means "inpatient" as defined in 42 CFR, Part 440, section 440.2;
- (13) "Interdisciplinary team" means a team that meets the requirements set forth in section 42 CFR, Part 441, section 441.156;
- (14) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;
- (15) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities;
- (16) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or to prevent a medical condition from occurring;
- (17) "Medical record" means "medical record" as described in 42 CFR, Part 482, section 482.61 and subsection (d) of section 19-13-D3 of the Regulations of Connecticut State Agencies;
- (18) "Overnight pass" means a conditional release to the client's proposed residence on discharge of not more than two days duration, after admission and prior to the day of discharge, in which the client has been permitted by the attending physician to be absent from the facility premises and in accordance with the client's treatment needs and goals as specified in the plan of care;
- (19) "Provider" means a PRTF that is enrolled in Medicaid;
- (20) "Provider agreement" means the signed, written contractual agreement between the department and the provider;
- (21) "Psychiatric emergency" means a sudden onset of a psychiatric condition, as determined by a physician, that manifests itself by acute symptoms of such severity that the absence of immediate medical care and treatment in an inpatient psychiatric facility could reasonably be expected to result in serious dysfunction, disability or death of the client or harm to self or another person by the client. Court commitments and clients admitted on a physician emergency certificate are not automatically deemed to qualify as a psychiatric emergency;
- (22) "Psychiatric Residential Treatment Facility" or "PRTF" means a facility that meets all the requirements in 42 CFR Part 441, Subpart D and 42 CFR Part 483, Subpart G;
- (23) "Quality of care" means the evaluation of medical care to determine if it meets the professionally recognized standard of acceptable medical care for the condition and the client under treatment;
- (24) "Retrospective review" means the review conducted after services are provided to a client, to determine the medical necessity, medical appropriateness and quality of the services provided;
- (25) "Transfer" means that a client is discharged from a PRTF and directly admitted to another;

- (26) "Under the direction of a physician" means that health services may be provided by allied health professionals or paraprofessionals whether or not the physician is physically present at the time that the services are provided; and
- (27) "Utilization management" means the prospective, retrospective or concurrent assessment of the medical necessity and appropriateness of the allocation of health care resources and services given, or proposed to be given, to a client.

(NEW) Sec. 17b-262-806. Provider participation

In order to enroll in Medicaid and receive payment from the department, a provider shall meet the following requirements:

(a) General:

- (1) meet and maintain all applicable licensing, accreditation and certification requirements;
- (2) meet and maintain all departmental enrollment requirements; and
- (3) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into Medicaid. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

(b) Specific:

- (1) be accredited in accordance with 42 CFR 441.151(a)(2);
- (2) satisfy all federal and state requirements governing the use of restraint and seclusion including, but not limited to, a written attestation of facility compliance with CMS standards governing the use of restraint and seclusion and filed annually with the department no later than July 1st of each year; and
- (3) if located outside of Connecticut, meet all of the provider requirements in subsections (a) and (b) of this section and be an enrolled Medicaid provider in the provider's state of residence, when that state participates in the optional Medicaid of inpatient psychiatric facility services provided for clients.

(NEW) Sec. 17b-262-807. Eligibility

Payment for PRTF services shall be available, subject to the conditions and limitations set forth in sections 17b-262-804 to 17b-262-816, inclusive, of the Regulations of Connecticut State Agencies, for services rendered to clients.

(NEW) Sec. 17b-262-808. Services covered

- (a) The department shall pay a per diem rate, which is an inclusive payment for all services that are required to be provided by the facility as a condition for participation as a PRTF, including, but not limited to:
 - (1) therapeutic services provided by PRTF staff;
 - (2) active treatment services including, but not limited to, individual, group and family therapy;
 - (3) diagnostic testing and assessment;
 - (4) room and board; and
 - (5) case management, discharge planning.
- (b) The department shall pay for authorized PRTF services for clients provided by an enrolled provider.

(NEW) Sec. 17b-262-809. Services not covered

The department shall not pay for the following PRTF services that are not covered under Medicaid:

- (a) procedures or services of an unproven, educational, social, research, experimental or cosmetic nature or for any diagnostic, therapeutic or treatment procedures in excess of those deemed medically necessary and appropriate by the department to treat the client's condition;
- (b) services or items furnished for which the provider does not usually charge;
- (c) services that do not directly relate to the client's diagnosis, symptoms or medical history;
- (d) the day of discharge;
- (e) a PRTF admission or a day of care that does not meet all the department's requirements for inpatient services;
- (f) a day when the client is absent from the PRTF at the midnight census, unless the absence is a medically authorized overnight pass and part of the treatment plan; or
- (g) costs associated with the education or vocational training of the client which shall be excluded from Medicaid payments.

(NEW) Sec. 17b-262-810. Certification of need requirements

- (a) In order to receive payment for PRTF services for individual, admissions shall have a certification of need as required in 42 CFR 441 Subpart D, as amended from time to time.
- (b) The certification of need shall be based on a determination that:
 - (1) ambulatory care resources available in the community do not meet the treatment needs of the client;
 - (2) proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
 - (3) the services shall reasonably be expected to improve the client's condition or prevent further regression so that inpatient services shall no longer be needed.
- (c) When the admission of a client is elective, an independent team shall perform the certification of need. The facility shall maintain written documentation of the independent team's certification of need as evidenced by the signature of a member of the independent team on a certification of need form or letter(s) of authorization by the independent team.
- (d) When the admission is of a person who is not Medicaid eligible and who applies for Medicaid while in the PRTF, the certification of need shall be conducted at the time of application for or by the first day of Medicaid eligibility. The interdisciplinary team responsible for the individual plan of care shall perform the certification of need, which shall cover any period prior to application for which Medicaid claims are made. The facility shall maintain written documentation of the certification of need.
- (e) For psychiatric emergency admissions, the certification of need shall be performed by the interdisciplinary team responsible for the plan of care not later than fourteen days after the day of admission. The facility shall maintain written documentation of the certification of need as evidenced by the signature of a member of the independent team on a certification of need form.
- (f) When the client is admitted from a PRTF to a hospital and, upon discharge, is readmitted to the PRTF, a new certification of need shall be performed.

(NEW) Sec. 17b-262-811. Individual plan of care requirements

- (a) PRTF services for clients shall involve active treatment, as documented in the professionally developed and supervised individual plan of care.
- (b) A physician shall:
 - (1) assume professional responsibility for the services provided under the plan of care;
 - (2) assure that the services are medically appropriate;
 - (3) certify in writing that the services provided are necessary in the setting in which they will be provided; and
 - (4) be readily available in person or by phone but not necessarily on the premises.
- (c) Not later than seven days after admission, the interdisciplinary team shall establish a written plan of care for each client, designed to achieve the client's discharge from the PRTF at the earliest possible time. This plan shall:
 - (1) be based on a diagnostic evaluation that includes examinations of the medical, psychological, social, behavioral and developmental aspects of the client's situation and thereby reflect the need for PRTF services;
 - (2) be developed by the interdisciplinary team of professionals in consultation with the client and his or her parents, legal guardian, or others into whose care he or she will be released after discharge;
 - (3) state the treatment objectives;
 - (4) prescribe an integrated program of therapies, activities and experiences designed to meet the treatment objectives;
 - (5) include, at an appropriate time, post-discharge plans and coordination of PRTF services with partial discharge plans and related community services to ensure continuity of care with the client's family, school and community upon discharge; and
 - (6) be a recorded document which is maintained in the client's medical record.
- (d) The individual plan of care shall be reviewed every thirty days by the interdisciplinary team, starting on the date of admission. The purpose of the review is to determine whether services being provided are currently required, or were required on an inpatient basis, and to recommend any changes to the plan that are indicated by the client's overall progress towards the treatment goals.

(NEW) Sec. 17b-262-812. Utilization Review Program

- (a) The department conducts utilization review activities for services delivered by the PRTF for clients where Medicaid has been determined to be the appropriate payer.
- (b) To determine whether admission to a PRTF is medically necessary and medically appropriate, the department or the Administrative Service Organization shall:
 - (1) authorize each PRTF admission, unless the department notifies the providers that a specific admission or diagnosis does not require such authorization; and
 - (2) perform retrospective reviews, at the department's discretion, which may be a random or targeted sample of the admissions and services delivered. The review may be focused on the appropriateness, necessity or quality of the health care services provided.
- (c) All claims for payment for admission and all days of stay and services that are provided shall be documented. Lack of said documentation may be adequate grounds for the department, in

its discretion, to deny or recoup payment for the admission for some or all of the days of stay or services provided.

(d) The department may conduct medical reviews and inspections of care in PRTFs.

(NEW) Sec. 17b-262-813. Billing procedures

Claims from providers shall be submitted on the department's uniform billing form or electronically transmitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(NEW) Sec. 17b-262-814. Documentation and record retention

(a) A provider shall meet the medical record requirements for a PRTF and shall maintain records to support claims made for payment. All documentation shall be made available upon request by and to authorized department, state or federal personnel in accordance with state and federal laws. Documentation shall be retained by the provider for a period of at least five years, except if otherwise required by law or, if any dispute arises concerning a service, until such dispute has been finally resolved.

(b) Failure to maintain all required documentation or to provide it to the department upon request may result in the disallowance and recovery by the department of any amounts paid out for which the required documentation is not maintained or provided.

(NEW) Sec. 17b-262-815. Payment

The Department shall reimburse PRTFs at a negotiated per diem rate.

(NEW) Sec. 17b-262-816. Audit and compliance review

All supporting accounting and business records, statistical data and all other records relating to the provision of PRTF services paid for by the department shall be subject to audit or compliance review by authorized personnel. All documentation shall be made available, upon request, to authorized representatives of the department.

Purpose: To establish the requirements under which Psychiatric Residential Treatment Facility (PRTF) providers who are enrolled in Connecticut Medicaid are to provide services in order to receive reimbursement pursuant to section 17b-262 of the Connecticut General Statutes.

The main provisions of this regulation: (1) establish the requirements under which a provider can enroll in Medicaid; (2) indicate that reimbursement for provider services are limited to those services that are provided to Medicaid eligible persons under the age of 21 years; (3) define services covered and limitations; (4) specify services that are not covered by Medicaid; (5) establish requirements pertaining to Certification of Need and prior authorization; (6) outline billing procedures; (7) indicate payment procedures, rates, and limitations; and (8) reference necessary documentation and audit requirements.