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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #03-184(F)

DIGEST

Amends 405 IAC 5-20 to add coverage and reimbursement limitations for psychiatric residential treatment services (PRTF) for children under 21 years of age. Adds 405 IAC 1-21 setting forth the reimbursement criteria for PRTF services. Effective 30 days after filing with the secretary of state.

405 IAC 1-21	**405 IAC 5-20-3.1**
405 IAC 5-20-1	**405 IAC 5-20-4**
405 IAC 5-20-2	**405 IAC 5-20-7**

SECTION 1. 405 IAC 1-21 IS ADDED TO READ AS FOLLOWS:

Rule 21. Payments for Psychiatric Residential Treatment Facility Services

405 IAC 1-21-1 Purpose; scope
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 1. The purpose of this section is to establish a prospective, cost-based reimbursement methodology for services provided by psychiatric residential treatment facilities that are covered by the state of Indiana Medicaid program. Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475)*

405 IAC 1-21-2 "Psychiatric residential treatment facility" or "PRTF" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 2. As used in this rule, "psychiatric residential treatment facility" or "PRTF" means a facility that is licensed under 470 IAC 3-13 as a private secure child caring institution and meets the requirements set forth in 405 IAC 5-20-3.1. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-2; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475)*

405 IAC 1-21-3 Reimbursement rates
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 3. Covered inpatient psychiatric facility services for individuals under twenty-one (21) years of age provided in PRTFs shall be reimbursed in accordance with the following:
(1) The PRTFs shall be reimbursed for services provided to Medicaid recipients based upon the lower of:
(A) the statewide PRTF prospective per diem rate calculated by the office; or
(B) the usual and customary daily charges billed for the psychiatric treatment of eligible recipients.
(2) The applicable PRTF payment per diem rate determined in subdivision (1) shall provide reimbursement for all Medicaid covered services provided in the psychiatric residential treatment facility except for those costs described in subdivisions (3) and (6). Providers will include, and rates will be

determined using, only those allowable costs as listed in Medicaid provider reimbursement manuals and update bulletins.
(3) The per diem rate determined in subdivision (1) shall exclude those costs incurred for the following:
(A) Pharmaceutical supplies and services. Medicaid reimbursement for costs incurred for pharmaceutical supplies and services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in 405 IAC 5-24.
(B) Physician services. Medicaid reimbursement for costs incurred for physician services provided to eligible recipients shall be paid separate and apart from the PRTF per diem rate and in accordance with the reimbursement policies described in 405 IAC 5-25.
(4) All costs utilized to determine the statewide prospective per diem rate in subdivision (1)(A) shall be subject to reasonability standards as set forth in the Medicare Provider Reimbursement Manual, CMS-Pub. 15-1, Chapter 25.
(5) The per diem rate determined in subdivision (1) shall exclude such costs unrelated to providing psychiatric residential services, including, but not limited to, the following:
(A) Group education, including elementary and secondary education.
(B) Advertising or marketing.
(C) Nonpsychiatric specialty programs.
(6) Medicaid reimbursement for Medicaid covered psychiatric services provided to recipients residing in a psychiatric residential treatment facility shall be limited to the payments described in this rule. Costs for Medicaid covered services not related to the recipient's psychiatric condition but performed at the PRTF will be included in the PRTF per diem rate. Medicaid reimbursement for Medicaid covered services not related to the recipient's psychiatric condition is available, separate from the PRTF per diem, only in instances where those services are unavailable at the PRTF and are performed at a location other than the PRTF.
(7) The established per diem rate for psychiatric residential treatment facilities shall be reviewed annually by the OMPP or its contractor by using the most recent, reliable claims data and adjusted cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing inpatient psychiatric services, and adjusted as necessary, in accordance with this section.
(Office of the Secretary of Family and Social Services; 405 IAC 1-21-3; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2475)

405 IAC 1-21-4 Cost reports and audits
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15

Sec. 4. PRTFs shall file a cost report annually using a uniform cost report form prescribed by the office of Medicaid policy and planning (OMPP). The OMPP or its contractor may audit or review the cost reports as it deems necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 1-21-4; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; errata filed Apr 8, 2004, 10:35 a.m.: 27 IR 2499)*

SECTION 2. 405 IAC 5-20-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-1 Reimbursement limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) Medicaid reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, **psychiatric residential treatment facilities for children under twenty-one (21) years of age,** outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in this rule. **For purposes of this rule, "psychiatric residential treatment facility" or "PRTF" means a facility that meets the requirements set forth in section 3.1 of this rule.**

(b) Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a recipient under sixty-five (65) years of age unless the recipient is under twenty-one (21) years of age, or under twenty-two (22) years of age and had begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday.

(c) Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between twenty-two (22) and sixty-five (65) years of age in a certified psychiatric hospital of sixteen (16) beds or less.

(d) Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse. *(Office of the Secretary of Family and Social Services; 405 IAC 5-20-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476)*

SECTION 3. 405 IAC 5-20-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-2 Reserving beds in psychiatric hospitals and psychiatric residential treatment facilities
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) Medicaid reimbursement is available for reserving beds in a psychiatric hospital (and not in a general acute care hospital) for hospitalization of Medicaid recipients at one-half (½) the regular per diem rate when ~~one (1)~~ **all** of the following conditions ~~is~~ **are** present:
(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the facility.
(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days. If the recipient requires hospitalization longer than the fifteen (15) consecutive days, the recipient must be discharged from the facility.
(3) A physician's order for the hospitalization must be maintained in the recipient's file at the facility.

(b) Medicaid reimbursement is available for reserving beds in a psychiatric residential treatment facility for hospitalization of Medicaid recipients under twenty-one (21) years of age at one-half (½) the regular per diem rate subject to all of the following conditions:
(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the psychiatric residential treatment facility.
(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is four (4) days. If the recipient requires hospitalization longer than the four (4) consecutive days, the recipient must be discharged from the psychiatric residential treatment facility.
(3) A physician's order for the hospitalization must be maintained in the recipient's file at the psychiatric residential treatment facility.
(4) In no instance will Medicaid reimburse a psychiatric residential treatment facility for reserving beds for Medicaid recipients when the facility has an occupancy rate of less than ninety percent (90%).

~~(b)~~ **(c)** Medicaid reimbursement is available for reserving beds in a psychiatric hospital, but not in a general care hospital, for the therapeutic leaves of absence of Medicaid recipients at one-half (½) the regular per diem rate when ~~one (1)~~ **all** of the following conditions ~~is~~ **are** present:
(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the recipient's habilitation plan.
(2) **In a psychiatric hospital,** the total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per recipient. If the recipient is absent **from the psychiatric hospital** for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that recipient in that year.
(3) A physician's order for therapeutic leave must be maintained in the recipient's file at the facility.

(d) Medicaid reimbursement is available for reserving beds in a psychiatric residential treatment facility for therapeutic leaves of absence of Medicaid recipients under twenty-one (21) years of age at one-half (½)

the regular per diem rate when all of the following conditions are present:

(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the recipient's habilitation plan.

(2) A physician's order for therapeutic leave must be maintained in the recipient's file at the facility.

(3) In a psychiatric residential treatment facility, the total length of time allotted for therapeutic leaves in any calendar year shall be fourteen (14) days per recipient. If the recipient is absent from the psychiatric residential treatment facility for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that recipient in that year.

(4) In no instance will Medicaid reimburse a psychiatric residential treatment facility for reserving beds for Medicaid recipients when the facility has an occupancy rate of less than ninety percent (90%).

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476)

SECTION 4. 405 IAC 5-20-3.1 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-20-3.1 Psychiatric residential treatment facilities; requirements
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 3.1. Psychiatric residential treatment facilities must meet the following conditions in order to be reimbursed for inpatient services:

(1) The facility must be licensed as a private secure care institution under 470 IAC 3-13.

(2) The facility must be accredited by one (1) of the following:

(A) The Joint Commission on Accreditation of Healthcare Organizations.

(B) The American Osteopathic Association.

(C) The Council on Accreditation of Services for Families and Children.

(3) The facility must comply with all requirements in 42 CFR 483, Subpart G governing the use of restraint and seclusion.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-3.1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477)

SECTION 5. 405 IAC 5-20-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-4 Individually developed plan of care
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each Medicaid eligible patient admitted to a psychiatric hospital **or psychiatric residential treatment facility** must have an individually developed plan of care. In the case of a person between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less or a person sixty-five (65) years of age and over, the plan of care must be developed by the attending or staff physician. For a person under twenty-one (21) years of age, the plan of care must be developed by the physician and interdisciplinary team. In all cases, the plans of care must be developed not later than fourteen (14) days after admission. For a patient who becomes eligible for Medicaid after admission to a facility, the plan of care must be prepared to cover all periods for which Medicaid coverage is claimed and as follows:

(1) The individual plan of care for a recipient between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a recipient sixty-five (65) years of age and over shall set forth treatment objectives and prescribe an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives. The plan shall be based upon a diagnostic evaluation that includes examination of the medical, psychological, social, and behavioral aspects of the patient's situation. It shall include, at an appropriate time, a postdischarge plan and plan for coordination of inpatient services with partial discharge plans and appropriate related services in the patient's community to ensure continuity of care when returned to the patient's family and community upon discharge. The plan of care shall be reviewed and updated at least every ninety (90) days by the patient's attending or staff physician for determinations that the services provided were

and are required on an inpatient basis and for recommendations as to necessary adjustments in the plan as indicated by the patient's overall adjustment as an inpatient. The quarterly plan of care must be in writing and made a part of the patient's record.

(2) The individual plan of care for a recipient under twenty-one (21) years of age shall set forth treatment objectives and prescribe an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives. It shall be formulated in consultation with the child and parents, legal guardians, or others to whose care or custody the individual will be released following discharge. The plan shall be based upon a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the patient's situation. It shall include, at an appropriate time, a postdischarge treatment plan and plan for coordination of inpatient services with partial discharge plans and appropriate related services in the patient's community to ensure continuity of care when returned to the patient's family, school, and community upon discharge. Each plan of care must be reviewed and updated at least every thirty (30) days by the interdisciplinary team for determinations that the services provided were and are required on an inpatient basis and for recommendations as to any necessary adjustments in the plan as indicated by the patient's overall adjustment as an inpatient. The periodic update of the plan of care must be in writing and made a part of the patient's record. Recertification is required at least every sixty (60) days. Initial evaluative examinations are exempt from prior review and authorization.

(b) The interdisciplinary team required to develop the plan of care for an individual under twenty-one (21) years of age shall include at least one (1) of the persons identified in subdivisions (1) through (3) and one (1) of the persons identified in subdivision (4) as follows:

(1) A board certified or eligible psychiatrist.

(2) A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy.

(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 endorsed as ~~a~~ **an** HSPP or a licensed psychologist.

(4) One (1) of the following (deemed to be other professionals qualified to make determinations as to mental health conditions and treatments thereof):

(A) A licensed, clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling.

(B) An advanced practice nurse or a registered nurse who has specialized training or one (1) year experience in treating the mentally ill.

(C) An occupational therapist registered with the National Association of Occupational Therapists and who has specialized training or one (1) year of experience in treating the mentally ill.

(D) A psychologist endorsed as ~~a~~ **an** HSPP or a licensed psychologist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3334; filed Sep 27, 1999, 8:55 a.m.: 23 IR 314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477)

SECTION 6. 405 IAC 5-20-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-20-7 Unnecessary services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-13-7-3; IC 12-15

Sec. 7. Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization **or stay in a psychiatric residential treatment facility** is found not to have been medically necessary. Telephone precertifications of medical necessity will provide a basis for Medicaid reimbursement only if adequately supported by the written certification of need submitted in accordance with section 5 of this rule. If the required written documentation is not submitted within the specified time frame, Medicaid reimbursement will be denied. *(Office of the Secretary of Family and Social Services; 405 IAC 5-20-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2478)*

SECTION 7. **Subject to the conditions set out in 405 IAC 1-21 and 405 IAC 5-20, Medicaid reimbursement is available for psychiatric residential treatment services for individuals under twenty-one (21) years of age provided on or after the effective date of the state plan amendment approved by the Centers for Medicare and Medicaid Services.**

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