PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

In-state psychiatric residential treatment facilities (PRTFs) must either be licensed as a residential treatment center under the provision of ARSD Ch. 67:42:08 or as an intensive residential treatment center under the provisions of ARSD Ch. 67:42:15.

Out-of-state providers must have a residential treatment program for children age 20 or younger. In addition, the facility must be a PRTF accredited in the area of behavioral health care by the Joint Commission, the area of residential treatment services by the Council on Accreditation, or the area of behavioral health or child and youth services by the Commission on Accreditation of Rehabilitation Facilities.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. PRTFs must verify eligibility monthly after admission. Eligibility can be verified using South Dakota Medicaid's online portal.
The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;

- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Covered Services
Treatment at an eligible facility is a covered service if the following conditions are met:

- The recipient is age 20 or younger. If the recipient turns 21 while receiving treatment, treatment may continue until it is no longer necessary or until the individual turns 22, whichever occurs first;
- The State Review Team has determined that the required conditions stated below have been met;
- The Certification Team has certified that the requirements stated in the Certification Team section of this manual have been met;
- The services are expected to improve the individual's emotional and behavioral condition or prevent further regression.

The referring source for the recipient must gather and supply the documentation necessary to determine eligibility.

State Review Team Determination
The State Review Team consists of at least one representative from the following state agencies:

- The Department of Corrections;
- The Department of Social Services;
- The Department of Human Services; and
- The Department of Education.

In order for a recipient to receive PRTF services, excluding PRTF SUD services, the State Review Team must determine the following conditions exist:

- Outpatient services available in the community do not meet the recipient's treatment needs; and
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.

Certification Team
The state Certification Team determines whether a recipient needs psychiatric services. The Certification Team includes at least one physician, and the team includes other individuals knowledgeable about the diagnosis and treatment of the mental illnesses of children and of the individual's current situation.

<u>Certification</u>
For PRTF services to be covered, the Certification Team must certify the existence of the following based on medical documentation:

- The recipient requires intensive professional assistance and therapy for behavioral or emotional problems in the highly structured, self-contained environment of a residential treatment center, an intensive residential treatment center, or a psychiatric residential treatment facility;
- The services are medically necessary;
- The outpatient resources available in the community do not meet the individual's treatment needs;
- The proper treatment for the individual's mental illness requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.

In addition, the Certification Team must certify the existence of one of the following three criteria:

- The recipient has a diagnosis listed below and one of the problems listed below that is related to the diagnosis
    - Diagnoses:
        - Schizophrenia;
        - Psychotic disorders;
        - Depressive disorders;
        - Bipolar disorders;
        - Anxiety disorders;
        - Obsessive compulsive and related disorders;
        - Trauma and stressor related disorders;
        - Dissociative disorders;
        - Disruptive and impulse control disorders;
        - Conduct disorders;
        - Neurocognitive disorders;
        - Personality disorders; or
        - Other conditions not otherwise classified.
    - Problems related to the diagnosis:
        - Self-care deficit placing the individual at risk for self-harm. The deficit must be of such severity and long standing as to prevent placement of the individual in a community setting and without skilled intervention is placing the individual in a life-threatening, physiological imbalance;
        - Impaired safety, including a threat to self or others, continued suicidal or homicidal ideation with a plan of intent; continued violent or aggressive behaviors that require seclusion or restraints; verbal, physical, or sexually aggressive behavior that poses a potential danger to self or others; or antisocial behavior of such severity that it places the individual or others at risk;
        - Impaired thought process that results in an inability to perceive or validate reality to the extent that the individual cannot negotiate the individual's basic environment or participate in family or school life, including disruption of safety to self, family, or peer or community group; or impaired reality testing sufficient to prohibit participation in a community educational alternative; or

  - Severely dysfunctional patterns involving the individual's family, environment, or behavioral processes that place the individual at risk. Documentation must substantiate the existence of escalating symptoms, instability, or disruption that is placing the individual at risk.
- The recipient has a history of a psychiatric diagnosis and is posing an imminent danger to self or others; or
- In the absence of an identified psychiatric diagnosis, is exhibiting symptoms and behavior of such severity that it places the recipient or others at risk and warrants residential treatment under the direction of a physician.

Prior Authorization

Before a recipient may be admitted to a facility for treatment, the Certification Team must approve the individual's admission to the facility. Approval is based on a review of the following documentation:

- The recipient's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;
- A psychological or psychiatric evaluation and diagnosis that was completed within the past 12 months, if available;
- A summary of the recipient's behaviors during school from the individual's school district, if available;
- Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;
- A summary of outpatient care services that have been provided, including outcomes and recommendations; and
- An alcohol and drug screening assessment, if available.

The placing agency shall gather and supply to the department the required documentation. For emergency admissions, the Certification Team will complete its review on the first working day following the date of admission into the residential treatment center.

To obtain information about submitting a prior authorization request a placing agency should call Division of Economic Assistance at 605-773-3448. A completed prior authorization request should be submitted to:

Department of Social Services
Attn: Auxiliary Placement
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3448
Fax: 605-773-7183

Provider Notification Requirements

Placing Agency Notifications

The provider must notify the recipient's placing agency in advance of treatment team meetings. In addition, the provider must notify the placing agency within 24 hours after the occurrence of any of the following:

- The recipient has been discharged from the facility;
- The recipient has run away from the facility;
- The recipient has been admitted to a hospital; or
- The recipient has been placed in a juvenile detention center.

Failure to comply with this requirement may result in termination of coverage.

State and Federal Notifications

The provider must report each serious occurrence to both the State Medicaid agency and Disability Rights advocates. Serious occurrences that must be reported include:

- resident's death;
- serious injury to a resident; and
- resident's suicide or attempt.

"Serious injury" means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

The facility must report any serious occurrence involving a resident to the Department of Social Services via secure email to prtfreports@state.sd.us and to Disability Rights South Dakota via secure email to prtfreports@DRSDlaw.org by end of the next business day following the event. In addition, all runaways must be reported to DSS via secure email box to prtfreports@state.sd.us. If the serious injury results in death, that incident must be reported by close of the next business day to CMS Region VIII. All incidents must be reported no later than 24 hours after the event to the parents or guardians of residents under 18.

Requirements for Continued Stay

A recipient's continuous and uninterrupted stay in a facility is a covered service if the Certification Team determines, based on the child's progress report required by ARSD 67:42:08:07 or ARSD 67:42:15:11, that all of the following conditions are met:

- The recipient is actively participating in the treatment;
- The recipient continues to require the authorized level of care and is not able to function or use outpatient care as reflected in the medical record;
- The recipient is complying with the recommendations made by the treatment team; and
- The recipient's daily progress notes show improvement towards the goal of discharge.

The Continued Stay Form along with all other applicable records to substantiate the requirements must be submitted to:

South Dakota Foundation for Medical Care
2600 West 49th Street
Sioux Falls, SD 57105
Phone: 605-336-3505
Fax: 605-773-0580

Termination of Coverage

An individual's care becomes a noncovered service when the Certification Team determines that one of the following has occurred:

- The recipient has reached maximum potential in the current setting;
- The facility failed to submit the Continued Stay Form; or
- The recipient is no longer eligible.

Substance Use Disorder (SUD) Treatment

PRTFs accredited by the Office of Licensing and Accreditation and enrolled with Medicaid as a substance use disorder treatment agency can provide medically-monitored intensive inpatient treatment program services. SUD treatment services must be provided in accordance with the provisions of this manual and the applicable provisions of the Substance Use Disorder Agency Services Manual.

Prior Authorization

PRTF SUD services require prior authorization and must meet the following requirements:

- An addiction counselor completes an integrated assessment, the assessment indicates a diagnosis of a substance use disorder, and the addiction counselor determines the adolescent meets the criteria for placement in, transfer to, or continued stay in a substance use disorder treatment program;
- A physician or other licensed practitioner refers the adolescent for placement in, transfer to, or continued stay in a substance use disorder treatment program;
- The Division of Behavioral Health receives the referral and coordinates with the Certification team;
- The Certification Team determines if the treatment is medically necessary, based on medical documentation.

The Certification Team will notify the Division of Behavioral Health of their determination that medical necessity has been met or if the adolescent does not meet the severity of illness criteria.

Adolescent recipients may be admitted without prior authorization in cases of emergency or when staff are unavailable (example: evenings, weekends, holidays). The complete integrated assessment may not be available in cases that require emergency admission.

- The referring agency should send written documentation via email to SUDreferrals@state.sd.us briefly outlining the reasons supporting the need for placement within 24 hours of the admission. This should include any screenings utilized that support the need for emergency admission.
- The admitting agency must complete the integrated assessment in accordance with ARSD 67:61 within 10 days and submit it to the South Dakota Foundation for Medical Care (SDFMC) for authorization of funding, including the additional required documentation (Release of Information, Financial Eligibility Form, High Intensity Referral Form, and the Doctor's Referral if recipient is Medicaid Eligible).
- Upon review, if the documentation supports the clinical necessity for admission, the prior authorization will be back dated to the date of the initial written submission. If the

documentation does not support clinical necessity for admission to the PRTF SUD Program, prior authorization of funding will not be done.

NON-COVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

PRTF Non-Covered Services
The following are not reimbursable:

- The day of discharge;
- Days the individual is in a juvenile detention center; and
- Days when the individual is absent from the facility for nonmedical reasons.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
A PRTF reimbursement rate is provider specific and established by South Dakota Medicaid. South Dakota Medicaid bases the rate on the facility's allowable cost for existing providers or on prospective cost statements for a new provider. Allowable costs centers include salaries and benefits for facilities' personnel, payroll taxes, professional fees and contract services, travel/transportation, supplies, occupancy, equipment, depreciation, and other.

Out-of-State Facilities

South Dakota Medicaid reimburses out-of-state Psychiatric Residential Treatment Facilities (PRTFs) using the following methodology:

1. Cost-Based Rate Determination – Out-of-state services are generally deemed "extraordinary" due to the recipient being unable to be served in South Dakota. In these circumstances, South Dakota Medicaid may establish a per diem rate based on the facility's allowable cost of providing services. Rates determined under this methodology may not exceed the allowable cost of services provided by the facility.
2. Home-State Medicaid Rate – If the facility has not complied with the cost reporting requirements to establish a cost-based rate, the rate established by the Medicaid agency in the state where the facility is located for comparable services will be utilized for reimbursement.
3. Average South Dakota PRTF Rate – If a rate for a facility rate cannot be established under item 1 or 2, the average of the per diem rates in effect for in-state South Dakota PRTFs at the time services are first provided will be utilized for reimbursement.

Cost Report Submission Requirements for Cost-Based Rate Consideration

To ensure compliance with the South Dakota Medicaid State Plan and to appropriately evaluate rates determined by cost, providers seeking reimbursement based on cost to submit one of the following:

- A completed CMS-2552-10 Medicare Cost Report; or
- A completed Simplified PRTF Cost Report Template developed by Provider Reimbursement & Audits (PRA)
    - Available on the Department of Social Services (DSS) website at: https://dss.sd.gov/medicaid/providers/costreports/default.aspx

The most recently submitted cost report on file as of March 31st annually will be used to calculate rates for the upcoming rate period. Cost reports received after March 31st may not be used for the upcoming rate period and may result in the prior year's cost report being used for rate determination.

Cost reports may be submitted via:

- Postal mail; or
- Electronic submission to: DSSFinancePRA@state.sd.us

Failure to submit the required cost report may result in the provider not being eligible for a cost-based rate determination and reimbursement may instead be determined under one of the alternative methodologies described above.

Substance Use Disorder Treatment

PRTF SUD treatment services are reimbursed in accordance with the Substance Use Disorder fee schedule.

Claim Instructions

Claims for PRTF services must be submitted on a CMS 1500 claim form or via an 837P electronic transaction. PRTF services must be billed using HCPCS code T2048. PRTF SUD treatment services must be billed using HCPCS code H0019 with the HA modifier. Detailed claim instructions are available on our website.

DEFINITIONS

1. "Certification Team," a team of medical professionals that determines whether an individual is in need of psychiatric services;

2. "Department," the Department of Social Services;

3. "Juvenile detention center," a locked facility operated under the authority of a county that houses children who have been convicted or accused of violating South Dakota law;

4. "Outpatient care setting," professional services provided at a participating facility that does not include room, board, or services provided on a 24-hour basis;

5. "Placing agency," the agency or individual responsible for referring a person to the State Review Team for possible placement into a residential treatment setting;

6. "Provider," a facility described in ARSD 67:16:47:02 or 67:16:47:03 that has entered into an agreement with the department to provide residential treatment services under the provisions of this chapter; and

7. "Treatment Team," the team established under the provisions of ARSD 67:42:08:05 or 67:42:15:09, as applicable, that plans, provides, and monitors services to a child in residential care and the child's family.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Is a SUD PRTF responsible for medical care the recipient receives while a resident of the PRTF?**

   The reimbursement rate for SUD PRTFs includes the cost of routine acute and preventative medical care services the recipient receives while he or she is residing at the facility. Examples include evaluations and management services and immunizations. Nonroutine services such a prenatal services and services related to chronic diseases are not included in the reimbursement rate. Nonroutine services are separately billable to South Dakota Medicaid by the medical provider that rendered the services.

2. **How should a PRTF bill for services provided under a Care Coordination Agreement with Indian Health Services?**

   When a child is referred for PRTF services by Indian Health Services under a Care Coordination

Agreement, the PRTF must document the referral in the medical record. The facility must share records with IHS on a monthly basis; records may be sent to the coordinating IPA nurse if appropriate. The PRTF should coordinate discharge with IHS and the appropriate IPA nurse to ensure continuity of services upon discharge. The PRTF must bill for services referred by IHS by placing the referring information in block 17 and 17b of the CMS 1500 form. The referral information must be populated in Loop id 2310A in an 837P transaction.

3. **Can a PRFT bill for home visit days? Is there a limit to the length of or number of visits?**

   Home visits should be determined by the medical team based on what is appropriate and safe as part of the plan of care and to meet an individual's goals. Days when a recipient is away from the facility for nonmedical reasons are not covered. There is no limit on the length of a home visit. Continued coverage of PRTF services is in accordance with meeting the Requirements for Continued Stay section of this provider manual.