Medicaid and Long-Term Care
Questions and Answers for Facilities about Institutions for Mental Diseases (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), Therapeutic and Child Welfare Group Homes.

Please refer to the Centers for Medicare and Medicaid Services (CMS) Regulations that were given to all providers at the 9/15/2010 training.

General IMD/PRTF Questions
1) Are all IMDs PRTFs? Are all PRTFs IMDs?

(State Medicaid Manual 4930. Institutions for Mental Diseases [IMDs]) — An IMD is defined in the original Medicaid legislation P.L. 100-360 as an institution for mental diseases; a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can become a PRTF if they meet the CMS regulatory requirements of a PRTF. These facilities are not IMDs because IMDs are defined to be institutions with more than 16 beds. Therefore, not all PRTF’s are IMDs.

Similarly, not all IMDs are PRTFs. PRTFs are non-hospital accredited and physician-directed facilities meeting Medicaid PRTF requirements to provide inpatient psychiatric care. While services may be rendered to individuals of any age in a PRTF, Medicaid will only pay for services delivered to individuals under age 21 meeting medical necessity criteria. As noted above, an IMD can be a hospital, nursing facility or other large facility of more than 16 beds, which encompasses more facilities than just PRTFs.

2) Will all of the providers that want to be a PRTF have to be in place by July of 2012?

Yes, existing facilities must have made a decision to be a PRTF, be enrolled and working toward compliance with the PRTF guidelines by July 2012. In early 2011, the gap analysis and cost reports will be completed and PRTF rates will be set and finalized. In May 2011, the Department of Health and Human Services (DHHS) Medicaid and Long-Term Care will be
meeting with facilities to discuss reimbursement methodology and by July 1, 2011, DHHS will implement the State Plan amendment and regulations requiring all PRTF providers to be in compliance with CMS regulations by July 1, 2012. DHHS will be assisting facilities to become compliant between July 1, 2011 and June 30, 2012. Facilities that are not compliant by July 1, 2012 will no longer be reimbursed by Medicaid.

3) Is it so, that an IMD (facility with over 16 beds) cannot have a youth in the program at the same time that a youth is residing at the facility through a letter of agreement? Would this also apply to out-of-state PRTF’s (San Marcos, Heartland, KVC PRTFs)?

If a Medicaid eligible child is in an IMD (facility over 16 beds) and that IMD does not meet PRTF requirements and/or the child does not have a Certification of Need issued by Magellan, then Medicaid would not pay for any medical services for that child while they are in the IMD.

DHHS will apply the same PRTF requirements to all PRTFs regardless of location. Our goal is for all children to be served within the state. However, should an individual case arise that requires specialized PRTF services, DHHS reserves the right to negotiate for that individual child’s medically necessary care.

4) How will room and board be paid for in the PRTF?

The room and board for PRTFs will be included in the per diem.

5) Are physician and pharmaceutical services included in the Per Diem?

No, they are not. All treatment activities performed in and by the PRTF for services on the Active Treatment Plan (per 42 CFR441.154 and CFR441-555), except for pharmaceutical and physician services, are included in the per diem. Pharmaceutical and physician services on the Active Treatment Plan and provided in and by the PRTF may be billed separately. Medicaid reimbursement for pharmaceutical services provided in the PRTF and on the Active Treatment Plan to eligible recipients shall be paid separately, apart from the PRTF per diem rate and in accordance with the reimbursement policies for pharmacy. Medicaid reimbursement for physician services provided in the PRTF and on the Active Treatment Plan to eligible recipients shall be paid separately, apart from the PRTF per diem rate and in accordance with the reimbursement policies for physicians. Facilities and providers, including physicians and pharmacies, will receive billing guidance outlining the prohibitions of billing Medicaid for services to residents of PRTFs that are not on the Active Treatment Plan or are not provided by and in the facility.
6) How are emergency medical services paid for in the IMD or the PRTF?

The per diem rates will be established with the understanding that emergencies will occur. Medicaid will pay for services that are provided in the facility, by the facility and on the Active Treatment Plan. Services not anticipated and not included on the Active Treatment Plan (e.g., emergency room or physician office visits for infections or broken bones) and those that are not provided in and by the facility, will be the responsibility of the family or the legal guardian.

7) Can facilities include patterns of known behaviors and responses on the Active Treatment Plan? An example would be that the facility has the knowledge that this youth will cause him/herself physical pain when stressed that will require emergency medical care?

Any medical treatment that can be anticipated by the PRTF and is on the Active Treatment Plan will be paid for by Medicaid if provided in and by the facility. Inpatient stays or injuries that require emergency room treatment cannot be paid for as they are unable to be provided by and in the facility and cannot be anticipated. There will be billing guidance to physicians and pharmacies that specifies treatment and/or drugs not on the Active Treatment Plan and not provided by and in the facility cannot be billed to Medicaid. Any physician service on a claim with a place of service other than the PRTF cannot be reimbursed by Medicaid.

8) Will there be start-up funds available for the facilities that transition to PRTFs?

Medicaid has no start-up funds for facilities that are becoming PRTFs.

9) How will rates be determined for PRTFs and Therapeutic Group Homes?

To support the PRTF rate development, DHHS, with assistance of a consultant, has developed an expense report to collect the data to support the development of the rates. Facilities are currently in the process of completing the expense report. The report was designed to gather consistent information from all facilities. The results of the expense report will serve as a primary data source in the development of the PRTF and Therapeutic Group Home rates. Rates will also include consideration for medical costs associated with activities on the Active Treatment Plans anticipated to be incurred by the facilities, such as lab and therapy services.

10) When can providers expect this to be happening?

DHHS staff issued a final expense report template to providers on November 24, 2010 and conducted training on how to complete the report on November 30, 2010. Facilities had until February 8, 2011 to submit their expense report documentation. It is anticipated that PRTF rates will be shared with providers during May 2011. PRTF’s must be working to become compliant between July 1, 2011 and June 30, 2012. Facilities must meet all PRTF
requirements by July 1, 2012, including physician direction, Active Treatment Plan, seclusion and restraint, etc.

11) Will the rates vary from facility to facility, and will there be an estimated unbundled room/board charge that will need to be absorbed by the contract providers?

The State is analyzing the cost reports of all facilities and will establish rates for hospital-based PRTFs, non-hospital-based PRTFs and Therapeutic Group Homes. The PRTF per diem will include all medical services that can be anticipated, are on the Active Treatment Plan and provided in and by the PRTF. The PRTF per diem will include room and board. The Therapeutic Group Home per diem will not include consideration for room and board. The parent or legal guardian will be responsible for the room and board for youth residing in a Therapeutic Group Home.

12) When can providers expect the results of the gap analysis to be available to them?

It is expected that Eric Sergeant, Medicaid and Long-Term Care will be scheduling appointments with each facility to review the results of the gap analysis in March.

13) Will there be different per diem rates for the hospital-based PRTFs and the community-based PRTFs?

Yes, there will be different per diem rates for the hospital-based PRTFs and the community-based PRTFs. The rates will consider the expense report information and other claims data previously gathered by Mercer for the PRTFs and Therapeutic Group Homes. A document titled “Psychiatric Residential Treatment Facility: Required Activities by Facility Type and Corresponding Reimbursement Structure” was sent to providers by Eric Sergeant, Medicaid and Long-Term Care in the second week of January. Included in this document is information on items reflected in the PRTF per diem rates.

14) Is routine medical care/treatment to be on the Active Treatment Plan?

(State Medicaid Manual 4930) — PRTFs are required to ensure that all medical, psychological, social, behavioral and developmental aspects of the recipient’s situation are assessed and that treatment for those needs is reflected in the Plan of Care, per 42 CFR 441.155. In addition, the PRTF must ensure that the resident receives all treatment needed for those identified needs. For services provided by and in the facility that can be reasonably anticipated on the Active Treatment Plan, the PRTF must ensure that the resident receives all services identified on the Active Treatment Plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the recipient’s situation.
15) How can the hospital-based provider be penalized if they currently do not provide dental and vision services?

*Updated 09/09/11*

Generally speaking, our intent is not to “penalize” providers but rather to insure that our clients have quality services. A child who has a tooth ache or is unable to see to read will not gain the full benefit of this intensive level of MH/SA therapy. Mobile services that are brought to the facility are an acceptable alternative to providing the services directly. Medicaid will be responsible for the payment of these services, not Child Welfare, and as such the services must be on the active treatment plan and delivered in the facility for hospital-based PRTFs.

If it is a hospital based PRTF, dental services are included in the per diem, and they need to be on the active treatment plan. Mobile dental units that come to the PRTF would qualify the dental service as being delivered in the PRTF by the PRTF. If the dentist is a physician, (some are, some are not), they could bill Medicaid separately from the per diem service as is the case with all physicians. If the service rendering dentist is not a physician the dental service would be considered part of the PRTF per diem payment.

16) If a facility is to draw what is needed for the lab “in” and “by” the PRTF, can the actual processing of the sample be done outside of the facility?

Yes, the lab processing and interpretation of results may be done outside of the PRTF and be paid for in the per diem. The PRTF will need a contract/formal arrangement between the facility and the lab that is responsible for processing and interpreting the results. No lab services can be billed directly to Medicaid. These services are included in the per diem.

17) Can facilities use “extenders” to provide the medical?

Psychiatrically trained physician extenders may not supervise services in place of a psychiatrist or physician. In addition, physician extenders may not be used to provide physician direction under federal law and regulations found at 42 CFR 440.160(a). When regulations require a “physician” to provide the service, a physician extender cannot be used.

Per 471 NAC 32-001.04, physician extenders may provide direct care as allowed by the scope of practice guidelines set by the Nebraska DHHS, Division of Public Health, and the practice agreement of each individual. Physician extenders include physician assistants and nurse practitioners. Physician costs are excluded from the per diem and can be billed separately, while physician extenders are included in the per diem.
18) Can youth see a psychiatrist for the Initial Diagnostic review through tele-health?

No, they cannot. The State Medicaid Manual, under 4320, states that “a physician must see the patient at least once, prescribe the type of care provided, and if the services are not limited by the prescription, periodically review the need for continued care.”

19) Does physician refer to only the psychiatrist? If a patient needs to see a primary care physician can that be billed by the primary care physician?

Physician refers to any MD working within his or her scope of practice. When determining what can and cannot be billed to Medicaid, note that physician services which can be anticipated must be on the active treatment plan and can be billed separately by the physician. Physician services which are not on the active treatment plan cannot be billed to Medicaid. Additionally, all treatment must occur “in and by” the PRTF. Therefore, if a patient needs to see a primary care physician it can be billed to Medicaid by that primary care physician only if the need for the care is on the active treatment plan and if the care is delivered in the PRTF.

20) Can an APRN be used to complete physical exams upon admission?

The team conducting the initial assessment and evaluation must include, as a minimum, either –

(1) A Board-eligible or Board-certified psychiatrist;
(2) A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or
(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 who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association.

The team must also include one of the following:

(1) A psychiatric social worker
(2) A registered nurse with specialized training or one year’s experience in treating mentally ill individuals
(3) An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals
(4) A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association

The physical exam for a youth in the PRTF must be completed by the team which may include an APRN. The assigned team must provide the initial physical exam and participate in the initial plan of care. Each youth must have a physician assigned to them that is
responsible for the physical care and treatment plan for their youth. After the initial physical, the assigned physician may utilize an APRN to provide some services, as directed by scope of practice, to the youth in his/her absence. The physician maintains the responsibility for assuring the needs of the youth are met and that the services are consistent with the youth’s treatment plan. The assigned physician has final responsibility for appropriate medical follow-up for the youth assigned to him/her. The physician must also be a part of the team conducting the required 30 day reassessments.

21) How is “clinical” staff defined?

Clinical staff includes Physician, Psychiatrist, Psychologist, LIMHP, LMHP, PLMHP, PPhD or LDAC. Public health regulations define clinical staff as any licensed staff practicing within their scope of practice.

22) Does each facility have to be licensed separately?

How facilities are licensed is decided by the Division of Public Health. In Nebraska, facilities in separate locations are licensed separately. Licensure may help to define whether multiple facilities are part of a single institution.

23) If Magellan currently approved for a patient to be in the facility, will they continue to approve for transportation costs for families to come for therapy and family care meetings?

Transportation for families to attend therapy and family care meetings at the facility will not be billed separately for youth in PRTFs. Transportation services for the family included on the Active Treatment Plan will be the responsibility of the PRTF and consideration for these expenses will be included in the per diem rate. Additionally, there are wider changes to transportation taking place on May 1, 2011, when the transportation brokerage (ARM) takes over the authorization process. (See PROVIDER BULLETIN No. 11-07 http://www.dhhs.ne.gov/med/pb/pb1107.pdf ). Transportation for the child to services provided by and in the facility (e.g., from one facility to another) is included in the per diem. However, transportation for the child to community based services is excluded from the per diem.

Scenarios

24) Can an IMD facility break apart their over 17 bed unit into two units of 8 or 9 residents to avoid becoming an IMD?

Presuming the facilities would still be on the same campus, share the same medical director, clinical staff and operational functions, then “breaking the one unit of 17 beds or more into two separate facilities” would not change the institutions IMD status numbers. Federal definitions apply to all institutions and facilities in the same manner. The total combined beds on a campus, is one of the identifying factors in determining if the facility is an IMD.
25) Are there different rules that may apply to a 16 bed and under PRTF?

No, there are not. It is possible to have a PRTF with 16 beds or less, but the PRTF would still have to comply with all of the PRTF rules that the larger IMDs comply with to receive Medicaid funding. There are no separate rules that apply for PRTFs with 16 beds or less. Medicaid will have a single set of rules governing the operations of PRTF facilities. Providers may seek federal Medicaid reimbursement for emergency services provided to residents of PRTF facilities with 16 or fewer beds.

Every facility with 17 beds or more would be an IMD and would need to become a PRTF to obtain Medicaid funding for 24-hour care delivered to youth. However, a facility with 16 beds or less does not need to be a PRTF.

26) If a facility is an IMD, yet has two additional, yet geographically separate facilities, each of which are less than 17 beds, are the outlying facilities considered PRTFs?

If the outlying facilities share a medical director, clinical staff or administration, staff for lawn, laundry, facility maintenance, or food service with the IMD, they are part of the single institution and considered to be PRTFs. If the outlying facilities separate themselves from the IMD (e.g., do not share a medical director, clinical staff or administration, staff for lawn, laundry, facility maintenance, or food service), each facility could choose to be a PRTF or a Therapeutic Group Home, independent of the IMD. Note that each facility would be judged upon its own merits and would need to separately comply with facility requirements to determine if it individually meets PRTF, Therapeutic Group Home or Child Welfare Group Home requirements.

27) If a hospital-based IMD has a physician and psychiatrist on staff, would the facilities that are at a different location be able to utilize the services of the doctors at the location of the hospital?

If the outlying facilities are part of the single institution, they may utilize the doctor at the location from which the doctor is primarily located (e.g., the IMD). In this case, the services should be considered “in the facility, by the facility.”

If the outlying facilities are independent of the IMD (e.g., NOT part of the single institution), they may not utilize the doctor at the IMD. If the facility were to utilize the doctor who primarily worked at the IMD, this would be considered shared clinical staff and the outlying facility would then become part of the single institution.
28) If a provider has a Child Welfare Group Home on the campus of a community-based PRTF, is the Child Welfare Group Home going to need to become a PRTF?

If a Child Welfare Group Home is on the campus of a PRTF, it is a part of the IMD and must meet the PRTF requirements and accept referrals with the PRTF level of acuity to get Medicaid reimbursement. The Child Welfare Group Home would become part of the PRTF and would need to meet Medicaid pre-certification and medical necessity requirements for an inpatient psychiatric level of care for any Medicaid funding to be available for services to residents.

29) How will a facility that has day treatment as part of their programming be paid?

If a facility delivers Day Treatment services to youth who are not living on campus, the facility can bill Medicaid for the Day Treatment level of care. However, if the youth is residing in the facility, the activities associated with the day treatment program are considered part of the PRTF service and payment for these activities is included in the per diem.

**Therapeutic Group Home/Child Welfare Group Home**

30) What evidence-based practice is being looked at?

Medicaid long-term care staff is looking at a community-based, crisis-oriented Therapeutic Group Home model that emphasizes maintaining community connections. This model is emerging as a promising practice and reflects ‘practice-based evidence’ in that the model incorporates many promising elements of successful community-based models. Since Therapeutic Group Home is not in itself a specific research-based model, it must instead incorporate research-based models developed for a broader array of settings that respond to the specific problems of the clients served. Each Therapeutic Group Home should incorporate appropriate research-based programming for both treatment planning and service delivery. Programs should also incorporate some form of research-based, trauma-informed programming and training if the primary research-based treatment model used by the program does not.

Facilities will submit an annual audit conducted by a mutually agreed upon third party that demonstrates fidelity to the evidence or research-based practice.

31) How will room and board be paid for in the Therapeutic Group Home or the Child Welfare Group home?

Payment for room and board with the Therapeutic Group Home is not the responsibility of Medicaid. It is the responsibility of the parent or legal guardian of the youth. For Child Welfare Group Homes not meeting IMD criteria, room and board will continue to be paid as done currently.
32) **Who do facilities talk to if they want to become a Child Welfare Group Home?**

Facilities should discuss the possibilities with their Protection and Safety Contract liaison (or equivalent) or the Families Matter lead agency in the service area in which they reside.

33) **What is the criterion for Therapeutic Group Home?**

The Therapeutic Group Home model was distributed to providers for comment on January 4, 2011. Medicaid is currently in the process of preparing responses to the comments and questions from providers. Once a model has been established in March, criteria for that level of care will be developed.

*Change Log:*
03/07/11 Original Posted
[...]
09/09/11 Updated #15, added change log