Kansas
Department of Health and Environment
Division of Health Care Finance

KANSAS MEDICAL ASSISTANCE PROGRAM

Fee-for-Service Provider Manual

Psychiatric Residential Treatment Facility

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PART II
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
FEE-FOR-SERVICE PROVIDER MANUAL

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DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

PART II
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
FEE-FOR-SERVICE PROVIDER MANUAL

Updated 12/17

This is the provider specific section of the manual. This section (Part II) provides instructions, limitations, and requirements specific to Psychiatric Residential Treatment Facility (PRTF) providers. It is divided into the following subsections: Billing Instructions, Benefits and Limitations, and Appendix. Part I of the provider manual consists of five parts: General Information, General Benefits, General Billing, General Special Requirements, and General TPL Payment. Part I contains information that applies to all providers, including PRTFs.

The **Billing Instructions** subsection gives instructions for completing and submitting the billing forms applicable to PRTF services.

The **Benefits and Limitations** subsection defines specific aspects of the scope of PRTF services allowed within the Kansas Medical Assistance Program (KMAP).

The **Appendix** subsection contains information concerning codes. The appendix was developed to make finding and using codes easier for the biller.

Confidentiality & HIPAA Compliance
Providers shall follow all applicable state and federal laws and regulations related to confidentiality as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider is required to supply records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by the Kansas Medicaid Fraud Control Act; citation. K.S.A. 2017 Supp. 21-5925 through 21-5934 and K.S.A. 2017 Supp. 75-725 and 75-726, and amendments thereto.

7000. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY BILLING INSTRUCTIONS
Updated 12/17

PRTF providers must use the CMS Claim 1500 or electronic equivalent when requesting payment for medical services provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

Examples of the CMS 1500 Claim Form and instructions are available on the KMAP public and secure websites on the Forms page under the **Claims (Sample Forms and Instructions)** heading.

Additional instructions for completion of the CMS 1500 Claim Form are available in **Section 5800** of the *General Billing Fee-for-Service Provider Manual*.

Any of the following billing errors may cause a CMS 1500 claim to deny or be sent back to the provider:

- Sending a CMS 1500 Claim Form carbon copy.
- Sending a KanCare paper claim to KMAP.
- Using a PO Box in the Service Facility Location Information field.

For individuals residing in a PRTF, who have private insurance:

- The provider must bill the primary insurance first.
- The information obtained from the private insurance's explanation of benefits (EOB) will need to be included when billing the professional claim to Medicaid.

Providers should submit claims for the full amount. Client obligation and private insurance payment(s) are deducted automatically from payment during claims processing.

Submission of Claim

Send completed claim and any necessary attachments to:

Office of the Fiscal Agent
PO Box 3571
Topeka, Kansas 66601-3571

7010. PRTF SPECIFIC BILLING INFORMATION Updated 10/18

Place of Service Code

The only place of service code accepted on a PRTF claim is 56 with procedure code T2048 as the service billed. When billing for reserve days, modifier UC must be appended to procedure code T2048.

Prior Authorization Dates of Service

Dates of service billed must be within the dates of service approved by the prior authorization. Dates of service billed are not allowed to span two approved prior authorization periods. If procedure codes are authorized under different prior authorizations, separate detail lines on the claim form must be completed.

Client Obligation

For individuals residing in a PRTF, who have a client obligation:

- Providers are responsible for collecting the client obligation.
- The private insurance payment does not replace the client obligation payment.

Evaluation and Management Services

Effective with claims processed on and after November 1, 2018, Evaluation and Management (E&M) services will be covered when provided in a PRTF when billed using the appropriate place of service code of 56. The diagnosis codes used in billing will determine whether the service is deemed medically necessary.

7020. MS-2126 BILLING INSTRUCTIONS Updated 11/17

Introduction to the Notification of Facility Admission/Discharge MS-2126

The completion of the MS-2126 (Notification of Nursing Facility Admission/Discharge) must be done by the provider. The facility retains the original MS-2126 and submits a copy to the KanCare Clearinghouse.

Providers do **not** have to complete the MS-2126 for payment of a reserve day.

Note: This form must be copied or duplicated by providers since the fiscal agent does not furnish the form to providers.

The form and instructions are located on the KMAP website under the Publications tab on the Forms page.

When to Use the MS-2126

Sections I, II, and III

Facility placement/discharge, shall be initiated by the facility when:

- An eligible KMAP individual is admitted to or discharged from the facility.
- A resident of a PRTF becomes eligible for KMAP.
- An eligible KMAP individual transfers from one facility to another facility.
- A resident's KMAP eligibility is reinstated after suspension.

Section IV

This section is not used by the PRTF. Completion of this section is **not** required for approved leave days.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Issued 07/07

PRTF services are exempt from copayment requirements.

8300. BENEFIT PLANS Updated 11/17

KMAP individuals are assigned to one or more KMAP benefit plans. The benefit plan entitles the individual to certain services. If providers have questions regarding service coverage for a particular benefit plan, refer to **Section 2000** of the *General Benefits Fee-for-Service Provider Manual* for eligibility verification.

PRTF services are not covered under the current MediKan program.

8400. MEDICAID Updated 11/17

PRTF services must provide active treatment in a structured therapeutic environment for children and youth with significant functional impairments resulting from an identified mental health diagnosis, substance abuse diagnosis, or a mental health diagnosis with a co-occurring disorder (for example, substance related disorders, mental retardation/developmental disabilities, head injury, sexual misuse disorders, or other disabilities which may require stabilization of mental health issues). Such services are provided in consideration of a child's developmental stage.

Criteria

Providers must provide services in accordance with an individualized treatment plan under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the individual's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 C.F.R. Secs. 441.154 through 441.156.

Individuals receiving these services must be assessed by a licensed mental health practitioner (LMHP) or physician independent of the treating facility, using an assessment consistent with state law, regulation, and policy. Using this assessment, a community based services team (CBST), which complies with the requirement of 42 C.F.R. Sec. 441.153, must certify in writing their determination of the medical necessity of this level of care in accordance with the criteria and requirements outlined in 42 C.F.R. Sec. 441.152. Also, the need for this level of care must be shown by meeting all of the following circumstances:

- A substantial risk of harm to self or others, or a child or youth who is so unable to care for his or her own physical health and safety as to create a danger to his or her life.
- 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.
- All other ambulatory care resources available in the community have been identified, and if not accessed, determined not to meet the immediate treatment needs of the child or youth.
- Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.

Provider Requirements

KMAP grants a provider of PRTF services approval for enrollment as an active PRTF provider in KMAP following the receipt of a letter from the Kansas Department for Aging and Disability Services (KDADS), stating that the provider has met the qualifications or licensing requirements to deliver such services.

Providers are required to meet the PRTF service standards. To enroll as a KMAP provider, download enrollment material from the KMAP website (https://www.kmap-state-ks.us) or contact Provider Enrollment at 1-800-933-6593, option 3.

Provider Requirements (continued)
This process consists of applying for licensure approval from KDADS and submitting a provider enrollment application to KMAP.

You may contact either entity at the following addresses:

KDADS
Attn: BHS Children's Inpatient Systems Manager
503 South Kansas Avenue
Topeka, KS 66603-3404
785-296-1809

KMAP Provider Enrollment
Office of the Fiscal Agent
PO Box 3571
Topeka, KS 66601-3571
1-800-933-6593, option 3

Prior Authorization
Any Medicaid individual (child) presenting for PRTF admission consideration must be assessed for appropriateness of this level of care. The managed care organizations (MCOs) are responsible for the collection and evaluation of information necessary to determine medical necessity and authorization of PRTF admission or diversion/community services or both and the management of these services.

Effective with dates of service on and after June 15, 2017, Medicaid-covered individuals (children) presenting for PRTF admission consideration must be assessed for medical necessity for this level of care. If necessary, the collection and evaluation of information for authorization of services or community alternatives is considered an MCO administrative function.

If the child has no prior history of services or adequate information cannot be obtained from a Community Mental Health Center (CMHC) or private clinician, then the MCO can request that a CMHC or private clinician complete a Psychiatric Diagnostic Evaluation using codes 90791 or 90792. These codes can only be billed once per day and both cannot be billed in the same day. Additionally, a Community Based Service Team (CBST) meeting can be requested by the MCO using H0032-HA.*
*This code is only billable by a CMHC.

The CMHC or private clinician shall submit the Psychiatric Diagnostic Evaluation and/or the CBST results to the MCO. The MCO shall utilize assessment to determine medical necessity for admission to a PRTF. The MCO will begin their utilization management process by applying their criteria for medical necessity. If the MCO determines that the child meets medical criteria for placement in a PRTF, the MCO can either approve the child for placement in a PRTF or authorize community-based services to be provided.

Any Medicaid individual (child) presenting for PRTF admission consideration must be assessed for this level of care. The MCOs are responsible for gathering the information necessary to determine medical necessity and authorization for this level of care.

1. A KanCare child presents to an MCO for PRTF consideration through various means.
2. The MCO determines if further information is needed to determine medical necessity, diversion opportunities, or both.
    a. If additional information is NOT needed, the MCO determines medical necessity, diversion, or both.

b. If additional information is needed and already in the system, the MCO gathers the information to determine medical necessity, diversion, or both.
   - The MCO requests the existing information on the individual through a standardized request form.
     Note: This is an MCO Administrative Function – funded by the MCO.
   - The provider, CMHC, or other clinician completes the information form and submits it to the requesting MCO.

c. If additional information is needed and the information is not in the system, the MCO gathers the information to determine medical necessity, diversion, or both.
   - The MCO requests a psychiatric evaluation, CBST, or both as necessary in order to determine medical necessity, diversion, or both.
     Note: This is an MCO service – funded by the State Plan.
     If the child has no prior history of services or adequate information cannot be obtained from a CMHC or private clinician then the MCO can request that the CMHC or private clinician complete a Psychiatric Diagnostic Evaluation using codes 90791 or 90792. An MCO can request a CBST using code H0032-HA from a CMHC. All of these codes are defined as "per evaluation".
   - The provider, CMHC, or other clinician completes and submits the evaluation, CBST, or both to the requesting MCO.

3. If the MCO determines the need for medical necessity or diversion:
   a. If medical criteria are met and the individual is eligible for PRTF planned treatment, the individual is admitted to a PRTF and their care is managed by the MCO.
   b. If medical criteria are met and diversion is recommended, the community-based services are authorized and managed by the MCO.
   c. If medical criteria is not met and diversion is recommended, the community-based services are authorized and managed by the MCO.

Discharge Planning

Discharge planning for the residents shall begin as soon as possible upon admission to the PRTF. This process should include the CMHC staff where the youth will be discharging to (if determined); the treatment team and other facility staff; and the resident and their legal guardian (when possible). The CMHC and the legal guardian should remain in contact with the facility treatment team to assist in any transition discharge planning. Discharge criteria will be established when writing the plan of care.

Prior to discharge, the PRTF shall submit documents related to the resident's care in their facility to any mental health provider who will be providing aftercare. The key components on these documents include:

- Medical needs including allergies
- Medications: dosage, clinical rationale, prescriber
- Discharge diagnosis
- Prevention plan to address symptoms of harm to self or others
- Any other essential recommendations
- Appointments with service providers after discharge including the date, time, and place
- Contact information for internal providers
- Contact information for CMHC/PRTF liaisons

- CMHC Crisis Line number
- PRTF education provider's contact number

Note: For any resident who is currently receiving or who previously received psychotropic medication during their stay, the clinical rational for each medication shall be clearly documented on their psychiatric discharge summary or final evaluation. The reason for discharge will also be clearly stated on the discharge summary.

Residents on psychotropic medication must leave the facility with the following:

- A prescription written for at least a 30-day supply of medication
- A minimum supply of 3 days of medication

The expectation is that the PRTF will receive notification 10 days before the child must leave the PRTF to ensure proper discharge planning. If the discharge must occur sooner than a 10-day notification, it is the responsibility of the PRTF in conjunction with the custodial case manager or community case manager to ensure that the proper persons are notified of the resident's pending discharge, including the discharge date, and to assist with appointment setting in the community. The PRTF must ensure proper identification of individuals who pick up the resident upon discharge.

Payment of PRTF Reserve Days

Reserve days, for periods of absence from a PRTF, will be reimbursed to providers with prior approval.

Effective with dates of service on and after April 15, 2017, providers must use procedure code T2048 with modifier UC when billing reserve days for individuals in a PRTF.

An individual is considered present at the facility for an entire day if the individual is at the facility at 11:59 p.m. The facility should take an individual specific census at this time and ensure the facility's business manager has a record of which individuals are present in the facility on any given day and can accurately track reserve days for each individual.

Reserve days shall be defined when an individual is absent from a PRTF for more than 24 hours. PRTFs will be reimbursed for reserve days at 100% of the facility-specific per diem rate. The resident's plan of care shall provide supporting documentation indicating frequency, duration, and location of each reserve day along with specific documentation of PRTF administrative activities during the reserve day period.

Payment for reserve days shall be approved for days in which it is necessary to reserve a bed in a PRTF when the resident is absent for any of the following reasons:

- Medical appointment
- Hospital admission for a medical condition
- Home visit
- Court appointment
- Supervised visitation
- Other approved visitation indicated in the resident's plan of care
- Personal business (such as a funeral, wedding, or graduation)

There is no limit to the number of reserve days the individual can have during a calendar year.

8400. MEDICAID Updated 12/17

There are certain limitations for each episode for visitation days and other covered absences:

Visitation days
When indicated in the child's treatment plan (within the total number of days approved for the child's stay), a maximum of seven days per visit is paid at the contracted per diem rate. The frequency, duration, and location of the visits must be a part of the child's individual case plan developed for each episode by the facility before the visitation. An approved visitation plan must be documented in the child's official record at the facility.

Other covered absences
If an individual is absent from the facility for a short time due to circumstances needing the individual's immediate attention (death, wedding, personal business), or the individual leaves the facility without permission, the facility can be reimbursed for up to five days per episode at the contracted per diem rate unless the individual's placement is terminated sooner by the individual's guardian in conjunction with the PRTF.

Mental health services received during leave time are the PRTF's responsibility.
KMAP does not pay for individuals while they are in a correctional institution.
All other absences not defined above are not covered by KMAP.

Documentation
To verify services provided in the course of a postpayment review, documentation in the individual's medical record must support the service(s) billed. The individual's plan of care shall provide supporting documentation indicating frequency, duration, and location of each reserve day along with specific documentation of PRTF administrative activities during the reserve day period.

Ancillary Providers
KMAP does not make any payment to ancillary providers for services considered content of service of the PRTF. For a listing of procedure codes included in the content of service list, refer to the *Mental Health Fee-for-Service Provider Manual* and the Su*bstance Use Disorder Fee-for-Service Provider Manual*.

APPENDIX

CODES

Updated 11/17

Procedure code T2048 is covered with prior authorization.