beacon health options

6.3. Mental Health – Residential Treatment Services

DESCRIPTION OF SERVICES

A residential treatment center (RTC) offers 24-hour inpatient care in a facility licensed under COMAR 10.07.04. An RTC provides children and adolescents who have long-term and serious emotional disturbance with residential care in a structured therapeutic milieu and provides a range of diagnostic and therapeutic mental health services. RTC treatment focuses on maximizing a participant's development of appropriate living skills. This is a very intense level of care and can only be provided when therapeutic services available in the community are insufficient or have failed to address the participant's need.

Discharge planning must be considered prior to placement in an RTC and the discharge plan must be actively reviewed throughout the treatment process. Active discharge planning requires effective collaboration with the participant, the participant's family (or legal guardian), and other appropriate agencies and service providers.

Before admitting a youth to an RTC, Beacon Health Options, Inc. (Beacon) and the Core Service Agency (CSA) are responsible for assuring that the participant has received the maximum benefit from any available and appropriate community-based service. The overall focus for the RTC, Beacon, and the CSA is to help children adolescents and their families develop skills to manage the symptoms of their mental illness and to live successfully in the community.

The Maryland Department of Social Services (DSS), the Department of Juvenile Services (DJS), the Department of Human Resources (DHR), and any other agency involved in the care and supervision of the participant and/or the parents/guardians, are expected to contribute toward the development and implementation of a discharge plan.

PARTICIPANT ELIGIBILITY

Participants under the age of 21 who have Medicaid are eligible for RTC services. Some participants with a private insurance carrier may find it necessary to seek Medicaid when fiscal or time period limitations on their private policies have been exhausted. These participants will be reviewed by Beacon at the time of the application for Medicaid. Prior to admission to an RTC, the participant should be referred to their CSA for possible diversion services. The result of this review should determine if community services can meet the required level of treatment or if the participant should be referred for the RTC level of care.

PROVIDER ELIGIBILITY

All RTCs must have a Maryland or other state license to provide residential treatment services. The RTC must also have an active Maryland Medicaid provider number.

AUTHORIZATION PROCESS

The RTC requesting authorization must enter an authorization request in Beacon's ProviderConnect system to activate an RTC review. Required information must supplement the information in the previously submitted certificate of need (CON) and should include at least the following:

- All applicable diagnoses; the Maryland Public Behavioral Health System (PBHS)-eligible diagnoses can be found at:

http://maryland.valueoptions.com/provider/clin_ut/PMHS_Diagnosis.pdf

- Current need for treatment
- Precipitating even(s)
- Treatment history
- Current (and history of) medications
- Substance use history
- Risk assessment
- History of out-of-home mental health placements
- History of out-of-home non-mental health placements
- Attempts (and outcomes) of increasingly intensive, community-based services

Authorizations for initial and continued stay RTC services are requested electronically through Beacon. Electronic authorizations are completed by the provider through submission of a request in Provider Connect. Provider Connect can be accessed 24/7, including weekends and holidays through the Beacon website: http://maryland.beaconhealthoptions.com/provider-main.html. If the level of care is medically necessary, services will be authorized.

If a Beacon Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a Beacon Physician Advisor for review. If the services requested do not meet medical necessity criteria and are non-authorized, the determination of the non- authorized case will be communicated both via ProviderConnect and telephonically to the provider (refer to Chapter 10 on Grievances and Appeals for further information).

Treatment at this level of care requires family involvement. This must be documented in the participant's medical record. If this does not occur, there may be questions regarding whether medical necessity criteria are met and about the efficacy of residential treatment.

This authorization process continues until the participant is discharged.

BILLING CODES

RTCs must bill using the reimbursement rates approved by the Maryland Department of Health and Mental Hygiene (DHMH). Revenue code 100 or 101 must be used.

SERVICE RULES

A federally-mandated CON for services is required for Medicaid participants at the time an application is submitted. The CON is time-sensitive in that all elements must be dated within 30 days from when the participant enters the RTC. There is no standardized CON form; each provider uses his or her own format and all formats will be accepted if they each recommend an RTC placement. They must also include:

- A **psychiatric evaluation**, which must be completed by a board certified psychiatrist and must include a summary of the participant's:

- Presenting problem
- Current psychiatric symptoms and behaviors
- Treatment, medication, family, and educational history
- All applicable diagnoses
- A clear recommendation that the participant be placed in an RTC

- A **psychosocial evaluation**, which must be completed by a licensed mental health professional; an evaluation completed by a licensed graduate social worker (LGSW) or licensed graduate professional counselor (LGPC) must be co-signed by a licensed mental health professional. The psychosocial evaluation may include the components delineated in the psychiatric evaluation, but will provide further detail regarding:
  - The presenting problem
  - Family involvement
  - Religious, social, educational, and legal history
  - A clear recommendation that the participant be placed in an RTC
- A **history and physical examination** signed by a physician or certified registered nurse practitioner (CRNP) that attests that the participant is medically appropriate and cleared for RTC placement

The CON must be sent to both the CSA and Beacon. An authorization request (whether it be the initial or subsequent) for RTC services must be made to Beacon through the online, ProviderConnect system. Initial requests must be made prior to admission. If a medical necessity review for continued treatment is not reviewed before the authorization period expires, treatment is not authorized and the facility will be denied payment for unauthorized days.

Persons requesting RTC placement may send updated CON documentation if the original CON is drafted more than 30 days prior to admission. Any updated and abbreviated psychosocial, psychiatric, and history and physical addendums should be sent to Beacon and the CSA. The updated CON should refer to the prior CON evaluation and reiterate that the participant continues to need residential placement. Whenever possible, the updated CON should be submitted along with a copy of the original CON documentation.

The outcome of the RTC placement should be to return the participant to a home-like environment. If this is not a reasonable expectation, alternatives to RTC placement should be investigated. It should be expected that there will be a minimum of weekly family involvement. This may include, but is not limited to, family attending sessions in the RTC, RTC staff going with the participant to the home, or telephonic therapy.

Emphasis is placed on keeping children and adolescents who need residential treatment services in Maryland-based RTCs. When an out-of-state placement appears indicated, the CSA and the local coordinating council will need to be involved.

It is the responsibility of the RTC to ensure that the information contained in the CON accurately reflects the medical necessity of the RTC admission.

The RTC must contact Beacon when a previously non-Medicaid participant has applied for Medicaid and has been determined eligible.

The last date listed in the Beacon ProviderConnect authorization is not considered an authorized day for reimbursement purposes. For example, in an authorization from April 1 to May 1, May 1 is not considered an authorized day.

Psychological testing performed while a participant is being treated in an RTC is included in the RTC daily rate.

RTCs will be reimbursed for an overnight therapeutic leave of absence (TLOAs) of less than 72 hours. A TLOA that lasts longer than 72 hours requires pre-authorization by Beacon. Any TLOAs of 72 hours or more will not be paid for. TLOAs may be allowed when the provider identifies specific goals for this type of service planning and while the participant continues to meet medical necessity criteria for a continued RTC stay. TLOAs include, but are not limited to, the following:

- An admission to an inpatient psychiatric bed
- An admission to an inpatient medical bed
- Home or transitional visits to practice symptom management techniques developed in the residence

There are no reimbursable administrative days for care in an RTC beyond the point in time where the participant no longer meets the medical necessity criteria for continued stay. Authorization for payment is denied when a participant no longer meets the medical necessity criteria for residential treatment services.

Active discharge planning with a participant's family, legal guardian, and/or agency representative is expected to begin at the time of admission. This plan is to be routinely re-evaluated with the participant, family, guardian, and/or agency representative (as specified in COMAR 10.21.05). All interested parties (i.e. the participant, family, custodial agent, and local school system, etc.) should be kept apprised of the participant's progress toward meeting the discharge goals. When the Beacon Care Manager determines that the participant may soon no longer meet medical necessity criteria, a time-limited authorization may be given to operationalize a discharge plan. The provider should contact the participant's CSA to assist with accessing community-based mental health services.

Beacon will conduct a courtesy review for the medical necessity of RTC services when the participant has not yet been granted Medicaid eligibility. However, the responsible parties must apply for Medicaid immediately to the Maryland DHR. Beacon will not pay for any medically necessary services until the participant has been granted Medicaid eligibility. When the participant is newly or previously Medicaid eligible, the responsible parties are required to work with the State's Eligibility Determination Division to change the Medicaid eligibility from a community-based Medicaid to a long-term care span. To do so, the provider must submit the following:

- A **DES 1000 Form**, available at : https://mmcp.dhmh.maryland.gov/longtermcare/SiteAssets/SitePages/Long%20Term%20Care%2 0Forms/DES-1000.pdf
- A **9708 Application**, available at: https://mmcp.dhmh.maryland.gov/eid/Documents/9708A%20form.pdf

The DES Form is required to confirm the start date of the authorization/admission. It must be submitted to the Beacon Clinical Director. Once confirmed, the Clinical Director will sign the form and return it to the RTC provider for them to process with the State. The 9708 application, which determines financial eligibility, must be submitted to the Eligibility and Determination Division of DHMH.

A link to the applicable Maryland Health General Article (Standards for Institutionalized Services Article 19-308) is available at: http://mgaleg.maryland.gov/2015RS/Statute_Web/ghg/19-308.pdf.

A link to the applicable COMAR Titles (Conditions of Participation [10.08.29.03]) is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.29.03.htm.

RTC SPECIAL ISSUES

Although some participants in RTCs may present significant management challenges, enhanced support services are not available in an RTC. All services provided by the RTC must be included in the RTC rate. Participants with another primary insurer (i.e. a commercial plan, TRICARE, etc.) should seek treatment in RTC facilities that are credentialed by (in-network with) that insurer.

Admission to a non-participating facility, for any payer, does not make Medicaid the primary payer.

Information regarding participants' plans and progress toward discharge goals is to be shared with the Child and Adolescent Coordinator at the CSA for that participant's county of residence. Should issues arise which interfere with activating the discharge plan, the CSA Child and Adolescent Coordinator is to be contacted for assistance. A CSA directory is available at: http://www.marylandbehavioralhealth.org/core-service-agency-directory.

The mental health service provider is expected to exchange information and coordinate care with the participant's PCP and other treatment providers when clinically appropriate.

CLAIMS PROCESS

Claims should be submitted to Beacon only after:

- An authorization has been received
- The individual is Medicaid-eligible
- A long-term care span has been secured through the DES 1000 application process

Claims are required to be submitted on UB-04 forms. Claims must specify an ICD-10 code (not the DSM 5 code) for reimbursement.

Laboratory services are covered as outlined in Chapter 13 of this Provider Manual.

Prior to payment, the state of Maryland requires Beacon to review all claims for inpatient services at RTCs to determine if a long-term care span has been properly opened. A long-term care span is required when the participant meets the State's definition of an institutionalized participant. In general, a participant becomes institutionalized when he/she is admitted to a facility for more than one calendar month. The span is specific to the facility, participant, and the time period of the admission. The long-term care span allows the State to establish eligibility and to ensure that claims for services, other than those rendered by the RTC, are valid prior to payment. Most participants will become a "family of one" when the definition of institutionalization is met. The State may determine that renewable assets exist and that a “share amount" should be deducted from each monthly payment. The change in membership for the admitted participant may also result in membership changes for his or her family. To establish a long-term care span, the RTC must complete the DES 1000 form and submit it to the Waiver Unit at the State DHR.

It is equally important that facilities close the span when the participant leaves the facility. If the participant is transferred to another facility (regardless of the length of stay), the RTC must close the existing

longterm care span and then re-open the span if the participant later returns to the RTC. Unless the span is closed, the other facility may not be able to bill Medicaid. The participant may be eligible for additional Medicaid services in the community.

Please refer to Chapter 17 for specific instructions on claims procedures for RTCs. Claims for unauthorized days will be denied.

The RTC daily rate is established according to federal guidelines and is intended to cover all services a participant may require, including but not limited to, psychological and other specific types of testing and forensic and psychosexual evaluations. Likewise, the occasional need for intensive supervision of some participants is included in the determination of the annual provider rate of care.

If the services requested do not meet medical necessity criteria and care is non-authorized, please refer to Chapter 10, Grievances and Appeals, of this Provider Manual.