KDADS STANDARD POLICY

Policy Name:	PRTF Admission Process for Medicaid Covered Beneficiaries	**Policy Number:**	E2017-077
Commission:	Behavioral Health Services (BHS)	**Date Established:**	04/04/2017
Applicability:	BHS Children's Inpatient Program	**Date Last Revised:**	N/A
Contact:	BHS Children's Inpatient Systems Manager	**Date Effective:**	06/15/2017
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Revision History			

Purpose

Given the directive from CMS that pre-admission screening process is no longer allowed, a policy discontinuing reimbursement for the pre-admission screening process was effective Oct. 2015. Since that time, concerns have been raised regarding the lack of consistency for families seeking authorization for admission of youth into PRTF. This policy attempts to provide guidance of the PRTF admission process for Medicaid Covered (child) Beneficiaries.

Summary

Effective with dates of service from June 1, 2017 Medicaid covered (child) beneficiaries 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 or private clinician than the MCO can request that a CMHC or private clinician complete a Psychiatric Diagnostic Evaluation utilizing codes 90791 or 90792. The code is defined as "per evaluation", 90791 is no medical services, 90792 is with medical services. These codes can only be billed once per day and both cannot be billed in the same day. Additionally, a Community Based Service Team meeting (CBST) can be requested by the MCO (code only billable by CMHC's) utilizing H0032-HA.

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 PRTF. The MCO will begin their utilization management process by applying their criteria for medical necessity. If the MCO determines 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 in the community.

Entities/Individuals Impacted

Psychiatric Residential Treatment Facilities (PRTFs):

Florence Crittenton Services, Inc.
KVC Prairie Ridge
KVC Wheatland Kids TLC, Inc.
Lakemary Center, Inc.
Marillac Center for Children
Pathways Family Services, Inc.
Prairie View, Inc.
St. Francis Academy

Managed Care Organizations (MCOs):

Amerigroup Kansas
Sunflower Health Plan
United HealthCare

State of Kansas Community Mental Health Centers (CMHCs)

Private Behavioral Health Providers

I. Policy

Any Medicaid beneficiary (child) presenting for PRTF admission consideration must be assessed for appropriateness of this level of care. MCO's are responsible for the collection and evaluation of information necessary to determine Medical Necessity and authorization of PRTF/diversion/community services managed by the MCO.

II. Procedures

Effective with dates of service from June 1, 2017, any Medicaid beneficiary (child) presenting for PRTF admission consideration must be assessed for this level of care. MCO's are responsible for gathering information necessary to determine Medical Necessity and authorization for this level of care.

1. A KanCare child presents to an MCO for Psychiatric Residential Treatment Facility consideration through various means.

2. The MCO determines if further information is needed to determine Medical Necessity and /or diversion opportunities.

   If no, (proceed)

   i. The MCO determines no further information is needed to determine Medical Necessity, and/or diversion opportunities

   ii. MCO determines medical necessity/diversion.

   Medical criteria met. Eligible for PRTF planned treatment.
   - Admitted to PRTF and care managed by MCO

   Medical criteria met, diversion recommended
   - Community based services authorized and managed by MCO

   Medical criteria not met. Diversion recommended
   - Community based services authorized and managed by MCO

   If yes, (proceed)

3. Does necessary information to determine medical necessity and diversion opportunities for beneficiary exist in the system?

   If yes, (proceed)

   i. MCO requests existing information on Member in order to determine Medical Necessity and/or diversion opportunities through a standardized request form. (This is an MCO Administrative Function-Funded by MCO).

   ii. Provider, CMHC or other clinician complete information form and submits to requesting MCO.

   iii. MCO determines medical necessity/diversion.

   Medical criteria met. Eligible for PRTF planned treatment.
   - Admitted to PRTF and care managed by MCO

   Medical criteria met, diversion recommended
   - Community based services authorized and managed by MCO

   Medical criteria not met. Diversion recommended
   - Community based services authorized and managed by MCO

If no to 3. (Proceed here)

i. MCO requests a psychiatric evaluation and/or CBST as necessary in order to determine medical necessity/diversion (MCO Service-funded by State Plan)

(If the child has no prior history of services or adequate information cannot be obtained from a CMHC or private clinician than the MCO can request that a CMHC or private clinician complete a Psychiatric Diagnostic Evaluation utilizing codes 90791 or 90792 The code is defined as "per evaluation". An MCO can request a CBST utilizing code H0032-HA from a CMHC. The code is defined as "per evaluation").

ii. Provider, CMHC or other clinician complete and submit Evaluation or CBST results to MCO

iii. MCO determines medical necessity/diversion.

Medical criteria met. Eligible for PRTF planned treatment.
- Admitted to PRTF and care managed by MCO

Medical criteria met, diversion recommended
- Community based services authorized and managed by MCO

Medical criteria not met. Diversion recommended
- Community based services authorized and managed by MCO

III. Documentation

Provider Requirements

III. Definitions

Psychiatric Diagnostic Interview Examination

The code is defined as "per evaluation" with the Medicaid rate floor being $120. MCOs can exceed this rate per their provider contracts. 90791 is for no medical services. 90792 is with medical services. Both codes are $120 as the rate floor. 90791 or 90792 can only be billed once per day.

A. A complete medical and psychiatric history (including past, family, social)
B. Mental Status exam
C. Establishment of initial diagnosis
D. Evaluation of patient's ability and capacity to respond to treatment
E. Initial plan of treatment

F. Reported once per day and Not on the same day as an E/M service performed by the same individual for the same consumer
G. Covered once at the outset of an illness

Authority

§441.152 Certification of need for services.

(a) A team specified in §441.154 must certify that-

(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
(2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Related Information