Health, Department of

Medicaid

Chapter 40: Freestanding Psychiatric Residential Treatment Centers

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WYOMING MEDICAID RULES

CHAPTER 40

FREESTANDING PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101 et. seq. and the Wyoming Administrative Procedure Act at W.S. § 16-3-101 et. seq.

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern the furnishing of inpatient psychiatric services for individuals under age twenty-one in freestanding psychiatric residential treatment facilities.

(b) The Department may issue Provider Manuals, Provider Bulletins, or both, to interpret the provisions of this Chapter. Such Provider Manuals and Provider Bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in Provider Manuals or Provider Bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.

(b) General methodology.

(i) The Department reimburses FPRTCs for covered services using an all-inclusive, negotiated payment rate.

(ii) Department of Family Services shall pay the non-federal share of Medicaid payments to FPRTCs which provide covered services.

(c) Unless otherwise specified, the incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter, including any applicable amendments, corrections, or revisions, but excluding any subsequent amendments or changes.

Section 4. Definitions.

(a) "Active treatment." "Active treatment" as defined in 42 C.F.R. § 441.154, which is incorporated by this reference.

(b) "Acute." Having a short and relatively severe course.

(c) "Admission." The act that allows a reciept to officially enter a facility.

(d) "Admission certification." The determination pursuant to Chapter 8 that all or part of a reciept's's admission is or was medically necessary and that medicaid funds may be used to pay the facility and other providers of covered services for providing medically necessary services, subject to the rules of the Department.

(e) "Base rate." The rate which the Department of Family Services pays to a facility for room and board.

(f) "CARF." The Commission for the Accreditation of Residential Facilities, its agent, designee, or successor.

(g) "Certification of need for services." A certification pursuant to Section 8 that meets the requirements of 42 C.F.R. § 441.152 & 153, which requirements are incorporated by this reference.

(h) "Certified." Certified by DFS as in compliance with applicable statutes and rules.

(i) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.

(j) "Chapter 4." Chapter 4, Third Party Liability, of the Wyoming Medicaid Rules.

(k) "Chapter 6." Chapter 6, Health Check (formerly EPSDT) Program, of the Wyoming Medicaid Rules.

(l) "Chapter 8." Chapter 8, Inpatient Hospital Certification, of the Wyoming Medicaid Rules.

(m) "Chapter 16." Chapter 16, Medicaid Program Integrity, of the Wyoming Medicaid Rules.

(n) "Chapter 26." Chapter 26, Covered Services, of the Wyoming Medicaid Rules.

(o) "Chapter 30." Chapter 30, Level of Care Inpatient Hospital reimbursement, of the Wyoming Medicaid Rules.

(p) "Chapter 39." Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid Rules.

(q) "Claim." A request by a provider for Medicaid payment for covered services provided to a recipient.

(r) "CMS." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee, or successor.

(s) "COA." The Council on Accreditation for Children and Family Services.

(t) "Court ordered placement." The placement of a reciept in a facility pursuant to an order entered by a court of competent jurisdiction, other than an involuntary commitment pursuant to Title 25 of the Wyoming Statutes.

(u) "Covered service." Inpatient psychiatric services for individuals under age twenty-one.

(v) "Department." The Wyoming Department of Health, its agent, designee, or successor.

(w) "Desk review." A review by the Department or DFS of a facility's financial records, medical records, or both, to determine; (1) if the cost incurred by the facility are reasonably related to the care furnished to recipients; and (2) if the care furnished to recipients was medically necessary.

(x) "DFS." The Wyoming Department of Family Services, its agent, designee, or successor.

(y) "DSM-IV." The fourth edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, which is incorporated by this reference. The DSM-IV is published by the American Psychiatric Association, Washington, D.C., and is available from the publisher.

(z) "Emergency." The sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(aa) "Emergency detention." A person detained or involuntarily hospitalized pursuant to

W.S. § 25-10-109.

(bb) "Enrolled." Enrolled as defined in Chapter 3, Section 3(l), which is incorporated by this reference.

(cc) "Excess payments." Medicaid funds received by a provider which exceed the Medicaid allowable payment.

(dd) "Extended psychiatric services." Extended psychiatric services as defined by Chapter 30, which definition is incorporated by this reference.

(ee) "Facility." An FPRTC or a group home which has been certified by DFS or a similar agency in another state, and which is not licensed as a hospital.

(ff) "Field audit." An examination, verification and review of a provider's financial records, medical records, or both, and any supporting or related documentation conducted by employees, agents or representatives of the Department or HHS. A field audit may be conducted at the facility.

(gg) "Financial records." All records, in whatever form, including financial reports, used or maintained by a facility in the conduct of its business affairs and which are necessary to substantiate or understand the information contained in the facility's cost reports or a claim.

(hh) "Financial Report." A report of a facility's costs for a specified fiscal period prepared and submitted in the form and manner specified by the Department. Financial report includes any supplemental request by the Department for additional information relating the facility's costs.

(ii) "Foster home." A home certified by DFS as a foster home.

(jj) "Freestanding Psychiatric Residential Treatment Center (FPRTC)." A Freestanding Psychiatric Residential Treatment Center which has been accredited by CARF, COA, or JCAHO, and which is not licensed as a hospital.

(kk) "Generally accepted auditing standards (GAAS)." Auditing standards, practices and procedures established by the American Institute of Certified Public Accountants.

(ll) "Group Home." An institution certified by DFS as a group home.

(mm) "Hospital." An institution that:

(i) is approved to participated as a hospital under Medicare;

(ii) is maintained primarily for the treatment and care of patients with disorders other than mental diseases or tuberculosis;

(iii) has a provider agreement;

(iv) is enrolled in the Medicaid program; and

(v) is licensed to operate as a hospital by the State of Wyoming or, if the institution is out-of-state, licensed as a hospital by the state in which the institution is located.

(nn) "Individual written plan of care (plan of care)." A written treatment plan, prepared by an interdisciplinary team, that meets the requirements of 42 C.F.R. § 441.155, which is incorporated by this reference, except that the plan must be completed within seven calendar days of an individual's admission to the facility.

(oo) "Inpatient psychiatric services for individuals under age twenty-one." Inpatient psychiatric services for individuals under age twenty-one as defined in 42 C.F.R. § 441-Subpart D, which definition is incorporated by this reference.

(pp) "Institution." An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

(qq) "Interdisciplinary team." A team that meets the requirements of 42 C.F.R. § 441.156, which is incorporated by this reference.

(rr) "JCAHO." The Joint Commission for the Accreditation of Healthcare Organizations.

(ss) "Local agency." The County office of DFS, its agent, designee or successor.

(tt) "Master treatment plan." The initial plan of care for an individual.

(uu) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act and/or the Wyoming Medical Assistance and Services Act. "Medicaid" includes any successor or replacement program enacted by Congress or the Wyoming Legislature.

(vv) "Medicaid allowable payment." The per diem rate determined pursuant to Section 13.

(ww) "Medical necessity" or "medically necessary." A covered service that is:

(i) Consistent with the recipient's diagnosis and condition;

(ii) Recognized as the prevailing standard or current practice among the provider's peer group;

(iii) Required to meet the medical needs of the patient and provided for reasons other than the convenience of the patient or the provider; and

(iv) Provided in the most appropriate and cost-effective setting required by the recipient's condition.

(xx) "Medical record." All documents, in whatever form, in the possession of or subject to the control of the facility which describe the recipient's diagnosis, condition or treatment.

(yy) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.

(zz) "MFCU." The Medicaid Fraud Control Unit of the Wyoming Attorney General's Office, its agent, designee, or successor.

(aaa) "Overpayments." Overpayments as defined in Chapter 39, which definition is incorporated by this reference.

(bbb) "Patient." An individual who receives services at an FPRTC.

(ccc) "Physician." A person licensed to practice medicine or osteopathy by the Wyoming State Board of Medical Examiners or a comparable agency in another state.

(ddd) "Prior authorization." Approval by the Department pursuant to Section 9.

(eee) "Provider." A Provider as defined by Chapter 3, which definition is incorporated by this reference.

(fff) "Provider agreement." A provider agreement as defined by Chapter 3, which definition is incorporated by this reference.

(ggg) "Rate." A facility's medicaid allowable payment.

(hhh) "Recipient." A person who has been determined eligible for Medicaid.

(iii) "Recipient under age twenty-one." A recipient before or during the month in which he or she turns twenty-one years of age.

(jjj) "Standing orders." Orders from a physician or other provider that a certain service or services be provided to every patient, regardless of diagnosis.

(kkk) "Supervision." Supervision as defined by Chapter 26, which definition is incorporated by this reference.

(lll) "Third party liability." Third party liability as determined pursuant to Chapter 4, which is incorporated by this reference.

(mmm)"Usual and customary per diem charge." A provider's per diem charge for comparable services provided to non-Medicaid recipients other than persons eligible for payment on a reduced or sliding fee schedule.

Section 5. Provider participation.

(a) Payments only to providers. Except as otherwise specified in this Chapter, no facility that furnishes covered services to a recipient shall receive Medicaid funds unless the provider has signed a provider agreement, and is enrolled.

(b) Compliance with Chapter 3. A facility that wishes to receive Medicaid reimbursement for covered services furnished to a recipient must meet the provider participation requirements of Chapter 3, which requirements are incorporated by this reference.

(c) Additional provisions.

(i) An FPRTC must be certified.

(ii) No facility may become a provider or receive Medicaid funds for services furnished before the date on which an authorized individual signs an attestation letter which meets CMS requirements regarding restraint, seclusion, and death reporting policies, as set forth at 66 Federal Register 28110 through 28117 (May 22, 2001), to be codified at 42 C.F.R. Parts 441 and 483.

Section 6. Provider records.

RTCs are subject to the record-keeping provisions of Chapter 3, which are incorporated by this reference.

Section 7. Verification of recipient data.

A provider must comply with the verification of recipient data requirements of Chapter 3, which requirements are incorporated by this reference.

Section 8. Admission.

(a) Certification of need for services. Before admission to a facility, an interdisciplinary team shall complete a certification of need for services.

(b) Admission Certification. Admissions to FPRTCs are subject to the procedural requirements of Chapter 8, which are incorporated by this reference, except that the determination shall be whether treatment in an FPRTC is medically necessary. In place of the medical necessity criteria of that Chapter, the Department shall determine the medical necessity of admission to an FPRTC using the following criteria:

(i) Outpatient community-based treatment has failed; and

(ii) Placement in the reciept's's home, a foster home, or a group home has failed, and placement in a FPRTC is medically necessary.

Section 9. Prior authorization.

(a) Incorporation of Chapter 3. Prior authorization of FPRTC services shall be governed by the prior authorization requirements of Chapter 3, which are incorporated by this reference.

(b) Services which require prior authorization. All inpatient psychiatric services for individuals under age 21 furnished in a facility must be prior authorized.

(c) Failure to obtain prior authorization. The failure to obtain prior authorization shall result in the denial of Medicaid payment for the service.

(d) Submission of master treatment plan. The facility shall submit a request for prior authorization in the manner specified by the Department, including the master treatment plan, before the submission of a claim for such services. The Department may request, and the facility shall provide additional information as necessary to review the plan of care.

(e) Denial of plan of care. If a master treatment plan or any plan of care is disapproved, the provider may submit a revised plan or additional documentation within twenty calendar days of the disapproval as necessary for the Department to reconsider the plan.

(f) Reauthorization. The physician or the interdisciplinary team must review and recertify the recipient's plan of care at least every thirty days. Recertified plans of care are subject to the prior authorization provisions of this Section.

(g) Prior authorization of services furnished pursuant to a court-ordered placement. Since a reciept may be placed in a facility by a court before prior authorization can be obtained, a request for prior authorization will be considered timely if made within seven calendar days after the date of admission pursuant to a court-ordered placement.

Section 10. Covered services.

(a) Inpatient psychiatric services for individuals under age 21 furnished to a recipient under age twenty-one in an FPRTC are covered services if provided:

(i) After a certification of need for services has been completed pursuant to subsection 8(a);

(ii) After a certification of need for services has been completed pursuant to subsection 8(b);

(iii) After the services have been prior authorized, subject to subsection 9(g);

(iv) Pursuant to an individual written plan of care which provides for active treatment;

(v) By or under the supervision of a physician;

(vi) The recipient is under age twenty-one;

(vii) Outpatient, community-based services have failed; and

(viii) The reciept has a psychiatric diagnosis which meets the criteria of Axis I of the DSM-IV, is medically stable, and acute, inpatient hospital services are not medically necessary.

(b) Court-ordered placement. Services furnished to a reciept in a court-order placement are reimbursable if they meet the criteria of (a), except that such services may be prior authorized within seven calendar days of admission.

Section 11. Excluded services.

The following services are not Medicaid reimbursable when provided in an RTC:

(a) Services provided pursuant to emergency detention;

(b) Services provided in an emergency;

(c) Services provided pursuant to standing orders; and

(d) Acute psychiatric services.

Section 12. Out-of-state facilities.

Covered services provided in a facility located outside of Wyoming shall be Medicaid reimbursable to the same extent as services provided in a facility inside Wyoming.

Section 13. Medicaid allowable payment for covered services.

(a) In General. The Department reimburses for covered services provided to recipients under age twenty-one using an all-inclusive, negotiated, per diem rate determined pursuant to this Section.

(b) The Department may negotiate a separate rate for recipient's for whom Medicaid reimbursement is sought. The rate shall be the facility's base plus the reasonable, documented costs of providing medically necessary services as set forth in the plan of care requirements.

(i) Before beginning negotiations, the provider shall submit to the Department in the format prescribed by the Department;

(A) Its base rate;

(B) A proposed rate; and

(C) Supporting documentation, including:

(I) The plan of care for the individual;

(II) The services in addition to room and board which are medically necessary to meet the goals of the plan of care; and

(III) The additional cost the facility will reasonably and necessarily be incurring to provide the additional services.

(ii) The Department may request, and the provider shall furnish before a rate is established, additional information to document the medical necessity of the proposed services, added costs of furnishing those services, or both.

(iii) The rate shall be the rate agreed upon by the provider and the Department. The rate shall apply to all services furnished to the recipient unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the services are being furnished.

(c) All inclusive. The negotiated rate shall be an all inclusive per diem rate for all services and supplies furnished by the facility, except as otherwise agreed by the Department.

(d) Maximum rate. The negotiated rate shall not exceed the facility's usual and customary rate.

(e) The Department's refusal to agree to a rate requested by a provider is not an adverse action for purposes of Chapter 1.

Section 14. Preparation and submission of financial reports.

(a) Time of submission. Each facility must submit a complete financial report in accordance with the instructions of the Department.

(b) Preparation of financial reports. Financial reports shall be in the form specified by the Department and shall be submitted in accordance with the instructions of the Department.

(c) Submission of additional information. The Department may request, in writing, that a facility submit information to supplement its financial report. The facility shall submit the requested information within thirty days after the date of the request.

Section 15. Submission and Payment of claims.

The submission and payment of claims shall be pursuant to the provisions of Chapter 3, which are incorporated by this reference.

Section 16. Third-party liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Chapter 4, which is incorporated by this reference.

(b) Medicaid payment. The Medicaid payment for a claim for which third party liability exists shall be the difference between the Medicaid allowable payment and the third party payment. In no case shall the Medicaid payment exceed the payment otherwise allowable pursuant to this Chapter.

Section 17. Audits.

(a) The Department, MFCU, or CMS may audit a provider's financial records or medical records at any time to determine whether the provider has received excess payments or overpayments. An audit may be a desk review or a field audit.

(b) The Department, MFCU, or CMS may perform audits through employees, agents, or through a third party. Audits shall be performed in accordance with generally accepted auditing standards.

(c) Disallowances. The Department shall recover excess payments or overpayments pursuant to Section 18.

(d) Reporting audit results. If at anytime during a financial audit or medical audit, the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department final audit report regarding that provider, shall be referred to the MFCU.

Section 18. Recovery of excess payments or overpayments.

(a) The Department may recover excess payments pursuant to Chapter 39, which is incorporated by this reference.

(b) The Department may recover overpayments pursuant to Chapter 16, which is incorporated by this reference.

Section 19. Reconsideration.

A provider may request that the Department reconsider a decision to recover excess payment or overpayments. The request for reconsideration, the reconsideration, and any administrative hearing shall be pursuant to the reconsideration provisions of Chapter 3, which are incorporated by this reference.

Section 20. Disposition of recovered funds.

The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16, which provisions are incorporated by this reference.

Section 21. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this chapter shall control the titles of its various provisions.

Section 22. Superseding effect.

This Chapter supersedes all prior rules or policy statements issues by the Department, including Provider Manuals and Provider Bulletins, which are inconsistent with this Chapter.

Section 23. Severability.

If any portion of this chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect. 40-11