

PART II

POLICIES AND PROCEDURES
for
PSYCHIATRIC RESIDENTIAL TREATMENT
FACILITIES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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PART II
POLICIES AND PROCEDURES
APPLICABLE TO
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

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CHAPTER 600 - CONDITIONS OF PARTICIPATION

600.1 DEFINITIONS

Department of Community Health (DCH) - Department of Community Health (DCH) - Created in 1999 to serve as the lead state agency for health care planning and purchasing. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. DCH is also designated as the single state agency for Medicaid. The DCH also pursues and corrects fraud and abuse; develops health policy, approves the development and expansion of health care services and facilities.

Department of Human Services (DHS) - Created by the Georgia General Assembly in 2009; includes some of the agencies formerly in the Department of Human Resources (DHR): the Division of Family and Children Services, the Division of Aging Services, the Office of Residential Childcare Regulations, and the Division of Child Support Services.

Division of Family and Children Services (DFACS) - The division of DHS that investigates child abuse; finds foster care placements for abused/ neglected children; helps low income families, and provides numASOus support services and innovative programs to troubled families.

Healthcare Facilities Regulation Division (HFR) – A division within the Department of Community Health, responsible for ensuring quality healthcare and safety through professional standards regulation.

Code of Federal Regulations (CFR) - The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.

Active Treatment - The implementation of a professionally developed and supervised plan of care that is developed and implemented no later than seven (7) calendar days after admission and designed to achieve the goal of the resident's appropriate discharge from the PRTF at the earliest possible date.

Attestation – A written statement asserting the compliance of the facility.

Restraint - A personal restraint, mechanical restraint or drug used as a restraint as defined in 42CFR, Subpart G Condition of Participation for the Use of Restraint or Seclusion in PRTF's.

Administrative Services OrganizationAdministrative Services Organization (ASO) - An agency under contract with the Department of Behavioral Health and Developmental Disabilities to provide service authorization and utilization review for services.

Youth/Young Adult - The term 'youth' is used to address children and adolescents collectively. The term 'young adult' is used to address individuals 18 years and older.

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600.2 DEFINITION OF SERVICE

Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and young adults 21 years of age or younger who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. PRTFs serve as the most intensive, inpatient treatment for youth/young adults with severe behavioral health disorders.

PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/young adult to the community. Focus is on improvement of residents' symptoms through the use of strength- and evidence-based strategies and active family engagement. The program encourages family participation in the treatment planning and implementation processes and timely discharge planning and aftercare. Specific outcomes of the services include the resident returning to his/her family or to another less restrictive community living situation, as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.

This service is provided to youth/young adults in order to promote stability and build toward age-appropriate functioning in their daily environment. Stability is measured by decreased frequency, intensity, and duration of crisis episodes and by increased and/or stable participation in school and community activities, or activities that encourage/support community inclusion. Supports based on the residents' needs are used to promote resiliency while understanding the effects of the emotional disturbance and substance use/abuse and to promote functioning at an age-appropriate level.

Service activities include:

- diagnostic and assessment services;
- development of an individualized treatment/resiliency plan;
- psychiatric services;
- nursing services;
- medication monitoring and management;
- evidenced-based treatment interventions;
- individual therapy;
- family therapy;
- group therapy;
- individual and group interventions that focus on addiction and harmful use/abuse issues and relapse prevention, if indicated;
- substance abuse education;
- activities that support the development of age-appropriate daily living skills, including positive behavior management/support;

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- activities that support and encourage the parents' ability to re-integrate the youth/young adult into the home and community;**crisis intervention;**
- **overall** health monitoring;
- activities which promote the youth's/**young adult's** skills in managing his/her own health;
- consultation with other professionals including case managers, primary care professionals, community support workers, school staff, and others;
- educational activities;
- non-medical transportation services;
- on-going discharge planning, and transitional planning when appropriate, as needed to accomplish treatment objectives.

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600.3 PRTF PROGRAM OVERVIEW

Psychiatric Residential Treatment Facilities (PRTF) are not hospitals. They are inpatient facilities with an agreement with DCH to provide a behavioral health service benefit to eligible individuals 21 years of age or younger. It is the most intensive level of residential treatment for youth and young adults available.

Enrollment is open to facilities that possess the following required components:

1. Accreditation by the Joint Commission on Accreditation of Hospital Organization (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council On Accreditation (COA)

AND

2. Licensed in the State of Georgia as a Residential Mental Health Facility (RMHF) for Children and Youth.

AND

3. Meet the federal requirements of Conditions of Participation for the use of restraint or seclusion (42 CFR part 483, subpart G, §483.350 through §483.376); and Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric

Services must:

- Be provided under the direction of a physician
- Be provided before the individual reaches the age of 21, or, if the individual was receiving services immediately before reaching age 21, services must be concluded when the individual no longer requires service or by the age of 22.
- Be certified in writing to be medically necessary.
- Be reasonably expected to improve the recipient's condition or prevent further regression.
- Involve active treatment which means implementation of a professionally developed and supervised individual plan of care. Active treatment must be certified by a Treatment Team and involves:
 1. multidisciplinary observation
 2. assessment and evaluation
 3. diagnostic evaluation
 4. interdisciplinary treatment planning
 5. evaluation of treatment failures and appropriate revisions in the treatment plan
 6. identification of discharge criterion and discharge planning
 7. aftercare needs assessment

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- Be provided through an Individual Plan of Care, developed by an interdisciplinary team of physicians and other personnel. The team must include at minimum:

A) a Board-eligible or Board-certified psychiatrist

OR

B) a clinical psychologist who has a doctoral degree and a licensed physician;

AND

one of the following:

1. a psychiatric social worker
2. a registered nurse with specialized training or one year of experience in treating mentally ill individuals,
3. a licensed occupational therapist or;
4. a psychologist who has a master's degree in clinical psychology.

Other team members include educational staff, resident's therapist, appropriate direct care staff, parent/legal custodian.

Services provided to children and youth must:

- include coordination with family and significant others and with other systems of care such as the school system, juvenile justice system, child welfare system, and anticipated community providers when appropriate to treatment and educational needs.
- be provided by staff who are proficient in working with the target population and with families as partners.

The facility must:

- attest in writing that the facility is in compliance with the Centers for Medicare & Medicaid Services' (CMS) standards governing the use of restraint and seclusion
- provide interpreting services to a Limited English Proficient or Sensory Impaired (LEPSI) youth/young adult and/or LEPSI parent/legal custodian as follows:
- have an Organizational Plan that includes the following:
 1. The population to be served, age groups and other limitations

2. The Statement of purpose and objectives, with a formal, long-range plan adapted to guide and schedule steps leading to attainment of the stated objectives
 3. The description of the services offered, including particular rehabilitation, resiliency models utilized, types of intervention practiced, and typical daily schedule for staff and residents
 4. An organizational chart with a description of each unit or department and its services, its relationship to other services and departments and how these are to contribute to the priorities and goals of the facility.
 5. The description of the staffing pattern and how staff are deployed to assure that the required staff-to-resident ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated, and how the case mix is managed.
 6. The description of how the plan for services is modified or adjusted to meet the needs specified in every Individualized Treatment/Resiliency Plan.
 7. Plans for cooperation with other public and private agencies to assure that each youth/young adult will receive comprehensive treatment.
 8. Ongoing working arrangement contracts with agencies, such as schools and/or welfare agencies, shall be included as indicated, as well as regularly planned interagency conferences, which shall be documented.
 9. The policies that govern the provision of services and can document that it respects individuals' and/or families' right to privacy and confidentiality
 10. Established procedures/protocols for handling emergency and crisis situations for individuals who require psychiatric hospitalization
- work closely with the appropriate school entity to ensure adherence to the youth's Individual Education Plan (IEP).
 - ensure a smooth transition back to the home school or develop an alternative transition plan for those youth who are not returning to their home school
 - ensure that there is an adequate number of multi-disciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan
 - Verify eligibility status and determine type of eligibility at time of admission for each consumer in the PRTF*.

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Determination should include verification of type of eligibility for the month will require prior authorization through the CMO. All Medicaid members with fee-for-service Medicaid eligibility will require prior authorization by DBHDD or their agent.

***Note:** The Medicaid eligibility type for members in the Georgia Families 360 program may change at any point during the month — not only at the end of the month/beginning of the next which will still be the case for all other members of Georgia Families and straight Medicaid.

The program must:

- have a written program description that guides the facility's operations and delivery of services. Each PRTF is required to develop its own policies, procedures, and program description to implement the requirements in this provider manual.
- provide an interdisciplinary psychotherapeutic treatment program on a 24- hour basis, 7 days a week. An interdisciplinary team under direction of a physician is responsible for treatment interventions.
- have clear procedures which specify its approach to positive behavior supports and positive behavioral intervention.
- provide education services onsite that comply with Georgia Quality Based Education (QBE) standards. The facility must work closely with the appropriate school entity to ensure adherence to the youth's/young adult's Individual Education Plan (IEP). The facility must ensure a smooth transition back to the home school or develop an alternative transition plan for those youth/young adults who are not returning to their home school.

600.4 Staffing Requirements

The PRTF must ensure there is an adequate number of multidisciplinary staff to carry out the goals and objectives of the facility and to ensure the delivery of individualized treatment to each resident as detailed in their treatment plan. Included in the facility's Organizational Plan is a description of the staffing pattern and how staff are deployed to assure that the required staff-to-resident ratios are maintained, including how unplanned staff absences, illnesses, or emergencies are accommodated and how case mix is managed. The Organizational Plan must include the above listed requirements in a succinct manner so that these documents can be reviewed to determine compliance with staffing patterns.

Staff shall include, but not be limited to, child psychiatrists, licensed psychologists, licensed social workers, and licensed nurses. The authority and participation of such professionals shall be such that they are able to assume responsibility for supervising, and

reviewing the needs of the youth/young adults and the services being provided. These individuals shall participate in certain functions, such as assessment, treatment planning, individual case reviews, program planning, and policy and procedure development and review.

In addition, other professional and paraprofessional staff shall include, but not be limited to, educators, activity therapists, vocational counselors, and 24-hour non-clinical direct service staff.

All direct individual, group, and family therapy services delivered to the youth/young adult must be delivered by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, or a license eligible Master's level clinician. All non-licensed clinicians must be actively working towards obtaining licensure and must acquire the appropriate license within the timeframes determined by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists.

PRTF's must complete Criminal Records Checks (CRC) per Licensing Rules and Regulations.

600.4.1 Minimum Staffing Requirements and Composition

ADMINISTRATOR who is responsible for the general management of the facility. The administrator must have appropriate academic credentials and administrative experience in psychiatric treatment settings for children and adolescents as set forth in licensing rules, that is a master's degree in administration or a professional discipline related to child and adolescent mental health, and have at least three (3) years of administrative experience, or a baccalaureate degree with seven (7) years of experience in child and adolescent mental health care with no less than three (3) years administrative experience.

The Administrator cannot also serve as the clinical or medical director.

CLINICAL or MEDICAL DIRECTOR who is a board certified psychiatrist with experience in the delivery of child and adolescent mental health services.

If the facility does not employ a full-time Clinical/Medical Director, there must be a full-time Service Coordinator who is a licensed clinical social worker, professional counselor, marriage and family therapist, or psychiatric nurse. If the designated Clinical/Medical Director does not work full-time in PRTF then he/she must lead a team of one or more board eligible or board certified psychiatrists; the Clinical/Medical Director and team must collectively work at least forty (40) hours a week for the PRTF.

LICENSED CLINICAL SOCIAL WORKER (LCSW) who has a Master's degree in Social Work plus 3 years supervised full-time work in the practice of social work after the Master's degree,

LICENSED PROFESSIONAL COUNSELOR (LPC) who has a Master's degree,

OR

LICENSED MARRIAGE & FAMILY THERAPIST (LMFT) who has a Master's degree; and are licensed by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists.

SUBSTANCE ABUSE MANAGER (SAM), CERTIFIED ADDICTION COUNSELOR (CAC) or CERTIFIED ADDICTION COUNSELOR, Level II (CAC II), who has:

- a Bachelor's degree and at least 3 years experience in the practice of chemical dependency/abuse counseling
- 270 hours education in addiction field, and
- 144 hours clinical supervision;

And

- is certified by the Georgia Addiction Counselor's Association,

OR

- LCSW, LPC, LMFT with documented experience of no less than three (3) years in substance abuse/addiction counseling.

REGISTERED NURSE (RN) and **LICENSED PRACTICAL NURSE (LPN)** Clinical services and supervision must adhere to the appropriate state licensing and regulatory laws and requirements.

NON-CLINICAL DIRECT SERVICE STAFF-The direct service staff must be at least 21 years old, possess a high school diploma or GED. Preferred qualifications include one or more of the following:

- Two years of experience working with children and adolescents with Serious Emotional Disturbance and/or co-occurring Substance Abuse disorders
- Two years of post-secondary education in a human service related field and the study of child development.

Other professional and paraprofessional staff shall include, but not be limited to, appropriately licensed and/or certified educators, activity therapists, art therapists, and vocational counselors either on a regular basis or as consultants on a continuing basis.

Consultation shall be available as needed from dietitians, speech, hearing, and language specialists, and other therapeutic professionals.

600.4.2 Staffing Ratios

There must be sufficient full-time professional staff to provide clinical assessments, active therapeutic interventions and ongoing program evaluations, and to ensure sufficient supervision of all residents on a 24 hour a day basis. Staffing ratios must reflect the needs of the population served and should be increased when clinically appropriate and for safety. The following are minimum staffing ratios:

- Day Staffing should include the aforementioned licensed or certified clinical staff and one (1) Full Time Equivalent (FTE) RN. There should be a 1:5 direct service staff to resident ratio, not including the RN. There must be a maximum ratio of not more than ten (10) youth/young adult to one licensed clinical staff based on average daily attendance.
- Night staffing while residents are asleep should include one (1) FTE RN and a 1: 8 direct service staff to resident ratio. When there are nine (9) or more residents an additional staff must be added exponentially. Staff must be awake at night.
- Psychiatric coverage must be available 24 hours a day with a psychiatrist able to be on-site within one (1) hour. Nursing and psychiatric services must be available daily.

600.4.3 Staff Training

All training must be documented in the staffs' personnel file as well as a master training roster. Staff training and procedures must be in compliance with federal regulations for restraints and seclusions in Psychiatric Residential Treatment Facilities. Facilities must provide sufficient restraint/seclusion clinicians/nursing staff to provide coverage for needs of youth/young adults who may require restraint/seclusions.

A minimum of 40 hours of Orientation training designed to provide competencies in basic child development, interviewing skills, non-physical de-escalation/ intervention skills, child abuse/child protective service laws, fire safety, first aid, recognition of signs of physical distress in residents, active listening skills, agency policies and procedures must be attended by all new direct care and clinical staff hires. Each direct care and clinical staff person must have thirty-two (32) hours of in-service training annually. The following areas should be addressed:

- Community Based Alternatives for Youth (CBAY)
- Understanding System of Care principles and how to implement those principles in clinical practice, including discharge planning, continuity of care, and inter-agency collaboration, and the importance and imperative nature of working with families as partners
- Understanding cultural competency
- Understanding laws around Child Abuse and Child Protective Services, including reporting requirements, and signs and symptoms of abuse and neglect
- Characteristics of trauma informed care and attachment issues
- Mental Illness and SED/Co-occurring and other behavioral health needs in children as they relate to their bio-psychosocial needs
- State laws for medication administration, including understanding psychotropic medications, including types, appropriate uses and possible side effects
- Child development, normal and abnormal
- Best practices and methodologies for youth/young adult with SED and Co-occurring Substance Abuse disorders
- Documentation requirements and skills
- Understanding the recovery and resiliency models
- Restraint and seclusion
- HIPAA
- Safety, including infectious disease control, CPR/ first aid

600.4.4 Clinical Operations

Program Absences

A. Elopement

In the event a youth/young adult runs from the program, the facility shall notify law enforcement and the parent/legal custodian. If the youth/young adult is absent from the program for at least twenty-four (24) hours due to running away, the PRTF may bill for up to two (2) days. If the youth/young adult is located within fourteen (14) days and it is determined by the ASO that PRTF services are still appropriate, the PRTF must accept the youth/young adult back for treatment unless there is no bed available, at which time the PRTF is responsible for facilitating a lateral transfer. If this absence extends beyond fourteen (14) days, the PRTF shall discharge the child from the system through the ASO's electronic information system.

B. Leave

Appropriateness of therapeutic leave must be determined by clinical recommendations and/or safety concerns. PRTFs must assess each leave and determine the amount and type of supportive services that will be delivered to ensure that the leave is safe and effective for the youth/young adult and family. There must be evidence within the medical record of a clinical practitioner describing and justifying the use of therapeutic leave as it relates to the youth/young adult's treatment plan. Planned absences from the program for the purpose of transition/therapeutic leave will be paid at the unit rate, not to exceed three (3) consecutive days, based on midnight bed count. There will be no more than four (4) total absent days over any thirty (30) day period.

For any planned therapeutic leave from a PRTF, the following is required:

- A Leave Plan that includes:
 - Crisis plans
 - Therapeutic goals of leave
 - Information regarding how the PRTF will remain involved during youth/young adult's absence to ensure a safe and effective leave
 - Contact information handout (including names, phone numbers, etc.) for the family and youth/young adult to include:
 - PRTF
 - Therapist
 - Community Resources
 -
- PRTF must assess to determine the appropriate number of contacts made by the PRTF during the leave that will be clinically appropriate.
- PRTF must be available 24 hours a day to receive calls from youth/young adult or family
- PRTF must be available to take youth/young adult back on campus at any time
- PRTF staff (i.e. nursing or other licensed personnel) must process the leave outcome and review the Leave Plan goals with the youth/young adult and family within two (2) days of youth/young adult's return to campus

C. Acute Medical Care

Whenever it is necessary to seek medical treatment for a youth outside the PRTF (e.g. hospital services), the PRTF must discharge the youth on the date of service rendered by another provider in order for the other provider to be paid. The PRTF may choose not to discharge as long as it makes arrangements to pay the acute medical care provider directly. Discharge is mandatory for the youth/young adult to receive medical care that is an inpatient service and requires an overnight stay.

600.5 ATTESTATIONS

As a condition of participation, all PRTF providers must annually submit an **Attestation of Compliance**, indicating that:

- all requirements related to the use of emergency safety interventions in PRTFs as described in 42 C.F.R. 483, Subpart G are met

AND

- Effective January 1, 2013, Child Caring Institutions (CCIs) located on the same campus of a PRTF* **do not** serve a majority** of children who have a primary mental illness diagnosis for which active treatment is required.

* *Applicable only to PRTF's that share their campus with a CCI.*

** *"Majority" is specifically defined as "50% or more".*

Attestations are sent to the Department of Community Health and the Department of Behavioral Health & Developmental Disabilities annually. A facility enrolling as a Medicaid provider must meet this requirement at the time it executes a provider agreement with the Medicaid agency; a facility with a current provider agreement must provide its attestation to the State Medicaid agency by July 21 annually.

Attestations must include the following:

- a. Name, address, telephone number of the facility and the State provider identification number.
- b. Capacity: Total bed capacity; number of individuals currently served within the PRTF who are provided service based on their eligibility for the Medicaid inpatient psychiatric services for individuals under age 21 benefit and categorization by funding source; number of individuals, if any, whose Medicaid Psych under 21 benefit is paid for by any state other than the state of the PRTF identified in the attestation letter; identify by list all states from which the PRTF has ever received Medicaid payment for the provision of Psych under 21 services. See suggested format to demonstrate Capacity below.
- c. The signature of the facility director.
- d. The date the attestation was signed.
- e. A statement certifying that the facility currently meets all of the requirements of CMS standards §483.350 - §483.376 governing the use of restraint and seclusion.
- f. A statement acknowledging the right of the Healthcare Facility Regulation Division within the Department of Community Health, Administrative Services Organizations (ASO) or additional agencies, and, if necessary, CMS to
- g. conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences.

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- h. A statement that the facility will notify the State Medicaid Agency if it no longer complies with the requirements of the rule; and
- i. A statement that the facility will submit a new attestation of compliance annually and in the event a new facility director is appointed.
- j. A statement certifying that when the organization operates another type of program and/or facility that exceeds sixteen (16) beds on the same property as the PRTF, the organization ensures that the program/facility is separated physically, financially, administratively, and programmatically. The statement must further identify the type of program/facility that is co-located with the PRTF, and certify that the overall character of the program/facility is not established and maintained primarily for the care and treatment of individuals with mental diseases. The PRTF must attest to the ability to substantiate through documentation that at no time the number of youth/young adults with a primary mental illness diagnosis for whom active treatment was required constitutes fifty per cent (50%) or more of the program/facility's population.

Suggested format to demonstrate Capacity:

0	Total Bed Capacity		
1	Total Number of individuals receiving Medicaid inpatient psychiatric services for under age 21 benefit for year (July 22-July 21)		
2	Current bed occupancy as of July 22		
3	Does your PRTF also include a CCI on the same campus?	Yes _____ No _____	
4	If yes, what is the # of CCI children?	_____	
5	What is the percentage of the CCI children with a Mental Illness diagnosis?	_____ %	
6	a. Total number of individuals served during year who were/are GA Medicaid Members: Total: _____	Medicaid Fee-for-Service	
		Amerigroup	
		Peach State	
		Wellcare	
	b. Total number of GA residents served during year who were/are funded through private insurance:	Private Insurance	
7	Total number of individuals served during year who were/are funded through another State: Total: _____	#	State

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Assessment, Treatment and Discharge Planning

Comprehensive multi-disciplinary assessments are begun within twenty-four (24) hours of admission and include assessments of youth/young adult, family, community strengths and resources, and specific multi-modal treatment recommendations that target the specific factors that precipitated the admission. The assessment also must include comprehensive evaluations of the youth/young adult's medical (including screening for health risk and current health conditions, as well as laboratory workups including routine blood work and urinalysis), psychological, social, behavioral, and developmental issues, including developmental issues, including developmental milestones and course, family dynamics, current and past school issues, substance use/abuse issues, and a summary of prior treatment interventions including an assessment of their degree of success or failure.

An individualized treatment/resiliency and discharge plan must be completed within seven (7) calendar days of the admission. The plan must be signed by the youth/young adult, the parent/guardian for youth under the age of 18, and the therapist. For a youth admitted at age 17 ½, an independence plan must be developed, in conjunction with the treatment plan, within fourteen (14) calendar days of admission date. When a youth reaches the age of 17 ½ while in treatment, an independence plan must be developed within seven (7) calendar days of that milestone. The independence plan includes, but is not limited to, entitlements, housing options, life skill building, and behavioral health treatment options and how to access those options. The individualized treatment/resiliency plan must be provided under the direction of a physician and must incorporate the information gained from collateral contact with previous treatment providers. At a minimum, the treatment/resiliency plan must include goals, measurable treatment objectives, prescribe an integrated program of therapies and activities designed to meet the objectives, timeframes, and responsible parties. The treatment plan must address interventions which include: stressor reducing, support enhancing, and symptom reducing interventions specifically targeted to aid the youth/young adult's return to a less restrictive level of care.

An interdisciplinary team *must* review the treatment plan/discharge plan/independence plan at least every thirty (30) calendar days to:

- a. Determine that services being provided are, and continue to be, medically necessary and;
- b. Recommend changes in the plan as indicated by the youth/young adult's overall adjustment.
- c. Update and adjust the discharge plan to assure services are in place to meet the identified needs of the youth/young adult upon discharge and include parents/legal custodians, community partners, and others of pending discharge date if different from the previous plan.

The facility must actively and assertively engage the youth/young adult's family, legal custodian, or other natural supports in assessment, treatment plan development, treatment, and discharge planning. The family's involvement must be an integral part of the treatment/resiliency plan, unless clinically contraindicated. Evening and/or weekend services must be available to provide families access to programming. If contraindicated, there must be valid documentation.

**PART II -
700
SPECIAL ELIGIBILITY
CONDITIONS**

700.1 TARGET POPULATION

All Medicaid eligible children, adolescents, and young adults ages 21 or younger who:

- a. Require an intensive program in an out-of-home setting due to behavioral, emotional and functional problems which cannot be addressed safely and adequately in the home;
- b. Have a Mental Health Diagnosis; Co-Occurring Substance-Related Disorder and Mental Health Diagnosis; Co-Occurring Mental Health Diagnosis and Mental Retardation/Developmental Disabilities

700.2 DIAGNOSIS

Members must have a clinically significant disorder of thought, mood, or Behavior that is listed in the current edition of the American Psychiatric Associations Diagnostic and Statistical Manual of Mental Disorders.

Members must have a Level 6 CASSI (CALOCUS) score. **OR Child and Adolescent Needs and Strengths (CANS) - Trauma Comprehensive**

700.3 DURATION

The child's individualized treatment plan must describe the likely duration of the mental disorder.

The child must also meet the following criteria for ***continuing stay***:

1. Child/Adolescent continues to meet admission criteria; **and**
2. Child/Adolescent demonstrates documented progress or maintenance of skills relative to goals identified in the Individualized Treatment/Resiliency Plan.

The child must meet the following criteria for ***discharge***:

An adequate continuing care plan has been established; **and one or more of the following:**

- a. Goals of Individualized Treatment/Resiliency Plan have been substantially met and youth no longer meets continuing stay criteria;
or
- b. Family requests discharge and the youth is not imminently in danger of harm to self or others; **or**

- c. Transfer to another service is warranted by change in the child/adolescent's condition.

700.4 DISABILITY

The disability must result in serious functional limitations due to two or more of the following indicator:

- a. Behavior leading to public demand for intervention;
- b. Substantial risk of harm to self or others;
- c. Substantial inability to demonstrate daily living skills at an age appropriate level;
- d. Substantial need for care to augment or replace insufficient or unavailable natural support from a family or family equivalent unit;
- e. Significant delay in perceptive and expressive language development or learning ability; and

The member must:

- a. Display marked to severe impairment which disrupts academic and/or developmental progress; or
- b. Display marked to severe impairment which disrupts family, surrogate family or peer relationships; and
- c. Be in psychiatric distress and at risk of prolonged and significant problems without the receipt of the appropriate residential service.

700.5 EXCLUSIONS

Service Exclusions

All other Medicaid-reimbursable Behavioral Health Core and Specialty services are excluded until the individual has been unconditionally discharged from the PRTF.

Clinical Exclusions

Youth/Young Adults with the following conditions are ***excluded*** from admission because the severity of cognitive impairment precludes provision of services in this level of care:

- Severe and Profound Mental Retardation

The following diagnoses are not considered to be a sole diagnosis for this service:

- Personality Disorders
- Rule-Out (R/O) diagnoses

Youth/Young Adults with the following conditions are ***excluded*** from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for psychiatric intervention:

- Organic Mental Disorder
- Traumatic Brain Injury

Youth/Young Adults with the following conditions are ***excluded*** from admission unless there is clearly documented evidence that an additional psychiatric diagnosis is the foremost consideration for psychiatric intervention:

- Conduct Disorder

Youth/Young Adults with the following conditions are ***excluded*** from admission unless there is clearly documented evidence that a psychiatric diagnosis is the foremost consideration for this psychiatric intervention:

- Mild Mental Retardation
- Moderate Mental Retardation
- Autistic Disorder

Behavioral health issues must not include those behaviors that are indicative of the normal developmental process or delinquent behavior not associated with the identified behavioral health diagnosis.

PART II - CHAPTER 800

PRIOR APPROVAL/CERTIFICATION

Service must be pre-authorized/certified by the ASO. See Admission and Continuing Stay Criteria below.

Children/adolescents enrolled in this service are reported through a special MICP enrollment and reporting process defined by DBHDD.

800.1 ADMISSION CRITERIA (Effective 10/15/2010)

Youth/Young adult must meet the target population criteria as noted above, and one or more of the following:

Youth/Young adult has shown serious risk of harm in the past thirty (30) days, as evidenced by the following:

- Current suicidal or homicidal ideation with either clear, expressed intentions and/or past history of carrying out such behavior; and **at least one of the following:**
 1. Indication or report of significant and repeated impulsivity and/or physical aggression, with poor judgment and insight, and that is significantly endangering to self or others.
 2. Recent pattern of excessive substance use (co-occurring with a mental health diagnoses as indicated in target population definition above) resulting in clearly harmful behaviors with no demonstrated ability of child/adolescent or family to restrict use.
 3. Clear and persistent inability, given developmental abilities, to maintain physical safety and/or use environment for safety.

The clinical documentation supports the need for the safety and structure of treatment provided in a high level of care and the youth/young adult's behavioral health issues are unmanageable as evidenced by **both:**

1. There is a documented history of multiple admissions to crisis stabilization programs or psychiatric hospitals (in the past 6 months) and youth/young adult has not progressed sufficiently or has regressed; **and two of the following:**

Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs, **and**

Past response to treatment has been minimal, even when treated at high levels of care for extended periods of time, **or**

Symptoms are persistent and functional ability shows no significant improvement despite extended treatment exposure.

AND

Youth/Young adult and/or family has history of attempted, but unsuccessful follow through with elements of a Resiliency/Recovery Plan which had resulted in the exhibition of specific mental, behavioral or emotional behaviors that place the recipient at imminent risk for disruption of current living arrangement including:

- Lack of follow through taking prescribed medications,
- Following a crisis plan, **or**
- Maintaining family integration.

800.2 CONTINUING STAY CRITERIA (Effective 10/15/2010)

Youth/Young Adult continues to meet admission criteria when:

CAFAS/CASII/LOCUS/CANS scores continue to support PRTF level of care the individual is under the age of 22;

And

- The youth/young adult's treatment does not require a more intensive level of care, and no less intensive level of care is appropriate.
- The youth/young adult is actively participating in treatment, or there are active efforts being made that can reasonably be expected to lead to the youth's/young adult's engagement in treatment.
- Unless contraindicated, family, guardian, and/or custodian is involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
- If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress.

PART II - CHAPTER 900 REFERRAL TO PRTF

PRTF services require a referral. Because the Behavioral Health Core Services Provider serves as a clinical home and coordinates all behavioral health care services, the Core Services Provider determines when a youth/young adult requires PRTF services and makes the referral accordingly. The only exception to this referral process is when a youth/young adult is in another PRTF, a Crisis Stabilization Program or a State Hospital. In these cases, the PRTF, State Hospital, or DBHDD Crisis Stabilization Program (CSP) refers the youth/young adult for PRTF services respectively.

When making a referral, the authorized referring agency submits a prior authorization request from the DBHDD's Administrative Services Organization (ASO) to approve the PRTF services. For more detailed referral processes than described here, please see the DBHDD PRTF Provider Manual.

900.1 Referrals for Youth Covered by a Care Management Organization Each Care Management Organization under the auspices of the Department of Community Health has its own referral and application process. The PRTF is obligated to follow that CMO's referral, continued stay, and discharge processes. A CMO-covered youth/young adult is not eligible for a referral to the ASO for continued stay when the CMO has determined that the youth/young adult no longer meets their criteria for medical necessity for PRTF level of treatment.

Revised
07/2012

NOTE: CMOs are required to notify and explain to Medicaid members their appeal rights when denied a covered service. CMO's are also required to document this information in the member handbook and on the CMO website. Please defer to the CMO's website, handbook and/or 1800 numbers for detailed appeal procedures and/or grievance procedures if you experience issues regarding compliance with these requirements.

900.2 Referrals for DFCS Involved Youth

The Division of Family and Children Services (DFCS) may not make a referral directly for PRTF services, but must go through a Core Provider. To secure a referral to PRTF services for *youth/young adults in DFCS custody*, the DFCS may contact a Core Services Provider directly or contact the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225 or www.mygcal.com to identify a Core Provider. Once identified through the GCAL, an appointment will be made at the Core Services Provider agency for an assessment and potential referral.

It is incumbent upon DFCS to ensure that a youth/young adult eligible for Medicaid is in active Medicaid status throughout the youth/young adult's stay in the PRTF.

PART II - CHAPTER 1000

SCOPE OF SERVICES

Rev 07/01

1000.1 General

Psychiatric Residential Treatment Facility (PRTF) services provide comprehensive mental health and substance abuse treatment to children, adolescents, and young adults 21 years of age or younger who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the youth/young adult to the community. Focus is on improvement of residents' symptoms through the use of strength- and evidence-based strategies and active family engagement. The program encourages family participation in the treatment planning and implementation processes and timely discharge planning and aftercare. Specific outcomes of the services include the resident returning to his/her family or to another less restrictive community living situation, as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.

This service is provided to youth/young adults in order to promote stability and build toward age-appropriate functioning in their daily environment. Stability is measured by decreased frequency, intensity, and duration of crisis episodes and by increased and/or stable participation in school and community activities, or activities that encourage/support community inclusion. Supports based on the residents' needs are used to promote resiliency while understanding the effects of the emotional disturbance and substance use/abuse and to promote functioning at an age-appropriate level.

1000.2 Covered Services

Service activities include:

- diagnostic and assessment services
- development of an individualized treatment/resiliency plan
- psychiatric services
- nursing services
- medication monitoring and management
- evidenced-based treatment interventions
- individual therapy
- family therapy
- group therapy
- individual and group interventions that focus on addiction and harmful use/abuse issues and relapse prevention, if indicated

- substance abuse education
- activities that support the development of age-appropriate daily living skills, including positive behavior management/support
- activities that support and encourages the parents' ability to re-integrate the youth/young adult into the home and community; crisis intervention
- overall health monitoring
- activities which promote the youth's/young adult's skills in managing his/her own health
- consultation with other professionals including case managers, primary care professionals, community support workers, school staff, and others
- educational activities
- non-medical transportation services, on-going discharge planning, and transitional planning when appropriate, as needed to accomplish treatment objectives.

1000.2 Non-Covered Services

The following will not be reimbursed by Medicaid as part of the Psychiatric Residential Treatment Services Program:

- a. PRTF services to individuals involuntarily living in the secure custody of law enforcement, judicial or penal systems.
- b. PRTF Day of Discharge
- c. Community Mental Health (COS 440) services provided during a PRTF stay (with the exception of date of admission).
- d. Acute medical "outpatient" procedures unrelated to behavioral health needs and outside the PRTF plan of care (e.g. Emergency Room care).

PART II – CHAPTER 2000 BASIS FOR REIMBURSEMENT

2000.1 Reimbursement Methodology

Rev 12/09

Effective July 1, 2008, Psychiatric Residential Treatment Facilities (PRTFs) will be reimbursed at provider specific prospective rates based on 2006, or more recently available, cost reports, subject to maximum capped amount of \$370 per day (the cap). PRTFs will be reimbursed at a provider-specific, prospective per diem rate based on allowable costs as reported on the provider's Fiscal Year 2006, or more recent, cost reports filed with the Department of Community Health.

Annual reporting of audited allowable costs and utilization data adjusted to 90% of licensed capacity is used to find the program specific per-diem costs. DCH will apply the utilization standard of 90% of operational capacity for those PRTFs demonstrating appropriate staff to child ratios as described in Section 600.5.B. of this manual. Reimbursement is set at the lesser of cost or approved rate cap. These rates will be trended for inflation to the mid-point of each rate year (State fiscal year), based on the CMS Hospital Market Basket (Global Insight's Health Care Cost Service, Fourth Quarter Forecast for each rate year)

Rates for PRTFs that do not have 2006 or more recent cost reports reflective of the provision of PRTF services will be based on the median rate of other PRTF providers then in effect and subject to the cap. These initial rates will be subject to cost settlement and will be established as the lesser of the cost-settled rate or the cap. New PRTF providers are encouraged to submit per diem rate proposals based on budgeted estimates so long as these estimates are no greater than the median of rates then in effect. Upon notice of the provider specific rate, providers will have 30 days to appeal their new rates, based on the submission of an amended cost report.

PRTFs shall submit a cost report annually using a uniform cost report form prescribed by the Department of Community Health and supported by the facilities most recent certified financial audit. Cost reports are used as the basis for rate setting as well as establishing documentary support for federal reimbursement.

The definitions for allowable and unallowable costs and expenditures for federal claiming are based on federal criteria. For governmental entities these are identified in the Office of Management and Budget Circulars A-122, A-133 and A-87, "Cost Principles for Nonprofit Organizations", "Audit Principles for Non Profit Organizations" and "Cost Principles for State and Local Governments." Cost principles defining allowability for non-governmental entities follow Medicare reimbursement principles in the CMS Provider Reimbursement Manual (PRM 15-I). Allocation of reasonable costs to the program shall be supported by approved methodology and documentation retained by the reporting agency.

2000.2 Reimbursement Rules

Claim Submission

PRTF services are billed at a per diem rate as determined specific to each facility's cost report per the methodology described above. The Revenue Code 1001 and Procedure Code T2048 are the only codes recognized for PRTF claims. Claims are to be submitted according to the billing frequency as described below.

Frequency Billing

PRTFs must follow the prescribed frequency billing protocol as outlined below:

PRTF bill type and frequency codes are as follows:

- A. Type of bill for PRTF is 86 – Residential Facility.
- B. Type of bill frequency can be one of the following:
 - 1 - Admit through discharge claim
 - Use when there will only be one claim submitted for a date of service range beginning with date of admission and ending with date of discharge without breaks
 - 2 – Interim billing (first claim)
 - The first of a series of claims. Use when submitting the first of two or more claims for dates of service in a range when the range does not include a discharge date
 - 3 – Interim bill (continuing claim)
 - Use when submitting claims for dates of service in a range that do not include the date of admission or date of discharge
 - 4 – Interim billing (last claim)
 - Use when submitting the last claim for dates of service in a range which includes the date of discharge.
 - 6 – Adjustment of prior claim
 - Use when modifying information on a previously submitted claim.
 - 7 – Replacement of prior claim
 - Use when a previous claim for same member, same provider id and same dates of service has been voided and needs to be submitted again.
 - 8 – Void/cancel of prior claim
 - Use when a previously submitted claim needs to be voided and/or canceled.

Covered Days

Effective April 1, 2019, completion of the covered days field on all claims for PRTF services is required. This field cannot be left empty and should include the accurate amount of covered days in it. Information on how to complete the covered days field can be found in the Georgia Medicaid/PeachCare for Kids Provider Billing Manual UB-04 located at www.mmis.georgia.gov; Provider Information, Provider Manuals.

Rev April 2019

2000.3 General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will edit claims for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Please refer to the Medicaid and Peachcare for Kids Part I Policies and Procedures manual, Section 112, for more information.

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

The following resources are available for more information:

- Access the department's DCH-i newsletter and FAQs at <http://dch.georgia.gov/publications>
- Search to see if a provider is enrolled at <https://www.mmis.georgia.gov/portal/default.aspx>

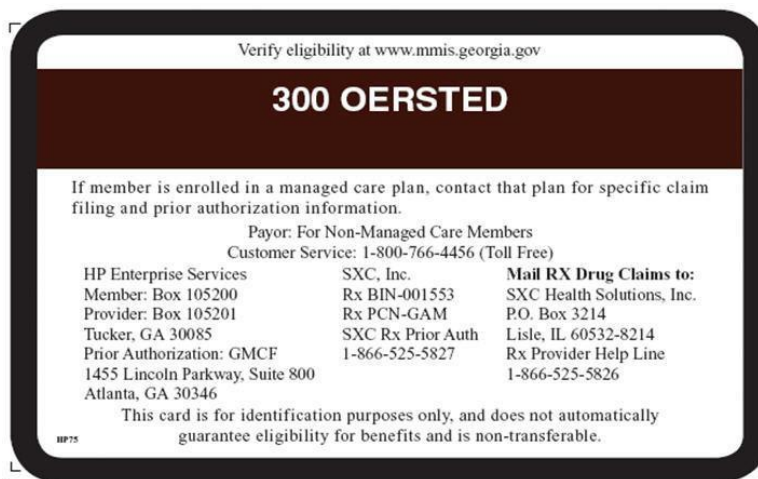
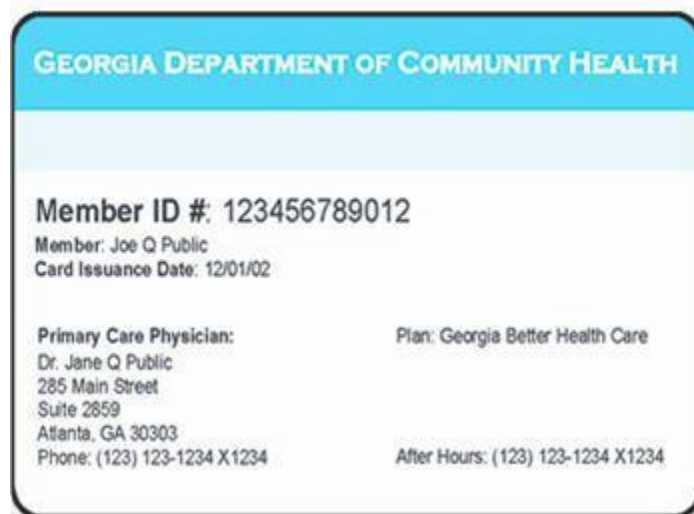
Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

- Access a provider listing at <https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx>

Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

APPENDIX A

Medicaid Member Identification Card Sample



APPENDIX B
DXC CONTACT INFORMATION

The most current and accurate contact information for DXC can be found at the following link:

<https://www.mmis.georgia.gov/portal/PubAccess.Contact%20Information/Links/tabId/45/Default.aspx>

APPENDIX C
PROCEDURE CODES AND RATES

Psychiatric Residential Treatment Facility services must be billed with a procedure code and revenue code. Rates and codes are as follows:

Revised October 2013

Procedure Code

T2048

Definition

Behavioral Health, Long Term Care, Residential, (Non-Acute care in a residential treatment program where stay typically is longer than 30 days with room and board per diem)

Revenue Code

1001

Definition

Residential Treatment/Psychiatric

A unit = 1 day.

Psychiatric Residential Treatment Facility (PRTF) Admission Review Form

35

1.16 Admission Diagnosis:		
Axis I Diagnosis (Primary)	Axis II Diagnosis (1)	Axis III Diagnosis (2)
Axis I Diagnosis (Secondary)	Axis II Diagnosis (2)	IO Score
Axis I Diagnosis (Tertiary)	Axis III Diagnosis (1)	M-GAF

1.17 Risk Symptoms & Behaviors necessitating placement into a Psychiatric Residential Treatment Facility (PRTF)				
Clinical Status				
1.	Does the consumer require residential treatment due to behavioral/emotional and family problems that cannot be addressed safely/adequately in the community/home?	Yes ☐	No ☐	
2.	Does the consumer require intensive, psychiatric treatment to decrease risk factors such as suicidal/homicidal ideation and/or aggressive behavior?	Yes ☐	No ☐	
3.	Is the consumer unable to return home or to a temporary residence at night due to psychiatric symptoms?	Yes ☐	No ☐	
4.	For at least the past 6 months, has the consumer been served at lower levels of care to address behavior and/or psychiatric symptoms with little/no success, or are those levels of care considered inappropriate due to behavioral health risks?	Yes ☐	No ☐	
5.	Is there evidence of significant family dysfunction or social relationship problems due to consumer's behavior and/or psychiatric symptoms?	Yes ☐	No ☐	
6.	Is there a family history of mental illness and/or substance abuse?	Yes ☐	No ☐	
7.	Is the family/caregiver willing to engage and participate in treatment as partners in the consumer's care?	Yes ☐	No ☐	
8.	Is the consumer eligible to return to their current home or community placement once they are appropriate to discharge from this LOC?	Yes ☐	No ☐	
9.	Is there a pattern of significant disruptive behavior, related to a diagnosed behavioral health disorder, negatively affecting functioning in school, community, or family lasting at least the previous 6 months?	Yes ☐	No ☐	
10.	Has the family/caregiver been informed and agreed to participate fully in family therapy sessions as deemed necessary and appropriate?	Yes ☐	No ☐	
11.	Does the consumer have a history of sexual offense?	Yes ☐	No ☐	
12.	Has the consumer been victimized? (please check all that apply)	Yes ☐	No ☐	
	☐ neglect ☐ physical abuse ☐ sexual abuse			
13.	Does the consumer have a substance abuse/dependence issue?	Yes ☐	No ☐	
Admission Criteria Narrative (Please give additional details explaining the symptoms and circumstances which preclude a less restrictive level of care and necessitate the PRTF level of care)				
1.18 Safety Concerns				
Has a safety plan been developed to ensure the consumer's safe transition from a residential placement back to your agency and the community following discharge? Yes ☐ No ☐				
Safety concerns are related to which support deficit? (Check all that apply)				
☐ Natural supports	☐ Behavioral supports	☐ Medical Supports	☐ School Supports	☐ Living Supports
1.19 Number of Out-of-Home Placements prior to current admission (Please check one)				
☐ 0-3		☐ 3-6	☐ 6-10	☐ More than 10

1.20 Current Symptoms and Severity

Indicate all symptoms/behaviors exhibited within the past 30 days and their level of severity, with 1 being mild and infrequent and 5 being the most severe and frequent. (see examples in Field Definitions document). All fields must be completed, if the symptom does not apply to this consumer select NA.

Aggressive Behavior	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Obsessive/Compulsive	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Conduct Problems	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Depressed	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Oppositional Behavior	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Manic	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Suicidal Risk	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Poor Hygiene	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Homicidal Risk	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Enuresis/Encopretic	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Self Injurious Behavior	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Sleep Disturbance	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Sexual Acting Out	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Appetite Disturbance	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Distorted Thinking	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Weight Gain/Loss	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Hallucinations	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Social Withdrawal	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Anxious	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	SA cravings/fixations	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
Impulsivity	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐	Elopement Attempts	NA ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Symptoms Narrative (please give more detail on all symptoms above that are > 3)

1.21 What other community behavioral health services have been attempted in the previous six months? (Check all that apply)

Type of Service	Frequency (Approximate)	Please indicate the consumer's level of progress and engagement in the services utilized. 1= None, 2= Minimal, 3=Moderate, 4= Significant	
		Progress	Engagement
☐ MH Day Treatment	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ SA Day Treatment	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ IPI/MST	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ CST	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Family Therapy	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Individual Therapy	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Group Therapy	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Crisis Intervention	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ CSI	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Medication Administration	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Activity Therapy	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Consumer/Family Assistance	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Crisis Stabilization	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Residential Supports (I, II, Other)	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Respite	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Other/List:	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Other/List:	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐
☐ Other/List:	☐ Daily ☐ Weekly ☐ Monthly ☐ PRN	1 ☐ 2 ☐ 3 ☐ 4 ☐	1 ☐ 2 ☐ 3 ☐ 4 ☐

Previous Treatment Narrative (please give additional details regarding the reasons previous treatment has not been effective)

Please complete the **PRTF Admission Packet Checklist Cover Sheet** and Fax to APS at 1-800-728-6524

APPENDIX E NON EMERGENCY TRANSPORTATION

Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950.**

Region	Broker / Phone number	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, ChASOkee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long,

		Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX F

Georgia Families

Rev July 2017

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

 Amerigroup Community Care 800-249-0442 www.myamerigroup.com	 CareSource 888-901-0014 www.caresource.com
 Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	 WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
PeachCare for Kids®	Aged, Blind and Disabled
Parent/Caretaker with Children	Nursing home
Children under 19	Long-term care (Waivers, SOURCE)
Women's Health Medicaid (WHM)	Federally Recognized Indian Tribe
Transitional Medicaid	Georgia Pediatric Program (GAPP)

Refugees	Hospice
Planning for Healthy Babies	Children's Medical Services program
Resource Mothers Outreach	Medicare Eligible
Newborns	Supplemental Security Income (SSI) Medicaid
	Medically Needy

Georgia Families

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid as well as new services. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education.

All four CMOs are State-wide.

The Department of Community Health has contracted with four CMOs to provide these services: Amerigroup Community Care, CareSource, Peach State Health Plan and WellCare. Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at **www.georgia-families.com** or call **1-800-GA-ENROLL** (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM

183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB <= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

APPENDIX G



Rev April 2014

Information for Providers Serving Medicaid Members in the Georgia Families 360SM Program

Georgia Families 360SM, the state's new managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population. DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM members will also have a medical and dental home to promote consistency and continuity of care. Providers, foster parents, adoptive parents and other caregivers will be involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements.

Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management will focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.

APPENDIX H
ICD-10 Overview

Rev July
2015

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