WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

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531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

POLICY METADATA

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BACKGROUND

This policy describes West Virginia Title XIX Medicaid's coverage for Psychiatric Residential Treatment Facilities (PRTF) and any service, procedure, or situation not discussed in this policy must be presumed not covered. Providers of PRTFs are required to provide services as they are outlined in this policy. Each agency is subject to monitoring and evaluation by all appropriate State entities and is bound to all requirements outlined in this policy. This policy does not address all the complexities of Medicaid policies and Procedures, and must be supplemented with all State and Federal laws and regulations.

A PRTF is defined as a separate, stand-alone entity or a distinct part of an acute care general psychiatric hospital which holds licensure in West Virginia as a behavioral health agency pursuant to West Virginia code §27-9-1 or §27-2A-1 and licensed as a child care agency pursuant to West Virginia Code §49-2B-3.

PRTF's located outside the State of West Virginia must meet all licensing requirements for PRTFs in the state where the facility is located and be certified to serve Title XIX recipients in that state as a PRTF. West Virginia is not in a position to interpret other state's descriptive designations to confirm that they do in fact comply with the PRTF designation. Therefore, if a state does not offer a PRTF designation on a license, facilities will be required to provide documentation from their state's licensing agency, signed and dated by the director of the state licensing agency, on official states' letterhead, that the facility meets all criteria for psychiatric residential treatment facility service provision as indicated in 42 CFR and is approved to serve Title XIX recipients in that state as a PRTF or evidence of certification as a PRTF provider from another jurisdiction. PRTFs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities, or any other accrediting body with comparable standards that are recognized by the State licensing agency. When different accreditation, certification or licensing standards exist, between West Virginia and the state where the facility exists, the more stringent standard must be followed, for West Virginia Medicaid members (West Virginia CSR §78-3-22.2. Accreditation Requirements).

The purpose of a PRTF is to provide full-time psychiatric treatment for children under age twenty-one (21) with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but whose symptoms are severe enough to require supervision/intervention on a twenty-four (24) hour basis. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22). (42 CFR §441.151). The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR §441.152(a)(3)).

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PRTF care is the most restrictive type of care for children. A secure facility is used for treatment of children who have been clearly diagnosed as having a psychiatric, emotional, or behavioral disorder that is so severe the child is a danger to himself or others. All services must be delivered under the direction and orders of a physician and psychiatrist. Educational services for the child must be provided on the grounds of the facility. The ultimate goal of the PRTF services is to promote a successful return of the child or adolescent into the community.

PRTFs are limited in size to 30 beds within the state of West Virginia according to the West Virginia State Plan. PRTFs providing services to children out of state are limited to the number of beds prescribed by that state's plan or licensure.

POLICY

531.1.1 PROVIDER PARTICIPATION REQUIREMENTS

To be certified as a PRTF, the facility must attest to meeting the Conditions of Participation (CoP) found in 42 CFR Subpart A, Definitions §440.160, 42 CFR Subpart D-Inpatient Psychiatric Services for individuals under age 21 in Psychiatric Facilities or Programs, sections §441.150 - §441.182, Subpart G, Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21, 42 CFR Subpart G, §483.350 - §483.376.

Each PRTF that provides inpatient psychiatric services to individuals under age 21 must attest, in writing that the facility is in compliance with CMS' standards governing the use of restraint and seclusion. This attestation must be signed by the Facility Director. A facility with a current provider agreement with West Virginia Medicaid must provide that attestation to BMS at the time of enrollment and yearly by July 21, or upon a change in the Facility Director. (42 CFR §483.374).

Providers of PRTF services will receive a reminder to submit the attestation letter to BMS' fiscal agent 90 days prior to July 21 each year. Facilities failing to submit the attestation letter will be considered in non-compliance and will be subject to withholding payment until the facility is in compliance.

In order to participate in the West Virginia Medicaid program for reimbursement of covered services provided to West Virginia Medicaid members, PRTF services must be approved through BMS' fiscal agent contract enrollment process **prior** to billing for any services. *Chapter 300, Provider Participation Requirements* presents an overview of the minimum requirements that health care providers must meet to enroll in and be reimbursed by the West Virginia Medicaid Program.

All providers are required to meet eligibility requirements. In addition to the licensing and certification requirements, all PRTF's must maintain good standing with the West Virginia Bureau for Medical Services, the West Virginia Bureau for Children and Families (BCF), and the West Virginia Department of Education, (DOE) in order to continue to participate as a West Virginia Medicaid provider. The Bureau for Medical Services requires that all educational instruction for West Virginia Medicaid members meet West Virginia standards, unless the standards are higher in the state where the PRTF is located. West Virginia is the final arbitrator of whether the treatment services or educational standards are sufficient for West Virginia Medicaid members. Failure to remain in good standing with the BCF and/or DOE resulting in admission restrictions by BCF will result in admission restrictions by the Bureau for Medical Services. If

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the state agency licensing the facility places admission restrictions on the PRTF facility as a result of a negative review of services, the West Virginia Bureau for Medical Services will place admission restrictions on the facility until the negative action is corrected and BCF/BMS is notified by the licensing agency that the admission restrictions have been lifted.

All providers are required to sign/date a West Virginia Medicaid Provider Agreement. Additionally an agreement specific to psychiatric residential treatment services must be signed/dated by the Administrator. This agreement may be renewed at BMS' discretion and is subject to the terms and conditions contained therein and all applicable state and federal law and regulations.

The goal for WVDHHR is for all children to be served within the state. Out-of-state facility applications for enrollment with West Virginia Medicaid will be considered **ONLY** if a child in DHHR custody requires this level of service and the service is not available to meet the child's needs in West Virginia.

531.1.1.1 Physical Environment/Equipment

The facility must be housed, equipped, and maintained in a manner that is suited to the program of services being provided and that reflects the facility's positive regard for its members. The physical environment must be consistent with contemporary, accepted concepts of service and care and is one that enhances individual dignity and feelings of self-worth for the members served.

Bedrooms must be adequately furnished and provide a minimum of 80 square feet of floor space per person for one person occupancy and a minimum of 60 square feet of floor space per person for two or more person occupancy. Each member of a facility shall be provided a permanent, separate bed with a clean, comfortable, covered mattress, clean bedding, clean towels, and other furnishings appropriate to the length of stay and needs of the member. Each bedroom window must have covering for privacy. Furnishings shall be homelike and personalized.

The facility must allocate sufficient space and safe and varied equipment for outdoor play to meet the member's recreational needs.

Offices or rooms must be available and accommodating to personnel to engage in interviewing or counseling families and children in a private and confidential manner.

The West Virginia DHHR through BCF, BMS, and the West Virginia DOE through the Office of Institutional Education Programs (OIEP) and the Office of Special Programs (OSP) have engaged in a collaborative effort to evaluate and monitor the quality of services provided by all PRTFs on an annual basis. This is to ensure children are in a safe environment and are provided behavioral health treatment and educational services commensurate with acceptable standards as set forth by West Virginia DHHR and the West Virginia DOE.

531.1.1.2 Non-Discrimination

The facility must assure that no person shall be excluded from participation, denied benefits, or otherwise subjected to discrimination in the performance of the services or in employment practices on the grounds of disability, age, race, color, religion, sex, national origin, or any other classification protected by federal, West Virginia State Constitutional, or statutory law.

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- Written facility policy must assure that the need for the facility's services are the primary criterion of eligibility and its services are offered without discrimination.
- The facility must have a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer, and promotion of employees.
- The facility must actively recruit, employ, and promote qualified personnel broadly representative of the community it serves and administer its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, disability, or religion of the individual under consideration.
- The facility provides for internal and external dissemination of its equal opportunity policy and recruitment materials that specify the nondiscriminatory nature of the facility's employment practices.
- If the facility recruits and selects with regard to specific characteristics, it does so with the needs of the facility's defined clientele in mind and in accord with exemptions in the law(s) governing equal opportunity employment.
- The facility shall show proof of nondiscrimination and post in conspicuous places, available to all employees and applicants, notices of nondiscrimination.
- The facility is free of those architectural barriers that restrict the employment of or use by personnel with disabilities. Likewise, the facility is free of architectural barriers that restrict use by the aged, families with young children, and persons with disabilities and/or makes provision for use of accessible facilities in order to provide services to persons with disabilities.

A copy of the Resident's Rights and Responsibilities is visibly displayed in the facility. At time of admission the West Virginia Medicaid member and the parent/guardian must be provided with a clearly written and readable statement of rights and responsibilities. The statement must be read to the resident or parent/guardian if either cannot read.

531.1.1.3 Staffing Requirements

PRTF's participating in the West Virginia Medicaid program are required to have the following staff:

1. **Facility Director**: The governing body of the PRTF must appoint a Facility Director to be responsible for the overall management of the facility. The Facility Director must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The Facility Director is responsible for the fiscal and administrative support of the facility's clinical program.
2. **Medical Director**: The facility must appoint a medical director to be responsible for coordinating medical services and directing member treatment. The medical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.
3. **Clinical Director**: The facility must appoint a full-time director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be a board eligible or board-certified psychiatrist (experienced in child/adolescent psychiatry), a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, a licensed psychologist who is experienced in child/adolescent mental health treatment, a psychiatric mental health nurse practitioner (PMHNP)/advanced practice registered nurse (APRN) who is experienced in child/adolescent mental health treatment, or a Licensed Professional Counselor

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(LPC), a Marriage and Family Therapist (MFT) or a licensed certified social worker who is experienced in child/adolescent mental health treatment. A board eligible or board-certified psychiatrist with experience in child/adolescent psychiatry (or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry) may serve as both medical director and clinical director provided that he/she is a full-time employee.

4. **Professional staff**: The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate residential supervision 24 hours a day, seven days a week. Professional staff must be appropriately licensed, trained, and experienced in providing mental health and residential treatment.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist; (as indicated by needs of child);
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s);
- A Recreation Specialist; and,
- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

The PRTF must notify BMS of changes in the facility director, medical director or clinical director. The Director of Facility Based & Residential Care at BMS must receive notification via the signed/dated Attestation Letter from the facility, in writing within 72 hours of the effective change.

Attestation Letters must be mailed to BMS, Attention: Office Director, for Facility Based and Residential Care.

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

The staffing ratio for a PRTF shall be one staff to three members (1:3) during day and evening hours (one staff whose primary responsibility is providing direct care for every three children) and (1:6) during sleep hours with the capability to increase staff ratio in response to acuity, extending to the provision of one-on-one (1:1) care when necessary. (78 CSR §3.22.3 Employee Ratios) Staff assigned to work a defined unit and providing care to the children on that unit including nursing, teachers, and activity's therapists can be included in the staff to client ratio. Staff assigned to supervisory duties or whose duties cause them to be away from the unit (nursing supervisor) cannot be included in the count.

531.1.1.4 Fingerprint-Based Background Check

West Virginia Code, Chapter 49 (Child Welfare), Article 2B, Section 8 requires a criminal background check of personnel criminal records for licensed, certified and registered child welfare agencies. The Adoption and Safe Families Act requires criminal background checks on all individuals and agency staff providing care for foster children.

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A thorough Fingerprint-Based Background Check and review by a Federal Registry is required with results of an on-line preliminary check available for review **PRIOR** to employment of any individual (including volunteers) who will be working in a facility providing treatment or care for **all** West Virginia Medicaid members (custodial and non-custodial). The on-line preliminary results may be used for a period of three months (90 days) while awaiting the final results of fingerprinting. During that time period the individual may **not** work unsupervised. Results of the Fingerprint-Based Background check must be documented in the personnel file **within three months (90 days)** of hiring the employee. (Refer to requirements listed below regarding exclusions/sex offender registries lists which must be completed with a negative result prior to hiring or allowing to volunteer.) An applicant must complete a Statement of Criminal Record every two years after the initial submission to the respective agency or department. A subsequent Fingerprint-Based Background Check must be completed at least every five years, but may be submitted at any point if there is an indication that the Fingerprint-Based Background Check information may have changed.

The applicant shall not be approved, employed, utilized, nor considered for employment if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, malicious wounding, unlawful wounding, felonious domestic assault or battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Misdemeanor domestic battery or domestic assault;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Health care fraud; and
- Felony forgery.

The applicant shall not be approved or employed if on parole or probation for a felony conviction.

It is the responsibility of the employer to check the list of excluded individuals/entities (LEIE) monthly at:

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- (LEIE) at: http://exclusions.oig.hhs.gov/;
- (Formerly EPLS) https://www.sam.gov/;

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, on a monthly basis. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

531.1.1.5 Staff Training

A PRTF that contracts with DHHR ensures that qualified personnel meet or exceed the requirements for pre-service and in-services trainings with respect to facility objectives, policies, services, community resources, DHHR policies, and best practice standards. See 78 CSR 3-11 for training and Supervision of Employees.

The facility is required to document evidence of the participation/completion of all employee training and retain in each personnel record the required new worker orientation and annual in-service training, as well as any in-service training provided by the facility during the year. Facilities will provide proof by individual employee records that training requirements are fulfilled. Review of those records will occur during monitoring both by the UMC retrospective reviews and the Certification Review Process as well as review by the Office of Program Integrity (OPI). Personnel records must reflect the date of training, number of training hours, and the signature of the participant.

In addition, the facility will keep a log/calendar of ongoing training that includes the title of the training, the type of training (video/lecture/lab), dates of training, location of training, sign-in sheets, subject matter, name, phone number, credentials of the instructor and any reviews by employees.

All training is to be provided by licensed or certified professional staff, or an agency qualified trainer. Video, audio, and on-line or web based trainings are restricted to no more than 50% annually for each employee. Training which includes live lecture must also contain demonstration and the active participation of employees. Training attendees are expected to attend training for the entire session. The log on training is to be kept by the facility for a period of five years.

531.1.1.6 Direct Care Staff, Case Manager, and All Clinical Staff

All direct care staff shall have a minimum of a high school diploma or GED and professional staff shall have appropriate education and certification consistent with professional licensing standards. (78 CSR §3-22.4.a. Employee Training and Credentials).

Personnel development is an ongoing, integral, and identifiable part of the facility's program of services, and the facility has specific guidelines as to the time commitment expected of personnel in various positions. Pre-Service Training including all of the following that demonstrates training sessions last at a minimum eight and one-half hours excluding first aid and CPR training which are prescriptive in nature with specific training criteria.

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The following pre-service training is required:

All personnel are required to have pre-service and annual in-service trainings in the following topics.

- All appropriate/applicable facility policies,
- Conflict resolution,
- Member rights,
- Managing behavior,
- Psychiatric emergencies,
- First aid (All staff having direct contact with West Virginia members must receive training in first aid.),
- CPR (facility staff member must be immediately available who has been trained in CPR.),
- Incident reporting/completion/follow up,
- Recognition of substance abuse,
- Elopement procedure/reporting
- Child abuse prevention/reporting,
- Suicide prevention,
- HIPAA/Confidentiality
- Emergency/Disaster Preparedness,
- Infection Control,
- Sexual harassment including prevention,
- Cultural awareness,
- De-escalation procedures.

All training sessions must include both lecture and active participation (return demonstration) activities for the staff.

All policy on de-escalation, restraint, seclusion, CPR certification, and requirements must be readily available to all staff 24 hours a day, seven days a week. The facility shall post in a centralized location the name of at least one person who is on-duty with proper CPR certification for the use of all staff at all times West Virginia Medicaid members are in the facility. Evidence of current certification in CPR must be maintained and available upon request.

All staff utilizing or monitoring restraints must do so as required under federal regulations. Such staff shall be CPR certified and fully trained and certified in nationally recognized physical restraint methods. Facility policy regarding Restrain/Seclusion must be readily available to all staff 24 hours a day, seven days a week.)

(See also *Section 531.1.9 and its subparts on Specialized Procedures/Seclusion/Restraint*).

531.1.1.7 Confidentiality

Strict standards of confidentiality of medical records and information must be maintained in accordance with applicable state and federal law. The facility must have written policies and procedures governing access to, use of, and release of all information about its members, and assures that such policies meet

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any applicable legal requirements. Written policies must be approved by the governing board and must specify the responsibility of all personnel for maintaining confidentiality of information contained in member and personnel records.

A release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, the parent or legal guardian (when the West Virginia member is a minor), authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A West Virginia member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need to know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of West Virginia Medicaid members are to be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays or for promotional materials, are prohibited.

All West Virginia Medicaid member information is kept locked in a secure place.

531.1.1.8 HIPAA Regulation

Providers must comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all corresponding federal regulations and rules. The enrolled provider will provide upon request of BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of BMS.

Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

531.1.1.9 Emergency/Disaster Preparedness Procedures

The facility's governing body/designee must establish written procedures for personnel to follow in an emergency/disaster. Evacuation of a facility may become necessary in the event of an emergency/disaster (e.g., fire, smoke, bomb threat, explosion, prolonged power failure, structural damage, water loss or sewer loss, tornado, flood, earthquake, chemical leak, chemical spill, or elopement. This is not an all-inclusive list of emergency/disasters). The facility's emergency/disaster care procedures must include at a minimum:

- Care of the child;
- Notification of the attending physician/psychiatrist, EMS, law enforcement, parent/guardian and other persons responsible for the West Virginia Medicaid member;
- Arrangements for transportation;
- Arrangements for hospitalization;
- Arrangements for other appropriate services;

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- Arrangements for emergency physician/psychiatrist services and;
- An elopement plan and;
- An evacuation plan.

The facility's governing body/designee must ensure staff rehearses, at a minimum annually, the facility's emergency/disaster plans. Fire drills must be conducted as required by the state where the facility is located.

531.1.1.10 Infection Control

The facility must have in place policy and procedures approved by the governing board that address:

a. Infection control policies and practices (e.g. **hand washing**, glove use, isolation procedures, and outbreak precautions).
b. The potential for the spread of infection in bathrooms, bedding, food preparation areas, prevention of the spread of preventative infection control practices including; infectious diseases including antibiotic resistant strains of bacteria, Cabapenem Resistant Klebsilla Pneumoniae (CRPK), Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcl (VRE), Clostridium Difficile (C Diff), eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, nosocomial infection, etc.
c. Locked storage of cleaning supplies and hazardous materials, including medication in a safe locked location, with all controlled medications under double locks.
d. Maintenance of a hazard-free environment in facilities through a daily log of all refrigerator temperatures and water temperatures, covering electric outlets, securing floor covering or equipment, and reviewing the adequacy of lighting and ventilation.
e. Policies and Procedures for the use of personal protective equipment (PPE).
f. Policies and Procedures concerning the cleaning of blood spills, Biohazards.
g. Policies and Procedures to cover safety measures when physical injuries occur.

531.1.1.11 Parental Involvement

Services are provided to children in order to meet their permanency needs. Each child served is prepared for a placement outside the home and:

- helped with conflicts about the placement and separation from family members;
- encouraged to maintain contact with the biological family and provided with support in making such arrangements, unless specifically contraindicated because of the child's safety;
- provided information about parents activities and progress toward the goal of returning home, unless the home is not a possibility;
- provided with assistance in maintaining the relationship with siblings through visits and shared activities; and
- prepared for the return home, adoption, or for placement in a stable, nurturing environment that is to be permanent, and when this in not possible;
- prepared for independent living and helped to identify a significant adult with whom a relationship can be maintained.

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Permanency is the primary goal for discharge. As permitted under the law and as appropriate for the child's safety and well-being, the facility shall make efforts to engage the parents in continuing contact with their child and implementing the plans for permanency for the child. Such contact shall include participation in developing case plans, updating the parents on progress and inviting the parents to all case conferences.

When in the best interests of the child, the facility designs and implements service in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles. A written plan of family involvement, when appropriate, shall be developed at intake and updated no less than quarterly. The plan of family involvement will address but not be limited to the following issues:

- visitation guidelines and/or restrictions;
- facility responsibility for working with the family;
- the state agency's (BCF) responsibilities for working with the family;
- any other appropriate issues.

The facility must provide coordination of social services to children, adults, and families as needed. The goals of such services may include family reunification, to stabilize family ties, or to obtain a permanent family for a child receiving services in the PRTF.
Services must be provided to help the child's parents maintain and enhance parental functioning, parental care, maintenance of parent-child relationships, or when in the best interest of the child termination of parental rights.

531.1.1.12 Incident/Accident Reporting and Policy

PRTF's are required to maintain a written Incident/Accident Reporting Policy in a centralized location for easy access to all staff personnel. The written policy must be approved by the governing body of the facility.

The facility accepting/admitting West Virginia Medicaid members for care must ensure that they are cared for in an environment which meets high standards of safety and maintenance and that special precautions are taken that no harm or injury to the member occurs. The facility promptly reports to appropriate state and/or legal authorities any serious accident, emergency, or dangerous situation, including immediate verbal reporting of instances of child abuse, and reports to parents or legal guardians any of the above which affect their child or the child for which they are responsible. The PRTF must **verbally** report to the parent/legal guardian any accident or incident involving a child which results in injury within 24 hours of the facility's knowledge of the accident or incident. The PRTF must **verbally** report suspected abuse or neglect of a child to the parent/guardian and the appropriate authorities in the state where the facility is located within 24 hours of the facility's knowledge of its occurrence with a detailed written report within five days. The PRTF must **verbally** report the findings of abuse and neglect investigations conducted by the state where the facility is located within 24 hours of completion of the investigation, with a detailed written report within five days.

Incident/Accident reports will be forwarded the following business day to BMS, Attention: Office Director, for Facility Based and Residential Care. Reports must be mailed to:

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West Virginia Department of Health and Human Resources
Bureau for Medical Services
Office Director, Facility Based & Residential Care
350 Capitol Street, Room 251
Charleston, West Virginia 25301

Serious injury of a West Virginia Medicaid member is defined as any significant impairment of the physical condition of the member as determined by qualified medical personnel. This includes, but is not limited to:

- Burns, lacerations, substantial hematoma requiring medical intervention by a licensed physician.
- Bone fractures
- Injuries to internal organs, whether self-inflicted or inflicted by someone else
- Suicide attempt
- Elopement (See also *Section 531.1.6.2, Elopements/Run Away*)
- Any allegations of sexual contact (member/member, member/staff)
- Any allegation of abuse and/or neglect
- Any injury of a member while in seclusion or restraint (See also *Section 531.1.9 and its subparts on Specialized Procedures/Seclusion/Restraint*)
- Medication errors requiring medical intervention by a licensed physician.

A death of ANY member or a serious incident involving harm to ANY member, regardless of whether they are a West Virginia Medicaid member or not, must be reported as follows:

- Immediately upon death (within eight hours) a phone call must be made to BMS at (304) 558-1700. If the death is that of a West Virginia Medicaid member, staff must identify the name of the member and a narrative description of the incident. If the death is not a West Virginia Medicaid member, the caller must provide sufficient details that will permit review of the incident.
- Within 24 hours, facility staff must fax a written report to BMS at (304) 558-1542.
- Immediately notify local law enforcement of the incident.

Reports may be faxed to the Bureau for Medical Services at (304) 558-1542, Attention: Director, Office of Facility Based and Residential Care.

531.1.1.13 Quality Assurance/Utilization Review

The facility must have an ongoing quality assurance program in which each service of the facility and service to individual members is reviewed quarterly and monitored in order to promote the highest quality service, to resolve problems that are identified, and to assure that services meet the facility's expectations as to outcome.

The overall scope of the quality assurance program is described in a written plan that describes mechanisms, committees, or other methods used to coordinate the facility's approach to monitoring and evaluating the quality and appropriateness of service.

The facility must set goals and objectives for the benefits or outcomes to be achieved by members who use the facility services, and on a regular basis the facility conducts member satisfaction surveys or

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utilizes other methods of determining the outcome of its services, including the reasons for termination of members who drop out of service, to the extent this can be ascertained.

The facility must monitor the quality of care and review the appropriateness of service at least quarterly.

The facility must have a utilization review or other quality assurance mechanisms that ensures that the cases of all members are formally reviewed on a quarterly basis.

The facility must participate in utilization reviews at least every 30 days. Utilization reviews are to include the Bureau's Utilization Management Contractor (UMC) representatives to evaluate the necessity, appropriateness, quality, and intensity of individual member services to facilitate permanency and less restrictive service delivery as soon as possible. The utilization review focuses on appropriateness and effectiveness of member services, and reduction of length of stay in out-of-home care. Documented, measurable criteria are utilized in the review process, extended treatment or service, changes in status or level of need presented by the member, and/or other criteria developed by the facility. Retrospective review of prior authorization requests and relevant clinical information will be conducted on and off site by the UMC. Requested information will be provided for reviews.

The facility cooperates with authorized external review systems (including the Bureau's Utilization Management Contractor (UMC), the Bureau for Children and Families (BCF), and the West Virginia Department of Education (DOE)), and, where applicable and where possible, organizes its internal review schedules to complement those conducted by external review systems.

531.1.1.14 Out-of-State Certification/Review Process

West Virginia Code 49-7-34 establishes the Commission to Study Residential Placement of Children. The Commission has been actively involved in carrying out their responsibilities since 2005. The Commission was to study and provide recommendations regarding:

- Current practices of placing children out-of-home and into residential placements, with special emphasis on out-of-state placements and,
- ways to certify out-of-state providers to ensure that children receive high quality services consistent with this state's (West Virginia) standards of licensure and rules of operation.

As a result of their work, recommendations currently being implemented include:

- Requirements that out-of-state placements be made **only** to providers meeting West Virginia standards of licensure, certifications, and expected rules of operation.
- Requirements that ensure education standards are in place and students are fully receiving the appropriate education services in all out-of-state facilities where West Virginia children are placed.

The West Virginia DHHR through BCF, BMS, and the West Virginia DOE through the Office of Institutional Education Programs (OIEP) and the Office of Special Programs (OSP) have engaged in a collaborative effort to evaluate and monitor the quality of services provided by out-of-state facilities. This is to ensure children are in a safe environment and are provided behavioral health treatment and

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educational services commensurate with acceptable standards as set forth by West Virginia DHHR and the West Virginia DOE.

The Team representing West Virginia DHHR and West Virginia DOE will conduct on-site reviews of facilities out-of-state that are providing services for West Virginia children. Focus will be on **all** West Virginia Medicaid members. West Virginia's ultimate goal is to solicit services from only facilities having demonstrated success in promoting positive growth and expected outcomes for children as defined within the West Virginia Out-of-State Facilities Standards.

When BMS has identified unnecessary and inappropriate practices through monitoring or other reviews, it may pursue one or more of the following:

- Recoupment of inappropriately paid monies;
- Requirement of a satisfactory written plan of correction;
- Limited participation in the plan that may include:
  - Prior authorization for all services;
  - Prepayment review of all applicable claims;
  - Suspension of payment until a plan of correction is filed and accepted;
  - Suspension of Medicaid admissions in the case of outpatient or inpatient facilities;
  - Ban on approving admissions for inpatient services.

When deficiencies are identified within the facility that constitute an immediate danger of serious harm to the child/children served by the facility, immediate action will be taken to remove the child/children from harm. That state's surveying agency will be notified immediately of the identified deficiencies.

In those instances BMS may pursue exclusion from participation in the West Virginia Medicaid Program through the following actions:

- Suspension;
- Disenrollment;
- Denial, non-renewal, or termination of provider agreements.

Refer to *Chapter 100, General Administration and Information* for details regarding compliance issues.

531.1.1.15 Corrective Action Plans

Within ten working days after receipt of the request for a plan of correction, the organization shall submit to the Secretary for approval a written plan to correct all areas of non-compliances that are in violation of this rule, unless a variance is requested by the organization and granted by the Secretary. The plan shall specify:

- Any action taken or procedures proposed to correct the areas of non-compliance and prevent their reoccurrence;
- The date or projected date of completion of each action taken or to be taken; and
- The signature of the chief executive officer or his or her designee.
- The Secretary shall approve, modify or reject the proposed Corrective Action Plan in writing. The organization may make modifications in conjunction with the Secretary.

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- The Secretary shall state the reasons for rejection or modification of any Corrective Action Plan.
- The organization shall submit a revised Corrective Action Plan within ten working days whenever the Secretary rejects a Corrective Action Plan.
- The organization shall immediately correct an area of non-compliance that risks the health or safety of child or other persons.
- The Secretary may determine if corrections have been made.

Once a plan of correction has been accepted by the state educational institution, certification institution, surveying agency, licensing or certifying agency, it must be sent immediately to the following address:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301

531.1.1.16 Waivers and Variances

A center shall comply with the provisions of West Virginia Code §49-2B et seq., the requirements of this rule, terms of the license or certificate of approval and any plan of correction, unless a written waiver or variance has been granted by the Secretary. A center may not obtain a waiver of the requirements of this rule on the basis of the inability to achieve compliance with the rule.
A request for a variance shall be submitted to the Secretary in writing. The request shall include:

- The specific requirement of this rule to be waived or varied: and
- The reason or reasons for seeking a waiver or variance.

A waiver or variance of a specific provision of this rule may be granted by the Secretary only if the following criteria are met:

- The center has documented and demonstrated that the provision of the rule is inapplicable in a particular circumstance, or that the center complies with the intent of the provision in the rule in a manner not permitted by the rule;
- The health, safety, and well-being of a child is not endangered; and
- The waiver or variance agreement contains provisions for a regular review of the waiver or variance;
- The waiver or variance agreement is subject to immediate cancellation if the center fails to comply with the stated terms of this rule.

531.1.1.17 Notice to BMS and Legal Guardian/Parent of Adverse Action

PRTF's are required to inform BMS within 72 hours of all deficiencies noted by any state educational institution, certification institution, surveying agency, licensing agency or any other state certification entity. Deficiencies include standard and complaint investigations.

The written notification and a copy of any notice, survey, or complaint may be sent to, Attention: Office Director, for Facility Based and Residential Care. Reports must be mailed to:

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When there is an adverse review of a facility that identifies moderate potential for harm or direct harm, termination of certification or a provider agreement, the facility must notify all West Virginia Medicaid members legal guardian/parent by regular mail within 72 hours of receipt of the deficiencies or termination notice. A copy of the letter of notification must be included in the West Virginia Medicaid member record.

531.1.2 MEDICAL ELIGIBILITY/MEDICAL NECESSITY

The West Virginia DHHR, BMS, utilizes a Utilization Management Contractor (UMC) to certify West Virginia Medicaid member medical necessity for admission and continued stays in all PRTF's. BMS is not financially responsible for reimbursement of a West Virginia Medicaid member who is not prior authorized for admission or continued stays in any facility by the UMC. The facility may not bill the West Virginia Medicaid member for any charges unless it is specifically documented, signed and dated that the parent/guardian is made aware and understands that West Virginia Medicaid will not reimburse for the service and the parent/guardian understands and agrees to pay for services.

PRTFs provide treatment to individuals under the age of 21 with severe emotional disturbances and/or long term psychiatric illnesses. The service must be provided before the individual reaches 21 years of age. If the individual was receiving services immediately before he or she reaches age 21, the services must cease at the time the individual no longer requires services or the date at which the individual reaches 22 years of age. (42 CFR §441.151(3)(i)(ii)).

Children in parental custody are referred to as non-custodial placements. When parents place their child in a PRTF, documentation must indicate the child has been receiving services in the community for at least **six months** with significant functional deficits in the school, home, and community except as a planned step down from acute care. Participation in the treatment process by the child and support for treatment by the parent must be documented and provided upon request for the prior authorization for services. The referring physician/psychiatrist, not affiliated with the receiving facility, must provide documentation of treatment and/or lack of response to treatment. The referring physician/psychiatrist, not affiliated with the receiving facility, must certify the need for this level of service and complete, sign and date the MCM-1 (Appendix 531.1 - MCM-1). The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. The child must meet all other admission criteria set forth for PRTF level of care also (see admission criteria).

531.1.3 SERVICE PROVISION

PRTFs provide a range of comprehensive services to treat the psychiatric condition of members on an inpatient basis under the direction/order of a physician/psychiatrist. The purpose of such comprehensive services is to provide treatment to individuals under age 21 with severe emotional disturbances and/or long term psychiatric illnesses. Symptoms are complex and of a significant duration, that have not responded to shorter-term interventions and/or community based interventions. Psychiatric care is provided to individuals under the age of 21 that do not require acute psychiatric care, but whose

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immediate treatment needs require active treatment on a 24 hour inpatient basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. PRTF services are generally short term (nine to twelve months) inpatient services intended to improve the West Virginia Medicaid member's condition or prevent further regression so that the services will no longer be needed. A PRTF is to provide a less medically intensive program of treatment than a psychiatric inpatient hospital or a psychiatric unit of a general hospital could provide, and must include an on grounds educational component that provides a continuum of the West Virginia Medicaid member's current grade level.

All services must be delivered under the direction and orders of a physician or a psychiatrist. PRTF services focus on the improvement of West Virginia Medicaid member's symptoms through the use of strength and evidence-based strategies which include:

- group and individual therapy
- family therapy
- behavior management
- medication management and medication monitoring
- active family engagement

Services are designed to improve and/or ameliorate the West Virginia Medicaid member's mental health or co-occurring mental health and substance abuse condition. (See *Section 531.1.3.2, Admission Criteria* in this chapter).

531.1.3.1 Admission

An admission occurs upon the formal acceptance by an enrolled PRTF of a West Virginia Medicaid member who has been prior authorized for admission by the West Virginia Medicaid program UMC. The day of admission is considered a day of care; the day of discharge is not considered a day of care.

PRTF services are appropriate when a West Virginia Medicaid member does not require emergency or acute psychiatric care but does require nursing supervision and meet medical necessity for treatment on a 24 hour basis. A board certified psychiatrist (experienced in child/adolescent psychiatry) or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges at the PRTF must order and provide oversight for each admission.

PRTF admissions are planned and **not** an emergency admission. Admissions after 5 p.m. on Friday or on holidays require prior authorization for reimbursement for services **prior** to placement.

Facilities accepting West Virginia Medicaid members into treatment are permitted to accept children within age groups defined by their licensing entity. When accepting West Virginia Medicaid members under age 12, the facility must provide, at time of enrollment application, documentation regarding the ability to provide increased staffing, depending on the acuity of the child, this may be 1 on 1 staffing, etc. to provide for the younger child as well as the policy standards that address therapy, milieu effects, and supervision to ensure the prevention of the child being targeted for abuse. Facilities serving younger children must provide groupings for the child that will provide for "separation according to developmental functioning, sex, social skills, group dynamics, and other variables if appropriate and necessary. Children have the right to be housed with children of the same approximate ages, developmental levels, and social needs. This separation must be a matter of organizational policy." (78-CSR-3.14.12, Groups and

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Groupings 14.12.b,) The facility must also describe their process to provide educational requirements necessary to serve the younger child.

West Virginia Medicaid members under the age **nine** are not to be placed in an out-of-state PRTF unless there is documentation provided indicating this is the only alternative available for the child because alternative resources have been explored and are not available in state and if the placement is not made the safety/well-being of the child is at risk.

For each West Virginia Medicaid member admitted to a PRTF facility a MCM-1 must be completed by the referring physician/psychiatrist, with no affiliation to the receiving facility, certifying the need for this level of care. A copy of the MCM-1 must be submitted to the UMC along with a request for authorization for admission to the facility. The original signed/dated MCM-1 must be part of the West Virginia Medicaid member record at the receiving facility and must be available for review immediately upon request. The signed/dated MCM-1 is effective for a period of 30 days prior to the request for prior authorization for admission. If prior authorization is not requested within 30 days of the physician's/psychiatrist's signature and date, a new MCM-1 will be required for prior authorization for admission. Prior authorization for admission to the PRTF is effective for 10 days. If the child is not placed within the facility within the 10 day period, a new authorization is required. Children entering care utilizing private medical insurance with the prospect of obtaining a West Virginia Medicaid Card for reimbursement after the insurance has expired are required to have an MCM-1 signed prior to admission to the facility.

The UMC reviews all requests for admission to and continued stay requests in all approved and enrolled PRTF's. The role of the UMC is to determine the medical necessity of PRTF services for child/adolescent members with psychiatric diagnoses, the appropriateness of a particular PRTF setting for each West Virginia Medicaid member, and the number of days reasonably required to treat a child/adolescent's condition.

The following information must be included in the admission packet:

a. Immunization records (See also *Section 531.1.4.3 on Physical Health Services*);
b. Court order(s) if applicable;
c. Birth Certificate;
d. Social Security card;
e. Insurance information/Copy of West Virginia Medicaid Card;
f. MCM-1; and,
g. School records, including special education records (where applicable).

531.1.3.2 Admission Criteria

Admission to a PRTF facility requires the West Virginia Medicaid member meet following criteria:

1. West Virginia Medicaid member is under the age of 21 and has a diagnosed DSM IV-TR mental health or a co-occurring mental health and substance abuse condition (42 CFR §456.180). A diagnosis of substance abuse alone will not constitute medical necessity for an admission to a PRTF, **and,**
2. Severe to acute psychiatric symptoms manifested from the qualifying diagnosis or condition. The severity of these symptoms contraindicate treatment at a lower level of care safely occurring **and,**

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3. Severe functional impairment due to psychiatric diagnosis, in three or more major life domains (school performance, family relationships, interpersonal relations, communication/thought processes, self-care, and community) is documented. Youth's impairments are determined in comparison to same age peers/developmental age, **and,**
4. Failure in less restrictive levels of care within the past six months, despite active participation in treatment based on clinical pathways addressing their qualifying condition, except as a planned step down from acute care. (Clinical pathways are standardized, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes,) **and,**
5. Individual demonstrates the ability capacity to positively respond to treatment services. Child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

When an admission is denied by the PRTF, the facility must notify the referral source of the reason(s) for the denial within 72 hours. The PRTF must keep a log of all denial notifications for review by UMC. If placement is denied because medical necessity is not established, the UMC will notify the referral source, the facility, and the parent/guardian of the denial and the appeal process rights. Refer to *Chapter 100, General Administration and Information*, for additional information on the appeals process.

531.1.3.3 Resident Rights and Responsibilities

Upon admission to the PRTF, staff must provide the West Virginia Medicaid member and parent/guardian with a statement of rights and responsibilities which must cover at a minimum:

- The member's right to access treatment regardless of race, religion, or ethnicity;
- The member's right to recognition and respect of personal dignity in the provision of treatment;
- The member's right to be provided treatment and care in the least restrictive environment possible;
- The member's right to an individualized treatment plan;
- The member and family's right to participate in planning for treatment;
- A description of care, procedures, and treatment the member will receive;
- The member's right to informed consent related to the risks, side effects, and benefits of all medications and treatment procedures used; and
- The right, to the extent permitted by law, to refuse the specific medications or treatment procedures and the responsibility of the facility if the member refuses treatment.

Discipline measures must be fully explained to each West Virginia Medicaid member and the member's parent/guardian. PRTF's must prohibit all cruel and unusual disciplinary measures including the following:

- Corporal punishment;
- Forced physical exercise;
- Forced fixed body positions;
- Group punishment for individual actions;
- Verbal abuse, ridicule, or humiliation;

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- Denial of three balanced meals per day;
- Denial of clothing, shelter, bedding, or personal hygiene needs;
- Denial of access to educational services;
- Denial of visitation, mail, or phone privileges for punishment;
- Exclusion of the West Virginia Medicaid member from his/her assigned living area; and
- The use of restraint or seclusion as a punishment or implemented for the convenience of staff.

531.1.3.4 Interstate Compact on the Placement of Children (ICPC)

All approved admissions to out-of-state facilities require the completion of Interstate Compact on the Placement of Children (ICPC) **prior** to the placement. In every state, the Compact office and personnel are located in an office that is part of the department of public welfare or the state's equivalent agency. In West Virginia, the Compact Administrator is the Commissioner of BCF. **All** out-of-state placements (DHHR custody and non-custodial placements) into PRTF's require approval prior to placement. Non-custodial placements require a signed/dated Statement of Assurance indicating the parent/guardian retains legal and financial responsibility for the child while in placement. The Statement of Assurance is kept by the ICPC office as part of the ICPC record.

531.1.3.5 Assessment

The initial assessment contains information concerning the child's initial treatment needs. Information will come from referral packets, intake information, family members, previous placements, and information forwarded in the referral packet.

The assessment process must be initiated within 24 hours of admission. The initial treatment plan completed within 72 hours of admission and will document minimally one primary treatment goal/problem listed on the MCM-1. A more comprehensive treatment plan in the first 14 days after admission to a PRTF must document the need for the PRTF level of care by the Multidisciplinary Team (42 CFR §441.155(b)(1)). The assessment process must include, but is not limited to, the following:

- A psychiatric evaluation;
- A medical history and examination;
- A psychosocial assessment which includes a psychological profile, a developmental profile with a validity statement;
- A behavioral assessment;
- An assessment of the potential resources of the West Virginia member's family (42 CFR §441.156(b)(2));
- A Child and Adolescent Needs and Strengths (CANS) assessment, or other nationally recognized functional assessment;
- An educational evaluation;
- A nursing assessment;
- A nutritional assessment; and,
- An occupational/physical/speech assessment as indicated.

The facility will maintain a policy to ensure the transfer of educational records, information, and individual support when a West Virginia member enters the PRTF within seven days of admission. The transfer of

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records from one school to another is vital to proper and prompt placement in a new school system. The facility will obtain and review previous educational records for each student prior to admission to the facility. West Virginia members who require special education services must be identified, and the facility must ensure that those services are provided according to the rules and regulations of the West Virginia Department of Education.

Upon admission, an academic assessment must be administered by a qualified instructor that measures (at a minimum) math, reading, and written expression skills. A nationally recognized vocational assessment must be administered to any student at least 14 years of age who has not been previously assessed.

531.1.3.6 Treatment Planning

The treatment planning process is a collaborative process through which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each member. Providers must provide services in accordance with an individualized treatment plan under the direction of a physician/psychiatrist. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. (42 CFR §441.154(b)) The activities included in the service must be intended to achieve identified treatment plan goals and objectives and be designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time. Services to be provided must be in accordance with 42 CFR Sections §441.154 through §441.156.

The treatment plan process begins within 24 hours of admission with implementation of the initial assessments/interviews defined above. A preliminary treatment plan must be completed within 72 hours of admission and will document minimally one primary treatment goal/problem, the member's treatment schedule, and preliminary treatment goal objectives. A more formalized initial treatment plan must be in developed and implemented no later than 14 days after admission to the facility. The treatment plan document must contain evidence of the member's and his/her parent/guardian's active participation in the treatment planning/review/revision process. The multidisciplinary treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission and monthly (30 days) thereafter. The West Virginia Medicaid member will participate to the maximum extent feasible in the development of the treatment plan. Participation (or lack of participation) by the member and the family in the treatment planning process must be documented in the member's record. Repeated failure to participate after attempts to engage must be documented in the member record.

531.1.3.7 Treatment Team Composition

The individual plan of care under (42 CFR §441.155) must be developed by the multidisciplinary team of physicians/psychiatrists and other personnel who are employed by, contracted by, or provide services to member's, in the facility.

Based on education and experience, including competence in child psychiatry, the team must be capable of (42 CFR §441.156(b)):

- Assessing the member's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

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- Assessing the potential resources of the member's family;
- Setting treatment objectives; and,
- Prescribing therapeutic modalities to achieve the planned objectives.

The mental health treatment team must include at a minimum the following:

- A Board-eligible or Board-certified Psychiatrist (experienced in child/adolescent psychiatry);
- A Licensed Psychologist (as indicated by needs of child);
- A Registered Nurse(s);
- A Psychiatric social worker(s), LPC;
- A Certified Teacher(s); and,
- An Occupational/Physical/Speech Therapist (as indicated by needs of child).

531.1.3.8 Treatment Team Development

The treatment plan delineates all aspects of the West Virginia Medicaid member's treatment and includes, at a minimum: (42 CFR §441.156):

- A multi-axial diagnosis,
- An assessment of the member's immediate therapeutic needs;
- An assessment of the member's long-range therapeutic needs;
- An assessment of the members' personal strengths and liabilities;
- Identification of the clinical problems that are to be the focus of treatment;
- Measurable and realistic treatment goals for each identified problem;
- Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement;
- Specific treatment modalities and/or strategies that will be employed to reach each objective, e.g. psychotherapy (individual, family, group), medication, behavior modification programs, etc.;
- Special procedures (i.e. those providing for the seclusion or restraint of a West Virginia Medicaid member) must **not** be included in the treatment plan unless justified by evidence (current or historical) of aggressive behavior which cannot be controlled by less restrictive interventions. If special procedures become necessary, the treatment plan must be amended or modified within one working day of the first incident to reflect the use of the least restrictive necessary measures;
- The clinician identified as responsible for each aspect of treatment;
- Identification of goals, objectives and treatment strategies for the family as well as the member, and identification of the clinician responsible for treatment;
- When a continued stay at the facility is needed, it is the responsibility of the member's Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met;
- An individualized discharge plan that includes:
  - Discharge criteria, indicating specific goals to be met, and
  - An estimated discharge target date.
- Prior to discharge the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the member. ("at an appropriate time") (42 CFR §441.155(b)(5)).

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The member's treatment plan must include a specific strength-based family integration/reintegration treatment plan when appropriate. It must also include guidelines for family participation while the member is at the facility. These family participant guidelines must contain frequency of family visits, whether visits are supervised, and location of visitations. Family counseling and family visits must not be contingent on the West Virginia Medicaid member's behavior.

531.1.3.9 Treatment Plan Review and Revision

The treatment team reviews and revises the treatment plan for each West Virginia Medicaid member as often as necessary to provide optimum treatment but must meet at least once during the first 14 days following admission and monthly (every 30 days) thereafter. (42 CFR section §441.155(c))

The treatment review team will assess the member's progress in treatment by:

- Documentation of treatment successes/failures (which objectives and/or goals have been achieved and when) and explaining treatment outcomes;
- Documenting changes in the treatment plan as needed;
- Documentation of the re-assessment of the member's need for continued residential care, as opposed to less restrictive treatment, and;
- Documentation of the member's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

531.1.4 ACTIVE TREATMENT

Inpatient psychiatric services must involve "active treatment," (42 CFR §441.154), which means implementation of a professionally developed and supervised individual plan of care, described in 42 CFR §441.155 that is;

a) Developed and implemented no later than 14 days after admission;
and
b) Designed to achieve the member's discharge from inpatient status at the earliest possible time.

Active treatment: The use of the term "treatment" in this manual refers to the active treatment of the West Virginia Medicaid member. Active treatment is a process comprising:

- Multi-disciplinary diagnostic assessment;
- Interdisciplinary treatment planning;
- Therapeutic intervention;
- Treatment evaluation/revision;
- Discharge/aftercare planning, and;
- Provision of Educational services in an on grounds school.

531.1.4.1 Mental Health Services

Psychotherapy is defined as the intentional, face to face interaction (verbal and/or non-verbal encounters) between a mental health professional and a client (an individual, family, or group) in which a therapeutic relationship is established to help resolve symptoms of the member's mental and/or emotional

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disturbance. It is required that all individual therapy, family therapy and group therapy must be provided by master's level therapists.

- **Individual therapy** is defined as psychotherapy that takes place between a mental health therapist and a member. A minimum of one hour of individual therapy must be provided each week unless its contraindication is documented in the treatment plan. It is required that providers of individual therapy must be a master's level therapist.

- **Family therapy** is defined as psychotherapy that takes place between a mental health therapist and a member's family or guardian, with or without the presence of the member. If a member is in the custody of the Department of Health and Human Services (DHHR), family therapy may also include, DHHR representatives, foster family members acting *in loco parentis*.

  Each member's family, guardian, or person acting *in loco parentis* must participate in family therapy at least twice a month unless its contraindication is documented in the treatment plan. If the Medicaid member's family is more than a two hour drive from the PRTF, one face-to-face family therapy session and one therapeutic conference call will be acceptable. Both of these contacts must be therapeutic in nature, (i.e. to discuss the member's functioning, treatment progress, goals and objectives). Social visits or phone calls are not considered family therapy.

  Members who are in the custody of the Department of Health and Human Services (DHHR) should complete one face-to-face family therapy session at the PRTF facility and complete the second family therapy session via telephone. In the case of non-custody placements, the facility is required to make every effort to accommodate the member's family in therapy sessions. Documentation of attempts and the family's ability to participate or noncompliance with attempts to involve the family must be recorded in the member's record and available for review.

  It is required that providers of family therapy will be master's level therapists.

- **Group therapy** is defined as psychotherapy that takes place between a mental health therapist and at least two but not more than twelve members at the same time. Groups of more than 12 participants are allowed if the primary therapist for the group is assisted by a co-leader. Group co-leaders are not required to be master's level therapists. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, self-esteem enhancement, etc.

  Each member must participate in a minimum of three hours, each week unless contraindication is documented in the treatment plan. The manner in which services are delivered (length, frequency, and timing of sessions) should be determined by what is developmentally appropriate for each member. It is required that providers of group therapy must be master's level therapists although larger groups (more than 12 participants) may be co-led by a person with a lesser level of training.

- **Milieu therapy** is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Emphasis is placed on clear, healthy, respectful communication between member/member, staff/staff, and staff/member,

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and on shared problem-solving and decision-making. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process.

One essential component of milieu therapy is the community meeting. This is a time when all members and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions (i.e. planning recreational activities for the group, etc.), set goals, and resolve conflicts. More than on community meeting may be held during the day. As a group function, participation and outcomes of the group must be documented.

Milieu therapy must be available.

- **Occupational/Physical/Speech Therapy** is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the member achieve functional outcomes that promote the highest possible level of independence. Occupational therapy must be provided by an Occupational Therapist Registered (OTR).

531.1.4.2 Therapeutic Behavior Management

Behavioral Management Services are specific activities that have been planned and tailored to eliminate inappropriate (maladaptive) behaviors and to increase or develop desired adaptive behaviors for an individual member. These services result from areas of need identified on the member's service plan. Behavior management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

The use of behavior management interventions, (e.g. time out, behavioral contracts, point systems, logical and natural consequences, incentive programs, level systems, positive behavioral reports, etc.) with members must be guided by policies and procedures developed by the facility. Policies must indicate the intent to maintain a safe, nurturing, and therapeutic environment that protects the rights of all members and that respects the ethnic, religious, and identified treatment parameters for each individual member in care. Policies must comply with DHHR licensing rules and applicable state/federal statutes and generally accepted best practice standards promulgated by national accreditation organizations.

Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan after implementation

Therapeutic Behavioral Services - Implementation is an integral component of Behavior Management services (refer to *Chapter 503, Behavioral Health Rehabilitation Services*.)

531.1.4.3 Physical Health Services

PRTF facilities must provide physical health services as part of their treatment of West Virginia Medicaid members. Physical health services may be provided directly by the facility or may be provided by a

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vendor outside the facility. Physical health services must be addressed on the member treatment plan and must include:

- Assessments and evaluations as required in (42 CFR §441.155(b)(1)).
- Diagnosis, treatment, and consultation for acute or chronic illnesses occurring during the West Virginia Medicaid member's stay at the facility or for problems identified during an evaluation.
- Preventative health care services to include periodic assessments in accordance with the periodicity schedule established by the American Academy of Pediatrics.
- Completion of immunizations if a West Virginia Medicaid member's immunization is not complete.
- Routine medical care for all West Virginia Medicaid members (i.e. care during outbreaks of flu, non-complicated lacerations, scrapes, burns, etc.)
- Dental examination within six months of admission with periodic screenings. If the West Virginia Medicaid member has dental work that is ongoing (i.e. braces) the treatment plan must include plans to ensure the necessary follow-up dental care/exams are completed as needed.
- Speech, language and hearing services to meet the identified needs of the West Virginia Medicaid members.
- Vision screening and follow-up as indicated.

If physical health services are provided outside the PRTF, the facility must track:

- The referral of West Virginia Medicaid members;
- Qualifications of staff providing services;
- Exchange of clinical information must be provided.

531.1.4.4 Pharmacy Services

Medication is an important cornerstone of psychiatric treatment. Documents pertaining to this aspect of treatment (patient/family education and consent, medication orders, administration, monitoring) must be accurate, readily located and available for review. When medication is a prescribed intervention for a problem identified in the member's treatment plan, it must be noted as such in the treatment plan. When medication changes are made, they should be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' updated at the next available staffing opportunity.

Psychotropic medication must be used only as one component of a total therapeutic program, and the diagnosis and projected/targeted behaviors must be included in a written treatment plan. Psychotropic medication must not, under any circumstances, be prescribed or administered for the purposes of program management control, for discipline or punishment reasons, for convenience of staff, or for experimentation or research purposes.

A facility director or designee must provide pharmaceutical services as outlined in (42 CFR §483.60) to accurately and safely provide or obtain pharmaceutical services, which include the provision of routine and emergency medications and biologicals and consultation of a licensed pharmacist, in order to meet the needs of its members. The facility director or designee shall ensure the development and implementation of written procedures based on policies approved, signed and dated, by the governing body, related to the provision of pharmaceutical services, including procedures that assure the accurate acquisition, labeling, receipt, dispensing and administration of all medications and biologicals. The facility

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director or designee shall assure that pharmaceutical services are provided in accordance with this rule and all other applicable federal, state and local laws and the rules of the states' Board of Pharmacy. The facility director or designee must employ or contract the services of a Licensed Pharmacist who is licensed to practice in the state in which the facility is located and is currently registered as a consultant pharmacist with the states' Board of Pharmacy. A pharmacist providing pharmacy consulting services in a PRTF must comply with all applicable federal, state and local laws and the rules of the state's Board of Pharmacy. In review of best practice, the consultant pharmacist must not be an employee of the pharmacy servicing the facility and operate independently as a consultant.
The consultant pharmacist must review the medication regimen of each member once a month or more frequently based on the member's needs. The consultant pharmacist must document the results of each member's medication regimen review in the member's medical record. The medication regimen review must include substances that are regarded as herbal products or dietary supplements. The consultant pharmacist must report any irregularities in the medication regimen review along with documented recommendations to the clinical director and the psychiatrist. The PRTF's pharmacist consultant must be available to advise the PRTF staff regarding questions or concerns. The consultant pharmacist recommendations must be reviewed within seven days by the psychiatrist with changes made in the medication regimen. If the decision is not to follow the recommendations, the psychiatrist must document the decline on the same form as the recommendations with signature and date of decision.

Drugs and biologicals used in the PRTF must be labeled in accordance with the requirements of federal, state and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date and time to be administered per physician's/psychiatrist's order. All over the counter medications must have the date opened and initiated by the employee administering the medication.

In accordance with state and federal laws, the facility director or designee must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility director or designee must provide separately double-locked, permanently affixed compartments for the storage of drugs subject to abuse and controlled drugs as identified by federal regulations. The PRTF may also use single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The facility director or designee and the dispensing pharmacy must maintain prescription records in accordance with state and federal laws, and provide such prescription records upon request by the West Virginia Medicaid agency or its representatives.

531.1.4.5 Consent for Medication

When medications are prescribed or changed, a member of the professional staff will review with each member's parent/guardian and document in the medical record the following information:

- The name/class of medication;
- The method of administration (oral, injection, etc.);
- The symptom(s) targeted/expected outcomes;
- Possible side effects of the medication;
- Possible long-term effects of the medication;
- Treatment alternatives;

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- Likely outcomes of using/not using the medication.
- The minimum and maximum dose to be administered.

When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference may be held by telephone, with the parent/guardian's responses noted and dated. This form must be signed by the parent/guardian within 30 days after the telephone consent is obtained. The PRTF professional staff must document this telephone consent obtained with one witness signature/date on the form after talking with the parent/guardian. Documentation regarding the parent's verbal consent must be located in the member record. Documentation of efforts to obtain the above signature must also be contained in the member record if the parent fails to return the form within the 30 day period.

Documentation that the education was presented and consent to proceed must be provided when parents/guardians are informed of all drugs being prescribed off-label (diagnosis not approved by the FDA, dosage outside the FDA guidelines, or if the drug has not been approved for the age of the West Virginia member). Decline in consent by the parent/guardian must be documented along with physician/psychiatrist notification.

531.1.4.6 Administration of Medication

Only licensed professionals may administer medications to WV Medicaid members. Examples of licensed staff include physicians, physician assistants, nurse practitioners, registered nurses and licensed practical nurses. No unlicensed or certified individual may administer medications to West Virginia Medicaid members in a PRTF facility, regardless of whether they are certified to do so by the state where the PRTF facility is located or are supervised by a professional staff member when administering medications.

Documentation must substantiate that medications have been accurately administered in accordance with the physician's or other licensed practitioner's orders. Any variances must be justified in the record by licensed medical staff. A Medication Administration Record (MAR) for monitoring medication side effects must be identified and includes all medications that are routinely administered to each member who is prescribed medication and will have documentation review by the psychiatrist upon admission, as medically necessary and at least every 30 days during his/her stay, and again at discharge.

"**Standing Order PRN medications" are not permitted.** Over the counter medications (PRN's), for each member must be prescribed for the member by a physician with prescribing privileges, with clear indications for use and start and stop dates for each medication prescribed.

531.1.4.7 Medication Errors

Medication errors will be tracked and quantified as part of the continuous quality improvement program of BMS to ensure that children in DHHR custody and non-custodial placements are receiving the best care possible.

Medication errors will be analyzed in terms of the type of error (e.g., wrong dose, omission, wrong time, etc.) and the severity of the error. All documentation related to medication errors will be readily available upon request by BMS.

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The physician/psychiatrist must be notified immediately of a medication error and the physician/psychiatrist order (if any) be obtained by nursing personnel or the physician/psychiatrist themselves.

531.1.4.8 Dietary Services

The PRTF must have written policies and procedures approved by the governing body for the provision of dietetic services for members. Adequate staff, space, equipment, and supplies must be provided for safe sanitary operation of the dietetic services, the safe and sanitary handling and distribution of food, the care and cleaning of equipment and kitchen area, and the washing of dishes. Nutritional aspects of member's care will be planned, reviewed, and periodically evaluated by a qualified dietician.
Food must be served to members and staff in a common eating place and:

- Must account for the special food needs and tastes of members;
- Must not be withheld as punishment, and;
- Must provide for the special dietary needs of each member.

At least three meals per day must be served with no more than a 15 hour span between the substantial evening meal and breakfast. The facility must arrange for and make provision for between-meal and unscheduled snacks.

531.1.4.9 Visitation with Parents and Extended Family

Visitation arrangements must be agreed upon as soon as possible after placement of the child and documented in the member's record. These arrangements must be made in agreement with the family/guardian, the residential facility and the member's DHHR caseworker. Any restrictions on visitation arrangements by the DHHR caseworker or the court must be noted in the member's treatment plan. All visits will be coordinated through consultation with the parent/guardian and the member's DHHR caseworker.

The facility must design and implement services in a manner that supports and strengthens family relationships and empowers and enables parents and family members to assume their roles. When a member's presenting problem affects or is affected by a member's family, the facility will provide coordination of social services to children, adults, and families that may be necessary to achieve family reunification, stabilize family ties, or obtain a permanent family for a member receiving out-of-home care. The family of a member in out-of-home care is expected to participate in making case plans, is kept advised of ongoing progress, and is invited to case conferences. When a member is in out-of-home care, the agency fully involves the family or individuals identified in the permanency plan as permanency options with a focus on timely permanency as the primary goal. The facility cannot deny visits, telephone calls, or mail contacts with a DHHR approved family. The facility is responsible for coordinating visitation with the member's family including provision of transportation as available to enable the visitation to occur.

In instances of non-custodial placement, transportation arrangements must be made with the facility, and the parent involved to ensure that the visitation does take place. Non-Emergency Medical Transportation

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(NEMT) **cannot** be used to transport the child to a facility located out of- state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.1.4.10 Life Skills

Facilities providing care to members has the responsibility to help them develop into self-sufficient adults. In addition, all facilities and individuals who provide substitute parental care for members are charged with helping to ensure that their social, emotional, and intellectual development is achieved to each member's highest potential.

The facility must ensure that all adults entrusted with the care of West Virginia children and youth demonstrate appropriate social behavior; respond properly to stressful situations; and promote good physical, emotional, and intellectual well-being. It is through the observation of positive adult behavior and through interaction with positive adult role models that children and youth develop and demonstrate positive attributes.

531.1.4.11 Therapeutic Leave

Therapeutic leaves are a necessary and integral part of a member's treatment. Therapeutic leaves allow for an evaluation period to determine the member's ability to adjust to the transition back into the home setting and/or to a lesser level of care facility. Therapeutic leaves of absence would occur when clinically appropriate, particularly toward the end of a member's placement to ensure adequate transition into the family/foster family home. A therapeutic leave day is defined as a day of absence when the member spends a night away from the PRTF without support from direct staff. The maximum allowable and reimbursable therapeutic leave days (absences) per PRTF shall be limited to eight (8) days per calendar year.

The medical record must contain a physician's/psychiatrist's order for therapeutic leave, the date and time of the beginning of the therapeutic leave, and the date and time the member returns to the PRTF. For therapeutic leave, the date the member leaves the PRTF is counted as a leave day and the day the resident returns to the facility shall not be counted as a leave day.

Documentation must include:

- The date/time of check-out
- The required time of return
- The name(s) of the person(s) with whom the leave will be spent
- The member's physical/emotional condition at the time of departure (including vital signs)
- The types/amounts of medication being provided and instructions (in lay terms) for taking them
- Therapeutic goals for the leave. Goals must relate to the goals established in the treatment plan.
- The name and signature of the person with whom the member is leaving
- The signature of the staff person checking the member out.

Documentation upon return must include:

- The date/time of check in

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- The member's physical/emotional condition at the time of return (including vital signs and notation of any physical injury or complaint)
- Whether or not any contraband was found
- The types/amounts of medication being returned, if any, and explanation of any missed does
- An explanation of any early return from leave
- A brief report on the outcome of the leave by the parent or guardian (were therapeutic goals achieved? Was the member's behavior appropriate?
- The name and signature of the person returning the member to the facility
- The signature of the staff person checking the member in
- An assessment of the outcome of the leave must be documented by the member's therapist within seventy-two (72) hours of the member's return from leave.

531.1.4.12 Billing and Reimbursement for Therapeutic Leave

The following revenue codes are to be utilized to bill Therapeutic Level:

REVENUE CODE	CODE DESCRIPTION
0183	Leave of Absence - Therapeutic
0185	Leave of Absence - Hospitalization

531.1.5 CONTINUING STAY CRITERIA

When West Virginia Medicaid members are prior authorized for PRTF admission by the UMC, they are authorized a limited number of days for that admission. It is the PRTF's responsibility to help the member accomplish treatment goals within that time frame or to justify to the UMC why a longer stay should be prior authorized. When a continued stay is needed, it is the responsibility of the member's Multidisciplinary Treatment Team and the Clinical Director to establish that the requirements for a continued stay have been met.

No later than seven days prior to the end of a member's authorized stay, the treatment team must have;

- developed a detailed discharge/aftercare plan for the member;

or

- applied to the UMC for additional treatment time.

In reviewing requests for extended treatment, the UMC reviews the appropriateness and quality of the member's ongoing treatment as planned, provided, evaluated, revised and documented by the treatment team.

The following criteria must be met in order for a continued stay prior authorization:

- Individual is still under the age of 21 and has a confirmed DSM IV-TR mental health or co-occurring mental health and substance abuse diagnosis,

and

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- Psychiatric symptoms manifested by the qualifying diagnosis or conditions continue to be severe and/or complex and the severity of the symptoms contraindicate treatment occurring safely at a lower level of care. The treatment plan has been modified to address barriers to achieving goals,

or

- New symptoms have emerged or previously unidentified symptoms have manifested that require continued treatment and the severity of symptoms contraindicate treatment occurring safely at a lower level of care,

and

- Multiple symptoms and functional impairments due to psychiatric diagnosis continue to be present despite progress being documented,

and

- Individual and/or family continues to be actively engaged and participating in the care plan.

When discharge problems arise because of the lack of an appropriate placement for the member (ex: unsuitable family environment, foster home unavailability, no group home vacancies), it is the responsibility of the PRTF, together with the party having legal responsibility of the member, to locate and/or arrange an appropriate placement. **The lack of post-discharge options alone will not be considered a valid basis for continued PRTF stay.** The discharge process begins on the day of admission and must be finalized at a minimum of seven days prior to discharge.

531.1.6 DISCHARGE

Discharge planning begins during the intake and placement process, for the member. When plans for the member are being developed with the member and the family, discharge plans are made, and continue as part of ongoing discussion throughout placement. After determining a tentative date for discharge, the multi/interdisciplinary treatment team is responsible for developing and implementing the discharge plan within the projected time frame. This may involve preparing the family for reunification, preparing a foster/adoptive family for the placement, coordinating the member's enrollment in the appropriate education program, keeping the group care facility informed of the plan, informing the member of the plan, or helping the member prepare for emancipation.

Discharge criteria would indicate that the symptoms and functioning have improved and a lower level of care can be safely provided or that a higher level of care is required to meet the member's needs.

Discharge planning is also initiated when the member's treatment plan goals and objectives have been substantially met and the discharge plan with appropriate, realistic and timely follow-up care is in place. When the care being provided at the facility no longer meets medical necessity, the member is discharged.

Discharging also occurs when the member is not making progress toward treatment goals despite persistent efforts to engage him/her and there is no reasonable expectation of progress at this level of care related to their psychiatric condition nor is it required to maintain the current level of functioning. The discharge plan must also include an aftercare plan that addresses coordination of family/legal representative, school/vocational and community resources to provide the greatest possible continuity of care for the member "at an appropriate time." (42 CFR §441.155(b)(5)) The plan's content will include, but not be limited to:

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- The planned discharge date;
- The date of the member's admission and discharge;
- The name of the person/agency expected to assume care and custody of the member;
- The physical location/address where the member is expected to reside; and,
- A list of the member's psychiatric diagnoses.

At the time of the member's discharge from the facility, the PRTF will provide the parent/guardian with:

- A written copy of the final aftercare plan;
- A supply of all current medications prescribed for the member, equal to the amount already stocked for that member by the PRTF but not less than a seven day supply; (When dispensing to a Long Term Care Facility, if the medications are not in the hands of the patient, they have reduced labeling requirements. If they are to be able to be taken home, the pharmacy would have to do full labeling. That would have to be spelled out for the pharmacy ahead of time so they can make sure any unit dosing system or unit of use system they are using to dispense would be able to do full labeling on the packaging, etc. if the patient is only to be gone one or two doses (That are unit dose packed) the nurse might give to caregiver with time instructions. Otherwise pharmacy must re-label to contain instructions for use.):
- Prescriptions for a 30 day supply of all medications prescribed for the member; and,
- Documentation of communication between the facility physician/psychiatrist and the community physician/psychiatrist assuming responsibility for the ongoing treatment to discuss the member's treatment plans while in the facility as well as the discharge plan.

The PRTF will seek the parent's/guardian's consent to release copies of the member's educational summary and recommendations to the member's school. When this consent is obtained, the educational information must be mailed to the member's school within one week following the member's discharge.

The PRTF must not send the member's complete aftercare plan, but must provide only information pertaining to education.

The PRTF will seek the parent/guardian's consent to release copies of the member's aftercare plan and discharge summary to the providers of follow-up mental health services. When this consent is obtained, copies of the aftercare plan and discharge summary must be mailed to the mental health aftercare provider within two weeks following the West Virginia member's discharge.

531.1.6.1 Emergency Discharge

Occasionally an emergency discharge/exit from a PRTF that are not in accordance with the West Virginia Medicaid member's case plan, are unavoidable. The facility must provide the West Virginia Medicaid member's caseworker with at least 72 hours' notice of discharge; parent/legal guardian notification must occur immediately when the decision is made. Upon receipt of such notice, the worker will begin locating and developing an alternative placement that is appropriate for the West Virginia Medicaid member's current and immediate situation and needs. The facility must work with the parent/guardian to ensure a safe and appropriate discharge is available to the non-custodial West Virginia Medicaid member and the member's family.

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If the member is discharged for medical reasons (i.e., medical needs not provided by the facility such as surgery, etc.), the parent/guardian must obtain a new MCM-1 and make a request for prior authorization for services prior to re-admission to the facility. The child must meet all other admission criteria set forth for PRTF level of care (see admission criteria).

There must **not** be any instance when a West Virginia Medicaid member is discharged immediately for his safety or the safety of others while the member is placed in a PRTF. The facility is required to provide sufficient staffing 1:1 if necessary to allow for a safe and appropriate discharge.

531.1.6.2 Elopements/Run Away

A member is considered in elopement/run-away status if the West Virginia Medicaid member leaves without authority/supervision. If the member is under the age of 12 or is a member with mental or physical issues that, without supervision may pose a child safety or community safety risk, the elopement/run-away incident is reported immediately. As soon as staff determines that a member has eloped/run-away from the facility that person will immediately call the local law enforcement agency and law enforcement may choose to enter the member into the National Crime Information Center (NCIC) data base. Members in custody as a status offender or with child abuse/neglect issues may be listed by local law enforcement as a Missing Person. The facility will notify the parent/guardian immediately. A member charged with juvenile delinquency must be reported to local law enforcement. Members in custody as an adjudicated juvenile delinquent may be listed by local law enforcement as a Wanted Person. A complete incident report form must be initiated to include the time of discovery along with all processes implemented to assist with locating and returning of the member to the facility and the outcome.

Reimbursement is not available when a child has eloped or is missing and is not in residence at the facility for more than 24 hours.

In cases of elopement/run-away incidents where the member has a history of “repeat run-away incidents,” the facility must develop a safety plan for the member in their treatment plan. Consideration should be given to the member’s history of running away, safety concerns (for both the member and the community), need for additional supervision, and/or need for a more secure facility placement.

Upon the return of a West Virginia Medicaid member from an elopement/run-away incident, the facility will notify the parent/guardian and law enforcement of the return so any alerts can be cancelled and documented. The incident report must have attached all written accounts of all processes implemented to assist with locating and returning the member to the facility. The documentation must contain the written account as well as written statements, names and times of all persons involved including the physician/psychiatrist.

If a West Virginia Medicaid member has been on elopement/run-away status and has missed his/her medication(s) for 48 hours or longer, the physician/psychiatrist must be notified for instructions/orders before restarting the medication(s) on the member’s return to the facility.

531.1.7 DOCUMENTATION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services

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will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of the Provider Manual.

Documentation must also include a physician/psychiatrist's order for admission, the results of the evaluation which establishes medical necessity for this level of service and the West Virginia Medicaid MCM-1. A permanent clinical record maintained in a manner consistent with applicable state and federal licensing regulations and agency record keeping policies. The clinical record is an essential tool in treatment. It is the central repository of all pertinent information about each member. It provides an accurate chronological accounting of the treatment process: assessment, planning, intervention, evaluation, revision, and discharge. Clinical records must be complete, accurate, accessible, legible, and organized. Records must contain five broad categories of information; Administrative, Assessments, Treatment Planning, Therapeutic Interventions, and Medications. The following sections identify the information that must be located in the record for each of these categories.

531.1.7.1 Administrative

This portion of the record contains all information related to the West Virginia Medicaid member's identification. It must include, at a minimum, a copy of the member's birth certificate and/or social security card, a recent photograph of the member, a copy of any legal documents verifying custody or guardianship of the member when the responsible party is anyone other than the members' legal parent(s). The name, address and phone number of the party bearing legal responsibility for the member must be clearly identified, along with his/her relationship to the child, e.g. "mother", or "paternal aunt, legal guardian". If the member is in the custody of the West Virginia Department of Health & Human Resources (DHHR), the county of custody must be specified and the caseworker identified as an agent of DHHR. The original MCM-1, with physician/psychiatrist signature/date and supporting documentation that establishes medical necessity for this level of service must be contained in this section of the record and available for review.

531.1.7.2 Documentation of Assessments

This portion of the record contains information gathered through history taking, observation, testing and examination of the member. It must include, at a minimum, all assessments identified as necessary in *Section 531.1.3.5, Assessments of this chapter*. Assessments must be updated as needed to provide current and continued treatment planning and provision of therapeutic services.

531.1.7.3 Treatment Planning

This portion of the record contains the individualized multi/interdisciplinary treatment plan, as well as all reviews and revisions. It must be noted that the treatment planning process is intended to take place in a multi/interdisciplinary forum where many points of view may be expressed and consensus reached, rather than through a process of serial communication among professionals. Treatment planning documents must reflect the collaborative nature of the process. The treatment team will meet to staff each member and review/revise his/her treatment plan as often as necessary to provide optimum treatment but at least once during the first 14 days following admission, again prior to the conclusion of the first month of stay, and monthly thereafter.

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531.1.7.4 Therapeutic Interventions

All interventions attempted/provided during the course of the West Virginia Medicaid member's treatment must be appropriately, accurately and legibly documented. Documentation for individual services must include at a minimum:

A. Psychotherapy Notes

Essential elements that must be documented for each therapy session are as follows:

- The date and time of the session (time in and time out);
- The type of therapy (individual, family or group);
- The person(s) participating in the session;
- The length of the session;
- The goals of the session with the member;
- Clinical observations about the member (demeanor, mood, affect, mental alertness, thought processes, risks, etc.);
- The content of the session;
- Therapeutic interventions attempted and the member's response to the intervention(s);
- The member's response to any significant others who may be present in the session;

The outcome of the session;

- A statement summarizing the member's degree of progress toward the treatment goals;
- Periodic (at least monthly) reference to the member's progress in relation to the discharge criteria; and the estimated discharge date; and,
- The signature (and printed name, if needed for clarity) of the therapist.

Monthly summaries are not acceptable in lieu of psychotherapy session notes.

B. Milieu Therapy Notes

Milieu notes must present a clear picture of the member's participation and interactions in the therapeutic community. Milieu notes for each day should describe the West Virginia member's actions, staff interventions, and the West Virginia member's response to those interventions. Milieu notes are completed by direct care staff. If a checklist is used, it must be accompanied by a brief narrative. Milieu notes must be behaviorally focused. Behavior and events must be described rather than labeled. For example:

- Behavior labeled: member was oppositional;
- Behavior described: member refused to make up bed when asked.

Milieu notes must be maintained in a professional manner and must accurately document any communication between staff and the member. The notes should emphasize the member's level of involvement and collaboration in his/her own treatment.

C. Community Meeting Notes

Participation in community meetings must be documented for each member and a brief narrative maintained for each community meeting describing the goals and achievement.

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531.1.8 RECORDS MAINTENANCE

Clinical records must be maintained for a period of five years from the date of discharge. The facility must ensure that the clinical record is not lost, destroyed or put to unauthorized use. The facility must ensure the confidentiality of all information contained in the member's record except when its release is authorized by the member's parent/legal guardian or required by State or federal law.

531.1.9 SPECIALIZED PROCEDURES/SECLUSION/RESTRAINT

Special procedures, **seclusion and restraint**, must be used as an immediate response only in emergency safety situations (42 CFR §483.356) when needed to help a member regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. Documentation indicates that the more restrictive techniques, while relieving stress for the adults in charge, usually increase stress for the youths with whom they are applied. The potential therapeutic effects (prevention of self- and other-injury and reinforcement of behavioral boundaries) must be weighed against the counter-therapeutic effects which include loss of dignity, increased feelings of impotence/helplessness, increased resentment/rage towards authority figures, and, for member's in recovery from physical/sexual abuse, the subjective experience of re-enacting their victimization.

531.1.9.1 Staff Training

When a facility provides for the use of seclusion/restraint, all staff who have direct member contact must have prior education, training, and demonstration of knowledge of the proper and safe use of seclusion/restraint **and** alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method which does not involve restraining a member in a face-down or spread-eagle (legs apart) position.

531.1.9.2 Member/Parent Notification

When a facility provides for the use of seclusion/restraint, the facility must inform, with documentation evidence, the prospective member and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. In the event that a member requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than 24 hours after the initiation of the procedure. Documentation must include notification was provided with date and time of notification and the name of the staff person providing the notification. (42 CFR §483.366(a))

531.1.9.3 Types of Seclusion and Restraints

Seclusion is the involuntary confinement of a member in an area, including rooms without locks or doors, from which they are physically prevented from leaving. It is used to ensure the physical safety of the member or others and to prevent the destruction of property or serious disruption of the milieu.

Restraint is the restriction of a member's freedom of movement or normal access to their body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the member's physical safety.

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- **Personal/Physical Restraint** is the restriction of a member through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a member from causing harm to self or others or to prevent destruction of property.
- **Mechanical Restraint** is the restriction of a member through the use of any physical or mechanical device, material or equipment attached or adjacent to the member's body that they cannot easily remove.
- **Pharmacological Restraint** is the limited use of a medication, which is not a standard part of the member's treatment regimen, to control or alter the member's mood or behavior or to restrict freedom of movement on a short term basis. Pharmacological restraint is used to ensure the safety of the member or others through a period of extreme agitation when less restrictive measures have not been effective. Pharmacological restraint may be initiated only by medical staff acting on a physician's/psychiatrist's orders. At the time of the order, the physician/psychiatrist must identify a specific time when the procedure is expected to end (i.e., the expected duration of the medication's effects).

Medication Adjustment refers to the process of medication reduction attempts including anti-psychotics, hypnotics, anti-depressants, narcotics, sedatives, and all schedule II drugs. Medication adjustment is not considered to be a special procedure. When an additional physician/psychiatrist order is provided to increase a member's routine medication in a *non-routine way* to help the member through a period of heightened stress or agitation, e.g., ordering the administration of an extra dose (usually in a lower amount) of the same (or similar, from the same class) medication that is already part of the member's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the member's treatment plan. When physician/psychiatrist orders for medication increase due to a period of heightened stress or agitation up to three times in a 30 day period, the physician/psychiatrist must determine if the increase in medication needs to become a change in the member's medication regime. If this does not occur then the medication must be considered a pharmacological restraint and the treatment plan must be updated. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedating, are only administered orally, and must be taken voluntarily by the member (and in some cases may be requested by the member).

531.1.9.4 Appropriate Use

Seclusion or restraint must be used only in situations where less restrictive interventions have been attempted and determined to be ineffective. Documentation in the record must reflect the attempted use of less restrictive interventions date/time/signature of staff responsible for use of the interventions. Neither procedure may be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a member's behavior, or as a substitute for individualized treatment. (42 CFR §482.356(a)(1)) Any use of seclusion or restraint must be:

- In accordance with the member's treatment plan (if the treatment plan does not provide for the use of seclusion/restraint prior to its use, the plan must be modified within one working day of the first occurrence)
- In accordance with the policy and procedures restraint/seclusion may only be applied by staff who have been trained and approved to use such techniques (42 CFR §482.356(a)(3));
- Implemented in the least restrictive manner possible (CFR §483.364(b)(2));

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- In a room where the member will be constantly viewed and monitored, that is safe and sanitary, with adequate lighting, ventilation and temperature control;
- All vital signs must be obtained every hour, times 12 hours unless documentation by licensed physician/psychiatrist indicates this can be modified;
- Access to fluids and toilet facilities must be offered and provided hourly with clear documentation of fluids ingested;
- Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the member's condition (42 CFR §483.356(a)(3)(ii)).

531.1.9.5 Prohibited Practices

Restraint and seclusion must not be used simultaneously. (42 CFR §482.356(a)(4))

- Any personal or mechanical restraint of a member in a face-down position is prohibited;
- Any personal or mechanical restraint of a member in a "spread-eagle" (legs and arms apart) position is prohibited;
- Standing or "as needed" (PRN) orders for seclusion or restraint are prohibited. (42 CFR §483.356(a)(2))

531.1.9.6 Procedural Requirements

The following actions are required and must be documented for **any form of special procedure** with the exceptions as noted below. (42 CFR §483.358(a))

- Orders for restraint or seclusion must be by a physician/psychiatrist, or other licensed practitioner permitted by the State Law and the facility to order restraint and seclusion and trained in the use of emergency safety interventions.
- If seclusion or personal/mechanical restraint is initiated verbally by order from a physician/psychiatrist or other licensed practitioner, a verbal or telephone order must be obtained from the physician/psychiatrist or other licensed practitioner and documented in the chart as soon as possible, but no later than one hour after the start of the procedure. If the physician's/psychiatrist's or other licensed practitioner order cannot be obtained within the one hour, the procedure must be discontinued.

The physician's/psychiatrist's or other licensed practitioner's order for seclusion or personal/mechanical restraint may under **no** circumstance exceed one hour for members younger than nine years of age, or two hours for members nine to 17 years of age and four hours for members ages 18 to 21.

The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure. (42 CFR §483.364(a))

Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing and monitoring the physical and psychological well-being of the member, and the safe use of restraint throughout the duration of the emergency safety intervention. (42 CFR §483.362(a))

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Within one hour of the initiation of the emergency safety intervention, a physician/psychiatrist or other licensed practitioner must conduct a face-to-face assessment of the physical and psychological well-being of the member, to include but not be limited to the following:

- The member's physical and psychological status,
- The member's behavior,
- The appropriateness of the intervention measures, and any complication resulting from the intervention. (42 CFR §483.358(f))

Even if the intervention is terminated in less than one hour, the face-to-face assessment must be conducted within 60 minutes of its initiation.

The health and comfort of the member must be assessed every 15 minutes by direct observation, and staff must record their findings at the time of observation.

There must be a policy and procedure for ending the special procedure (except for pharmacological restraint, which has an end-time identified by the physician/psychiatrist or other licensed practitioner), and the member must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate. A physician/psychiatrist or other licensed practitioner must evaluate and document the member's well-being immediately after the seclusion or restraint is terminated. (42 CFR §483.362(c))

No later than 24 hours following the conclusion of the special procedure, the member must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention. (42 CFR §483.370(a)) The goal is to enable the member to understand the precursors to loss of control and to rehearse acceptable means of handling frustration and emotional distress.

Within 24 hours after the use of restraint or seclusion, documentation must indicate that all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, conducted a debriefing session that included, at a minimum, a review and discussion of the emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention, alternative techniques that might have prevented the use of the restraint or seclusion, the procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and the outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion. (42 CFR §483.370(b))

The Registered Nurse or other licensed personnel in the PRTF must notify with documentation of the same, the member's parent/guardian as soon as possible, but no later than 24 hours after the initiation of any special procedure. The documentation will include the name/date/time the parent/guardian was contacted and the content of the conversation.

If the member's treatment plan does not already provide for the use of seclusion/restraint, then it must be amended or modified within 24 hours following the first use of any special procedure to reflect the use of that method as a part of the member's treatment.

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531.1.9.7 Documentation of Seclusion/Restraint

Documentation of each incident of seclusion or restraint (personal, mechanical and pharmacological restraint) will include, but not be limited to, the following information: (42 CFR §483.358)

- The date/time the procedure started and ended;
- The name of the physician/psychiatrist or other licensed practitioner who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring, and were responsible for terminating;
- The reason the procedure was initiated;
- Which less restrictive options were attempted, and how they failed;
- Criteria for ending the procedure (except for pharmacological restraint, when the end time is identified by the physician/psychiatrist or other licensed practitioner);
- The results of a face-to-face assessment conducted by a physician/psychiatrist or other licensed practitioner within one hour after initiation of the procedure to include:
    1. the member's physical and psychological status,
    2. the member's behavior,
    3. the appropriateness of the intervention measures and
    4. any complications resulting from the intervention;
- The member's condition at the time of each 15 minute reassessment and at the end of the procedure;
- The signature/date of the person documenting the incident;
- A record/documentation of both debriefing sessions (staff/member and staff only) which are required to take place within 24 hours of the use of seclusion/restraint, to include the names of staff who were present for or excused from the debriefing and any changes to the member's treatment plan that resulted from the debriefings. (42 CFR §483.370(c)); and,
- The facility must provide notification of the member's parent/guardian within 24 hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification. (42 CFR §483.366(b)).

This documentation must be part of the West Virginia member's permanent record.

A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. (42 CFR §483.358(i)) A multidisciplinary team must review the seclusion/restraint log monthly and must maintain documentation of such meetings in the form of minutes signed and dated by the participants.

Information regarding the number of times seclusion or restraint have been employed by a facility must be included **monthly** as part of the facility's census report.

531.1.10 EDUCATION

When caring for children in out-of-home placement it is necessary to provide services outside those identified as meeting medical necessity. These services are considered necessary for the health and safety of the member. Provision of education is a necessary component for all out-of-home placements. DHHR is committed to ensure all members receive educational services and continue educational goals. It is the responsibility of all involved parties to support each member's school placement and educational

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plan. The West Virginia Department of Education oversees the provision of educational services for West Virginia members.

For information regarding educational standards for West Virginia members, the West Virginia Department of Education can be reached at:

West Virginia Department of Education
Office of Assessment and Accountability
State Capitol Complex
Building 6, Room 330
Charleston, West Virginia 25305
Telephone: (304) 558-7805
http://wvde.state.wv.us

531.1.11 TRANSPORTATION AND VEHICLE MAINTENANCE

Transportation of members to and from medical appointments, court appearances, emergency transportation and transportation to family visits is a requirement of the PRTF. It is considered included in the PRTF per diem rate and not separately reimbursable.

- All vehicles must be maintained and operated in a safe manner.
- The facility provides adequate passenger supervision, as mandated by level of care.
- All facility-owned and staff-owned vehicles used for transportation of members **must be adequately covered by vehicular liability and comprehensive insurance** for personal injury to all occupants of the vehicles in the maximum amount allowed recommended by the state in which the facility is located. Documentation of such insurance coverage must be maintained in the facility's records, updated yearly, and readily available for review upon request by DHHR or designee. Staff providing transportation must possess a valid driver's license. Documentation of the license must be maintained in the facility's records and must be validated annually.
- All facility-owned and staff-owned vehicles used for transportation of members have a current license, registration and inspection, as required by the county of residence.
- Age-appropriate safety restraints must be used as required by state and federal law.
- The facility maintains the responsibility for and must be willing to provide transportation to members in the program including transportation to and from all medical/dental appointments, court appearances, emergency transportation, and transportation to family visits.
- No member must access public transportation unless supervised by a staff person or designee of the facility.

In instances of non-custodial placement, the cost of transportation must be provided by the facility and/or the parent. NEMT cannot be used to transport the child to a facility located out-of-state. The use of NEMT to transport a parent to the facility for visitation with the child is **not** a covered service.

531.1.12 CLOTHING

Members in DHHR care enter custody through the judicial system, or through the actions or inactions of adults in their lives. Therefore, DHHR urges child care facilities, whenever possible, to afford members the freedom to dress in ways that preserve their dignity, their freedom of expression, and their cultural

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identity. At the very least, agencies are to refrain from using uniforms, outfits, or identifying visual markers according to the children's disabilities, diagnoses, or referral behaviors. To do so classifies and stereotypes members in ways that add to the stigma associated with being in the custody of the DHHR. Wearing one's own clothing should not be held out as a reward but as a basic right. Additionally, any facility policy which requires uniform or identifying clothing when a member is in a community setting must be eliminated.

DHHR recognizes the need for facilities to utilize dress codes in order to maintain standards of hygiene and decency or to maintain accountability to the member at certain times. If dress code policy exists, it must be explained to the member and the parent/guardian at the time of admission to the facility. DHHR challenges facilities to involve members as much as possible in decisions about reasonable limits of clothing or dress codes.

The facility must supply any special clothing required for the member to participate in a certain program (i.e. camping, hiking, equine therapy, etc.)

The facility is responsible for program and normal age-related personal incidental costs for members in the program such as bedding, diapers for infants, toiletries, and personal feminine hygiene items for females, etc.

531.1.13 REIMBURSEMENT METHODOLOGIES

BMS will reimburse PRTFs according to the WV Medicaid State Plan, Attachment 4.19-A-2, *Payment for Medical and Remedial Care and Services*.

"Reimbursement will be based on a cost-based retrospective reimbursement system determined by applying the standards, cost reporting periods, cost reimbursement principles, and method of cost apportionment used under Title XVIII of the Social Security Act, prior to the Social Security Amendments of 1983 (Section 601, Public Law 98-21).

At final settlement a provider's total interim reimbursement for the reporting period will be reconciled to total allowable WV Medicaid program cost to an assigned WV State agency. Allowable WV Medicaid program cost will be determined using tests of reasonableness, appropriateness, and medical necessity, as demonstrated in Medicare Regulations. Final settlements will be calculated based upon a provider's filed cost report, appropriate supporting financial documentation, including the State's processing and statistical claims reports. Each provider, which does not request or qualify for a low utilization exemption, will be required to file a CMS 2552 cost report with the State. All filed cost reports will be subject to final settlement determinations utilizing internal desk review (un-audited) or full or partial financial audit procedures. Final payment determinations will not consider the incentive and cost sharing amounts provided for in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (public Law 97-248).

Development of a facility's initial interim per diem payment rate may be based upon one of the following: a documented host states' Medicaid reimbursement rate, a pro forma cost report, a similarly sized facility within close proximity. For established providers, interim per diem rates may be based upon a provider's most recent settled cost report or host state's PRTF approved rate. For interim cost rate reviews and rate update requests, a provider must submit their most recent fiscal year cost report to WVDHHR-Office of Accountability & Management Reporting Division of Audit & Rate Setting. Providers are responsible for

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adherence to cost reporting requirements as established in Chapter 300, Provider Participation Requirements."

531.1.13.1 PRTF Services Included in the Daily All Inclusive per Diem Rate

The West Virginia Medicaid daily per diem rate provides reimbursement for all medically necessary services identified on the child's treatment plan during the child's placement at the facility.

The PRTF agrees to:

- File appropriate claims for reimbursement in accordance with established BMS procedures. The submission by or on behalf of the PRTF of any claim for payment under the Medicaid program shall constitute certification by the PRTF that the services or items for which payment is claimed were actually provided by the PRTF to the person identified as the West Virginia member;
- File claims that do not exceed the PRTF's daily per Diem rate.
- File claims for items provided to persons who are West Virginia Medicaid members only;
- File claims which are correctly coded in accordance with billing instructions prescribed by BMS and file them in a timely manner in accordance with federal and state regulations; and
- Submit all information, with or in support of the information, in a true, accurate and complete manner.

531.1.13.2 Prerequisites for Payment

All PRTF's must have a current accurate signed and dated agreement with the Title XIX Medicaid Program on file with BMS' fiscal agent. The PRTF agrees to comply with all applicable rules, regulations, rates and fee schedules promulgated under Federal and West Virginia State laws. The PRTF represents and acknowledges that provider shall obtain a copy of those portions of the regulations and plans which bear on the providers of medical services of the type furnished by the PRTF. The PRTF further agrees to assure that all Medicaid services comply with Title VI of the Civil Rights Act of 1964; services shall be made available without discrimination due to race, religion, color, sex, national origin, age, ancestry, handicap or inability to pay; and all buildings and services shall comply as applicable, with Section 504 of the Rehabilitation Act of 1973 and the American With Disabilities Act (ADA).

The PRTF agrees to provide methods and procedures as required by Title XIX standards to safeguard against unnecessary or overutilization of care and services and assure that charges will be consistent with efficiency, economy and quality of care.

The PRTF agrees to maintain records in accordance with federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by the Department of Health and Human Resources. All supporting documentation for services provided to a member, including education, must be maintained in the individual members' cumulative record for a minimum of five years after discharge from the facility. Files must be stored in a secure manner. Appropriate measures must be taken to ensure the confidentiality of records, as well as safety from physical threats (e.g., fire, flood, etc.).

The PRTF agrees to make all records and documentation available upon request to DHHR, and/or the United States Department of Health and Human Services (HHS). Such records and documentation shall include, but not be limited to:

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- Financial Records;
- West Virginia Medicaid member Information;
- Description of Medical Services Implementation;
- Identification of Service Sites;
- Dates of Service for Each Service Component by member, client records, personnel records; and,
- MCM-1

The PRTF agrees, subject to appropriate procedural standards, to assume responsibility for repayments for state and/or federal funds which are subsequently disallowed or deferred by the state or federal government.

The PRTF agrees to participate in evaluations and audits authorized by the West Virginia DHHR and the United States HHS, the Comptroller General of the United States, or their duly authorized representatives relative to evaluation of the quality, appropriateness, and the timeliness of services pursuant to this agreement.
The PRTF agrees that payment and satisfaction of provider claims by BMS will be from federal and state funds, and that any false claims, statements or documents or concealment of material fact by a provider may be prosecuted by the Department under applicable federal or state law.

The PRTF agrees to permit regular medical reviews of each member, including a medical evaluation of the individual's need for PRTF services and to cooperate with state and federal personnel who make inspections, medical reviews and audits.

The PRTF must maintain in the member's medical record all information regarding the Interstate Compact Placement of Children (ICPC) and the 100-A form.

The PRTF's located out of state agree to inform BMS of all deficiencies received by that state's surveying licensing agency including annual and complaint investigations. The PRTF must have documentation of receipt that the member's parent/guardian(s), (non-custodial placement) and DHHR caseworker (custody placement) have received the results of the state surveying agency with deficiencies and complaint investigations. The state surveying agency's results will be easily accessible for all DHHR caseworkers West Virginia members/parent/guardian(s), and state personnel at all times and must be kept current.

The PRTF will provide to BMS' fiscal agent the results of the new nationally recognized accreditation when completed/updated.

The PRTF agrees to keep current with BMS' fiscal agent a new signed and dated Attestation/Certification letter by the Facility Director for all programs/sites when changes occur from information previously supplied. A completed attestation statement must be submitted to BMS annually by July 21st.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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Child and Adolescent Needs and Strengths Assessment (CANS): A multi-purpose tool developed to support care planning and level of care decision-making, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

Child and Adolescent Functional Assessment Scale (CAFAS): The CAFAS is the gold standard for assessing a youth's day-to-day functioning across critical life domains (subscales) AND for determining whether a youth's functioning improves over time The CAFAS is a professionally-rated measurement tool designed to assess the level of functioning in children and adolescents with emotional, behavioral, or substance use symptoms or disorders (Hodges, 1990).

Clinical Pathways: Standardized, evidenced-based, multidisciplinary management plans, which identify an appropriate sequence of clinical intervention, time frames, milestones and expected outcomes.

Guardian: A person who has temporary or ongoing legal responsibility to care for another person or to manage that person's property and affairs, in whole or in part. Courts appoint guardians to protect the interest of minors or legally incompetent adults.

Individualized Education Program (IEP): A written statement for an eligible student with an exceptionality that is developed, reviewed and revised in accordance with Policy 2419: Regulations for the Education of Students with Exceptionalities and IDEA 2004. The IEP is a product of collaboration between a parent or adult student and educators who, through full and equal participation, identify the unique needs of the student with a disability or giftedness and plan the special education and related services to meet those needs. It sets forth in writing a commitment of resources necessary to enable the student to receive needed special education and related services. In addition, the IEP is a management tool that is used to ensure that each eligible student is provided special education and related services appropriate to the student's special learning needs. It serves as an evaluation device for use in determining the extent of the student's progress toward meeting the projected outcomes. The IEP is a compliance/monitoring document that may be used by authorized monitoring personnel from each governmental level to determine whether an eligible student is actually receiving the free appropriate public education agreed to by the parents and the school.

Interdisciplinary Team (IDT): Team intervention or collaboration on behalf of a specific client or client system, which involves members of various professions or disciplines who develop an individualized plan for the treatment and discharge of each member. The treatment plan charts a course designed to help the member move to a less restrictive level of care as quickly as possible. Discharge planning begins on admission and is carried through on the initial treatment plan and each revision of the plan during the entire stay of the West Virginia Medicaid member.

Interstate Compact on the Placement of Children (ICPC): The Compact is a uniform law that has been enacted by all 50 states, the District of Columbia, and the U.S. Virgin Islands. It establishes orderly procedures for the interstate placement of children and fixes responsibility for those involved in placing the child. The Compact law contains 10 articles. They define the types of placements and placers subject to the law; the procedures to be followed in making an interstate placement; and the specific protections, services, and requirements brought by enactment of the law.

Loco Parentis: Latin word meaning, "in the place of a parent" or "instead of a parent." Refers to the legal responsibility of an adult or institution assuming the relationship toward an infant or minor of whom the

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adult is not a parent, but to whom the adult or institution owes the obligation of care and supervision of making legal decisions. It refers to an individual who assumes parental status and responsibilities for another individual, usually a young person, without formally adopting that person.

Milieu Therapy: A form of treatment and rehabilitation for people with social and mental disorders who usually live in institutional settings. Treatment is not restricted to individual hours with a professional therapist but also occurs in the total environment of this closed setting, which is also referred to as the "therapeutic community." Those being treated attend group sessions for everyone in the facility, elect their own leaders and provide one another with social and emotional support throughout the day. The entire environment is considered vital to the treatment process.

Multidisciplinary Treatment Team (MDT): A group of individuals from different disciplines who work together to:

- Access, plan and implement a comprehensive individualized service plan for a child involved in a court proceeding either because of abuse/neglect or status or juvenile delinquency proceedings
- Work with a child and family to develop a service plan and coordinate services.

Be the central point for decision making during the child's stay at the PRTF.

MCM-1: A form developed and used by the BMS to meet Federal Regulation (42 CFR) Subpart D, Inpatient Psychiatric Services for Individuals Under the Age of 21 in Psychiatric Facilities or Programs, 42CFR §441.151. General Requirements, Inpatient psychiatric services for individuals under age 21, must be certified in writing to be necessary in the setting in which the services will be provided. The West Virginia Medicaid Program utilizes the MCM-1 to meet the requirements for certification of inpatient services in the Medicaid-approved psychiatric facility for individuals under the age of 21 years. The MCM-1 must be certified by an independent team that includes a physician/psychiatrist, has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and has knowledge of the individual's situation.

Non-Custodial Placement: The placement of a child into a PRTF by physician/psychiatrist order utilizing the West Virginia Medicaid Card as reimbursement for services provided the child. The attending physician/psychiatrist must provide documentation of treatment and lack of response to treatment. The physician/psychiatrist must certify the need for this level of service and complete and sign the MCM-1. The parent retains legal custody and financial responsibility for expenses related to treatment, supervision, room and board, education, etc. not covered by medical insurance/Medicaid. Non-custodial placements must meet all eligibility requirements for this level of care.

Variance: A written declaration by the Secretary that a certain requirement of this rule may be satisfied in a manner different from that set forth in the rule.

Waiver: A written declaration by the Secretary that a certain requirement may be treated as inapplicable in a particular circumstance.

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531.1 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD

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