

## **HIGHLIGHTS PROPOSED REGULATIONS**

### **Residential Treatment Facility**

### **Chapter 1165**

- RESIDENTIAL TREATMENT FACILITY (RTF) - A facility which provides comprehensive inpatient mental health treatment and/or substance abuse services for children with severe emotional disturbances, substance abuse or mental illness under this Chapter, meets State and Federal participation requirements and adheres to Child and Adolescent Service System Principles (CASSP). *Must be accredited by a recognized accrediting body.*
- Regulations are based upon policy decisions dating back to Medical Assistance (MA) Bulletin 1165-93-01 effective January 1, 1993 and revised in MA Bulletin 1165-95-01 effective September 8, 1995. In addition there have been certain operational processes and standard regulatory language included in the regulations to bring them into conformity to other OMAP regulations.
- Regulation Highlights:
  - OMAP may publish as a public notice, additional accrediting bodies with comparable standards to the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) in the form of a public notice. This opens enrollment as an accredited residential treatment facility under proposed Chapter 1165 regulations to more facilities.
  - Adds a maximum number of residents per living unit. (16)
  - The regulations clarify the policy relating to Out-of-State facilities providing this service.
  - Adds information relating to change of ownership, annual cost reporting requirements.
  - Addresses the issue of facility responsibility during an employee strike or disaster.
  - Clarifies clinical issues, for example the frequency of face-to-face evaluations, and treatment plans.
  - Allows for the enrollment of locked perimeter (Secure Care) Pennsylvania RTFs for children adjudicated or alleged delinquent and/or court committed to a secure RTF for medically necessary treatment. \*
  - Allows for the enrollment of facilities treating residents with drug and alcohol diagnosis concurrent with severe mental illness by RTFs licensed by the Department of Health to provide drug and alcohol services. \*

\* Only applies to providers enrolled under Chapter 1165 not under Chapter 1157.

PLEASE NOTE: These regulations will be cross-walked with the BHRS regulations to address any inconsistencies.

## ANNEX B

### TITLE 55. PUBLIC WELFARE PART III. MEDICAL ASSISTANCE MANUAL

#### CHAPTER 1165. RESIDENTIAL TREATMENT FACILITY SERVICES

##### GENERAL PROVISIONS

###### **§ 1165.1. Policy.**

- (a) This Chapter applies to inpatient residential treatment facilities (RTFs) which meet the provisions at 55 Pa. Code Chapter 3800; 42 CFR § 440.160 (relating to inpatient psychiatric services for individuals under age 21); 42 CFR 483 (relating to requirements for State and Long Term Facilities) Subpart G (Conditions of participation); and subsequent State and Federal requirements.
- (b) The Office of Medical Assistance Programs (OMAP) provides coverage for medically necessary inpatient services rendered to eligible recipients under 21 years of age by enrolled RTF providers. Payment is made subject to this Chapter and Chapter 1101 (relating to general provisions).

###### **§ 1165.2. Definitions.**

The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

*ACTIVE TREATMENT* - Implementation of a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time.

*CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)* – A philosophy of collaborative service delivery in which services that are rendered to children, adolescents and their families are least restrictive/least intrusive, child-centered, family-focused, community-based, multisystem and culturally competent.

*CERTIFIED DAY* - A day of care approved by the Department under this Chapter.

*CHANGE OF OWNERSHIP* – The sale or transfer of a facility and all of its assets to another person, corporation, organization or partnership, with the expectation that the facility will continue to operate for the same purpose for which it is currently being used.

*COST SETTLEMENT* – A retroactive adjustment based on a cost report, following the end of a reporting period to bring the interim payments made to the provider during that reporting period into agreement with the reimbursable amount

payable to the provider for the allowable services actually rendered to program beneficiaries during the period. Final adjustment is made after an audit is completed.

*COUNTY CHILDREN AND YOUTH AGENCY (CCYA) / JUVENILE JUSTICE (JJ) PLACEMENT* - An admission of a recipient under 21 years of age who is in the custody of the CCYA, or under the supervision of the juvenile court and also has a diagnosed mental illness, severe emotional disorder or severe substance abuse condition, which medically necessitates residential treatment facility services.

*COVERED DAY* - A medically necessary day of care approved by the Department for residential treatment facility services and provided by the residential treatment facility.

*DAY OF CARE* - Room, board, and professional behavioral health services furnished to an eligible recipient on a 24-hour day basis utilizing a midnight census hour. The term includes those items and services ordinarily furnished by the residential treatment facility for the care and treatment of the recipient. The day of admission is counted as a patient day of care but the day of discharge is not counted as a patient day of care. A day of care is counted on the day the resident returns from temporary hospitalization but not on the day the resident departs.

*DELAYED COVERAGE* – When an admission or continued stay certification could not be accomplished because of a county assistance office (CAO) delay in determining recipient eligibility or a third party resource was responsible for payment of care.

*DEPARTMENT* – Department of Public Welfare.

*DEPARTMENT'S COST MANUAL* – The Office of Medical Assistance Programs' Therapeutic Rehabilitative-Residential Treatment Facility (TR-RTF) Services and Accredited RTF Services Manual for Cost Reporting Procedures.

*FACILITY* - A residential treatment facility regulated under this Chapter.

*FACILITY TEAM* - A team of professionals from the residential treatment facility comprised of professionals who meet the requirements at 42 CFR § 441.153(a) and (b) (relating to the team certifying the need for services) and § 441.156 (relating to the team developing individual plan of care).

*FISCAL YEAR* - A period of time beginning July 1 and ending June 30 of the following year.

*HOSPITAL RESERVED BED DAY* - A day when the recipient is approved for and admitted to an acute care general hospital, psychiatric or rehabilitation unit of an acute care general hospital, or a psychiatric or rehabilitation hospital for which the OMAP agrees to make a reduced payment in order to hold the bed for the recipient's return to the facility upon discharge from the hospital or hospital unit.

*INDEPENDENT TEAM* – A team comprised of professionals in accordance with 42 CFR § 441.153(a) relating to team certifying need for services.

*INTERAGENCY SERVICE PLANNING TEAM* – A county based team which includes: (1) The child and the family and/or legal guardian; (2) The prescribing psychiatrist or their physician designee, and psychologist; (3) A County Mental Health/Mental Retardation (MH/MR) Program representative; (4) A CCYA representative when applicable; (5) An education system representative from the school district responsible for planning for the child; (6) Representatives from all community service systems currently providing services to the child and family; (7) A juvenile probation (JP) program representative if applicable, and (8) A managed care program representative when applicable.

*LIVING UNIT*- The smallest physical subdivision in which an identifiable group of children sleep and in which a day-to-day individual group program and leisure activities may occur. Generally living units are known as cottages, wings, dormitories, or units.

*MENTAL HEALTH ONLY ADMISSION* - An admission of an eligible recipient who is not in the custody of the CCYA or under the supervision of the juvenile court and who is under 21 years of age with a mental health diagnosis, severe emotional disorder or severe substance abuse condition which medically necessitates residential treatment facility care.

*MENTAL HEALTH PROFESSIONAL* – A person trained in a generally recognized clinical discipline, including but not limited to psychiatry, social work, psychology or nursing, rehabilitation, special education or activity therapies who has a graduate degree and clinical experience.

*NON-COVERED DAY* – Any day where the recipient is physically absent from the facility for administrative reason, hospitalized beyond the hospital reserved bed day limit, AWOL in excess of the established policy limit or was on therapeutic leave in excess of the established therapeutic leave policy limits. This definition also includes any day of care which was determined not to be medically necessary, or was disapproved by the Department for failure to request admission or extension certification according to established time frames.

*PATIENT PAY AMOUNT* - Income or assets that the CAO has determined to be available to a recipient to meet the cost of medical care. The recipient, not the OMAP, pays this amount toward the cost of care.

*PLAN OF CARE SUMMARY*- Represents a visual overview of the child's diagnosis and individualized formal and informal services and supports provided to or requested for the child.

*RECIPIENT UNDER 21 YEARS OF AGE* – An individual who has been determined eligible for MA Program benefits and is eligible on the date service is rendered is one of the following:

- (1) Under 21 years of age.
- (2) Age 21 and was receiving inpatient psychiatric services in a residential treatment facility the day preceding the date the recipient reached age 21. This recipient continues to be recognized as a recipient under 21 years of age until the earlier of the date the recipient either:
  - (i) No longer requires inpatient services.
  - (ii) Reaches age 22.

*RESIDENTIAL TREATMENT FACILITY (RTF)* - A facility which provides comprehensive inpatient mental health treatment and/or substance abuse services for children with severe emotional disturbances, substance abuse or mental illness under this Chapter, meets State and Federal participation requirements and adheres to Child and Adolescent Service System Principles (CASSP).

*RESTRAINT AND SECLUSION REQUIREMENTS* – Requirements specified at 55 Pa. Code 3800 and 42 CFR 483 Subpart G, or subsequent revision.

*SECURE CARE RESIDENTIAL TREATMENT FACILITY* – A residential treatment facility in which unauthorized and unsupervised entrance to and exit from the facility by residents and the public are prohibited and prevented by means of a secure perimeter. A secure perimeter is created by the presence of locked, manually or electronically controlled exit and entry doors, perimeter fencing of all or part of the facility, tamper-proof windows and detention screens, and/or the use of cameras, monitors and other security devices and equipment which, in concert with security policies and procedures, monitor and control the passage of people and objects into and out of the facility. The purpose of a secure perimeter is to prevent the escape of residents subject to the jurisdiction of the juvenile justice system or committed for treatment of a mental and/or addiction disorder, limit access to the facility to staff and other authorized persons, and to prevent the introduction of contraband.

*THERAPEUTIC LEAVE* - A period of absence from an inpatient RTF directly related to the treatment of the individual's illness. A day of therapeutic leave is 12 to 24 hours of continuous absence for therapeutic reasons without regard to the calendar day. This type of leave shall not be used as a reward or punishment.

*TREATMENT PLAN* – includes a summary of the goals, objectives, discharge plan and behavioral interventions proposed to address the child's behavioral health issues in the environments in which the child exhibits a behavioral health treatment need; an explanation of the appropriate settings and time allocations; and a description of any changes or updates from previous treatment plans in sufficient detail that allows for full understanding of the planned goals, objectives and interventions and their clinical

relationship to each other, as well as, the continued medically necessary need for the service.

## **SCOPE OF BENEFITS**

### **§ 1165.21. Scope of benefits for the categorically needy recipients.**

Categorically needy recipients under 21 years of age are eligible for medically necessary RTF services provided by a participating residential treatment facility.

### **§ 1165.22. Scope of benefits for the medically needy recipients.**

Medically needy recipients under 21 years of age are eligible for medically necessary RTF services provided by a participating residential treatment facility.

### **§ 1165.23. Scope of benefits for State Blind Pension recipients.**

State Blind Pension recipients are not eligible for medically necessary RTF services unless the recipient is also either categorically or medically needy and under 21 years of age.

### **§ 1165.24. Scope of benefits for General Assistance recipients.**

General Assistance recipients under age 21 are eligible for medically necessary RTF services provided by a participating facility.

## **PROVIDER PARTICIPATION**

### **§ 1165.31. General participation requirements for RTF.**

- (a) The Department possesses the authority to regulate participation in the OMAP Program and has discretion to refuse to enter into provider agreements with applicants and to terminate provider agreements with participating providers to protect and advance the best interests of the Department.
- (b) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), to participate in the OMAP an RTF shall:
  - (1) Have an initial and annual on-site inspection conducted by the Department based upon the Department's Program Standards as issued by the Office of Mental Health and Substance Abuse Services (OMHSAS) and a program description approved by the Department under the service description guidelines regarding facility services.
  - (2) Be certified by the Department as a residential child care facility under Chapter 3800, or if the provider serves only individuals 18 years of age or

older, as a Community Residential Rehabilitation (CFR) services under Chapter 5310 or subsequent revision.

- (3) Have in effect a utilization review plan that meets the requirements set forth at 42 CFR Part 456, Subpart D (relating to utilization control: mental hospitals) and provide psychiatric services that meet the requirements of 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs).
- (4) Be in compliance with State and Federal restraint and seclusion requirements and attest to compliance on the Department specified form.
- (5) Provide the Department with requested fiscal information in accordance with the Department's Cost Manual.
- (6) Use an accounting system, which properly allocates costs, and maintains adequate statistical data to support the basis of the cost allocation. All allocations shall be made using the methodology identified in the Department's Cost Manual.
- (7) Be enrolled in the OMAP as an RTF.
- (8) Have a minimum of eight beds and a maximum of 16 beds per living unit.
- (9) Have a transfer agreement with an acute care hospital and inpatient psychiatric hospital.
- (10) Be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by any other accrediting body approved by the Department and published as a public notice in the Pennsylvania Bulletin.

**§ 1165.32. Participation requirements for out-of- state RTFs.**

- (a) Only RTFs located in contiguous states and within reasonable travel distance to the recipient's home residence, or providing medically necessary residential treatment services not available in the Commonwealth will be permitted to enroll and participate in the Commonwealth of Pennsylvania's OMAP as an RTF.
- (b) Be licensed and participate in the Medicaid Program of the state in which the facility is located, if that state recognizes facilities which provide equivalent services.
- (c) Have a program description that meets the Department's Program Standards as issued by the Office of Mental Health and Substance Abuse Services (OMHSAS) and is approved by the Department under the service description guidelines.



(d) Meet the requirements established in §1165.31 (3) through (8).

**§ 1165.33. Participation requirements for secure care RTFs.**

(a) All requirements in § 1165.31 (General Participation Requirements for RTFs) shall be met.

(b) Only a locked facility serving children with severe mental illness adjudicated or alleged delinquent and/or court committed to a secure facility, which does not meet the definition of a public institution at 42 CFR § 435.1009 or a privatized prison under the administrative control of a government unit may enroll as a secure care RTF.

(c) The service description approved by the OMHSAS shall contain information regarding the security of the facility and may not include locking residents in their rooms overnight.

**§ 1165.34. Participation requirements for facilities treating residents with drug and alcohol diagnoses concurrent with severe mental illness in RTFs.**

(a) All requirements in § 1165.31 (General Participation Requirements for RTFs) shall be met.

(b) The facility shall be licensed to provide drug and alcohol services by the Department of Health if clinically treating residents for substance abuse(s). Facilities that contract out for treatment of substance abuse are not required to meet the additional licensing requirement of this subsection.

**§ 1165.35. Ongoing responsibilities of providers.**

In addition to the ongoing responsibilities established in Chapter 1101 (relating to general provisions) RTFs shall:

(1) Maintain compliance with State and Federal regulations, policies and procedures. Where there are conflicting standards between the Chapter

3800 regulations, OMAP Bulletins and regulations, Federal Regulations, OMHSAS policy and/or accreditation standards, the more stringent standards apply.

- (2) Maintain effective agreements with general and psychiatric hospitals, community based mental health services, drug and alcohol services and to the extent possible, other RTFs for the prompt and appropriate transfer or referral of patients who require or may be expected to require care in another setting.
- (3) Establish and implement the resident's discharge plan, as appropriate. Maintain contact and agreements with the child's community based mental health services, drug and alcohol services and interagency service planning team to facilitate continuity of care upon discharge and availability of services to children returning to their community on therapeutic leave or upon discharge.
- (4) Promptly furnish complete and accurate copies of any requested patient records and fiscal records to the Department or its agents, or to Federal and State auditors.
- (5) Retain complete, accurate, legible and auditable clinical, medical and fiscal records for each medical assistance recipient for four years from the individual's discharge or until the Department's audit is final, whichever is later.
- (6) Maintain separate patient statistics and fiscal records, based on the Department's Cost Manual, on the cost of and charges for services provided to residents at each campus where any covered services are provided.
- (7) Obtain Department approval for any service description changes or revisions.
- (8) Notify the Department of program site changes.
- (9) Notify the Department if the facility loses compliance with the restraint and seclusion requirements.
- (10) Submit a new attestation of compliance letter with the restraint and seclusion requirements when responsible facility management changes.

**§ 1165.36. Changes of ownership or control.**

- (a) If the RTF changes ownership and the new owner wishes to participate in the OMAP, the facility shall submit a written application for participation to the OMAP.
- (b) When a facility changes ownership, the Department will approve enrollment by the new owner if the following conditions are met:
  - (1) The new ownership meets applicable State and Federal statutes and regulations.
  - (2) The Department determines the new owner to be eligible to participate in the OMAP as described under § 1165.31.
- (c) No facility shall be entitled to additional reimbursement solely due to changes in ownership or control.
- (d) In the event of a reorganization, or change in ownership or control, prospective payment rates will be established as follows:
  - (1) If only one facility is involved, the prospective payment rate prior to the change is maintained.
  - (2) If two or more facilities are being combined, the prospective payment rate will be established by bed-weight averaging the rates of the facilities involved based upon the number of medical assistance days for each facility over the most recent fiscal year and the per diem of each for the same time period.
  - (3) If the new facility divides into two or more locations, the prospective payment rate of the entity existing prior to the change will be used for all resulting entities until such time as the Department establishes individual per diem payment rates based upon audited costs, as defined by the Department's Cost Manual.
- (e) Prospective per diem payment rates established under subsection (d) are not rebased until a statewide rebasing occurs.
- (f) If the Department rebases prospective payment rates after a change of ownership has occurred by using a base year which predates or corresponds to the year of change, the cost report or cost reports and claims data for the base year are used regardless of ownership or control of the entity in the base year.
- (g) An RTF shall report a change in ownership or controlling interest of 5% or more to the OMAP. The report shall be received by the Department at least 30 days before the date the change occurs. Failure to submit a complete and accurate report constitutes a deceptive practice under section 1407(a)(1) of the Public

Welfare Code and justifies a termination of the provider agreement by the Department as set forth in Chapter 1101.77 (relating to enforcement actions by the Department).

- (h) The facility shall include in its notice of a change of ownership or control under (g), a copy of the agreement of sale or plan of merger, the effective date of the change, and other appropriate information to describe the nature and effects of the change.
- (i) If a facility fails to notify the Department as specified under (g) on a timely basis the facility forfeits one day of reimbursement for services for each day that the notice was untimely.
- (j) When the ownership of a facility changes, the new owner is liable for all obligations of the prior ownership. This requirement applies to obligations relating to prior ownership, whether those obligations are due on the date of change or become due subsequent to the change.
- (k) A facility that changes ownership or closes shall submit a final cost report to the Department within 45 days of the change of ownership or closure.

#### **PAYMENT FOR RESIDENTIAL TREATMENT FACILITY SERVICES**

##### **§ 1165.41. General payment policy.**

- (a) Payment for RTF services is subject to this Chapter and Chapter 1101 (relating to general provisions).
- (b) Behavioral health services provided during the stay (except staff psychiatrist professional component physician costs) as well as room and board are included in the prospective per diem payment for facility services and shall not be billed separately or in addition to the prospective per diem payment rate, by the RTF or any other entity with which the facility may have an agreement to provide these services.
- (c) The prospective per diem payment rate does not include services listed under § 1165.48 (c), (relating to non-compensable services and items). Non-behavioral health services, which are medically necessary and are not covered by the prospective per diem payment rate, may be billed by a provider who is enrolled in the OMAP to provide these service(s).
- (d) All admissions are subject to a retrospective review by the Department in addition to the prior authorization review. If the medical record documentation does not support the medical need for the admission or continued stay, or if care rendered is found to be inadequate, inappropriate, or harmful to the recipient, payment may be denied for all or part of the stay. Suspected cases of fraudulent practices

by the residential treatment facility may be referred for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit.

**§ 1165.42. Payment methods and rates.**

- (a) The method for determining prospective per diem payment rates under this section is based on whether the status of the RTF is “existing” or “new” as follows:
  - (1) An “existing” provider is an RTF that was enrolled in the OMAP for the entire period of July 1, 2001 to June 30, 2002. This includes facilities that had a change of ownership during this period.
  - (2) A “new” provider is an RTF that is enrolled in OMAP after July 1, 2001 (excluding providers that had a change of ownership).
- (b) The prospective per diem payment rate for an “existing” provider is the facility’s OMAP per diem payment rate established with the Department as of June 30, 2001.
- (c) The prospective per diem payment rate established for “existing” providers shall be considered the final per diem payment rate, unless re-established by audit.
- (d) For “new” providers the interim and final per diem payment rates are determined as follows:
  - (1) The Department will establish an interim per diem payment rate for each new provider. The interim per diem payment rate will be based upon each facility’s operating costs reflected in the facility’s cost report, based upon available historic costs, and/or a projected budget, applying the Department’s Cost Manual and other other reasonableness tests.
  - (2) The interim per diem payment rate shall be established by dividing the total operating costs, as defined in paragraph (1), by a minimum of 85% of the maximum possible number of days based on the number of the facility’s certified beds.
  - (3) The Department will audit each new facility’s cost report, after the first full year of operation, to determine reportable costs applying the Department’s Cost Manual.
  - (4) The final per diem payment rate is the audited MA per diem cost of the facility’s first full fiscal year of operation in the MA Program, which will include a patient day adjustment to an 85% occupancy rate if the provider reported less than the 85% occupancy rate, inflated by the appropriate

inflation factor.

- (5) New providers will be subject to cost settlement for a difference between the interim and final payment rate, before inflation factor, as determined under this section.
- (e) Regardless of whether the RTF is “existing” or “new”:
- (1) The final per diem payment rate, which becomes the prospective payment rate, will be adjusted annually by an inflation factor established by the Department and published in the Pennsylvania Bulletin unless the rate is recalculated based upon audited costs for a preceding year.
  - (2) The RTF’s payment is determined by the facility’s prospective per diem rate multiplied by the number of covered days and then reduced by any payment which would be paid by a third party payor, and the recipient’s or responsible party’s patient pay amount.
  - (3) Prospective payment rates established under this section are not rebased until a statewide rebasing. Rebasing will include adjustments made to rates due to Federal and/or Pennsylvania State requirements, as calculated by the Department.
  - (4) If the Department rebases prospective payment rates after a change of ownership has occurred by using a base year which predates or corresponds to the year of change, the cost report or cost reports and claims data for the base year are used regardless of ownership or control of the entity in the base year.

### **§ 1165.43. Limitations on Payment.**

(a) Payment for therapeutic leave:

- (1) In order to be compensable, the leave must be part of the treatment program and appropriately documented in the individual's medical record. Documentation must include a physician order for the therapeutic leave, a description of the desired outcome, the date and time the child went on therapeutic leave, prescribed medications, the date and time of return, and

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written summary conducted after the leave with the child and family or legal guardian. The summary shall describe the treatment objective(s) of the leave and the outcome(s).

(2) Payment for compensable therapeutic leave will be at the provider's approved prospective per diem rate for each day of therapeutic leave which meets the requirements of this Chapter.

(3) The facility is responsible clinically and fiscally for behavioral health services the recipient may require while on compensable therapeutic leave.

(4) Compensable therapeutic leave is limited to a maximum of 48 therapeutic leave days per calendar year, per recipient. This limit applies whether the recipient is in continuous or intermittent treatment at one or more RTF or therapeutic rehabilitation residential treatment facility (TR-RTF) during the calendar year.

(5) A facility may grant therapeutic leave in excess of 48 days; however, the OMAP will not make payment for therapeutic leave days exceeding the maximum annual limit.

(b) Payment for hospital reserved bed days:

(1) Payment to an RTF to reserve a bed due to the recipient's hospitalization will only be made if the recipient is admitted to a licensed hospital or hospital unit accredited by the JCAHO as a hospital and the hospitalization occurs during a certified RTF stay.

(2) Payment for reserved bed days is limited to 15 days per calendar year (per recipient) whether the child was in continuous or intermittent treatment at one or more residential facilities during the calendar year. If the child does not return to the RTF, the child shall be deemed discharged on the date of admission to the hospital.

(3) Hospital reserved bed days in excess of 15 days per calendar year, per recipient are non-compensable. If no other entity makes payment to reserve the bed for the non-compensable days, the child shall be returned to the first available comparable RTF facility bed when ready for discharge from the hospital.

(4) Payment for compensable reserved bed days will begin on the date of admission to the hospital and will be paid at one-third of the provider's approved prospective per diem payment rate.

- (5) If the reserved bed day limitation has not been exceeded, and the recipient is admitted to a hospital or hospital unit as specified in paragraph (1) of this subsection, the facility shall accept the child back when ready for discharge and return the child to the same or comparable residential bed.

(c) Absence without leave (AWOL)

- (1) Unauthorized absence from the facility is not compensable and shall be recorded as non-covered days on an invoice to the Department unless the conditions in paragraph (2) of this subsection are met.
- (2) The Department will recognize up to two days of unauthorized absence from the facility during a certified stay as covered days. All other AWOL days are non-covered. The following conditions shall be met for the two days to be covered.
  - (i) Upon determination that the recipient is absent without authorization, the facility must immediately file a police report and conduct an extensive search of the facility buildings, grounds and off-site areas where the staff believe the child might have gone.
  - (ii) If the recipient cannot be located within two hours of the initial determination that the recipient is missing, the facility must notify:
    - (A) The County MH/MR Office, and
    - (B) The CCYA, if the child is in its custody; the supervising juvenile court, if the child is under the supervision of the juvenile court; or the child's responsible family member or legal guardian, as appropriate.
  - (iii) Attempts to locate the child include at least 4 to 6 hours of off-facility grounds search during each 24-hour period that the child is absent without authorization.
  - (iv) When the child is found or returns voluntarily, the facility must notify all previously notified parties that the child is no longer absent without authorization.
  - (v) All actions taken to locate the recipient during the absence and required notifications shall be documented in the recipient's medical record. Each notation in the medical record shall be signed and dated upon entry by responsible facility personnel and must include a date, time and summary of each action taken. Documentation of on-site and off-site searches must specify the date and hours of



search, where the search was conducted, any pertinent findings, and be signed by staff who conducted the search.

- (d) Limitation on payment during strike or disaster situations requiring recipient evacuation.
- (1) The facility shall immediately notify: the OMAP, the appropriate regional field office of OMHSAS, the CCYA, the Office of Children, Youth and Families (OCY&F) and the child's family or guardian upon learning of an impending strike or disaster situation requiring evacuation from the facility. For disaster situations: the OMAP, OMHSAS, OCY&F and the child's family or responsible party shall be notified by phone or fax followed by a written notice.
  - (2) The facility shall provide a written list of the children in the facility whose care is paid by OMAP to OMHSAS, CCYA, OCY&F and OMAP within 3 to 5 days of learning of the strike or disaster. The list shall identify each child by name, county with custody (if applicable), medical assistance Access identification number, and as either mental health only or in the custody of OCY&F, or under the supervision of the juvenile court, and information identifying where the recipient has or will be transferred.
  - (3) If a resident is transferred as a result of a strike or disaster, the transferring facility is responsible to transfer the resident to the closest participating facility capable of providing the needed service. Payment will be made to the receiving facility at the receiving facility's per diem payment rate based upon the admission or continued stay approval obtained by the transferring facility.

#### **§ 1165.44. Reportable costs.**

The Department uses the Department's Cost Manual and Medicare principles as established by the Social Security Act (42 U.S.C.A. § 301-1399) as a basis for determining what cost items are allowable for purposes of Medical Assistance reimbursement.

#### **§ 1165.45. Nonreimbursable costs.**

Costs not reimbursable under the OMAP are:

- (1) Costs exceeding the limits established by the Department.
- (2) Costs related to the provision of a non-compensable service or item.

- (3) Costs related to days of care determined by the Department not to be medically necessary or appropriate.
- (4) Costs for legal services relating to litigation against the Commonwealth, including administrative appeals, if the litigation is ultimately decided in favor of the Commonwealth.
- (5) Administrative costs in excess of 13 percent or other MA eligible costs based upon the Department's Cost Manual.
- (6) Costs for which Federal Financial Participation (FFP) is precluded by statute, except as may be expressly provided for otherwise in this Chapter.
- (7) Education costs associated with the child's Individual Educational Plan (IEP), Individual Family Service Plan (IFSP) and the Individual Service Plan (ISP), which are or should be paid for by the recipient's school district.
- (8) Costs related to direct medical education.
- (9) Costs Services or items which are non-reimbursable under this Chapter includes, but is not limited to, the following
  - (i) Advertising (excluding employment opportunities).
  - (ii) Charitable Contributions
  - (iii) Employee Recognition, such as gifts, awards, dinners.
  - (iv) Employee Social Functions, such as picnics, athletic teams.
  - (v) Excessive Benefits (non-standard).
  - (vi) Fund Raising/Marketing Expenses.
  - (vii) Life Insurance (Provider is beneficiary).
  - (viii) Lobbying.
  - (ix) Meals for Visitors.
  - (x) Political Activities.
  - (xi) Related Party Rental/Leases or other payments in excess of the provision of the Department's Cost Manual.
  - (xii) Reorganization Costs.
  - (xiii) Taxes-Federal, State or Local income and excess profits.
  - (xiv) Taxes from which exemptions are available to the provider.
  - (xv) Bad Debts and Contractual Adjustments.
  - (xvi) Barbers/Beauticians Costs.
  - (xvii) Client Allowances.
  - (xviii) Clothing/Shoes.
  - (xix) Living Expenses for live-in employees, including lodging, meals and personal laundry.
  - (xx) Meals for Employees, except for employee meals provided as part

of

- client training activities.
- or
- (xxi) Penalties, Fines or Late Charges assigned by any source, whether not related to the provider.
  - (xxii) Personal Hygiene Items.
  - (xxiii) Personal Travel for employees, including personal use of provider vehicles.

**§ 1165.46. Reserved**

**§ 1165.47. Annual Cost Reporting.**

- (a) The facility's cost report shall:
  - (1) Be prepared using the accrual method of accounting.
  - (2) Contain complete and accurate information necessary for the proper determination of costs payable under the program.
  - (3) Except as noted in paragraph (4) of this subsection, cover a fiscal period of 12 consecutive months, from July 1 to June 30.
  - (4) In the event a facility begins operations after the start of the fiscal year, cover the period from the date of approval for participation in the OMAP to June 30.
- (b) The facility shall submit the completed cost report form in compliance with the Department's Cost Manual to the Department by September 30 of each year. The Department may grant a 30-day extension upon receipt of a written request from the residential treatment facility.
- (c) If the provider does not submit a cost report by September 30 of each year, or later if an extension is granted by the Department under the procedures of the cost report, the OMAP will establish an interim per diem payment rate for the provider equal to the lowest rate for any RTF for the current fiscal year. This rate will begin on the first day after the required report is due and continue until the last day of the calendar month in which the required report is received.

**§ 1165.48. Noncompensable services and items:**

- (a) Payment is not made to an RTF for:
  - (1) Experimental or investigation procedures or clinical trial research and services that are not in accordance with customary standards of medical practice or are not commonly used.

- (2) A day of care solely for the purpose of performing evaluations, diagnostic tests or tests not related to a diagnosis that requires this level of care.
- (3) Any service if payment is available from another public agency, insurance or health program, or any other source.
- (4) Services not ordinarily provided to the general public.
- (5) Methadone maintenance.
- (6) Days of care during which the patient was absent from the facility such as: absences without leave, elopement or against medical advice; hospitalization, therapeutic leave, or administrative leave of any kind, unless an absence meets the criteria at § 1165.43 (relating to limitations on payment).
- (7) Custodial care related or unrelated to court commitments. Payment for services provided to recipients confined to a facility under a court commitment for any reason will be made only if medical necessity exists for residential treatment facility services.
- (8) Diagnostic or therapeutic procedures for experimental, research, or educational purposes.
- (9) Unnecessary admissions and days of care due to conditions which do not require psychiatric residential treatment care.
- (10) Days of care for recipients who no longer require this level of care.
- (11) Days of care for a recipient who does not have a current DSM diagnosis and Axes I-V or diagnosis along with Axes III-V supported by clinical documentation.
- (12) Days of care not certified in accordance with the Department's admission and continued stay review process.
- (13) Days of care due to failure to promptly request or perform necessary diagnostic studies or consultations.
- (14) Days of care on or after the effective date of a court commitment to another facility.
- (15) Days of care due to failure to promptly apply for a court ordered commitment.

- (16) Days of care provided to a recipient who is suitable for an alternate non-residential treatment type or level of care, regardless of whether the recipient is under voluntary or involuntary commitment.
  - (17) The day of discharge.
  - (18) Days of care disallowed by care review.
  - (19) Days of care where requirements were not met under 42 CFR Part 441, Subpart D (relating to inpatient psychiatric services for individual under age 21 in psychiatric facilities or programs).
- (b) The Department does not pay RTFs for services or items provided in conjunction with the provision of a service or item in subsection (a), even if the attending physician or facility's utilization review (UR) committee determines that the stay was medically necessary.
- (c) When provided to a recipient in a RTF, the following services and items are not included in the per diem and may not be included as a facility cost:
- (1) Non-behavioral health related services.
  - (2) Prescription drugs.
  - (3) Ambulance services.
  - (4) Staff psychiatrist professional component services.
  - (5) Clothing, allowances, and personal care items.
  - (6) Diagnostic procedures or laboratory tests.
  - (7) Dental.
  - (8) Inpatient hospitalization.
  - (9) Emergency room visits.
  - (10) Transportation and living costs associated with on-campus family visits.

**§ 1165.49. Third party liability.**

- (a) RTFs shall utilize available third party resources for all services a recipient receives while in the facility.

- (b) If expected payment by a third party resource is not realized, the facility may bill the OMAP for services certified by the Department and provided to the recipient.
- (c) If the facility receives reimbursement from a third party subsequent to payment from the Department, the facility shall repay the Department by submitting a replacement of prior claim, according to instructions in the Provider Handbook.
- (d) If a recipient or the legal representative of a recipient requests a copy of the record of payment or amounts due, the facility shall submit a copy of the invoice and the request to the Department's Office of Administration, at the address specified in the Provider Handbook.
- (e) Except as specified in subsection (f), if a recipient is entitled to insurance benefits, the Department pays the lesser of:
  - (1) The facility's per diem payment rate multiplied by the number of covered days, minus any third party resources available to the recipient for the care, including any Medicare Part B payment; or
  - (2) The amount of the insurance plan's deductible and coinsurance minus any other third party resource available to the recipient for care, including any Medicare Part B payment.
- (f) If the third party resources available to a recipient for care equal or exceed the facility's per diem rate multiplied by the number of compensable days, the Department makes no payment for the RTF care.
- (g) The facility shall utilize resources available through Medicare Part B for those services provided in the RTF that are covered and approved for payment by Medicare Part B.

**§ 1165.50. Payment for out-of-state RTF services.**

- (a) The Department will pay for compensable services as established under this Chapter, furnished by out-of-state RTFs enrolled to participate in the OMAP only if either:
  - (1) Residents in a given area of Pennsylvania generally receive their care in a particular out-of-state facility; or
  - (2) Documentation is provided verifying that a particular RTF is the only facility equipped to provide the type of care that the individual requires.
- (b) The prospective per diem payment rate for services provided by an out-of-state facility as established at §1165.42 cannot exceed the lesser of:

- (1) The facility's home-state Medicaid per diem payment rate for equivalent services, or
  - (2) The average bed-weighted prospective per diem payment rate for RTFs located in Pennsylvania adjusted, if appropriate, for specialized care not available within Pennsylvania, based on the Department's Cost Manual, or
  - (3) The Statewide bed-weighted average Pennsylvania per diem rate for inpatient psychiatric hospitals.
- (c) The Department will pay the rate established in accordance with this section minus any payments from the recipient, a legally responsible relative or a third party resource for the services a recipient receives while in the facility.
- (d) The Department's payment rate will not include costs which are precluded from recognition by the Social Security Act (42 U.S.C.A. § 301-1399).

**§ 1165.51. Billing requirements.**

- (a) The facility shall submit invoices to the Department under the instructions in the Provider Handbook and subsequent bulletins.
- (b) The Department will not pay for RTF services if the facility submits the invoice for payment for those services later than 180 days following the last certified day of care on the invoice, unless granted an exception by the Department.
- (c) All original and resubmitted claims, including replacement claims, must be received for final adjudication within 365 days following the last date of service on the invoice.
- (d) If the service spans two fiscal years, a separate invoice must be prepared for each fiscal year.
- (e) If the service spans two differing per diem payment rates, a separate invoice must be prepared for each time period covered by the differing rates.
- (f) Except as specified in 1165.48(c), services and items provided to the recipient while in the facility are included in the prospective per diem and shall be included in the RTF services bill and shall not be invoiced separately.

**PAYMENT CONDITIONS FOR RESIDENTIAL  
TREATMENT FACILITY SERVICES**

**§ 1165.61. Payment conditions: general.**

- (a) The individual must be a recipient under 21 years of age, eligible for RTF services on the date of service.
- (b) The individual must have a documented need for services requiring placement in an RTF.
- (c) The recipient's admission and treatment in the facility must be in accordance with State and Federal regulations governing admission, continued stay, and service provisions in an RTF.
- (d) The interagency service planning team assessment as to the recipient's need for admission or the facility treatment team assessment for continued treatment in a RTF must be based upon evaluations that include a face-to-face examination of the medical, psychiatric, social, behavioral and developmental aspects of the individual's situation and reflect the medical necessity and effectiveness of RTF care for the recipient.
- (e) The facility must comply with the prior authorization process and continued stay process specified in the Department's Utilization Review Manual for RTFs which include continued interagency service planning team involvement.
- (f) The service must be approved prior to admission or continued stay unless the service meets the conditions specified at § 1165.64 (relating to admission certification and continued stay request).
- (g) The recipient must receive documented active treatment provided by mental health professionals at a frequency and intensity to justify 24-hour, out-of-home care instead of outpatient services which support the recipient in the home community.

**§ 1165.62. Evaluations and treatment plans.**

- (a) Team members specified at § 1165.63(a) must perform and prepare within the scope of their practice medical, psychiatric and psycho-social evaluations within the following time frames:
  - (1) Within a maximum of 30 days prior to the Department's receipt of an admission certification request or continued stay request; or
  - (2) Before authorization for payment, if the individual becomes eligible for medical assistance after admission.
- (b) Team members specified at § 1165.63(a) shall, within their scope of practice, prepare the treatment plan of care in compliance with 42 CFR § 441.155(b) (relating to individual plan of care), and 42 CFR § 456.180(b) (relating to individual



the written plan of care) based upon face-to-face contact. The plan shall document the active treatment to be provided and be designed to achieve the recipient's discharge at the earliest possible time.

(c) A written report of each evaluation, plan of care and update must be entered in the applicant's or recipient's record according to the time frames specified at 42 CFR § 456.181 (relating to reports of evaluations and plans of care).

**§ 1165.63. Information required to request admission or continued stay.**

(a) Certification of need for RTF services shall be included in the documentation specified in (b) of this section and certified by:

- (1) The interagency service planning team, prior to admission.
- (2) The facility treatment team in concert with the interagency service planning team for continued stay.

(b) Documentation prepared by the team specified in (a) and used by the RTF UR committee to request admission certification or continued stay certification must include all of the following.

- (1) The Department designated form signed by the prescribing physician or designee requesting certification of the admission or continued stay, which includes information as specified in the Department's Utilization Review Manual for RTFs.
- (2) The most recent psychiatric evaluation signed by the treating psychiatrist performed no more than 30 days before the planned admission date or the date the request was received by the Department. The child must have a face-to-face psychiatric evaluation that supports a DSM diagnosis, Axis I through V or an ICD-9-CM diagnosis along with Axis III through V of the most current DSM.
- (3) The recipient's current or proposed treatment plan which meets the requirements of § 1165.62 (relating to treatment plan of care).
- (4) The recipients current or proposed plan of care summary.
- (5) The completed Department form entitled "Community Based Mental Health Services-Alternatives to Residential Mental Health Treatment" form or any subsequently revised form which describes services considered and tried prior to the recommendation for RTF services and indicates

whether the County MH/MR Office recommends admission or continued stay in the facility.

**§ 1165.64. Admission certification and continued stay certification request.**

- (a) Admission Certification – Admission certification is requested according to the process in the Department’s Utilization Review Manual and containing information required in § 1165.63 (relating to information required to request admission or continued stay.
- (1) Mental Health Only Admission - The admission must be prior authorized by the Department and occur within 30 days of the date the Department approves the admission. If the admission does not occur, a new certification request must be completed to update the status of the recipient and certify that RTF care is still medically necessary.
- (2) CCYA/JJ Placement –
- (i) The certification request for a recipient receiving service through the CCYA or under the jurisdiction of the juvenile court is the same as (a)(1) of this section, unless the CCYA or the juvenile court determines the child needs immediate placement. For immediate placements the following criteria shall be met:
- (A) the child has a DSM-IV (or subsequent version) diagnosis, Axes I through V or severe ICD-9-CM (or subsequent version) diagnosis, along with Axes III through V, and is not in a mental health or substance abuse crisis; and
- (B) the child requires placement because of child safety and/or protection issues; and
- (C) the interagency service planning team recommends RTF placement to meet the child's treatment needs.
- (ii) If the recipient is admitted to an RTF in accordance with (i) of this subsection, all information to support the admission must be received by the OMAP within 20 days of the child's admission.
- (iii) If the OMAP denies the admission certification, the OMAP will not make payment for RTF services for the recipient.
- (b) Continued Stay
- (1) Recertification for continued stay - The request for continuation of stay must be made 30 days prior to the expiration of the certified length of stay.

(2) Delayed coverage:

- (i) The request must be made within 30 days of the date the individual was determined eligible for medical assistance, or
- (ii) The request must be made within 30 days of the notification by a third party resource, originally expected to cover the individual's care, that the requested service is not covered or coverage is exhausted.
- (iii) This process does not apply to a period of service which was not covered by another payor because the service was not medically necessary, or the other entity's payment policies were not followed and, therefore, resulted in a rejection.

**§ 1165.65. Certification Determination.**

- (a) The documentation for the certification request and information given to the Department must include accurate and sufficiently detailed medical information to justify the admission or continued stay.
- (b) The request will not be accepted until all required information is available. If the required information is not present, the request will be returned to the county case manager to assure completion and resubmission.
- (c) The Department will certify or deny the admission certification request or continued stay certification request based upon medical necessity and compensability for services within a maximum of 21 days of each request. The request will be deemed approved if a determination is not made within 21 days.
- (d) Department approval is for medical necessity of care and does not assure the individual is, will be, or will continue to be eligible for OMAP services on the date service is provided.

**§ 1165.66. Effective date of coverage.**

(a) Admissions

(1) Mental health only admission.

- (i) The effective date of coverage will be the date of admission provided the admission occurs within 30 days of the date of the approval decision made by the Department. The facility shall advise the Department of the actual admission date.

- (ii) If the request is not approved by the Department prior to admission due to incomplete approvable information, certification will begin on the date complete and approvable information is provided to the OMAP.

(2) CCYA/ JJ Placement.

- (i) If prior authorization for the admission is received from the OMAP, the effective date of coverage is as specified in paragraph (1) of this subsection.
- (ii) If the child is placed by the CCYA or juvenile court under §1165.64(a)(2) and approvable information is submitted to the Department within 20 days of admission to the facility, the certified days are effective on the date of admission providing they meet the criteria specified in § 1165.64(a)(2).
- (iii) If the child was placed by the CCYA or the juvenile court but the documentation package is not received by the OMAP within 20 days of admission to the facility, the effective date of the approval will be the date complete and approvable information is received by the OMAP.

(b) Continued stay

(1) Recertification for a continued stay.

- (i) If an approvable recertification request is received by the Department 30 days prior to the expiration of the certified length of stay, the effective date is the first day after the last day previously certified stay.
- (ii) If the recertification request is received by the Department less than 30 days prior to the expiration of the certified length of stay, and the stay is approved after the expiration of the previously approved stay, each day of delay in requesting an extension subsequent to the last previously certified stay shall result in the reduction of a corresponding number of days approved.

(2) Delayed coverage

- (i) If the individual was not determined eligible for medical assistance

subsequent to admission, the effective date of the approval will be the date the continued stay certification was requested and approved if the request is made after eligibility was determined, or the date the individual is determined eligible for OMAP coverage if the request was initiated before eligibility was determined.

- (ii) If other insurance was expected to pay in full for the service but failed to materialize, the effective date will be the later of:
  - (A) the admission date, or
  - (B) the date the individual became eligible for services after the admission.
  
- (iii) If other insurance was expected to pay in full for the service but coverage was exhausted, the effective date will be the later of:
  - (A) the date coverage was exhausted ,
  - (B) the date the request for certification was received by the Department, or
  - (C) the date the individual became eligible for services after the admission.

## **UTILIZATION CONTROL**

### **§ 1165.71. Scope of claim review process.**

All RTF services provided to recipients are subject to the UR procedures set forth in this Chapter and Chapter 1101 (relating to the general regulations), and 42 CFR Part 456, Subpart A (relating to general provisions), Subpart B (relating to utilization control: all Medicaid services), and Subpart D (relating to utilization control: mental hospitals).

### **§ 1165.72. Admission certification review.**

- (a) The Department approves or disapproves the recipient's need for admission and need for continued services through its UR process.
  
- (b) The Department regularly monitors the facility's UR program to determine whether or not it is operating in accordance with the Department's Utilization Review Manual and this Subpart (Utilization Review). Monitoring is carried out through review of admissions, continued stays, patient records, and claims paid by the Department.

**§ 1165.73. Facility utilization review.**

- (a) A RTF under this Chapter shall have in place a UR plan in compliance with 42 CFR Part 456 Subparts B and D (relating to utilization control: all Medicaid services and mental hospitals).
  - (i) The UR committee must be composed of two or more physicians, one of whom is knowledgeable in the diagnosis and treatment of mental diseases,  
and assisted by other professional personnel.
  - (ii) The UR committee may not include any individual who is directly responsible  
for the care of patients whose care is being reviewed; or has a financial interest in any mental hospital.
- (b) The facility shall conduct reviews of each recipient's need for admission and continued need for residential treatment services in accordance with instructions in the Department's UR Manual for RTFs.
- (c) The facility UR committee shall conduct the required review(s), ensure that complete documentation is obtained, and that the certification request is given to the OMAP within the appropriate time frame specified at § 1165.64 (relating to admission certification and continued stay certification request).
- (d) The facility shall maintain the original signed copy and continued stay copies of the request documentation package, and the notification of the number of days certified with the patient's medical record. Another copy of the notification of days certified will be kept with the facility's billing records.
- (e) The facility UR committee representative shall notify the Department according to the schedule established by the Department:
  - (1) Of a recipient's admission to the facility.
  - (2) Of a recipient's discharge from the facility.
- (f) The facility shall maintain UR records for a minimum of four years from the date of submission of that year's end cost report or until the cost report is audited by the Auditor General, whichever is later.
- (g) The facility shall submit copies of UR records and documents, medical records, and psycho-social records, certification of days records and discharge planning information to the Department upon request.

- (h) The facility UR committee shall review cases that the Department has identified as being a questionable utilization of RTF services or that contain noncompensable services or items as listed in § 1165.48 (relating to noncompensable services and items).

**§ 1165.74. Adverse determinations**

- (a) An adverse determination letter shall be sent to the County MH/MR Office, the OCY&F, the CCYA with custody, the supervising juvenile probation office, in addition to the entities listed at 42 CFR § 456.237 on each case for which the UR committee denies admission or continued stay.
- (b) The adverse determination letter shall include:
  - (1) The patient's name.
  - (2) The patient's age.
  - (3) The patient's full Medical Assistance number.
  - (4) The facility's name.
  - (5) The admission date.
  - (6) The discharge date, if known.
  - (7) The diagnoses (only required on the copy sent to the OMAP and the County MH/MR Office).
- (c) The facility's UR committee shall send the adverse determination letter no later than either the last day of the approved length of stay or the day after the determination, whichever is earlier.
- (d) Each month, the facility UR committee shall complete and submit a summary report of adverse determinations in accordance with the instructions in the Department's Utilization Review Manual for RTFs.
- (e) The facility UR committee shall mail the monthly summary report specified in subsection (d) no later than 15 days after the end of the month.

**CARE REVIEW**

**§ 1165.81. Care reviews: general.**

- (a) On-site visit(s) will be conducted by the Department at each RTF as deemed appropriate to determine if the facility continues to meet mental health certification standards.
- (b) The facility shall provide a list of all medical assistance recipients in the facility on the date of the review to the program office conducting the review. The facility shall also make the medical records of these individuals and personal contact with the recipient readily available to the team.
- (c) The Department representative(s) will conduct inspections based upon State and Federal regulations and Department Program Standards.

**§1165.82. Care reports.**

- (a) The Department or its designated agency will report to the facility according to the program office's reporting guidelines.
- (b) If a Department Care Team recommends alternate care for a recipient:
  - (1) The CAO will notify the recipient or the recipient's representative and the facility administrator of the intended denial of payment authorization.
  - (2) If the recipient or the recipient's representative requests a fair hearing within ten days from the date the notice is mailed, payment for TR-RTF care will continue pending the outcome of the hearing.
  - (3) If a request for a fair hearing is entered after the tenth day, payment is discontinued effective with the first day the care team recommended alternative care pending the outcome of the hearing.
  - (4) The recipient or the recipient's representative has 30 days from the date the notice is mailed to grieve the decision or request a fair hearing. The facility does not have the right to grieve or request a fair hearing unless it is acting as the recipient's representative.
  - (5) If the Department is sustained in its action, and payment had continued pending the outcome of the hearing, the Department will recover from the facility any payment that would not have been made if the action of the Department had not been forwarded through the fair hearing or grievance process. The period for which the Department will recover excess payment begins on the effective date specified on the notice and ends with the date that the appropriate change in the level of care is made.
- (c) If the report of the Care Team cites deficiencies:



- (1) The facility shall submit a written response to the identified Department office within 30 days of the control date on the summary report. The response shall outline the facility's planned course of action including acceptable time frames for correcting deficiencies.
- (2) The Care Team will conduct follow-up visits to determine if the deficiencies have been corrected.
- (3) The facility is subject to sanctions up to and including termination from the program.

## **ADMINISTRATIVE SANCTIONS**

### **§ 1165.91. Provider abuse.**

If the Department determines that a provider has billed for services inconsistent with this Chapter, provided services outside the scope of customary standards of medical practice, or otherwise violated the standards set forth in the provider agreement, the provider is subject to the sanctions in Chapter 1101 (relating to general provisions).

### **§ 1165.92. Administrative sanctions.**

- (a) If the facility UR committee fails to conduct a continued stay review or fails to notify the OMAP within 30 days of the expiration of the previously assigned length of stay, the Department will not certify those days between the expiration of the previously assigned length of stay and the date the request for continued stay is received.
- (b) If the Department determines that services or items provided by the facility were not provided according to standards of practice for the particular discipline providing the service, not medically justified or were unnecessary, inappropriate, or otherwise noncompensable, the Department will deny payment for those and related services and items and recover payments already made for those and related services and items.

## **PROVIDER RIGHT OF APPEAL**

### **§ 1165.101. Provider right of appeal.**

- (a) RTFs, as the providers of service, have the right to appeal adverse actions of the Department under Chapter 1101 (relating to general provisions).
- (b) RTF staff and subcontractors of mental health and substance abuse services shall not have the right to an appeal.

- (c) If a facility appeals a decision by the Department to fully or partially deny payment for a case, the Department will withhold the denied payments pending a decision on the appeal.