Residential Treatment Center

Residential Treatment Centers (RTCs) are facilities capable of being locked, and providing 24-hour structured inpatient care, treatment and supervision for children and adolescents under age 21 with an Intensity of Needs Level 6 (see Medicaid Services Manual (MSM) Chapter 400, Section 403.8).

RTCs are designed as a medical model of therapeutic care to assist recipients who have behavioral, emotional, psychiatric and/or psychological disorders who have not benefited from, or who are not appropriate for, a higher or lower level of care.

Covered Services

Nevada Medicaid's all-inclusive RTC daily rate includes room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications (for Axis I, II and III diagnoses), quarterly RTC-sponsored family visits, psycho-educational services and supervised work projects (MSM Chapter 400, Section 403.8A.1).

The RTC per diem rate is covered by Fee for Service (FFS) Medicaid.

If the recipient is enrolled in a Managed Care Organization (MCO), the MCO is responsible for reimbursement of the first month of admission. Recipients will be disenrolled from the MCO on the first day of the next administratively possible month following the RTC admission.

If the recipient is enrolled in Nevada Check Up, it is the MCO's responsibility to reimburse for any ancillary services and the daily bed rate is covered by FFS Medicaid.

> **Note:** It is the provider's responsibility to contract with the MCOs to become one of their participating providers. If a recipient has an MCO plan and you are not contracted with that MCO, refer the recipient to the MCO and instruct them to ask for assistance in finding an in-network provider who is currently accepting new patients.

The all-inclusive daily rate does not include general physician (non-psychiatrist) services, neuropsychological, dental, optometry, durable medical equipment, radiology, lab, and therapies (physical, speech and occupational). All of these services are benefits that must be billed separately by the particular service provider (MSM Chapter 400, Section 403.8A.2).

Prior Authorization

Prior authorization is required:

- For all RTC admissions
- For therapeutic home passes longer than 72 hours
- If more than 3 passes will be requested within 1 calendar year

Nevada Medicaid does not generate a separate authorization number for RTC days and therapeutic home pass days; therefore, RTC days and therapeutic home pass days should be billed on the same claim form. See the Billing section below for details.

The QIO-like vendor (DXC Technology is the QIO-like vendor and is referred to as Nevada Medicaid) must authorize all RTC stays for both FFS and MCO Medicaid.

Form FA-15

All RTC admission requests must be received using form FA-15, the Residential Treatment Center Prior Authorization Request Form, no less than five business days prior to the recipient's admission or transfer (MSM Chapter 400, Section

403.8C). The recipient's current psychiatric/psychological evaluation (within 6 months of the admission date) must be submitted along with the initial request for review (MSM Chapter 400, Section 403.7A).

Form FA-13

To request continued services, form FA-13, the Residential Treatment Center Concurrent Review, must be received prior to the expiration of the current authorization period (MSM Chapter 400, Section 403.8C).

Form FA-13A

Use form FA-13A to:

- Notify Nevada Medicaid of any absence of a recipient from an RTC, excluding elopements. See form FA-29 below.
- Notify Nevada Medicaid of a recipient's 72-hour or less therapeutic home pass
- Request prior authorization for a therapeutic home pass longer than 72 hours
- Request prior authorization if exceeding three therapeutic home passes within one calendar year

Therapeutic home pass 72 hours or less

- A therapeutic home pass must be used:
- To facilitate a recipient's discharge back to their home or less restrictive setting
- Within 90 days of the recipient's planned discharge and
- In coordination with their discharge plan

Before a therapeutic home pass is approved by the RTC, the recipient must:

- Have demonstrated a series of successful incremental day passes first and
- Be in the final phase of treatment in the RTC program

Form FA-29 to correct start date or discharge date

- The provider should submit, via the Provider Web Portal, form FA-29 (Prior Authorization Data Correction Form) to correct the start date on a prior authorization. Please note that when the start date is after the first authorized date of service, the end date will remain the same for that period of the authorization.
- When the recipient discharges prior to the last authorized date, the provider is to submit, via the Provider Web Portal, form FA-29 with the corrected discharge date.

Critical event or interaction

RTCs are required to notify Nevada Medicaid of any critical event or interaction involving any RTC recipient within 48 hours of the occurrence. Information which must be reported includes, but is not limited to, deaths, injuries, assaults, suicide attempts, police or sheriff's investigations, and physical, sexual or emotional abuse allegations (MSM Chapter 400, Section 403.8B.2a). Notifications should be made to Medicaid via secure email to BehavioralHealth@dhcfp.nv.gov.

Transfers

RTCs must notify Nevada Medicaid of the transfer of a recipient to an acute psychiatric hospital or unit within 24 hours following an emergent transfer. If the transfer is not emergent, the hospital must prior authorize the transfer (MSM Chapter 400, Section 403.8C).

Prior authorization is required for transfer of the recipient back to the RTC after discharge from an acute psychiatric hospital.

Prior authorization is required prior to transferring a recipient from one RTC to another.

Residential Treatment Center

Billing

Submit a claim for each recipient once each month for dates of service the previous month.

Submit claims that include a therapeutic home pass as shown in the example under Covered codes below.

Submit claims using Direct Data Entry through the Electronic Verification System (EVS) secure Provider Web Portal or use an approved Trading Partner to submit your claims. See EVS User Manual Chapter 3 Claims and the Institutional Fee-for-Service 837I Companion Guide for claim submission instructions.

Outpatient Stays lasting less than 24 hours:

- The RTC should submit a claim for the entire month of service since there was no interruption in service.

Outpatient Stays lasting greater than 24 hours:

- The RTC should submit a claim for the time period prior to the recipient being discharged.

Inpatient Stays:

- The RTC should submit a claim for the time period prior to the recipient being discharged.

Outpatient and Inpatient Stays:

- Even though the date of discharge is included on the claim, providers are not reimbursed for the date of discharge.

Rates

List the daily rate established by Nevada Medicaid multiplied by the number of days in the month for which services are being billed (usually 30 or 31 days, unless the child was admitted/discharged at the beginning, middle or end of the month).

Covered Codes

Use revenue code 0100 to bill for RTC days.

Use revenue code 0183 to bill for therapeutic home pass days.

Claim Line	Revenue Code	Description	Service Units
1	0100	RTC Days (all-inclusive rate)	# of RTC days
2	0183	Therapeutic Home Pass Days	# of THP days

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

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Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx