

**Division of Medicaid (DOM)**  
**Psychiatric Residential Treatment Facility**  
**Admission and Continued Care Criteria**

**General Guidelines**

A Psychiatric Residential Treatment Facility (PRTF) provides psychiatric care when an individual [under the age of twenty-one (21)] does not require acute psychiatric care, but does require supervision and active treatment on a twenty-four (24) hour inpatient basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. Admission to a PRTF is not considered an emergency admission. In addition, admission for a primary diagnosis of alcohol/substance abuse is not authorized. For admission to a PRTF, a psychiatrist with admitting privileges shall accept the admission recommendation.

Beneficiaries under the age of twenty-one (21) admitted to a PRTF must have a confirmed or suspected mental disorder that is clinically stable. In addition, the beneficiary's condition must be such that it is not feasible or safe to manage the illness in the home or in a group home setting.

Review of PRTF admissions must be conducted according to the criteria outlined below. PRTF admissions are considered to be elective admissions and **always** require precertification by HSM prior to admission.

If the clinical information meets the admission criteria below, the admission is approved and an initial length of stay of thirty (30) days is assigned. For continued stay in the PRTF, an additional thirty to sixty (30-60) days or less (to coincide with planned discharge date, if applicable) may be assigned if criteria continues to be met and based on the needs of the beneficiary.

**Admission Criteria**

To be considered an appropriate admission, a child must:

1. have a diagnosable psychiatric disorder, and
2. have a full scale IQ of sixty (60) or above unless there is substantial evidence that the IQ score is suppressed due to active psychiatric illness, and
3. exhibit patterns of disruptive behavior for the last six (6) months with evidence documented in the treatment plan of disturbances in family functioning or social relationships with persistent psychological and/or emotional disturbances such that the child is not manageable in a less restrictive environment, and
4. have failed to respond to less restrictive treatment methods within the last three (3) months, or is not manageable in a less restrictive environment as evidenced by the degree of disturbance that is documented by the referring physician/professional
5. have psychiatric evaluation done within sixty (60) days prior to the proposed date of service by a psychiatrist or psychologist who is independent of the receiving facility. The psychiatrist or psychologist that performs the psychiatric evaluation must recommend treatment in the residential setting. *(If a beneficiary is in an acute care setting, a pre-discharge recommendation will be accepted in place of the independent evaluation.)*

**Continued Stay Criteria**

For continued stay reviews, emphasis is placed on evaluating the progress made in the active individualized clinical treatment provided and on appropriate discharge plans. For continued stay to be considered appropriate, the clinical record documentation must demonstrate:

1. ongoing disruptive behavior that continues to interfere with family functioning and social relationships, or
2. disruptive behavior is less, but there continues to be functional disturbances, or
3. different behavioral disturbances surface which are appropriate for PRTF level of care, or
4. minimal or no progress has been made, and discharge to a lower level of care is not appropriate, or
5. ongoing active treatment as defined in the **active individualized treatment plan**, including measurable goals/objectives relevant to each identified problem, interventions by qualified mental health professionals, and specific timeframes for achieving outcomes, and

**Note: Active treatment means all of the following are performed:**

- multidisciplinary observation
  - assessment and evaluation
  - diagnostic evaluation
  - interdisciplinary treatment planning
  - evaluation of treatment failures and appropriate revisions in the treatment plan
  - identification of discharge criterion and discharge planning
  - aftercare needs assessment.
6. evaluation of treatment progress to include timely reviews and updates as appropriate for the child's treatment plan; and
  7. when there is failure to improve, reassessment and revision of the treatment plan that reflects:
    - treatment regiment alternatives
    - measurable goals and objectives
    - explanations of any failure to achieve goals and objective
    - level of care required for each problem, and
  8. unless therapeutically contraindicated, the family and/or guardian must actively participate in the continuing care of the patient through direct involvement at the facility and/or therapeutic conferences directed by the child's therapist.

**Note 1: Active family participation is defined as a minimum of two therapeutic sessions a month. If the child's family is more than a two (2) hour drive from the facility, a minimum of one (1) face-to-face family therapy session and one (1) therapeutic conference call is acceptable. Contacts must be therapeutic between the child's therapist and the family/legal representative to discuss the child's functioning, progress, goals and objectives. Social visits or telephone calls are not considered family therapy.**

**Note 2: Under special circumstances, family therapy may be conducted by a geographically distant family therapist, particularly when family issues must be resolved or remediated before face-to-face sessions that include the child can be productive and therapeutic. In this situation, a therapist at another facility may be the designated family therapist. The treatment plan must indicate the geographically distant therapist, the goals of such therapy, and the mechanisms for exchange of information between the PRTF and the therapist.**

**Length of Stay**

An active individualized treatment plan presumes that successful behavior modification can be achieved in one hundred eighty (180) days or less; however, the presumption may be rebutted in individual cases. (The PRTF benefit is separate from the acute inpatient mental health care benefit.)

A request for consideration of a continued stay beyond 180 days must document in the clinical record that:

1. active treatment has taken place for the past 180 days and substantial progress has been made according to the plan of treatment
2. the progress made is insufficient due to the complexity of the illness of the child to be discharged to a less restrictive level of care
3. specific evidence is provided to explain the factors which interfered with treatment progress during the 180 days of PRTF care
4. the request included specific timeframes and a specific plan of treatment which will lead to discharge.

Where family or social issues complicate a transfer to a less restrictive level of care, the PRTF is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the PRTF fails to meet this responsibility adequately, the existence of such family or social issues will not be a basis for a continued stay.

**Other**

By the fourteenth (14<sup>th</sup>) day following admission, the PRTF must have developed a treatment plan that includes:

- an evaluation of the child's social, psychological, medical and developmental processes
- an evaluation of the child's family structure
- planned interventions including individual, group and family psychotherapy, as appropriate, to improve the child's psychiatric condition to a point where a lower level of care is appropriate
- measurable goals and objectives relevant to each identified problem
- specific dates and timeframes for achieving goals and objectives
- other interventions as needed to assist the child with achieving goals and objectives, and
- estimated discharge date and post-discharge plans specifying coordination required with the family/legal representative and school/vocational and community services needed to ensure continuity of care.

Documentation for continued stay must include:

- date and length of each therapy session
- notation of the child's current clinical status as evidenced by his/her signs and symptoms
- content of each therapy session
- statement summarizing the therapeutic intervention used during each therapy session, along with the child's response to the intervention, outcome of each session, and response to family/legal representative and others
- statement summarizing the child's progress toward meeting treatment goals and objectives, and
- progress toward meeting the discharge plan established in the initial treatment plan.