HSCSN

HSCSN Internal Policy

POLICY NAME: Psychiatric Residential Treatment Facility Placement

POLICY ID: UM_02

DEPARTMENT: Utilization Management

POLICY EFFECTIVE DATE: 10/24/2025

POLICY LAST UPDATED DATE: 10/24/2025

I. PURPOSE

This policy supports governance of HSCSN's delivery of quality services to its enrollees while ensuring compliance with regulations and implementation of industry-specific standards.

II. POLICY STATEMENT

Summary

A Psychiatric Residential Treatment Facility (PRTF) provides non-acute inpatient facility care for enrollees with a behavioral illness or substance abuse/dependency, who require 24-hour supervision and specialized interventions. Health Services for Children with Special Needs, Inc.'s (HSCSN) primary goal is to treat and maintain children and youth within their communities in the least restrictive and supportive environment. Community-based alternatives to residential placement must be explored prior to referring a child or youth for psychiatric residential placement, absent exceptional circumstances. This policy sets forth the requirements and procedures that HSCSN will follow when making medical necessity determinations for Psychiatric Residential Facility placement. The policy and procedure is consistent with federal guidelines 42 Code of Federal Regulations 441.152 and District of Columbia Municipal Regulation 29 DCMR 948 for making a medical necessity determination. The decision-making approach incorporates elements of the District of Columbia's Department of Behavioral Health process for managing referrals for treatment in a Psychiatric Residential Treatment Facility.

As much as possible, HSCSN's policy and procedures will be consistent with Department of Behavioral Health and will require: a) whenever possible, participation by inter-agencies in the multidisciplinary team meetings; b) exploration of all community-based alternatives to residential placement before a PRTF placement recommendation is made; and c) documentation of efforts to stabilize the child/youth, which include an explanation of why lower levels of community services have not been successful, and compelling reasons why placement in a PRTF is necessary. All determinations are based on medical necessity using InterQual® Level of Care Behavioral Health Criteria for Residential Treatment.

III. PROCEDURE

Definitions

Adverse Benefit Determination [C.3.14] - In the case of a Contractor or any of its Providers, Adverse Benefit Determination means any of the following per 42 C.F.R. § 438.400:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirement for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services promptly as defined by the District; or
- The failure of the Contractor to act within the timeframes for the resolution and notification of Grievances and Appeals; and
- The denial of an enrollee's request to dispute a financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Care Manager (CM) – The HSCSN care managers assigned to each member are responsible for activities which include but not limited to ongoing transition planning; coordination of regularly scheduled face to face enrollee visits; care plan development and monitoring; all coordination of medical and behavioral health service needs and participation in multidisciplinary team meetings.

Concurrent Review [C.3.47] - A review to determine extending a previously approved, ongoing course of treatment or number of treatments. Concurrent reviews are typically associated with inpatient care, residential Behavioral Health care, intensive outpatient Behavioral Health care, and ongoing ambulatory care.

Denial of Services [C.3.65] - An adverse decision in response to an Enrollee's or Provider's request for the initiation, continuation, or modification of treatment. A denial may be either wholly or partially adverse to the Provider or Enrollee. The failure to decide on a request for treatment within the timeframes governed by the Agreement constitutes a denial of services. A denial includes complete or partial disapproval of treatment requests, a decision to authorize coverage for treatment that is different from the requested treatment, or a decision to alter the requested amount, duration, or scope of treatment. A denial also constitutes an approval that is conditioned upon acceptance of services in an alternative or different amount, duration, scope, or setting from that requested by the Provider or Enrollee. Approval of a requested service that includes a requirement for a concurrent review by the Contractor during the authorized period does not constitute a denial. All denials are considered Adverse Benefit Determinations for purposes of Grievances and Appeals.

Medically Necessary [C.3.174] - Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and following generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.

Psychiatric Residential Treatment Facility (PRTF) [C.3.217] - Under 42 C.F.R. §483.352, a facility, other than a hospital, that provides inpatient psychiatric services to individuals under age 21.

Psychiatric Residential Treatment Facility Site Review Care Manager (PRTF CM) – The HSCSN licensed care manager dedicated to carryout PRTF care management functions. This includes but not limited to transition planning for admission through the post discharge period; coordination of regularly scheduled face to face family therapy and therapeutic leave; quarterly face to face member visits while at the PRTF; care plan development and monitoring; manages and coordinates health and medically appropriate services for members who have moderate to complex medical and mental/behavioral health needs.

Utilization Management Reviewer (UM Reviewer) – May be a licensed registered nurse, licensed practical nurse or licensed social worker with current license in the District of Columbia. The licensed HSCSN reviewer conducts inpatient behavioral health, neuropsychological evaluations and PRTF reviews for requests for service.

Details

1) Referral Requirements

A. Requests for PRTF placement are accepted from providers and District of Columbia agencies including, but not limited to Department of Behavioral Health, Child and Family Service Agency (CFSA), Department of Youth Rehabilitation Services (DYRS), DC Public Schools (DCPS) and Court Social Services.
B. *Requests from parents, attorneys, and HSCSN Care Management staff are not accepted*.
C. All enrollees must have a written recommendation for PRTF from a Board Certified/Eligible psychiatrist who has a treatment history with the enrollee. Note: In the event that the recommendation comes from an external agency or a BC/BE psychiatrist who does not have a treatment history with the enrollee, the HSCSN Chief Psychiatric Medical Officer (CPMO)/designee will determine if written recommendation supports the medical necessity. The HSCNS PRTF Medical Necessity Review Referral Form (**Attachment A**) completed by the requesting individual/entity.
D. Required documentation that must be submitted with the referral form includes:
    1. Psychiatric evaluation (within last the last 90 days)
    2. Psychological testing (with last 2 years) that describes enrollees intellectual functioning.
    3. Psychosocial Evaluation/Summary
    4. Individualized Education Program, if applicable
    5. District of Columbia Department of Behavior Health Child & Youth Services Division Authorization to Use or Disclose Protected Information Form. Must be signed by all youth aged 14 and above.
    6. PRTF packet must be reviewed and signed by parent/guardian
E. Supporting Documentation:
    1. Court social services evaluation
    2. Court reports
    3. Psychoeducational evaluations
    4. Diagnostic assessment
F. Participation by referring entity, parent/guardian/caregiver; community stakeholders and HSCSN in a Pre-Residential Placement/Care Management

Planning multidisciplinary team meetings/calls to review needs and plan care irrespective of result of medical necessity review. If engaged with the member the following entities are required to participate and provide information in order to plan for member's treatment and support needs: CFSA, DYRS, OSSE, DCPS

2) Roles and Responsibilities

A. Requesting Entity or Individual
   1. Must complete the HSCSN Admission to a PRTF Medical Necessity Review Referral Form, provide all required/supporting documentation and submit electronically to UM@hschealth.org or via fax to 202-721-7190. (See Attachment A – PRTF Medical Necessity Review Referral Form).
   2. The HSCSN team promotes a collaborative process in order to address the complex treatment needs of the membership. As such, system of care Multidisciplinary team (MDT) meetings are used as a vehicle to drive access to high quality, evidenced based treatments for enrollees. The MDT also allows for exchange of essential information and opportunities to problem solve when complex treatment and systems issues arise. Based on this model, the referring provider, parents/guardians, representatives from District of Columbia Public Schools, (DCPS), Child and Family Services Agency (CFSA), Department of Youth Rehabilitation Services (DYRS) or others considered appropriate to the case are required to participate in regularly scheduled multidisciplinary team meeting to review the member treatment needs and plan irrespective of the medical necessity determination. If a determination is to approve PRTF then a MDT meeting will occur prior to admission. This meeting can be face to face or via phone conference or combination thereof. If a denial determination is made the multidisciplinary team meeting occurs in order to address ongoing treatment and support needs.

B. Utilization Management Reviewer (Refer to UM_09 for full Policy details)
   1. Processing Referrals and Decisions:
      a. Receives the initial placement request and documents the date the referral was received in the HSCSN IT system.
      b. Reviews submitted documentation for completeness following Authorization of Health Services Policy UM_09.
      c. HSCSN utilizes the appropriate InterQual® Behavioral Health Residential & Community-Based Treatment Level of Care Criteria, and available clinical documentation reviewed by a board-certified Psychiatrist to make medical necessity determinations for admissions and continued stays. Additional criteria applied when making a medical necessity determination include:
         1. Community-based services available in the District do not meet the treatment needs of the child or youth;
         2. Proper treatment of the child or youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
         3. Services in a PRTF can reasonably expect to improve the child or youth's condition or prevent further regression so that PRTF services will no longer be needed;
         4. Caregiver/guardian/referring agency participates in the Multi-disciplinary treatment team meetings

d. The UM Reviewer reviews submitted documentation against the InterQual® Level of Care Behavioral Health Criteria for Residential Treatment (Initial Review). The UM Reviewer applies the criteria, documents the outcome in HSCSN IT system and prepares the case for medical necessity review by the CPMO/designee.
e. Upon completion of medical necessity review by the CPMO/designee, UM Review communicates the determination to the caregiver/guardian/referring agency per UM_09.
f. A notification via e-mail is provided to the Department of Behavioral Health within 24 hours of admission to the PRTF by the UM Reviewer.
    1. **If approved**, the UM Reviewer will: 1.Prepare the residential disposition letter to send to the referring provider, enrollee, caregiver, and guardian, which provides notice of approval decision for admission to residential treatment facility; 2.begin identification of facility placement options and coordination of admission services; 3. generate an authorization for the first thirty (30) days of the admission; 4. Forward admission packets to the appropriate residential facilities to review for admission consideration. Facility admission requirements (services, minimum IQ, special programs, etc.) are considered when determining where to send admission packets; 5. enter the date each packet was sent into the HSCSN Referral system and the date of approval or rejection rendered by each facility; and 6. notify the referring provider, enrollee, caregiver, guardian of each residential facility's acceptance. 7. In coordination with Care Manager Ensure Early and Periodic Screening, Diagnostic and Treatment is up to date prior to placement. 9. Determine responsible party for transport when external agencies are involved. 10. Notify DMH of enrollee acceptance to PRTF.
    2. **If denied**, the UM Reviewer will: 1. Prepare the HSCSN non-certification letter for mailing to the referring provider, enrollee, caregiver, guardian and PCP; the non-certification letter is generated based on the information on the PRF; 2. Send the non-certification letter to the Chief Psychiatric Medical Officer (CPMO) for signature then send by certified mail to all parties involved. In the absence of the CPMO, determination letters will be signed by the Chief Medical Officer.

2. Monitoring and Concurrent Review:
    a. The UM Reviewer maintains clinical information on all PRTF placements and participates in multidisciplinary team and discharge planning meetings.
    b. The UM Reviewer conducts monthly continued stay reviews using the appropriate InterQual® Behavioral Health Residential & Community-Based Treatment Level of Care Criteria using the documentation (doctor notes, therapist notes, and treatment plan reviews) submitted by the residential facility and other information provided by the HSCSN Monitor for the facility.

c. The UM Reviewer authorizes continued stay up to one month until enrollee no longer meets criteria for continued stay.
d. The UM Reviewer and PRTF CM review the clinical status of residential (PRTF) cases during scheduled Rounds with the CPMO/designee. Cases may also be discussed on an ad hoc basis as the clinical and administrative need arises.
e. If there is a question about the information received from the PRTF, the UM Reviewer/will contact the PRTF by telephone to obtain the needed clinical information. If the information cannot be obtained or there remains a question about whether continued stay criteria are met a physician-to-physician review will be requested.
f. Upon completion of the peer-to-peer review, the CPMO makes the determination as to whether medical necessity is met for continued stay at the PRTF level of care. The results are placed in the HSCSN IT system.

3. Adverse Benefit Determination Process:
    a. The HSCSN CPMO/designee follows HSCSN Authorization of Health Services Policy UM_09 for completion of the medical necessity review, adverse benefit determination and documentation process. The CPMO/designee applies InterQual®Behavioral Health Residential & Community Based Treatment Level of Care Criteria.
    b. Initial Review: When the HSCSN CPMO/designee determines medical necessity is not met for an initial PRTF level of care request the HSCSN CPMO/designee follows HSCSN Authorization of Health Services Policy UM_09 for completion of the medical necessity review, adverse benefit determination and documentation process. For notification of adverse benefit determinations HSCSN UM Reviewer follows the process outlined in UM_08 Notification of Adverse Benefit Determination.
    c. Concurrent Review (Continued Stay): When the HSCSN CPMO/designee determines the enrollee no longer meets InterQual®Behavioral Health Residential & Community Based Treatment Level of Care Criteria for continued stay, the HSCSN CPMO/designee follows HSCSN Authorization of Health Services Policy UM_09 for completion of the medical necessity review, adverse benefit determination and documentation process. For notification of adverse benefit determinations HSCSN UM Reviewer follows the process outlined in UM_08 Notification of Adverse Benefit Determination.
        1. When the HSCSN CPMO/designee determines the enrollee no longer meets InterQual®Behavioral Health Residential & Community Based Treatment Level of Care Criteria for continued stay the UM Reviewer/ contacts the PRTF representative to inform the facility of the decision.
        2. The UM Reviewer also prepares the HSCSN non-certification/denial letter for mailing to the PRTF provide, enrollee, caregiver, guardian. The denial letter is sent to the provider and parent/guardian, with the date of

discharge, the InterQual® basis for the denial, and the procedure for appeal.

C. Care Management
    1. The PRTF CM is the main point of contact for the PRTF specific to ongoing care coordination activities once the enrollee is admitted to the PRTF. The PRTF CM will work closely with the enrollee's multidisciplinary team at the facility and ensure comprehensive care coordination throughout the placement period including transition to discharge.
    2. The PRTF CM conducts monthly teleconferences and quarterly face to face visits at the facility. Quarterly face to face visits may occur via virtual platforms with prior approval from DHCF. Based on the findings from these visits, HSCSN will determine whether more visits are warranted.
    3. The PRTF CM will ensure that there is a person-centered Care Plan, developed by individuals trained in person centered care planning, the duration of the PRTF length of stay.
    4. The PRTF CM will review and revise the Care Plan upon reassessment of functional need and in accordance with the Enrollee's Acuity as described in section C.3.7 and when the Enrollee's circumstances or needs change significantly, or at the request of the Enrollee during the length of stay.
        a. In collaboration with designated PRTF team members, coordinates and participates in the multi-disciplinary treatment team meeting.
            1. Ensures meetings are conducted in a timeframe that allows referring and other interested parties an opportunity to participate in the meeting.
            2. In collaboration with the PRTF treatment team, the PRTF CM works to ensure that parents, guardian, probation officers, etc. are invited to attend the monthly MDT meeting
    5. Upon receipt and confirmation of discharge recommendations by the attending physician/treatment team at the facility, the PRTF CM will coordinate all post-discharge services prior to discharge.
    6. The PRTF CM will maintain active engagement with the MDT in order to facilitate discharge planning which promotes a stable transition of behavioral health services and supports consistent with practice standard.

3) Discharge Planning and Coordination

A. HSCSN will ensure that Enrollees are scheduled to be seen by an outpatient provider within the first seven (7) days of discharge to the community from a psychiatric inpatient facility admission or PRTF. HSCSN will ensure that within those seven (7) days the provider must assess the Enrollee, provide prescriptions, if needed, and make arrangements for pick up or delivery of the medication if assistance is needed. HSCSN will ensure that a subsequent appointment occurs within the first thirty (30) days of discharge from any acute care admission.

B. Discharge planning is an ongoing process which begins upon admission. To facilitate ongoing system of care collaboration and management, HSCSN team members will have active engagement with the PRTF and MDT of stakeholders throughout the placement period. This includes participation in the monthly multidisciplinary treatment team meeting. The UM Reviewer, in collaboration with the CPMO and PRTF Care Manager, will assess each enrollee's clinical needs prior to discharge. The assessment will include:

1. Expected living arrangement post-discharge.
2. Available assistance from caregivers.
3. Possible need for enrollee/family education and training to meet care needs
4. Transfer to the appropriate more/least restrictive level of care or site as per the treating facility recommendations.
5. Clinical services required to maintain enrollee at next recommended level of care.
6. Other needs identified by the treatment team.

C. Upon non-certification the PRTF CM begins to coordinate the discharge arrangements with the PRTF and care giver, guardian which should include:
    1. Identifying the date of discharge;
    2. Informing the parent/guardian of the decision;
    3. Arranging therapeutic visits including home visit;
    4. Working with the Care Manager on needed community- based referrals and services.
D. The UM Reviewer, assisted by the enrollee's PRTF Care Manager, will link the enrollee to appropriate community-based services, including outpatient wraparound services.
E. When there is a disagreement about the discharge plans, every effort is made to resolve the disagreement amicably, including telephone conferences and physician to physician conferences.

4) Enrollees Not Placed by HSCSN

A. HSCSN will not pay for PRTF when the determination is made by another agency without consultation with HSCSN. When other agencies are involved (CFSA, DYRS, DBH, OSEE), HSCSN will coordinate to plan care.
    1. Once HSCSN is notified by the placing agency, (e.g., review body designated by the District of Columbia for placements made by CFSA, DYRS, DMH, or DCPS) the UM Reviewer collects admission and current clinical information from the placing agency and the facility and discusses the placement with primary caregiver and enrollee.
    2. The UM Reviewer conducts a thorough review of enrollee treatment records and reports the findings and recommendations to the CPMO/designee.
B. Regardless of the payer for the residential placement, HSCSN authorizes and pays for all medical costs including EPSDT, doctor visits, lab tests, etc.

5) Coordination of Benefits Process

Enrollees with coverage through a primary insurer other than HSCSN (other insurance primary or public agency is payer) follow the **HSCSN Coordination of Benefits Policy CL_12**.

6) Transportation and Accommodations for Caregiver travel (Reference Transportation Provider Management Policy):

A. Transportation for the purposes of family therapy and therapeutic visits/leave to a specialty facility such as Psychiatric Residential Treatment Facility (PRTF) or sub-acute hospital may be approved by the CPMO/designee based on Medical Necessity review and must be part of the treatment plan. Limited lodging accommodations is also provided based on medical necessity. **(Refer to Transportation Policy Transportation Provider Management for further**

information on HSCSN transportation policies and procedures). Exception: HSCSN does not authorize transport for any ward agents of CFSA or DYRS.

B. Accommodations for the purpose of family therapy and therapeutic visits/leave at a specialty facility such as PRTF or sub-acute hospital may be approved by the CPMO/designee.
    1. HSCSN covers the cost of a maximum of 2 nights paid accommodations for 2 persons; one must be the legally responsible adult (guardian) or legally authorized representative.
    2. **Exception:** Accommodations do not include the cost of meals or local transportation to and from the PRTF.
C. The CPMO/CMO or designee on a case-by-case basis may approve supervised discharge transport.
D. Home visitation is planned and coordinated with expectation of parent/guardian participation for the duration of the stay. Enrollee supervision in the form of respite, or PCA service is not provided from HSCSN.

7) Out of Network Facilities

HSCSN authorizes residential services at facilities that best meet the enrollee's needs. Participating/In-Network facility use is encouraged. In the event the enrollee's needs cannot be met with at an in-network facility, the following process will be utilized to identify and authorize services at a non-contracted facility:

A. The CPMO and/or the UM Reviewer will identify a potential non-contracted facility that meets the needs of the enrollee.
B. The Contracting Department is notified. The Contracting Department makes initial contact with the facility to determine pertinent information including accreditation status.
C. Care Management is notified of the Out of Network Placement need and provided facility information obtained from Contracting.
D. HSCSN will conduct a site visit for placement of enrollees in a non-contracted facility and will not place enrollees in facilities that have not passed a site visit
E. If the facility passes the site visit, a single case agreement is initiated by Contracting and the HSCSN Frequently Asked Questions document is provided with the single case agreement.

8) Family Participation

The Enrollee and/or caregiver shall participate in discussions and meetings, as appropriate. Documentation is required to justify non-participation by the Enrollee and/or their caregiver. Face to face family therapy is required on a regular (minimum of twice a month) and intensive basis and HSCSN has expanded its transportation policy in order to decrease barriers for caregiver travel. Lack of care giver involvement initiates review of placement, possible disruption of treatment and mandated reporting to CFSA for neglect.

9) Quality, Safety Reporting and Oversight:

A. HSCSN submits a monthly report on behavioral health related inpatient hospitalization and emergency department visits, denials for inpatient behavioral health hospitalization, seven (7) and thirty (30) calendar day follow up after hospitalization, readmissions within thirty (30) calendar days after hospitalizations, court-ordered behavioral health evaluations and PRTF placements. HSCSN provides the Institutional and Long-Term Care report to DHCF comprised of monthly and annual enrollee admissions to PRTFs.

B. HSCSN monitors the facility management, including Human Resources files, and the medical record documentation of practitioners/providers through the facility management and medical record reviews conducted during the quality site visit. The PRTF Site Review Care Manager, under the oversight of the Quality Department is responsible for conducting the site visits. On occasion, contractors may be utilized to fulfill these requirements with oversight by the Quality/Accreditation department. Quality site visits may be conducted in response to an identified or potential quality of care or service issue; in response to an enrollee grievance; or practitioner/provider reaching an occurrence threshold. The severity of an issue will always be considered. Site visits may be announced or unannounced.
C. HSCSN requires all PRTFs to inform both the enrollee and in the case of a minor, his or her parent(s) or legal guardian(s) at time of admission of its policy regarding the use of restraint or seclusion. Simultaneous use of restraint and seclusion or combining a mechanical restraint intervention with seclusion is prohibited.
D. Reporting of Unusual Incidents: All unusual incidents involving HSCSN enrollees should be reported to HSCSN on a designated facility Incident Report form, DBH Incident Report form, or HSCSN Incident Report form. The Office of Appeals and Grievance (OAG) reviews all unusual incidents. If any unusual incident results in a Critical/ Sentinel/Never Event or HCAC, OAG will report the event to DC DHCF within 24 hours.

IV. ACCOUNTABLE EXECUTIVE(S) AND REVIEWER(S)

A. Accountable Executive(s): Bogrov, Michael
Levey, Eric

B. Committee(s) Responsible for Review: Benefits and Utilization Management Committee

V. APPROVAL

Approved by:

_____ _____

Bogrov, Michael
Levey, Eric

Date

VI. REFERENCES

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References:
NCQA Standards: N/A
CN Documents/Policies: N/A
CASSIP Contract Sections: C.5.57
Federal Regulations: 42 CFR §438.400, 42 CFR §441.152, 42 CFR §483.352
District Regulations: 29 DCMR 948
Transmittals: N/A
Internal Policies: CL_12 Coordination of Benefits Policy, UM_08 Notification of Adverse Benefit Determination, UM_09 Authorization of Health Services
Internal Documents: N/A
Committees: Benefits and Utilization Management Committee (BUMC)