



## **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)**

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**This document is subject to change. Please check our web site for updates.**

This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services provided by Psychiatric Residential Treatment Facilities (PRTFs) that are licensed and enrolled with North Dakota (ND) Medicaid.

### **CERTIFICATE OF NEED**

ND Medicaid will not cover PRTF services unless the individual meets certificate of need criteria.

### **IN-STATE PRTFS**

The rate established for in-state PRTFs is an all-inclusive rate for routine services. Routine services include supplies, therapies, personal supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid. Enter only the room and board charges. Do not enter ancillary charges.

### **OUT-OF-STATE PRTFS**

The rate for out-of-state PRTFs is based on the rate for comparable services established by the Medicaid agency in the state where the facility is located.

Before a child can be considered for placement in an out-of-state PRTF, the following information must be submitted to ND Medicaid:

- Current diagnosis and combined symptoms that indicate why in-state PRTFs are unable to meet the treatment needs;
- How will the out-of-state PRTF meet the treatment needs of the child;
- Written denials from all in-state PRTFs;

- Current documentation from any inpatient psychiatric placement or outpatient therapy; and
- Name of ND Medicaid enrolled provider (facility) and contact individual.

The request and all supporting documentation must be faxed to (701)-328-1544.

## BILLING GUIDELINES

PRTFs must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.

Claims must be submitted to ND Medicaid using the applicable *Bill Type 211-218*.

The bill type frequency must coincide with the status code billed. Claims must be submitted using the following status codes:

- 01** Discharged to Home or Self-Care
- 02** Discharged/Transferred to a Short-Term General Hospital
- 04** Discharged/Transferred to a Facility that Provides Custodial or Supportive Care
- 20** Expired
- 30** Still a Patient
- 40** Expired at Home
- 41** Expired in a Medical Facility
- 42** Expired – Place Unknown
- 50** Hospice - Home
- 51** Hospice – Medical Facility Providing Hospice Level of Care
- 61** Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
- 62** Discharged/Transferred to an Inpatient Rehabilitation Facility including Rehabilitation Distinct Part Units of a Hospital
- 63** Discharged/Transferred to a Medicare Certified Long Term Care Hospital
- 65** Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
- 66** Discharged/Transferred to a Critical Access Hospital
- 70** Discharged/Transferred to another Type of Healthcare Institution

Claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

- |                         |                        |
|-------------------------|------------------------|
| Revenue Code <b>110</b> | In-House Medicaid Days |
| Revenue Code <b>183</b> | Leave Days             |

Leave days are non-covered days. Leave day status is determined at midnight. Payment is not available for any period that a member does not actually occupy a bed.

The number of units billed must include the date of discharge or death.

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance has paid for the charges. This allows the system to start applying member liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.