OhioRISE Out of State PRTF Program Manual

Version 1.0

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Contents

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Section 1: OhioRISE Purpose and Goals

Ohio Department of Medicaid (ODM), supported by the Governor's Family and Children First Cabinet Council, developed Ohio's first-ever integrated program to help youth who have complex and serious behavioral health needs in partnership with stakeholders, providers, and partner state agencies. OhioRISE (Resilience through Integrated Systems and Excellence) aims to improve care and outcomes for these youth and their families/guardians/caregivers by:

- Creating a seamless delivery system for children and youth, families/guardians/caregivers, and system partners.
- Providing a "locus of accountability" by offering community-driven comprehensive care coordination through local Care Management Entities (CMEs).
- Expanding access to critical behavioral health services and supports needed for this population such as Intensive and Moderate Care Coordination, Mobile Response and Stabilization, Respite, Intensive Home-Based Treatment, Flexible Funds, and Psychiatric Residential Treatment Facilities (PRTF).
- Assisting youth, families/guardians/caregivers, state, and local child serving agencies, and other health providers to locate and use these services.

ODM selected Aetna Better Health of Ohio (Aetna) to serve as the specialized managed care organization for the State's youth with the most complex behavioral health needs for the OhioRISE program. Aetna is working with ODM, partner state agencies, providers, families/guardians/caregivers, youth, and stakeholders to implement a youth and family/guardian/caregiver-centric model featuring new-targeted services and intensive care coordination delivered by community partners.

The foundation for OhioRISE and its success in supporting youth with complex behavioral health needs and their families/guardians/caregivers rests in Systems of Care (SOC) principles and High-Fidelity Wraparound practice. A system of care[1] is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs to help them to function better at home, in school, in the community, and throughout life. As such, OhioRISE principles reflect:

[1] https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

- **Family/Guardian/Caregiver and Youth Voice and Choice**: Family/guardian/caregiver and youth voice, choice and preferences are intentionally sought and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family/guardian/caregiver-focused and youth-centered from the first contact with or about the family/guardian/caregiver or youth.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. There is an expectation to participate in the Child and Family Team (CFT) to understand roles of others on the CFT providing services (including care coordination) and to incorporate services and roles into the child and family-centered care plan (CFCP) critical for ensuring service and interventions support the goal of the CFCP and ensure services to meet those goals while avoiding duplication and fragmentation.
- **Natural Supports**: The team actively seeks out and encourages the full participation of members drawn from the youth and family's/guardian's/caregiver's network(s) of interpersonal and community relationships (e.g., friends, neighbors, community, and faith-based organizations). The CFCP reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home- and Community-Based**: Youth are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, responsive, accessible, and normative, and least restrictive setting possible. A high-quality network of providers is important to support youth in remaining as close to families/guardians/caregivers and communities as possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the youth and family/guardian/caregiver and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family/guardian/caregiver. The services are also tailored to meet the needs of youth with disabilities, including intellectual and developmental disabilities. They are monitored regularly and adjusted as necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths-Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of

the youth and family/guardian/caregiver, their community, and other team members.

- **Outcome-Based**: Based on the youth and family's/guardian's/caregiver's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are designed to be persistent and flexible, helping to overcome setbacks and achieve their intended goals and outcomes. Safety, stability, and permanency are priorities.
- **Unconditional**: A CFT's commitment to achieving its goals persists regardless of the youth's behavior, disabilities, placement setting, family's/guardian's/caregiver's circumstances, or availability of services in the community. The team continues to work with the family/guardian/caregiver toward their goals until the family/guardian/caregiver indicates that a formal process is no longer required. For more information related to National Wraparound Initiative visit: https://nwi.pdx.edu/

Section 2: OhioRISE Delivery System: Key Partners

ODM and DBH partnered to develop Ohio's PRTF service with the input of Aetna Better Health of Ohio, Ohio's other child-serving agencies Ohio Department of Developmental Disabilities (DODD), Ohio Department of Job and Family Services (ODJFS), Ohio Department of Education and Workforce (DEW), Ohio Department of Youth Services (DYS), Ohio Department of Health (ODH), Ohio Department of Children and Youth (DCY) and Ohio Family and Children First (FCFC) and stakeholders.

OhioRISE Plan (Aetna)

Aetna Better Health of Ohio (Aetna) serves as the OhioRISE plan, a specialized managed care organization for the state's youth with the most complex behavioral health needs. Aetna serves as the point of access to PRTF and connects youth and their families/guardians/caregivers with the care they need at the right intensity of treatment.

Aetna is responsible for selecting and contracting with PRTF providers, both in state and out of state, and supporting the PRTF role as part of the OhioRISE system of care continuum. Aetna is also responsible for coordinating efforts with PRTFs, CMEs and other community providers (IHBT, BH respite, etc.) to seek alternative community-based services for Medicaid enrolled youth who seek admission to a PRTF. In contracting with PRTFs and a range of behavioral health providers, Aetna will ensure availability and consistent quality for all OhioRISE behavioral health services.

Care Management Entities

CMEs are Aetna's contracted regionally based organizations that are responsible for face-to-face care coordination and comprehensive service planning for youth and their families/guardians/caregivers with intensive and moderate care coordination needs in accordance with Ohio Administrative Code (OAC) rule 5160-59-03.2. CMEs coordinate CFT meetings and implement CFCPs for each youth and their family/guardian/caregiver. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to care planning.

The goal of CMEs is to identify and provide linkages to necessary supports and services in the community whenever possible. Some youth experience needs during their course of treatment that may prompt the CFT to consider a higher intensity of service than can be provided in the youth's community, such as PRTF. Removing a youth from the home for treatment has a significant impact on the youth and family/guardian/caregiver and must be done thoughtfully to maximize the treatment benefit potential, reduce the youth's length of stay, maintain family/guardian/caregiver relationships, and increase sustainability of the youth's progress. Therefore, CMEs partner with the PRTF and other providers to reduce PRTF lengths of stay and successfully provide this treatment in one episode per youth.

The CME's role is to help families/guardians/caregivers succeed by developing a plan to address their needs and removing barriers that may impede progress. Their goal is to help youth and families/guardians/caregivers develop a long-term, sustainable plan that will support them in improved functioning long after CME involvement. The CFT removes barriers to care, drives care in the SOC approach, and facilitates creative, flexible planning to support the families/guardians/caregivers and youth. As such, the CME will continue to provide care coordination while a youth is receiving PRTF services, and PRTF staff are expected to participate on a youth's CFT for the duration of the youth's PRTF treatment and following a youth's

transition in order to support successful transition back to the community, school and family/guardian/caregiver. Additional discussion of collaboration with CMEs occurs in Section 9 of the manual.

Collaboration with Ohio's Child/Youth Serving Systems

Collaboration with service and custodial agencies such as the Public Children Services Agencies (PCSAs), Title IV-E courts and Bridges are essential to achieve the goals of the OhioRISE Program. All PRTFs are required to work closely with lOhio PCSAs, Title IV-E courts and Bridges regional teams in concert with the CME, in the course of work on behalf of individual youth and their families/guardians/caregivers. Additional discussion of collaboration with child serving agencies occurs in Section 9 of the manual.

Section 3: Psychiatric Residential Treatment Facilities Purpose and Goals

Out-of-State PRTFs will serve as a supplement to the residential system of care when in state treatment options are not available or the type of specialty care required, is not available. While the short-term solution changes, the overall goals remain the same to care for the youth within their community.

PRTFs aim to reduce long-term and repeated psychiatric hospitalization by delivering intensive care designed to help stabilize a youth, provide for immediate treatment needs, and quickly return youth to their prior care setting in less than six months to continue their course of treatment. As such, they are an integral part of the OhioRISE home and community-based continuum of care. ODM and the Ohio Department of Behavioral Health (DBH) have partnered with state system partners, Aetna, and stakeholders to develop standards that are included in this manual. For the purpose of this document, an Out-of-State PRTF must adhere to, and be licensed by, their governing state licensing agency. The PRTF must be able to furnish proof of this licensure upon request.

PRTFs provide active, trauma-informed treatment at an inpatient level of care in the community under the direction of a physician, seven days per week, 24 hours per day, to youth under age 21 with complex mental health needs and their families, based on medical necessity as determined by the OhioRISE plan. A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. The key elements of a trauma-informed approach are:

(1) realizing the prevalence of trauma;

(2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce;
(3) responding by putting this knowledge into practice; and
(4) avoiding re-traumatization.

PRTF is a specialized treatment service that supports youth with chronic behavioral health needs that would not be addressed in an acute psychiatric hospital stay meant to stabilize a mental health crisis. PRTF includes daily active treatment, achieved through a combination of family/guardian/caregiver, group, and individual therapy adapted to meet the individual needs and capabilities of the youth, consultation, and treatment planning with a comprehensive team of medical and behavioral health staff, in a highly structured living environment that accommodates the individual needs of the youth.

Transition planning begins at the time of admission to aid in a successful return to home, school and community within six months. Comprehensive transition planning is done with the OhioRISE care coordinator (from an OhioRISE CME or Aetna) working with the youth's CFT. More information regarding the Child and Family Team process can be found in the CME Manual located on the OhioRISE Care Management Entities page. In addition, PRTF staff are expected to participate on a youth's CFT for the duration of the youth's treatment at the PRTF.

PRTFs engage youth and their families/guardians/caregivers in a strength-based and compassionate manner that is sensitive to cultural and linguistic differences to facilitate feelings of safety and comfort, identify and address behavioral health challenges, and stabilize symptoms through the utilization of evidence-based practices to prepare youth for a less restrictive environment.

Through a comprehensive and collaborative individual plan of care that outlines short-term treatment goals, while actively pursuing plans for long-term stabilization at home or in an alternate living situation, the PRTF collaborates with the CME through CFT meetings at the time of engagement with PRTF and ongoing throughout the episode of care, including transition from PRTF.

It is expected that the appropriate PRTF staff will be actively involved with the youth's CFT throughout treatment and will encourage and maintain care coordination involvement throughout treatment in order to promote successful transitions throughout treatment. This will be determined throughout the youth and family teaming process, where PRTF staff will be active participants.

Upon initial admission to PRTF treatment, CFT members and PRTF staff will meet at a minimum, every 30 days, and more often if it is determined needed by either the PRTF staff or members of the CFT.

It is the expectation that the guardian and the OhioRISE care coordinator will be invited to and participate in all treatment planning calls. It is expected upon request that a representative with knowledge of the member's treatment participate in CFTs as defined in section "Transition Planning and Post-Transition."

When youth is within 60 days of transition, CFT members and PRTF staff will meet at least three

times within each 30-day period up until transition (or more if needed) for planning and successful transition back into the community.

The PRTF provider provides a consistent and predictable environment with intensive support and supervision in which there is a demonstrative understanding of the explicit and/or implicit trauma the youth may have experienced, delivers evidenced based and informed interventions to stabilize a youth and provide quality treatment to support a youth's rapid return home, and interventions that are reflective of the OhioRISE programs commitment to reduce seclusion and restraint. The PRTF provider demonstrates the ability to successfully engage youth and families/guardians/caregivers in PRTF services, and responsiveness to youth and family/guardian/caregiver voice.

Interventions offered by PRTFs are time limited and aimed at stabilizing a youth's identified behaviors and needs, while addressing the underlying etiology of these behaviors and needs so that the youth may safely return home with as little disruption to their life as possible. A core component of PRTF is engaging with the family/guardian/caregiver, supporting the family/guardian/caregiver to understand their youth's behavioral health needs, and to share strategies to address their youth's behavioral health needs. The goal of PRTFs is to facilitate the youth's reintegration into the family/guardian/caregiver and community or preparing for independent living. PRTF is one of the OhioRISE program's most restrictive interventions and thus should only be accessed when it is determined that all other therapeutic interventions will not safely or adequately address the youth's behavioral health needs.

PRTF is part of the home and community-based continuum of services, and one component of a robust system of care. The PRTF strives to minimize the time a youth is away from their family/guardian/caregiver and works to successfully provide this treatment in one episode per youth. There may be instances when a youth with intensive behavioral health needs that meet PRTF criteria have limited family/guardian support or no viable family/guardian/caregiver options at the time of admission. In these instances, the CFT will provide a developing/ progressing permanency plan for the youth that includes securing a family/caregiver/home-like setting for the youth to be incorporated into the ongoing transition planning process.

Given the focused clinical nature of PRTF, it is not designed to be used in lieu of legal consequences or to rehabilitate criminogenic behavior. However, certain criminal charges should not prohibit a youth from PRTF treatment when the youth otherwise meets the medical necessity criteria for PRTF treatment.

Section 4: Youth Who May Benefit from PRTF

Individuals referred to PRTF programs are young people under age 21 with complex needs, including significant behavioral challenges. These individuals have a mental health diagnosis or co-occurring mental health and other diagnosis, e.g., substance use, intellectual disability, and cannot be maintained in a community setting with a reasonable degree of safety. The youth approved for these programs require exceptional care on a 24/7 basis in an environment with intensive psychiatric clinical monitoring, medication management, and a concentrated

individualized treatment protocol.

Many youth referred to a PRTF will have experienced trauma. Trauma is defined as the experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and /or the witnessing of violence, terrorism, or disasters.

Adverse Childhood Events (ACEs) have serious mental health consequences, and youth often learn to deal with them by adopting negative coping mechanisms (Felitti et al. 1998). Trauma-informed care therapeutic models are essential in understanding the impact of a youth's exposure to past and current traumatic events (Bloom, S.L., 1994). Youth identified for PRTF require continued intensive psychiatric care in a highly staffed and supportive residential milieu before they can return home or transition to a less intensive out-of-home treatment setting.

Individuals who may receive treatment in a PRTF that specializes in providing treatment for individuals with co-occurring MI/ID include youth with traumatic brain injuries, neurocognitive disorders, and other cognitive deficits, regardless of their etiology.

Section 5: PRTF Service Definition

What is a PRTF?

A PRTF is an inpatient level, intensive multi-disciplinary residential treatment provided in a non-hospital setting for young people with complex needs. A PRTF delivers trauma-informed, evidence-based, and individualized services to young people and their families/guardians/caregivers under direction of a physician in order to stabilize behaviors in as short as possible time frame to help young people and their families/guardians/caregivers develop the knowledge and skills needed to safely manage the youth's needs in the community, so that the young person can succeed in all aspects of community living, e.g., home and family, school, employment, etc.

PRTF services:

- Are nurturing, warm, engaging, and therapeutic environments that meet the developmental needs of the youth served.
- Are delivered by supportive staff and in a peer culture that encourages support and acceptance, and celebrates growth and success
- Demonstrate that wellness, recovery, and self-determination are possible and recognize the positive potential inherent in all youth and their families/guardians/caregivers.
- Are strength-based and individualized to each person, with the goals established, quantity and frequency of services adjusted based upon the needs and strengths of individuals. As such, PRTFs do not use coercive practices, phases or level systems.
- Are trauma-informed, recognizing that youth who experience trauma, need trauma-informed approaches.
- Are time limited with lengths of stay generally within six months or less, with treatment focused on the objectives that are most important for the young person

to address to achieve a successful transition to the community.

- Are able to address the intensive treatment, supervision, and safety needs of the young person referred.
- Possess the capacity and expertise to provide targeted treatment services to address the variety of needs of each young person.
- Are family/guardian/caregiver-driven, able to actively engage the families/guardians/caregivers, support the families/guardians/caregivers to understand their youth's behavioral health needs, and to engage the families/guardians/caregivers to learn strategies to address their youth's behavioral health needs from admission of the youth throughout the duration of PRTF treatment.
- Are inclusive of up-to-date knowledge and evidence-based treatment services that focus on the strengths of the young person and their family/caregiver.
- Are provided in a non-acute home-like environment (as discussed later in this section).
- Are culturally and linguistically competent, demonstrating commitment to equity, diversity, and inclusivity.

PRTF Service Components

The PRTF service is comprised of multiple components:

Initial Youth and Family/Guardian/Caregiver Introduction to PRTF Treatment Services

There are three steps related to engagement to consider when a youth prepares to enter treatment in a PRTF. It is important to always recognize that a new environment can feel very unpredictable and may create anxiety for a youth. They are being transitioned out of their community/state, family, and home to a place they have never been before, so it is important to give them as much up-front knowledge and familiarity with their treatment services and location as possible. Recognizing facilities outside of the youth's home state may necessitate variations to the below, the three following points are the standard to which facilities should strive.

1. The first step to engagement involves the PRTF provider speaking with the youth and the family/guardian/caregiver about the PRTF: what it is, what treatment services will be provided, what to expect while the youth is there, how often they will be able to speak with family/guardian/caregiver, the purpose of the PRTF stay and general amount of time at the location. The PRTF staff will also provide an opportunity for the youth and family/guardian/caregiver to ask any questions they may have about the PRTF. This initial engagement should provide the youth and family with evidence of the supportive and nurturing culture of the PRTF environment and should occur within 48 hours of the PRTF receiving the referral from Aetna. For out of state providers, a virtual meeting is acceptable.

2. The second step involves the youth and family/guardian/caregiver taking a tour of the facility and meeting some of the staff they will be working with on site. They will be able to

see what their room will look like, where they will sleep, where they will have breakfast, lunch and dinner, and staff will give a general description of a “day in the life” at the PRTF. The staff will share with the youth and family/guardian/caregiver when they will be able to visit one another and talk to each other during the week and on weekends. The youth and family/guardian/caregiver will be able to ask questions about the PRTF. This will provide an opportunity for the youth and family/guardian/caregiver to experience the culture of the environment where they will be receiving treatment services. Individual youth and family circumstances should be considered when scheduling tours. Admission should not be delayed if a tour cannot be scheduled timely or if an individual youth’s circumstances indicate a tour is not feasible. For out of state providers, a virtual tour is acceptable.

3. Finally, the youth and family will come to the facility for admission. Staff will show the youth to their room, introduce them to their roommate (if they have one) show them where to keep their things, give them a schedule for the week so they understand what they can expect to happen in the first few days of being in the PRTF (safety and predictability), go over PRTF-specific policies and procedures (to include restraint and seclusion policies) shares contact information for Disability Rights Ohio, patient rights grievance process, and allow them some time with family/guardian/caregiver before they leave and the youth’s treatment begins. It is suggested that youth and family/guardian/caregiver leave one another with a plan for their next interaction (via phone call/visit/letter). The staff, youth and family/guardian/caregiver will work together to create a safe environment that takes into consideration the youth’s history of trauma and behavioral health needs as they begin this path of treatment collaboratively.

Admissions

The following activities occur upon or shortly after admission, any deviations must be reviewed in advance with Aetna OhioRISE:

- A **physical health examination** by a physician or advanced practice registered nurse is required for all youth not later than twenty-four hours after admission, to include an expanded laboratory (bloodwork) panel and other diagnostics.
    - At times, youth with MI/ID will present with decreased self-report and low threshold for other objective data to rule out undiagnosed medical conditions. Personal Protective Equipment will be carefully considered as persons with MI/ID are at increased risk of COVID-19 and other infectious diseases due to potential decreased self-report of symptoms (resulting in delayed diagnosis), as well as vulnerability to pulmonary and central nervous system conditions.
- A **psychiatric evaluation** by a psychiatrist or other qualified physician not later than forty-eight hours after admission. The evaluation may be conducted virtually as needed. For youth with intellectual disabilities, the evaluation should be performed by a psychiatrist with training or experience in intellectual disability.
- A **strengths-based bio-psychosocial assessment** will be completed for all youth. For youth with MI/ID, the developmental stage of the youth (mild, moderate, or severe intellectual disability) will be considered and integrated into a bio-psychosocial-developmental assessment and plan.
- An **individual plan of care**, developed with the family/guardian/caregiver and youth within 14 days of admission, describing measurable goals that the youth and family/guardian/caregiver want to attain, the interventions, and how progress towards the goals will be monitored with a focus on addressing the issues that are leading to the need for behavioral health services within a PRTF setting. These Targeted Treatment Goals (TTGs) will be initially identified by the Child and Family Team prior to the youth admitting to PRTF and refined by the PRTF. These TTGs will also inform the concurrent clinical reviews that will be conducted by Aetna while the member is being treated at the PRTF.
- An **individualized approach to safety planning and crisis response** will be incorporated for youth in PRTF settings. It should incorporate details of previous crisis and safety plans developed by the youth's CFT if one already exists for the youth and when appropriate. Since the PRTF is a highly structured setting, youth will be informed upon admission of rules within the setting to maintain safety for everyone. Youth will have

opportunities to develop a crisis and safety plan with their clinical team and PRTF staff collaboratively while they are staying in the PRTF setting. Specific crisis and safety plans will be created collaboratively with PRTF staff, youth, and parent/guardian/caregivers if a youth temporarily leaves the treatment facility for a family visit or community outing.

Treatment

The following services are included as part of PRTF treatment plans and tailored for individual youth needs:

- Psychiatric assessment and consultation (including input into the clinical component of an individual plan of care).
    - For youth with intellectual disability, psychiatric consultation will be available by psychiatrists with training or expertise in MI/ID. The consultation may involve a collateral data source for those youth with limited expressive language skills.
- Age and developmentally appropriate individual, group and family/guardian/caregiver therapy as described in the youth's individual plan of care.
- Weekly face-to-face consultation and psychiatric services when clinically indicated. Psychiatric services must be available at all times on site, telehealth, or by telephone, including routine and emergency psychiatric evaluations, medication evaluations, and prescription adjustments.
- Medication monitoring and education.
- Nursing services.
- Case management in collaboration with the youth's OhioRISE care coordinator or other entity leading care coordination for the youth.
- Independent daily living skills (Includes, but not limited to, Money Management, Socialization and Relationship Building, Meal Preparation, Interview Skills, Resume Building, etc.).
- Access and connection to other services such as:
    - psychological testing
    - vocational counseling
    - medical services to include vision and dental screening, as needed
    - Individualized therapeutic ancillary support materials and/or therapeutic support devices
    - sensory informed OT evaluation and communication evaluation for youth with MI/ID.

Other Services

- Education services that meet the minimum standards prescribed by the state board of education, whether through a public school, community school, or chartered nonpublic (private) school operated by or at the PRTF.
    - The PRTF must coordinate education services with the youth's school district when applicable.
    - All youth, including those with MI/ID will receive educational services according to their individualized educational plan.
- Art and music therapies as well as other ancillary services and organized recreational activities to support normative developmental experiences, i.e., outdoor play, relaxation, interests.
    - Youth with MI/ID will be offered recreational services that accommodate their individual medical, neurological and physical needs and capabilities.
- Transportation to other medical services, including laboratory, dental, vision, physical therapy, occupational therapy, or speech therapy, which the PRTF may provide directly or through coordination with the youth's Medicaid MCO.

Throughout Service Delivery

Regular, active, and ongoing family/guardian/caregiver engagement will be maintained in all aspects of the PRTF service, including family/guardian/caregiver coordination, communication with staff, as well as regular and consistent contact with their youth via face-to-face family time, phone/video calls, normative family/guardian/caregiver activities at the PRTF location, and opportunities for family/guardian/caregiver outings when clinically appropriate.

Coordinated case management and transition planning with the OhioRISE care coordinator begins at the time of admission, and participation in the youth's CFT is crucial to facilitate rapid stabilization and return to the youth's family, community or prepare for independent living.

Frequency of Services and Expected Timelines

While all treatment is individualized to the youth's needs, and providers are expected to demonstrate unique plans addressing the specific needs of each youth and their families/guardians/caregivers, the PRTF is expected to maintain the following MINIMUM frequency and/or duration of service components described in the table below.

Table 1: Frequency and Duration of Service Components

Service Component*	Minimum Frequency	Minimum Total Duration
A face-to-face consultation with a psychiatrist, other qualified	Once a week	Fifteen minutes

physician, or a prescriber either under the direction of a physician or other practitioner with prescribing authority or practicing under a collaborative agreement		
Individual counseling sessions with a licensed clinician	Twice each week	Ninety minutes
Group counseling sessions with a licensed clinician	Five times each week	Five hours
Family/guardian/caregiver therapy or other family/guardian/caregiver interventions	At least once each week and in accordance with the young person's individual plan of care	In accordance with the young person's individual plan of care
Art and music therapeutic services	In accordance with the young person's individual plan of care	In accordance with the young person's individual plan of care
Medication administration, monitoring, and education	As prescribed	As prescribed
Substance use disorder treatment in accordance with the American society of Addiction Medicine (ASAM) criteria	When clinically indicated and included in the PRTF's admission criteria	When clinically indicated and included in the PRTF's admission criteria
Ancillary services based on the young person's clinical needs as indicated in the young person's individual plan of care	Daily	Two hours each day

**At least one therapeutic service specified in this table must be provided on site each day. Therapeutic services must be provided for at least eight hours each week.*

Table 2: Timelines for Delivering Required Service Components

Timelines for Delivering Required Components	
Within 24 hours of admission	• A physical health examination by a physician or advanced practice registered nurse. * • Initial treatment and crisis plans will be completed, and copies provided to the youth and family/guardian/caregiver. • A nursing assessment will be completed and incorporated into the initial treatment and crisis plans. • The youth and their family/guardian/caregiver will be oriented to the services and facility-specific policies and procedures. • All necessary consents, releases and family/caregiver/guardian acknowledgement of receipt of restraint and seclusion policies will be completed and filed.
Within 48 hours of admission	• A psychiatric assessment, report and recommendations will be completed. *
Within 72 hours of admission	• A Substance Abuse screen will be completed. • A comprehensive individual crisis plan that details youth identified triggers, helpful and unhelpful environmental responses and specific interventions for staff. • A treatment team meeting will be conducted and a comprehensive treatment and transition plan that integrates all of the treatment team's input, assessments, and recommendations will be completed. The individual plan of care shall contain clearly delineated goals and objectives with specified timelines and benchmarks for success, including a detailed description of the treatment goals that must be attained in order for the youth to be considered transition ready. • A Nutritional screening will be completed. • Educational programming will be arranged. • Referrals for medical, dental, neurological or other identified evaluations.
Within fourteen	• An individual plan of care will be developed and implemented

days of admission	
Each day	• Comprehensive and well-documented communication regarding significant events, youth behaviors, and other relevant information will be provided for each shift. • All youth will be properly supervised; staffing and ratios will be reinforced. • Supervision ratios must be maintained at all times, including during crisis situations. • Beginning and end of day meetings will be convened to monitor the emotional state of each youth. • Medication will be dispensed by the amount and frequency prescribed and monitored as needed. • Youth will be transported to medical appointments, family/guardian/caregiver family time, community outings, and any other off-site requisite activities as needed. • A licensed clinician will have face-to-face contact and "check-in" with each youth. • All youth will have access to any necessary individually accommodating services and therapeutic/ancillary supports that have been defined on the individual plan of care.
Each week	• Documented units of services by service components (i.e., individual, group, family/guardian/caregiver therapy, family/guardian/caregiver engagement, etc.) and the youth's response to the provided services and supports.
At least every 30 days	• Review the individual plan of care to ensure service provision and update as needed

**A PRTF may accept an examination that was completed in the 72-hours prior to admission, but cannot require one to be completed as a condition of admission. The examinations must be reviewed by the interdisciplinary treatment team within the first 72 hours and incorporated into treatment planning.*

Transition Planning and Post-Transition

Transition planning, in coordination with the youth's CFT, begins upon admission. CFT members and PRTF staff will meet at a minimum every 30 days, and more often if it is determined needed by either the PRTF staff or members of the CFT. When youth is within 60 days of transition, CFT members and PRTF staff will meet at least three times within each 30-day period up until

transition, or more if needed, to transfer skills and strategies, plan and connect with providers, schools, and/or employers for post-transition resources to support successful transition into the home, community, school, and workplace.

CFT / Care Coordinator and PRTF Transition Planning Guidelines	
Before 60 Days of Transition	CFT/CC + PRTF meeting 1 x per month
60 Days before Transition	CFT/CC + PRTF meeting = *3x per month
30 Days before Transition	CFT/CC + PRTF meeting = *3x per month

**CFT/CC will have discretion regarding how these meetings are used. For example, if they need to be used for coordinating services locally and then informing PRTF of progress via email/phone/or CFT that may be documented as appropriate transition planning care coordination activities in collaboration with the PRTF.*

While preparing for, during, and after the transition from PRTF services, the CFCP developed by the CFT will delineate roles, services, and supports to be delivered by the PRTF and other providers. When planning for the transition from PRTF services is taking place as outlined above. As driven by the CFT process, it may be appropriate for external providers to hold individual and/or family therapy sessions with the young person and/or their family while they are still receiving PRTF services.

PRTF staff will remain available for consultation to the youth, family/guardian/caregiver, and CFT for a reasonable period of time following transition from PRTF services to participate in CFT meetings and be available to the youth and family/guardian/caregiver to reinforce skills and strategies learned during PRTF, as well as collaborate on transition needs as the youth returns home.

Treatment Environment

Treatment Environment

While PRTF is very structured and is the most intensive supervised treatment setting, it remains important that each youth has access to a normal age-appropriate environment and activities. This includes supporting frequent contact via phone and visitation with family/guardian/caregiver or other supports. It is expected that the PRTF provider will support regular, consistent contact between the youth and their family/guardian/caregiver, unless otherwise indicated by court order or a legal guardian. The youth will be able to have contact with the family/guardian/caregiver regularly, including telephone calls, emails, letters, and face to face family time according to written policies established by the provider, and family/guardian/caregiver interactions will not be withheld due to behavior or used as part a reward.

Expectations for all youth receiving PRTF treatment:

- Required family/guardian/caregiver participation and coaching to translate knowledge and teach strategies and tools to be implemented in the home/next environment.
- Required local team participation in youth and family/guardian/caregiver meetings throughout the course of care, including transition planning meetings.
- The PRTF will provide support to youth transitioning back into the community through aftercare consultation with the care coordinator and child and family team.
- Teaching and coaching may occur at the PRTF facility or off-site, as dictated by the needs of the individual and capacity of provider. Teaching and coaching will occur while the youth receives treatment at the PRTF and for a reasonable amount of time following transition.
- Respect the young person's choice regarding services and support, and who provides them, as much as possible.
- Respect the young person's choice of schedule and activities and access to food as clinically appropriate.
- Allow the young person freedom to furnish and decorate their sleeping and living areas as much as possible while being consistent with considerations for the health and safety of the young persons.

Age Range Considerations for youth in PRTF

Typical age ranges consist of 6 to 12; 13 to 17; or 18 to 21. Youth will not be placed in the same unit/cottage that exceed age ranges more than three years apart, any exception should be reviewed with the CFT prior to placement. Special consideration will be given to youth whose age is outside of these age ranges but have treatment needs consistent with the PRTF service capacity. Additionally, considerations will be made for developmental versus chronological age when appropriate. Size and behaviors of youth may also be considered for unit placement. Further considerations may be made based on the size of the unit. Age should be considered as it relates to appropriate therapeutic milieu and developmentally appropriate sleeping arrangements.

Trauma-Informed Treatment

PRTFs provide trauma-informed active treatment at an inpatient level of care in the community under the direction of a physician, seven days per week, 24 hours per day, to youth under age 21 with complex mental health needs and their families/guardians/caregivers. The treatment should incorporate Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) key principles of trauma-informed care:

- Safety.
- Trustworthiness and transparency.
- Peer support, e.g., development of a youth and/or family/guardian/caregiver peer mentor program, peer council, etc.
- Collaboration and mutuality.
- Empowerment, voice, and choice.

- Cultural, historical, and gender issues.

Additionally, the treatment should incorporate the following trauma-informed practices:

- Reduces and avoids re-traumatization that can occur in a residential treatment environment.
- Provides a therapeutic setting where all staff understand the impact of trauma on young people and their development, and staff interaction with youth reflects trauma-informed practice.
- Is nurturing, non-coercive, family-friendly, and provides for normalcy and consistency. The PRTF does not use punitive systems, e.g., a level system or a "token economy" where a young person may lose an earned level.
- PRTF staff will reinforce youth strengths as levers to reinforce positive behaviors and encourage an environment where all youth and staff focus on celebrating accomplishments.
- Focuses on assisting young people with self-regulation.
- Staff identify trauma-informed strategies around safety as part of engagement, including developing comfort plans for each young person, as well as incorporating other strategies and tools such as making available the use of sensory items for a young person. A comfort plan is an individualized plan that is established by the youth and staff and includes youth's personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress. Comfort plans do not reflect any punitive measures or consequences.
- Staff recognize crisis triggers during treatment, assist the young person if needed with implementing individual comfort plans and engage with the young person to prevent the escalation of behaviors.
- The trauma-informed services that the youth receives while at PRTF promote the use of more adaptive coping strategies to encourage resilience and improved function. Treatment at PRTF is not designed or intended for youth "process" all their trauma.

Young Person and Family Engagement

PRTF is a youth and family/guardian/caregiver driven service. The youth and their family/guardian/caregiver are viewed as full participants in the treatment team, and their needs, preferences, and choices are valued and respected.

The PRTF shall orient the family/guardian/caregiver and youth to the PRTF service and provide the family/guardian/caregiver clear communication and explanations related to the young person's service needs at a frequency defined by the young person and their family/guardian/caregiver and/or care plan.

The young person shall be asked directly for their input on and offered choices in their treatment services, as their input and choices are respected and incorporated into the individual plan of care whenever clinically and developmentally appropriate.

The PRTF actively engages the family/guardian/caregiver in partnership with the OhioRISE care

coordinator (or other entity leading care coordination for the youth) and the CFT. The family/guardian/caregiver is invited to participate in PRTF's treatment team meetings, which are held at times convenient to the family/guardian/caregiver. Families/guardians/caregivers are encouraged to be full participants in the youth's ongoing care including participation in clinical appointments. The family/guardian/caregiver is invited to participate in family/guardian/caregiver counseling from the time of the young person's admission. The PRTF will provide additional family/guardian/caregiver services and supports or, via the OhioRISE care coordinator (or other entity leading care coordination for the youth) refer the family/guardian/caregiver for recommended individualized services and supports in the community, e.g., individual therapy, parenting classes, parent mentors or peer supports, parenting self-care information, etc.

PRTF makes available and utilizes technology for visitation, clinical services, and treatment team meetings. Additionally, the PRTF will identify and create individualized opportunities for family/guardian/caregiver involvement when needed to support engagement.

Assessment

A cross-discipline bio-psychosocial assessment addressing psychiatric, nursing, and clinical issues will include the youth and family's/guardian's/caregiver's strengths and needs that will inform the individual plan of care. Assessment will either incorporate the most recent CANS information, or the PRTF provider will work with the OhioRISE care coordinator (or other entity leading care coordination for the youth) to update the CANS to reflect new information, as indicated.

CANS assessments are to continue to be completed at a minimum of every 90 days or whenever there is a significant change in the youth's behavioral health needs or circumstances. At a minimum, the family/guardian/caregiver, youth, treatment team including the clinician, education staff, and others as recommended in the CANS reference guide available at www.cansohio.org are to be contacted and their input included in the assessment process. The PRTF will participate in the CANS assessments as requested by the OhioRISE care coordinator.

Individual Plan of Care

The PRTF program will develop individualized plans of care with a multi-disciplinary team that includes the youth, family/guardian/caregiver, clinicians, milieu staff and psychiatric care providers. The individualized integrated plan of care will include referrals for medical, dental, neurological or other identified evaluations, as well as identify strengths that will be built upon or leveraged to meet the youth and family's/guardian's/caregiver's stated goals.

The individual plan of care shall be in writing and developed for each young person to improve their condition to the extent that PRTF care is no longer necessary. The individual plan of care must:

1. Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the young person's situation and reflects the need for PRTF care.

2. Be developed by a team of professionals in consultation with the young person and their family/guardian/caregiver.
3. State treatment objectives.
4. Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives.
5. Incorporate the following three components:
    a. Comfort plan – an individualized plan that is established by the youth and staff that includes the youth's personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress.
    b. Safety plan – a plan developed for staff on how to positively approach a youth when a specific behavior begins to escalate. This plan will include strengths, needs, triggers, and detailed strategies that will be used with a particular focus on early recognition of triggers, de-escalation, and calming techniques. The safety plan may be implemented in an immediate and expedient manner to manage imminent safety issues by a unit staff member, treatment team member or clinical leadership when a youth's risk behaviors disrupt the milieu.
    c. Behavior plan – plan for goals that the treatment team and the youth work on to control the youth's behavior.
6. The plan must be reviewed at least every thirty days, and more often when clinically indicated by the treatment team and the youth and family/guardian/caregiver to:
    a. Determine those services being provided are or were required to be provided in the PRTF.
    b. Recommend changes in the plan as indicated by the young person's overall progress in the PRTF.

Individualized Therapeutic Services

All PRTF services and interventions must be directly related to the goals and objectives established in each youth's individual plan of care. PRTF providers are expected to incorporate up-to-date clinical knowledge and evidence-based and evidenced-informed practices into service delivery.

It is anticipated that interventions include, but are not limited to:

- Instruction in learning adaptive frustration tolerance and expression, which may include anger management
- Instruction in stress reduction techniques
- Problem solving skill development
- Psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors
- Social skills development
- Instruction in Activities of Daily Living
- Behavioral Support Plan as indicated
- Family/guardian/caregiver training and support for transition of the youth back home

Care Coordination, Transition Planning and Continuity of Care

Youth will have an OhioRISE care coordinator (CME or Aetna) and the PRTF provider is expected to participate in the youth's CFT team. The PRTF coordinates care with the CFT while anticipating transition into the PRTF for treatment, during treatment, as part of transition planning, and after treatment.

The PRTF provider will work closely with the CFT team to develop a transition plan that ensures successful integration into PRTF treatment, evolves to build upon the successes and strategies identified during the PRTF intervention, and helps the CFT Team to anticipate common challenges that can occur during transition to the home or community and collectively strategize on how to address. The PRTF provider will participate with the youth's CFT meetings that occur during the youth's tenure in a PRTF and post transition as requested by the CFT.

While the CFT Team and OhioRISE care coordinator will also have responsibilities to support the youth's transition to the community, it is the PRTF provider who begins transition planning within a reasonable amount of time following admission through active family/guardian/caregiver education and engagement in the care of young people and contact with the care coordinator to facilitate exchange of information.

The PRTF provider, as part of the CFT, will partner with the young person and family/guardian/caregiver to engage and utilize natural community supports as part of transition planning and establish individualized warm hand-offs with community providers or partners prior to the transition. The PRTF provides written documentation to all participants of the transition plan prior to the young person leaving the PRTF with information on how to access additional supports from the PRTF and community providers, including contact information and steps required to access each provider.

As part of treatment and transition planning, it is anticipated that many youth would benefit from therapeutic passes, allowing the youth and family/guardian/caregiver time outside of the PRTF to engage in typical family/guardian/caregiver activities, practice strategies being learned in treatment, and support reintegration into the youth's family home, school and community. All use of therapeutic passes must be:

- Individualized to the particular treatment needs of each youth.
- Goal-directed, and clearly described in the individualized plan how therapeutic passes support the youth attaining their particular goals.
- Planned and no more than three-consecutive days at a time.
- Include a clear plan for the youth and family/guardian/caregiver in the event they need support from the PRTF during the therapeutic pass.
- Include a debrief with the youth and family/guardian/caregiver to reinforce successes, reinforce skill development, and adjust the plan as needed.

There may be some instances in which a youth receiving PRTF services requires other emergent medical services that the PRTF provider cannot provide. The PRTF provider will have a written transfer agreement in effect with one or more Medicaid participating hospitals that reasonably

ensure that a youth will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical or acute psychiatric care, in accordance with 42 CFR 483.372. In situations in which a youth may need overnight stays in a hospital, the PRTF will coordinate care with the medical provider and hold capacity to serve that youth upon their return.

There may be some instances in which a youth may need an overnight stay in an acute inpatient hospital for behavioral health reasons. This occurrence is expected to be infrequent and the PRTF is required to notify the OhioRISE plan and the family/guardian/caregiver of this leave event within twenty-four hours. While the PRTF is an inpatient level of care, it is also a non-hospital setting. Infrequent, though anticipated, instances when a PRTF recommends an acute hospital setting for a youth could provide immediate access to an inpatient behavioral health provider. The PRTF will coordinate care with the acute inpatient behavioral health provider and hold capacity to serve that youth upon their return for at least three consecutive days.

The PRTF is available to community partners, the young person, and their family/guardian/caregiver for a reasonable amount of time when the youth is transitioned to a community setting.

Education

PRTF providers are expected to facilitate the ongoing provision of an appropriate educational program as required under federal and state education law. Medicaid does not fund educational programs and services that youth are entitled to under those laws or provide on-site educational services for youth in out-of-home treatment settings. As such, the PRTF provider will be expected to provide for educational programming and services as described in the provider application as well as follow all federal and state and education laws.

Regardless of the way the PRTF provides for education, youth must have access to career-technical education. When attending the local public district and/or contracting for educational services, students can access career-technical education through the delivery method typically offered within the district. When operating as a public charter school, the PRTF may apply to have their own career-technical education programming or contract with another entity. When operating as a chartered nonpublic school, the PRTF may contract with another entity, or the student may directly enroll into career-technical education.

Establishing communication protocols and processes for student transition should happen at the point of acceptance of a youth into a PRTF. While planning these processes, consider the following: student records, Individualized Education Program (IEP) or Evaluation Team Reports, related services requirements, graduation requirements course completion and academic credits, demonstration of competency and readiness in order to participate in transition goals.

All providers must commit to providing accurate documentation to the educational entity providing service to facilitate the educational process for students in their care.

In addition to access to school requirements noted above, the collaboration and coordination

of services for youth in the facility should consider also inviting education staff as part of the treatment team. Communication about productive treatment approaches and barriers among team members are aimed to support the therapeutic treatment which best supports a successful transition out of the facility with sustained stability across all aspects of the whole youth, including education. Accordingly, genuine and proactive coordination and collaboration between the provider and educational professionals is expected.

PRTF providers shall ensure:

1. A balanced and coordinated effort between clinical treatment and educational programming and service delivery and a trauma-informed environment and approach to education;
2. Daily before and after school communication strategies with education staff;
3. Daily support of student homework, special projects, and study time;
4. Specific strategies, including responsible staff and timelines, for including families-of-origin and/or natural supports available to the youth in educational programming and progress review;
5. Availability of computers for student use to support homework and projects;
6. Problem resolution strategies;
7. Immediate and therapeutic responses to problems that rise during the school day;
8. Supervision of students who are unable to attend school due to illness or suspension;
9. Shall ensure that the state compulsory education rule as well as meeting the minimum service minutes as written in the students' IEP goals;
10. Supervision of and programming for students who do not have a summer school or who have graduated high school as well as for breaks/vacation times;
11. Adequate supervision, programming, and professional staff contact in support of any educational work outside of school hours such as a student with independent work, online classes, homework and or projects.
12. For youth with intellectual disability, the PRTF will request consultation with OCALI as needed. Educational liaison between the onsite educational programming and the LEA/Local Team/Family will occur.

The possibility of a variety of situations may arise regarding connecting with a school district of the youth's residence and the school district providing educational services which may require additional support from an Education Area Coordinator.

If you have a situation not covered by the above table, please reach out to an Area Coordinator.

Restraint, Seclusion and Time-Out

PRTFs must comply with the CMS Condition of Participation regulating the use of restraint and seclusion in 42 CFR § 483.350 – 483.376. As such, PRTFs are subject to CMS surveys.

Furthermore, it is expected PRTFs will be in full compliance with their state accreditation standards for the use of restraint and seclusion. A PRTFs restraint and seclusion policies and any reports related to compliance must be made available to ABH upon request.The facility's executive director, chief executive officer, president, or similar position must provide an attestation certifying it is compliant with CMS standards governing the use of restraint and seclusion. A copy of this attestation must be provided to ABH when upon initial contracting and upon request anytime thereafter. The required attestation form is in Appendix A of this document.

Use of seclusion or restraint entails documentation, monitoring, notification, and reporting requirements, as noted in the CFR regulations above. Thorough documentation about the emergency safety intervention must be included in the youth's record, to include the signed order for restraint or seclusion, the time the emergency safety intervention began and ended, the time and results of the one hour assessment, the emergency safety situation that required the youth to be restrained or put in seclusion, the name of the staff involved in the emergency safety intervention, consultation with the treatment team physician, notification of the parent/guardian/custodian, detailed information about required debriefing sessions, injuries that resulted from the emergency safety intervention, and reporting of serious occurrences and/or deaths.

OhioRISE Philosophy on Restraint and Seclusion

ODM, DBH and Aetna believe seclusion and restraint of youth are not treatment and are contrary to the mission of OhioRISE. A prevention-oriented philosophy is preferred consisting of progressive policy, regulations, forms, training and supervisory philosophy and milieu environment.

ODM, DBH and Aetna are committed to the reduction and ultimate elimination of the use of seclusion and restraints. The Six Core Strategies for Reducing Seclusion and Restraint Use is an evidence-based model developed by the National Association of State Mental Health Program Directors that has successfully reduced the use of seclusion and restraint in a variety of mental health settings for youth and adults across the United States and internationally.
PRTF providers are expected to develop policies, procedures, training, supervisory, and quality oversight processes that address all six strategies and align with Ohio's goal to eliminate use of restraint and seclusion.

ODM, DBH, and Aetna are concerned with the management, treatment, and prevention of trauma that affects so many youth. Adopting trauma-informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a youth's treatment. Youth who present with challenges requiring services should be understood in terms of their experiences of trauma and consequent difficulties in forming and maintaining healthy attachments. Trauma may affect youth in a multitude of ways, such as disruption in emotional responses, behavior, cognition, physical health, self-concept, and future orientation. Increased isolation and fewer social opportunities can contribute to low self-esteem and less opportunity to learn about abuse prevention. PRTF providers will develop policies, procedures, training, supervisory, and quality oversight processes that ensure a nurturing, trauma-informed

treatment approach is delivered by all PRTF staff.

The goal of reducing and minimizing the use of seclusion and restraint is one that must be shared and articulated by the provider's leadership. The elevation of oversight by leadership of each use of seclusion or restraint to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal.

Restraint or seclusion shall not be used unless it is in response to a crisis, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is possible. Restraint or seclusion shall be employed for the least amount of time necessary in order that the individual may resume their treatment as quickly as possible.

Seclusion and restraint are intrusive techniques to be used by trained, qualified staff as a last resort to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's trauma history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods. Best practices must be based on understanding and consideration of the individual's history of traumatic experiences to gain insight into origins and patterns of the individual's actions. A youth's behavior plan should first be implemented as a way to mitigate the potential for seclusion and restraint.

Use of seclusion or restraint must be subject to performance improvement processes to identify ways in which the use of these methods can be decreased or avoided, and more positive, relevant and less potentially dangerous techniques used in their place.

When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and possible transfer to a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.

For youth with MI/ID, care providers must receive specialized training in the area of seclusion and restraints due to the multiple neurological, cardiac, and pulmonary needs of the MI/ID patient population to address the increased safety risks and potential limited verbal capabilities/self-report of the youth.

PRTF Building and Living Expectations

PRTFs will:

- Be in either a separate, free-standing building or a building with other services, which may include a class one residential facility, but be located on a separate floor or in a separate unit or wing.
- Provide each youth a single or double occupancy bedroom based on clinical needs..
- Respect as much as possible the youth's choice regarding services and supports, and who provides them.
- Respect the youth's choice of schedule and activities, and activities and access to food as clinically appropriate.

- Allow the youth freedom to furnish and decorate their sleeping and living areas as much as possible while being consistent with considerations for the health and safety of the young persons.
    -

For youth with intellectual disabilities, building and living arrangements will abide by the requirements set forth by the Americans with Disabilities Act, which includes environmental modifications for paint color, lighting, auditory adaptations, and furniture.

Licensing

PRTF providers are required to be licensed as a PRTF ; maintain compliance with applicable state and federal laws and regulation; hold and maintain other required licenses or certificates as applicable, e.g., school, dietary, etc.; and meet the federal emergency preparedness requirements of 42 C.F.R. 441.184, including testing the emergency plan twice per year.

PRTF providers are required to comply with their state's survey agency requirements. Providers are expected to report any issues resulting from surveys to Aetna OhioRISE.

Section 6: Staffing

Required Staffing

PRTF staff shall include:

- Physician medical director. If the medical director is not a board-certified or board-eligible psychiatrist, the PRTF shall also employ or contract with a psychiatrist who meets this qualification.
- Administrative director, who shall meet one of the following qualifications:
    - Master’s degree in human services field plus two years prior human services supervisory experience.
    - Bachelor’s degree in human services field plus four years prior human services program supervisory experience.
- Clinical director who is trained in an evidence-based trauma treatment/intervention model with two years clinical experience in a mental health setting that served youth or adolescents with emotional problems.

    - The clinical director may also serve as the administrative director.
    - The physician medical director may also serve as the clinical director if employed at least forty hours/week.
- Sufficient clinical staff to meet each resident's treatment needs and who are appropriately credentialed to provide mental health services. If the PRTF provides services to young people with co-occurring substance use disorders, sufficient clinical staff shall be credentialed to provide substance use disorder treatment. If the PRTF provides services to youth with MI/ID, the PRTF will have sufficient clinical staff with expertise in treatment for youth with intellectual and developmental disabilities.
- Sufficient direct care staff, which may include clinical and nursing staff, to meet all residents' supervisory and care needs.
    - During the hours of eight a.m. until ten p.m., PRTF maintains a staffing ratio of at least one direct care staff for each three residents. The PRTF will have a minimum of two direct care staff at all times, including a practitioner with a scope of practice of at least a registered nurse.
    - During the hours of ten p.m. until eight a.m., the PRTF maintains a staffing ratio of at least one direct care staff for each six residents. The PRTF will have a minimum of two direct care staff at all times, including a practitioner with a scope of practice of at least a licensed practical nurse.
- The PRTF includes additional staff as needed to meet resident's dietary, educational, social, recreational, cultural, and other needs.
- When PRTF staff are on duty, they are dedicated to the PRTF service. If there is another residential or outpatient services facility on the grounds where the PRTF is located, when direct care and nursing staff are on-duty in the PRTF, these staff are specifically assigned to the PRTF with duties separate from other services, e.g., acute, other residential or outpatient services.
- The PRTF increases staff when necessary to meet the acuity needs of the young person. The PRTF provider will develop a plan to demonstrate how it will provide this flexible staffing.
- The following staff shall be on call at all times and available to come on-site to the PRTF when one is not available on-site:
    - Psychiatrist, Doctorate level behavioral health professional, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician with behavioral health experience. If the staff person available to come on-site is not a psychiatrist, a psychiatrist shall be on call.

- Licensed clinician. With the exception of a certified nurse practitioner, this does not include staff who are registered or certified by an Ohio licensing board, e.g., a registered social work assistant or certified chemical dependency counselor assistant.

Psychiatrists providing treatment for youth with MI/ID should have training or experience with MI/ID patient population.

Section 7: Pathway from PRTF

The PRTF will work with the youth's OhioRISE care coordinator and the CFT to support planning for transition immediately upon the youth's admission as reflected in the initial and each succeeding individual plan of care. Youth and family/guardian/caregiver voice are components of transition planning. Therefore, their input must be thoroughly considered and discussed throughout the transition planning process.

The PRTF Team will provide a transition action plan detailing week-to-week activities supporting a smooth and well-planned transition from PRTF. At a minimum, the transition action plan must include:

- Ongoing meetings with the youth and family/guardian/caregiver to discuss youth and family/guardian/caregiver strengths, continuing goals, successful strategies, and potential challenges.
- Plans for times during the transition phase when youth and/or family/guardian/caregiver may encounter difficulties that challenge transition. This plan will identify the critical staff necessary to re- focus, rally, and support the youth and family/guardian/caregiver through to transition.
- Action steps that youth and family/guardian/caregiver will take to build on successes and achievements that were accomplished during treatment.

In instances in which a youth may not already be engaged with an OhioRISE care coordinator at time of the PRTF admission, the PRTF Provider will work with Aetna to facilitate referral to a care coordinator and will work directly with the care coordinator and the CFT to support transition planning. The PRTF will not discharge a youth prior to completion of successful treatment, including if the youth temporarily leaves the PRTF for admission to a hospital for medical or psychiatric care, unless the youth is transferred to another PRTF provider whose admission criteria can better meet the youth's treatment needs. This does not permit a PRTF to refuse to discharge a youth when the legal custodian requests discharge. In some situations, it may be appropriate to transition a youth to a different provider or service, in these instances, written details will need to be submitted to Aetna for review and approval.

Transition/Return to the Community Plan

The goal of PRTF treatment is to prepare the youth for the return to the community in the most family-centered or natural setting possible. It is critical that the process of transition planning

begin upon admission and continue throughout the entire course of treatment. The family is supported in being actively involved in the development of the plan for return to the community (or a transition plan for the youth if placement/ permanency goals and/or court directives otherwise define transition goals). The Transition/Return to the Community Plan identifies the family's strengths, needs and cultural values previously identified in the individual plan of care, supports needed by the youth and family after transition from the PRTF and living arrangements of the youth after PRTF treatment is complete. In collaboration with the OhioRISE care coordinator, PRTF providers are expected to:

- Prioritize family/guardian/caregiver involvement in transition planning using a spectrum of practices including family therapy, parent skills training and family support groups. The family/guardian/caregiver is an equal and expert partner in the treatment and transition planning processes.
- Educate and communicate to families and other supports about the shared responsibilities involved in transition planning. Through the youth's CFT, other involved supports, including child-serving systems are invited to remain actively involved with the youth and family while receiving PRTF treatment.
- Identify and address barriers to transition at the onset of treatment.
- Develop realistic goals for completion prior to transition, in collaboration with the interagency team, and include the transition criteria on the individual plan of care. PRTF is an intervention intended to stabilize the youth and promote successful community reintegration.
- Define interventions that work for the youth and ensure that this information is integrated into the transition plan. Educate families/guardians/ caregivers about what interventions have proven to be most helpful to a youth.
- Ensure that therapeutic leaves/ home passes occur early in and throughout the treatment process. They are not to be approved or cancelled based upon behavior but viewed as opportunities to further treatment and transfer skills from the PRTF to the youth's home, school and or community.
- Help families/guardians/caregivers anticipate and respond to behaviors likely to occur during transitions (i.e., honeymooning, anxiety, ambivalence, limit testing).

Transition planning includes all of the following components:

- Transition planning meetings with the CFT at least monthly and more frequently when within 60 days of a planned transition date.
- Identification of triggers for relapse and a relapse prevention plan.
- Identification of family/guardian/caregiver supports.
- The PRTF, in coordination with the CFT, ensures that initial appointments for all follow-up services, including psychiatric medication management, are in place prior to

transition. The first therapy appointment is expected to be scheduled no more than seven days following the transition date.

- Arrangements for appropriate educational placement.

Follow-up Practices:

- Send written transition summaries to all involved systems within 7 days of transition.
- For a reasonable time post transition, PRTF providers will be available for consultation with the CFT team to share knowledge about interventions and practices that have been helpful to the youth in the past and to assist the team in addressing any problems the youth may be experiencing post transition.
- PRTF providers will demonstrate they can work closely and collaboratively with a wider range of referring entities, including CMEs, around care coordination, transition support, planning and transition from PRTF.

Discharge Before Meeting Treatment Goals

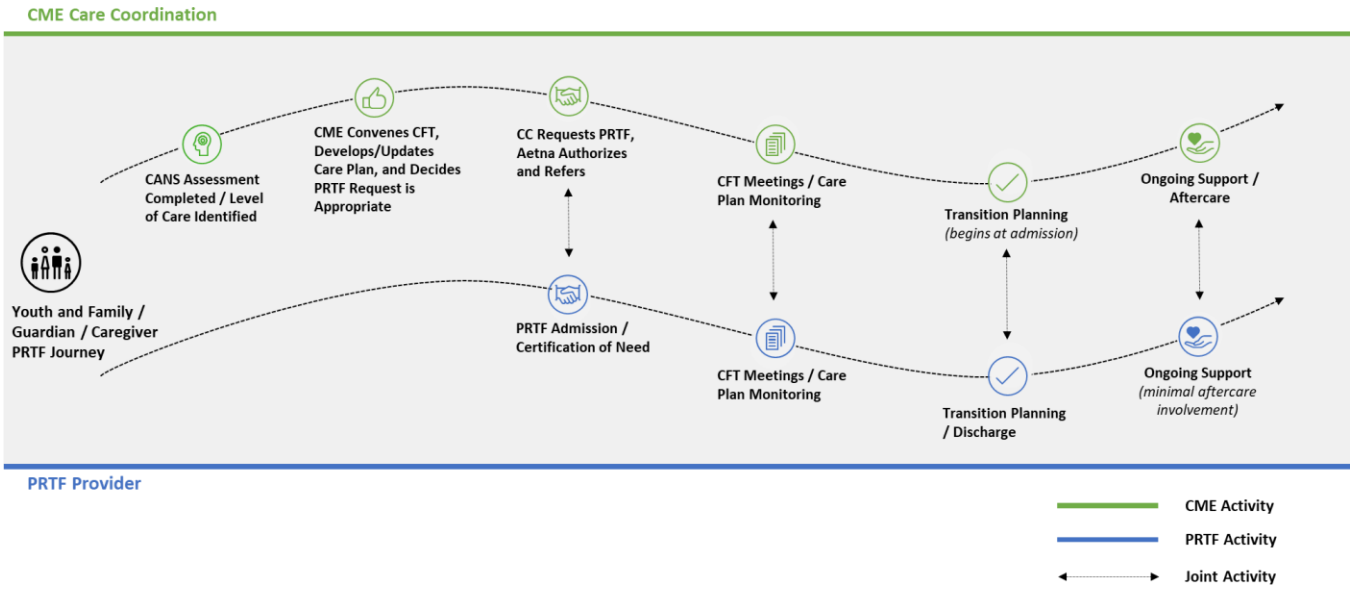
Under no circumstances may a provider discharge a youth without first contacting and receiving written approval from Aetna and the CFT. Once a PRTF has accepted a youth and during the course of treatment has determined that they can no longer adequately meet the needs of the youth, they must notify Aetna as soon as they make this determination, and work with Aetna and the CFT to transition the youth to a more appropriate treatment setting. They are expected to implement measures to help maintain the young person in the PRTF until a safe transition can be made. Issuing of 60-day discharge notices is not an option. The facility must submit this request in writing with supporting documentation. Aetna will make the final determination about disposition for the youth. Careful controls and monitoring regarding the number and type of disputes will be maintained by Aetna and may result in regulatory action within the contract year. Additionally, any eject/reject activities will be addressed at the time of contract renewal.

Section 8: Collaboration with Other System Partners

Collaboration with Aetna and CME Care Coordination

Most youth entering PRTF will already have an OhioRISE care coordinator engaged via a Care Management Entity, FCFC, or Aetna. These care coordinators will continue to provide care coordination, development of the Child and Family Centered Care Plan (CFCP), and ongoing convening of the Child and Family Team, in which the PRTF will participate.

Figure B: CME and PRTF Provider Collaboration on Admissions and Transitions



Collaboration with Children Services, Juvenile Justice, and Courts

PRTF is a medically necessary therapy service that is part of the home- and community-based continuum of services, and one component of a robust system of care.

Some youth receiving PRTF services may be involved with Children's Services, Juvenile Justice and/or courts. PRTFs must establish relationships with Title IV-E entities, PCSAs, courts and the department of youth services to ensure parties are informed of programming, services available and processes for admission. PRTF providers will work with and include these parties, as appropriate, in treatment planning, provision of medical care, and training opportunities.

Section 11: Data and Quality

Aetna is committed to continuous improvement and performance measurement as an important part of our partnership with PRTF providers. As part of that effort, Aetna seeks to actively and regularly collaborate with providers to improve program results. Aetna will include PRTF providers in the network who are focused on improving performance over time and expects all PRTF providers to engage and use data to monitor and understand performance, troubleshoot challenges, spread best practices, and adjust service delivery over time.

The Quality Improvement strategy ensures that quality in PRTFs is not just defined by licensing compliance or operational outputs but is inclusive of real, measurable outcomes that matter to youth, families, and systems.

Key elements include:

•Shared quality framework: Outcomes tracked across five domains—system-level performance, provider practices, post-discharge follow-up, functioning and level of need, and experience of care.

- •Data-driven culture: Standardized measures, such as the CANS, family/youth surveys, and post-discharge tracking, will be used to improve care delivery and drive policy decisions.
- •Collaborative improvement: Providers will collaborate with one another and state partners and share best practices to address issues such as timely referrals, discharge planning, and restraint/seclusion reduction.
- •Continuous feedback loop: Provider feedback and fidelity monitoring will ensure the strategy remains relevant and effective.
- •Public stewardship: Acknowledging that OhioRISE is a public investment, this strategy is designed to demonstrate impact and accountability to state leadership, families, and taxpayers.

The PRTF quality improvement strategy is organized around five domains that reflect the full scope of a youth's residential interventions experience. These domains are designed to align with national best practices, reflect OhioRISE and Ohio priorities, and center the voices of youth, families, and providers.

- Provider measures
- Post-discharge outcomes
- Experience of care
- Youth and family level of functioning
- System performance

Quality Improvement reporting requirements will be coordinated with the individual PRTF to ensure the appropriate level of detail is obtained for monitoring purposes.

Critical Incidents

A PRTF must meet the incident reporting requirements. The objective of reporting and managing critical incidents is to work in conjunction with various delivery systems to ensure the health and welfare of the youth. In addition, tracking critical incidents can:

- Support other investigative entities' open and ongoing critical incident cases.
- Ensure immediate health and welfare of the OhioRISE youth.
- Be used to analyze the root cause of a critical incident for each specific case for the purposes of informing preventative practices.
- Be used to track and trend patterns for the purposes of developing meaningful oversight and best practices for serving youth with multi-system needs.

Critical incidents are defined as follows:

Critical Incidents Definitions	
Incident	**Definition**
Abuse	The injury, confinement, control, intimidation, or punishment of an individual that has resulted in physical harm, pain, fear, or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal, or sexual abuse, or the use of restraint, seclusion or the use of restrictive intervention without authorization from the waiver case management agency, or the OhioRISE plan or its designee
Neglect	When there is a duty to do so, failing to provide an individual with any treatment, care, goods, or services necessary to maintain the health or welfare of the individual.
Exploitation	The unlawful or improper act of using an individual or an individual resources through the use of manipulation, intimidation, threats, deceptions, or coercion for monetary or personal benefit, profit, or gain
Misappropriation	The act of depriving, defrauding, or otherwise obtaining the money, real or personal property (including prescribed medication) of an individual by any means prohibited by law that could potentially impact the health and welfare of the individual.
Unnatural or Accidental Death	Death that could not have reasonably been expected, or the cause of death is not related to any known medical condition of the individual,

	including inadequate oversight of prescribed medication or misuse of prescribed medication.
Self-Harm or Suicide Attempt	Self-harm or suicide attempt that includes a physical attempt by an individual to harm themselves that results in emergency room treatment, in-patient observation, or hospital admission
Lost or Missing	The health and welfare of the individual is at risk due to the individual being lost or missing.

Upon discovering an incident, the PRTF will assure the immediate health and safety of the youth, and immediately afterwards verbally report the incident to the youth's guardian. The PRTF will also immediately, but no later than twenty-four hours after discovering the incident, unless licensure or certification requirements require quicker reporting, verbally communicate to the youth's Care Coordinator. Finally, within the same twenty-four hour window, the PRTF will report the incident to the Aetna OhioRISE plan or its designee by utilizing the IMS form link https://forms.office.com/r/WdgR375Tc5?origin=lprLink sending an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.

The report to OhioRISE must include the name of the resident, a description of the occurrence, and the name, street address, and telephone number of the facility. Providers are also responsible for reporting Potential Quality of Care (PQoC) concerns to Aetna. Aetna Better Health's Quality Management department reviews the practitioner's/provider's report and follows up with the practitioner/provider as necessary to confirm that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.

If you believe an event may be a PQoC, email risepqoc@aetna.com within 2 business days to alert QM staff.

Serious Occurrence Reporting

A PRTF must also report serious occurrences in writing to Aetna by sending an email with Subject Line: 'SERIOUS OCCURRENCE' to PRTFIMS@aetna.com by the close of business the next business day following the incident. A serious occurrence is a youth death or suicide attempt and any serious injury that is results in significant impairment of the physical condition of the youth, as determined by qualified medical personnel (includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else). Staff must document in the resident's record the date and time that the serious occurrence was reported, and the name of the parents, custodian, or legal guardian to whom the incident was reported. A copy of the report must be maintained in the youth's record and in the incident and accident report logs kept by the

facility. In the instance of a youth's death while in the PRTF, the CMS Regional Office must also be notified.

Section 10: Claims Submission

Encounters, Claims, and Billing guidance can be found in Appendix G of this manual.

Section 11: Resources

Resource Title	Description
Building Bridges Initiative (BBI)	BBI is a national initiative working to identify and promote best practice and policy that will create strong and closely coordinated partnerships and collaborations between families/guardians/caregivers, youth, advocates, community and residential service providers, and oversight agencies.
Wraparound Ohio	Wraparound Ohio provides resources that range from research articles on systems of care to intervention and sustainability tools designed for youth, families/guardians/caregivers, their clinicians and communities, supervisors and system leaders, advocates and funders.
The Child and Adolescent Needs and Strengths (CANS)	The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of service.
Ten Principles of the Wraparound Process	The Wraparound theory assumes that, when wraparound is undertaken in accordance with the principles and the practice model specified by the NWI, the result is an effective team process that capitalizes on the expertise and commitment of all team members while also prioritizing the perspectives of the youth and family/guardian/caregiver.
SAMHSA Tip 57: Trauma-Informed Care in Behavioral Health Settings	Gathers experience and information for experts in behavioral health to highlight best practice guidelines to implementing a trauma-informed approach and services

System of Care Definition and Philosophy	A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.
Systems of Care Principles	Guiding principles that include interagency collaboration, individualized strengths-based care, cultural competence, family and youth involvement, community-based services, and accountability.

Section 12: Definitions

Term	Definition
Behavior Plan	A plan for goals that the treatment team and the youth work on to control the youth's behavior.
Comfort Plan	An individualized plan that is established by the youth and staff that includes the youth's personal triggers, warning signs and comfort measures that help the youth calm and self-soothe during periods of distress.
Family/Guardian/Caregiver	The individual/individuals identified in the permanency and concurrent plan that will ultimately support the timely and effective transition of the young person into the community.
Home-like Environment or Home-like	A living environment that provides for positive, nurturing interactions between caregivers and young people which may reduce the tensions of living in a group setting. Home-like environments provide softness and challenge, stability and flexibility, space for shared living and for private moments. Furnishings should be chosen for comfort as well as for durability. The home-like environment should include items such as artwork, artifacts, plants, pillows, and area rugs to add softness. The selection of wall colors, lighting fixtures, furniture, window treatments, floor coverings, and decorative accessories should also enhance the home-like environment. The home-like environment should not compromise the health and safety considerations of the young people residing in the PRTF.

Individual Plan of Care	A plan developed with the family/guardian/caregiver and youth, describing measurable goals that the youth and family/guardian/caregiver want to attain, the interventions, and how progress towards the goals will be monitored with a focus on addressing the issues that are leading to the need for behavioral health services within a PRTF setting.
Psychiatric Residential Treatment Facility (PRTF)	A trauma-informed, inpatient level, intensive multi-disciplinary residential treatment provided in a non-acute setting for young people with complex needs. A PRTF delivers trauma-informed, evidence-based individualized services to young people in order to stabilize behaviors in as short as possible time frame, help young people and their family/guardian/caregiver to develop the knowledge and skills needed to safely manage their needs in the community, so that the young person can succeed in all aspects of community living, e.g., home and family, school, employment, etc.
Safety Plan	A plan developed for staff on how to positively approach a youth when a specific behavior begins to escalate. The safety plan may be implemented in an immediate and expedient manner to manage imminent safety issues by a unit staff member, treatment team member or clinical leadership when a youth's risk behaviors disrupt the milieu.
Serious Injury	Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
Services Plan	A written statement that describes the special education and related services the school district will provide to a parentally placed youth with a disability enrolled in a nonpublic school who has been designated to receive services, including the location of the services and any transportation necessary.
Transition	A young person has met their treatment goals and is transitioning to a community setting or a lower level of residential care including a group home.
Youth	A child, youth, or young adult under the age of twenty-one.

Definitions Related to Restraint and Seclusion

The following definitions shall apply to rules 5122-26-16 to 5122-26-16.1 of the Administrative Code and are in addition to those contained in rule 5122-24-01 of the Administrative Code:

Term	Definition
Advance directives	A legal document used by an adult to direct in advance the mental or physical health treatment in the event the adult lacks the capacity to make such decisions. Two types of advance directives related to mental health treatment are a "Declaration for Mental Health Treatment", and a "Durable Power of Attorney for Health Care".
Behavior management	The utilization of interventions applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to support the individual's recovery and increase the individual's ability to exercise those rights.
Comfort rooms	Adapted sensory rooms that provide sanctuary from stress or can be places for persons to experience feelings within acceptable boundaries. Formerly known as "quiet" or "time-out" rooms.
Emergency safety intervention	The use of restraint or seclusion as an immediate response to an emergency safety situation.
Emergency safety situation	Unanticipated youth behavior that places the youth or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.
Individual crisis plan	A written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of the person's behavior in the early stages of a crisis. It may also be referred to as a "behavior support plan."

Licensed independent practitioner	An individual authorized by the provider to order seclusion and restraint. A licensed independent practitioner includes a "medical practitioner authorized to order seclusion and restraint," as well as any other practitioner that has ordering seclusion and restraint in their scope of practice.
Mechanical restraint	Any method of restricting a person's freedom of movement, physical activity, or normal use of their body, using an appliance or device manufactured for this purpose.
Medical practitioner authorized to order seclusion and restraint	An individual who is authorized by the provider to order seclusion and restraint and who is a psychiatrist or other physician, or a physician's assistant, certified nurse practitioner or clinical nurse specialist authorized to order restraint or seclusion in accordance with his or her scope of practice and as permitted by applicable law or regulation.
Order	Written or verbal authorization to implement seclusion or restraint
Physical restraint	Also known as "manual restraint", means any method of physically restricting a person's freedom of movement, physical activity, or normal use of the person's body without the use of mechanical restraint devices. Transitional holds are not physical restraint.
PRN (pro re nata)	As the situation demands. Orders for seclusion or restraint may not be on a standing or PRN basis.
Prone Restraint	All items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a facedown position. Prone restraint may include either physical (also known as manual) or mechanical restraint.
Qualified person	An employee or volunteer who carries out the agency's tasks under the agency's administration and/or supervision, and who is qualified to utilize or participate in the utilization of seclusion or restraint by virtue of the following: education, training, experience, competence, registration, certification, or applicable licensure, law, or regulation.

Seclusion	The involuntary confinement of a person alone in a room where the person is physically prevented from leaving.
Sensory rooms	Appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.
Time-out	An intervention in which a person is required to remove them self from positive reinforcement to a specified place for a specified period, for the purpose of providing the individual an opportunity to regain self-control. Time-out is not seclusion or restraint, including it does not include physically preventing an individual from leaving a room.

Section 13: Acronyms

Acronym	Definition
ACE	Adverse Childhood Event
ASAM	American Society of Addiction Medicine
BCBA	Board Certified Behavior Analyst
BH	Behavioral Health
CANS	Child and Adolescent Needs and Strengths
CC	Care Coordinator
CFCP	Child and Family-Centered Care Plan
CFR	Code of Federal Regulations
CFT	Child and Family Team
CME	Care Management Entity
CMS	Centers for Medicare and Medicaid Services
CON	Certification of Need
DBH	Ohio Department of Behavioral Health
DCY	Ohio Department of Children and Youth

DEW	Ohio Department of Education and Workforce
DODD	Ohio Department of Developmental Disabilities
DYS	Ohio Department of Youth Services
EMIS	Education Management Information System
ESC	Educational Services Center
FCFC	Ohio Family and Children First Council
IEP	Individualized Education Program
MCO	Managed Care Organization
MH	Mental Health
MI/ID	Mental Illness and Intellectual or Developmental Disability
MOU	Memorandum of Understanding
OAC	Ohio Administrative Code
OCALI	Ohio Center for Autism and Low Incidence
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODM	Ohio Department of Medicaid
OT	Occupational Therapy
PCSA	Public Children Services Agency
PRTF	Psychiatric Residential Treatment Facility as defined by 42 C.F.R. 483.354, as authorized under section 1905 (a)(16) and (h) of the Social Security Act.
PT	Physical Therapy
QRTP	Qualified Residential Treatment Program
SA	Survey Agency

SAMHSA	Substance Abuse and Mental Health Services Administration
SOC	Systems of Care
TTG	Targeted Treatment Goal

Appendix A: PRTF Provider CMS Attestation Form

Per CMS requirements, the facility's executive director, chief executive officer, president, or similar position must provide an attestation certifying it is compliant with CMS standards governing the use of restraint and seclusion. A copy of this attestation must be provided to ODM within seven calendar days of enrolling as a PRTF provider, by July 21 each year, and at any time the individual with the legal authority to obligate the facility is no longer in such position.

Appendix B: Certification of Need

42 C.F.R. 441.152 requires Certification of Need for Psychiatric Residential Treatment Facility (PRTF) services to be documented in the youth's PRTF record. The below has been created as a template for Ohio's PRTFs to meet this requirement.

The CON should be completed, signed by the appropriate PRTF interdisciplinary treatment team members as noted below, and stored in the youth's record within 14 days of admission.

Upon or before admission, the PRTF provider will obtain the Certification of Need, signed by a psychiatrist or another physician and a licensed mental health professional, that certifies:

- Ambulatory care resources available in the community do not meet the treatment needs of the youth;
- Proper treatment of the youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the youth's condition or prevent further regression so that the services will no longer be needed.

Appendix C: PRTF Clinical Criteria

Service/Admission Guidelines	
Continued Stay Criteria (Youth Specific)	All of the following criteria are necessary for continuing treatment at the PRTF intensity of service: A. There is evidence that the youth continues to demonstrate severe emotional or behavioral symptoms that continue to impact/impair functioning, and continue to require the PRTF intensity of service. B. The Ohio Children's Initiatives CANS Assessment and/or other relevant information indicate the youth continues to need the PRTF Intensity of Service. C. The youth's treatment does not require a higher Intensity of Service treatment program or a lower Intensity of Service treatment program. D. Services at this Intensity of Service continue to be required to support reintegration of the youth into a less restrictive environment. E. The youth and the parent/guardian/caregiver or other individuals identified by the youth are actively participating in treatment, to the fullest extent possible. F. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved and adjustments in the individual plan of care include strategies for achieving these unmet goals for those instances where, during a continued stay review, a youth does not appear to be

	progressing, the team has developed an alternative approach to treatments and supports to be trialed over the next stay review period, with clearly identified milestones and timelines to monitor progress. G. There is documented evidence of active, individualized transition planning.
Continued Stay Criteria (PRTF Responsibility)	A. The individual plan of care is appropriate to the youth's presenting treatment needs, with realistic and specific goals and objectives that include target dates for accomplishment. B. Individualized services and treatments are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice. C. When clinically necessary, appropriate psychopharmacological evaluation has been completed and ongoing treatment is initiated and monitored.
Transition Criteria	Please indicate which of the following criteria are met for transition: **Required for all transitions; others as they apply to individual youth/family/caregivers:* A. *The youth's documented treatment plan goals and objectives for this intensity of service, as reported in the youth's individual plan of care, have been met or have documented progress and barriers toward meeting goals. B. *There is documented justification that youth meets the criteria for a higher intensity of service treatment program or a lower intensity of service treatment program. C. *The youth and the youth's family/guardian/caregiver have been connected to OhioRISE Care Coordination. D. The youth and/or the parent/guardian/ caregiver are competent but non-participatory in treatment or non-adherent with the treatment program's rules and regulations. The nonadherence is significant enough to negatively impact the overall treatment course and compromises the youth's ability to have a successful, positive response to treatment. Attempts at ongoing engagement to increase participation and adherence should be documented in the youth's treatment plan over time before the consideration of a placement/treatment transition. E. There has been limited progress toward treatment goals with no reasonable expectation of progress at this intensity of service, despite attempts to modify and revise the individual plan of care for the benefit of the youth. F. The Ohio Children's Initiatives CANS Assessment and/or other relevant information indicate that the youth needs a higher

	intensity treatment program or a lower intensity treatment program. G. Consent for treatment is withdrawn by the family/guardian/ caregiver and/or the youth. H. Young person transitioning from PRTF to independent living, or adulthood, ensure that support systems and specific therapeutic services to maintain stability in a lower level of care have been identified and set up prior to transition. I. A youth's support systems and specific therapeutic services (which allow the youth to be maintained in a lower Intensity of Service treatment program) have been identified, documented and set up prior to the transition of the youth. Ideally, the youth and community-based treatment provider have had at least one, if not more, transition sessions prior to the transition occurring. J. *A comprehensive transition plan has been developed with family/guardian/caregiver along with the child and family team to include contingency planning to address any significant changes for the youth after transition and includes local community supports and services, which includes a follow-up appointment within seven calendar days of transition.

Appendix F: Cross-System Incident Reporting Requirements

Upon discovering an incident, the PRTF assures the immediate health and safety of the youth, and immediately afterwards verbally report the incident to the youth's guardian. The PRTF also immediately, but no later than twenty-four hours after discovering the incident, unless licensure or certification requirements require quicker reporting, verbally communicates to the youth's Care Coordinator and guardian. Finally, within the same twenty-four-hour window, the PRTF reports the incident to the Aetna OhioRISE plan or its designee by sending an email with Subject Line: 'CRITICAL INCIDENT' to PRTFIMS@aetna.com.

Incident	Report Location
Suicide (includes attempt)	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death or Critical Incident (Suicide Attempt)
Homicide by Client	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death
Accidental Death	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death
Physical Abuse	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Sexual Abuse	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Neglect	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Neglect)
Defraud	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Misappropriation)
Involuntary Termination without Appropriate Client Involvement	PRTF reports to Aetna OhioRISE Aetna not required to report to ODM at this time
Sexual Assault by Non-staff, including a visitor, client or other	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Physical Assault by Non-Staff including Visitor, Client, or Other	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Medication Error	PRTF reports to Aetna OhioRISE Aetna not required to report to ODM at this time
Adverse Drug Reaction	PRTF reports to Aetna OhioRISE Aetna not required to report to ODM at this time
Employee Theft of Medication	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Misappropriation)
Medical Events Impacting	PRTF reports to Aetna OhioRISE

Provider Operations	Aetna not required to report to ODM at this time
Temporary Closure of One or more Provider Sites	PRTF reports to Aetna OhioRISE Aetna not required to report to ODM at this time
Inappropriate Use of Seclusion or Restraint	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Use of Seclusion/Restraint by a Provider without Prior Notification that the Provider Permits the Use of Seclusion or Restraint	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Seclusion/Restraint related Injury to Client	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS)= Critical Incident (Abuse)
Seclusion/Restraint related Death	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Unnatural Death or Critical Incident (Suicide Attempt)
Seclusion	If physical harm: PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Mechanical Restraint	If physical harm: PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Physical Restraint excluding Transitional Hold	If physical harm: PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Transitional Hold	If physical harm: PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Seclusion/Restraint related Injury to Staff	If non-approved restraint: PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)
Exploitation	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS)= Critical Incident (Exploitation)
Natural Death	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS)= Critical Incident (Death)
Lost or Missing	PRTF reports to Aetna OhioRISE Aetna not required to report to ODM at this time
Inappropriate Restraint Techniques and other Use of Force	PRTF reports to Aetna OhioRISE Aetna enters in ODM's Incident Management System (IMS) = Critical Incident (Abuse)

Methods prohibited:
1. Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises
2. Any technique that restricts the client's ability to communicate
3. Any technique that obstructs vision
4. Any technique that obstructs the airways or impairs breathing, including placing a cloth or other item over an individual's mouth or nose
5. Use of mechanical restraint on a client under age 18
6. A drug or medication that is used as a restraint to control behavior or restrict the client's freedom of movement and is not a standard treatment or dosage for the client's medical or psychiatric condition or that reduces the client's ability to effectively or appropriately interact with the world around him/her
7. The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and tasers

Appendix E: Aetna Better Health of Ohio's Encounters, Billing, and Claims Guidance

Provider Network Management (PNM) System Overview

Under Ohio Next Generation of Managed Care, the introduction of Provider Network Management System was developed to help providers, managed care organization and entities (MCEs), and Ohio Department of Medicaid (ODM) to improve data exchanges. The new system will replace the current MITS system and provider portal. The PNM module serves as the single-entry point for secure portal functions such as claims submissions, prior authorizations, and member eligibility verification. For more information, please refer to: https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Overview

Aetna Better Health of Ohio processes claims for covered services provided to members in accordance with applicable policies and procedures, and in compliance with applicable state and federal laws, rules, and regulations. On February 1, 2023 the Fiscal Intermediary (FI) began processing of claims via the Electronic Data Interchange (EDI). Fee-for-service claims submitted to the EDI are processed, adjudicated, and paid by the FI. Managed care claims submitted via the EDI will be routed to the MCOs for processing, adjudication, and payment. Additional FI functionality will come later related to portal claims submitted via the PNM portal. Providers, trading partners, and managed care entities will not directly interact with the FI.

Billing Encounters and Claims Overview

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the claim processing system.

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing.

- A member may be billed only when the member knowingly agrees to receive non-covered services under the OhioRISE plan.
- Provider MUST notify the member in advance that the charges will not be covered under the program.

- Provider MUST have the member sign a statement agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims are to be submitted electronically to through the ODM Fiscal Intermediary/EDI using the Payer ID#: 45221. Before submitting a claim through your clearinghouse, please make sure your clearinghouse is compatible with the FI.

Clean Claims

We require clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received in a timely manner. Our timely filing limitations are as follows:

Participating Providers:

- New Claim Submissions – Please consult your contract for your contractual timely filing limit for new claims. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Non-Participating Providers New Claim Submissions:

- Claim submissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.
- Claim Disputes and Resubmissions – Claim disputes and corrected claims must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

How to File a Claim

Beginning February 1, 2023, all claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the health plan for processing and payment.

Injuries Due to an Accident

Medicare and Medicaid laws only permit subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e., auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

Important Points to Remember

We do not accept direct Electronic Data Interchange (EDI) submissions from our providers. We do not perform any 837 testing directly with our providers but perform such testing with Change Healthcare.

Correct Coding Initiative

We follow the same standards as Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit: http://www.cms.hhs.gov/NationalCorrectCodInitEd/ .

We utilize ClaimsXten as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies. Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection.
Clear Claim Connection is a web-based, stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimsXten. It enables us to share with our providers, the claim auditing rules, and clinical rationale inherent in ClaimsXten.

Providers will have access to Clear Claim Connection through our website (https://www.aetnabetterhealth.com/ohiorise/index.html) and a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim, so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers

In order to communicate detailed information in an efficient, standardized way, modifiers are two character suffixes that healthcare providers or coders attach to a CPT or HCPCS code to provide additional information about the practitioner or procedure. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims. Procedure modifiers designated to practitioner type and licensure level are required for OhioRISE in order to describe specific circumstances and align appropriate rate pricing.

Applicable behavioral health provider type and specialty modifiers can be found in the Provider Requirements and Reimbursement Manual. Please see this reference for more information: https://bh.medicaid.ohio.gov/Portals/0/2-1-2022%20BH%20Manual%20FV%201_21.pdf

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website http://www.aetnabetterhealth.com/Ohio/ or by calling the Claims Inquiry Claims Research (CICR) Department **1-833-711-0773 (option 2)**.

Online Status Through the Secure Web Portal

We encourage providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims.

Provider Experience

The Provider Experience Department:

- Answer questions about claims.
- Assist in resolving problems or issues with a claim.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim.
- Correct errors in claims processing:
    - Excludes corrections to prior authorization numbers (providers must call the Prior Authorization Department directly).
    - Excludes rebilling a claim (the entire claim must be resubmitted with corrections). Please be prepared to give the service representative the following information:
- Provider name or NPI number with applicable suffix if appropriate.
- Enrollee name and enrollee identification number.
- Date of service.
- Claim number from the remittance advice on which you have received payment or denial of the claim.

Payment in Full Information

The OhioRISE payment for any covered services constitutes payment in full and OhioRISE will ensure its subcontractors do not charge members, their custodians, or ODM any additional co-payment, cost sharing, down payment, or similar charge, refundable or otherwise.

Payment of Claims

We process claims and notify providers of outcomes using a remittance advice. Providers may choose to receive checks through the mail or electronically. We encourage providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than remittance advice received through the mail, enabling you to post payments sooner. **Beginning February 1, 2023**, all managed care claims submitted by trading partners, with dates of service on and after February 1 must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the selected MCEs for processing and payment. Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal. Aetna will conduct the usual adjudication of the claim. Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment from the OhioRISE plan will be made on separate check. Aetna Better Health is partnering with Change Healthcare to introduce the new EFT

Registration Services (EERS), a better and more streamlined way for our providers to access payment services.

EERS will offer providers a standardized method of electronic payment while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage EFT with multiple payers on a single platform.
EERS will give payees multiple ways to set up EFT in order to receive transactions from multiple payers. If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.
Providers who currently use Change Healthcare as a clearinghouse will still need to complete EERS enrollment, but providers who currently have an application pending with Change Healthcare will not need to resubmit. Once enrolled, payees will have access to the Change Healthcare user guide to aid in navigation of the new system.

How and When Do I Enroll?

All Aetna Better Health plans will migrate payee enrollment and verification to EERS. To enroll in EERS, please visit https://payerenrollservices.com/.
For questions or concerns, please reach out to your Aetna Provider Network team or visit the Change Healthcare FAQ page.

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.
Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Instruction for Specific Claim Types

General Claims Payment Information

Our claims are always paid in accordance with the terms outlined in your Provider Agreement. Prior authorized services from non-participating health providers will be paid in accordance with Medicaid claim processing rules.

Same Day Readmission

Providers submitting claims for inpatient facilities should use the CMS 1450 electronic format.

There may be occasions where a member may be discharged from an inpatient facility and then readmitted later that same day. We define same day readmission as a readmission with twenty-four (24) hours of discharge. For example: Discharge Date: 10/2/20 at 11:00 a.m. / Readmission Date: 10/3/20 at 9:00 a.m.

Since the readmission was within twenty-four (24) hours, this would be considered a same day readmission per above definition.

Provider Remittance Advice

We generate checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to make certain proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission. Providers who are interested in receiving electronic remittance advices from the new EDI will need to sign up. Providers must have enrolled using the ODM-06306 835 designation form which is located Authorized Trading Partners (ohio.gov). By using this form, providers will receive all 835 electronic remittance advices (ERA) from all payers, i.e., Change Healthcare and MCEs. The PDF versions of the remittance advices from all payers will be available via the PNM portal.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Ohio for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment, depending on the terms of the Provider Agreement.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Ohio due to overpayment.

- Reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of “REVERSED” in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Ohio after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically, then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed, along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number. The Claim Header area of the remit lists information pertinent to the entire claim. This includes:

- Member Name
- ID
- Birth Date
- Account Number
- Authorization ID, if obtained
- Provider Name
- Claim Status
- Claim Number
- Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.

The Message at the end of the remit contains claims inquiry and resubmission information, as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for Electronic Remittance Advice (ERA), you must currently submit claims through Electronic Data Interchange (EDI) submissions and receive payment for claim by Electronic Funds Transfer (EFT). You must also have the ability to receive ERA through 835 files. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to

receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process.

Encounter Data Management (EDM) System

Aetna Better Health of Ohio uses an Encounter Data Management (EDM) System that warehouses claims data and formats encounter data to the Ohio Department of Medicaid (ODM) requirements. The EDM System also warehouses encounter data from vendors and formats it for submission to the ODM. We use our state-of-the-art EDM System to monitor data for accuracy, timeliness, completeness, and we then submit encounter data to the ODM. Our EDM System processes CMS1500, UB04 (or UB92 claims and the most current coding protocols (e.g., standard CMS procedure or service codes, such as ICD-10, CPT-4, HCPCS-I, II). Our Provider Agreements require providers to submit claims on the approved claim form and each claim must contain the necessary data requirements. Part of our encounter protocol is the requirement for providers to utilize National Drug Code (NDC) coding in accordance with the ODM's requirements.

The EDM System has top-of-the-line functionality to track encounters accurately and consistently throughout the submission continuum including collection, validation, reporting, and correction. Our EDM System is able to electronically accept a HIPAA compliant 837 (I and/or P) electronic claim transaction, 835 Claim Payment/Advice transaction, and the National Council for Prescription Drug Programs (NCPDP) transaction in standard format. We require our providers and their clearinghouses to send electronic claims in these formats. We collect claims information from multiple data sources into the EDM System for processing, including data from our claims adjudication system, as well as data from third-party vendors under contract to process various claims. Our EDM System accommodates all data sources and provides a single repository for the collection of claims/encounters. Through our EDM System, we conduct a coordinated set of edits and data checks and identify potential data issues at the earliest possible stage of the process. Below we describe in more detail the different checkpoints.

Encounter Data

Aetna Better Health requires the submission of all processed claims data for encounter data collection by the State of Ohio. Failure to follow the same standards as the Correct Coding Initiative (CCI) will result in a claims payment denial.

Claims Processing

Our business application system has a series of active claim edits to determine if the appropriate claim fields contain the required values. We deny, completely or in part, claims submitted without required information or with invalid information. The provider is required to resubmit the claim with valid information before they receive payment. After adjudication and payment, we export claims data from our business application system into our EDM System. Our Encounter Management Unit validates the receipt of all the business application system

claims data into EDM System using a transfer validation report. The Encounter Management Unit research, tracks, and reports any discrepancy until that discrepancy is completely resolved.

Another critical step in our encounter data correction process is the encounter error report. We generate this report upon receipt of response files from ODM and give our Encounter Management Unit critical information to identify and quantify encounter errors by type and age. This data facilitates the monitoring and resolution of encounter errors and supports the timely resubmission of corrected encounters.

Appendix F: Aetna Better Health of Ohio's Non-Discrimination Notice

Aetna Better Health® of Ohio follows state and federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, sex, gender identity, sexual orientation, religion, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, or geographic location.

If you would like to file a complaint, please contact Aetna Better Health by either:

Mail:

Aetna Better Health
7400 W Campus Rd, Suite 200
New Albany, OH 43054

Phone:

1-833-711-0773 (TTY: 711)

Email: OhioRISEMemberServices@Aetna.com

If you would like to file a complaint with Health and Human Services Office for Civil Rights, please go to **https://ocrportal.hhs.gov/ocrsmartscreen/main.jsf** or by mail or phone at:

Mail:

U.S. Department of Health and Human Services
200 Dependence Avenue, S.W.
Washington, D.C. 20201

Phone:

1-800-368-1019, TDD: 1-800-537-7697

Language Assistance, Interpretation Services, and Auxiliary Aids

ENGLISH: To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to, oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling Aetna Better Health Member Services at **1-833-711-0773 (TTY: 711)**

SPANISH: Para ayudarle a entender este aviso, disponemos de asistencia lingüística, servicios de interpretación y ayudas y servicios auxiliares si los solicita, sin costo alguno para usted. Los servicios disponibles incluyen, entre otros, traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando al Departamento de Servicios para Miembros de Aetna Better Health al **1-833-711-0773 (TTY: 711)**.

NEPALI: यो सूचना तपाइलाइ बु सहायता गन तपाइको ि न ि नः शु पमा आग्रह गनुभएअनुसार भाषाको सहायता, अनुवादका सेवाह र थप सहायता र सेवाह उपल छन्। सम्पेशभएका सेवाह उपल छन् तर मौखक अनुवाद, ि लखत अनुवाद र थप सहायतामा सीि मत छ्न्। तपाइले **1-833-711-0773 (TTY: 711)** मा Aetna Better Health सद सेवाहमा फोन गरेर यी सेवाह र/वा थप सहायता आग्रह गन स ुन्छ।

مساعدتك في فهم هذا الإخطار، تتوفر المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات والخدمات المعينة عند الطلب مجانا .تشمل الخدمات المتاحة، على سبيل المثال لا الحصر، الترجمة الشفوية والترجمة الكتابية والمساعدات المعينة .يمكنك طلب هذه الخدمات و أو المساعدات الإضافية عن طريق الاتصال بخدمات أعضاء Aetna Better Health على الرقم 0773 -711—833-1 **(TTY: 711)**

SOMALI: Si lagaaga caawiyo fahanka ogaysiiskan, kaalmada luqadda, adeegyada turjumaada hadalka ah, iyo qalabka kaalmada naafada iyo adeegyada waxaa la heli karaa marka la codsado iyagoon kharash kugu taagnayn adiga. Adeegyada la heli karo waxaa ku jira, laakiin kuma xadidna, turjumaada hadalka, turjumaada qoran, iyo qalabka kaalmada naafada. Waxaad codsan kartaa adeegyada iyo/ama qalabka kaalmada naafada addoo soo wacaya Adeegyada Xubinta Aetna Better Health lambarka **1-833-711-0773 (TTY: 711)**

RUSSIAN: Если вам нужна помощь в понимании данного уведомления, вы можете обратиться за языковой поддержкой, услугами устного перевода, а также вспомогательными средствами и услугами, которые по запросу оказываются бесплатно. Доступные услуги включают, помимо прочего, устный перевод, письменный перевод и вспомогательные средства. Вы можете обратиться за данными услугами и/или вспомогательными средствами в отдел обслуживания участников Aetna Better Health по телефону **1-833-711-0773 (TTY: 711)**

FRENCH: Pour vous aider à bien comprendre cet avis, vous pouvez faire appel à des services gratuits d'interprétation et d'aide auxiliaire. Par exemple, vous pouvez vous faire traduire un texte par oral ou par écrit, ou encore bénéficier d'autres services auxiliaires. Pour solliciter ces services et/ou une aide auxiliaire, appelez le service réservé aux membres Aetna Better Health au 1-833-711-0773 **(TTY: 711)**

VIETNAMESE: Để giúp quý vị hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ thông dịch, và các dịch vụ và hỗ trợ phụ trợ được cung cấp miễn phí theo yêu cầu cho quý vị. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn, dịch nói, dịch văn bản và các hỗ trợ phụ trợ. Quý vị có thể yêu cầu các dịch vụ này và/hoặc hỗ trợ phụ trợ bằng cách gọi cho Dịch vụ Hội viên của Aetna Better Health theo số 1-833-711-0773 **(TTY: 711)**

SWAHILI: Ili kukusaidia kuelewa ilani hii, usaidizi wa lugha, huduma za ukalimani na vifaa vya kusikia na huduma zinapatikana ukiomba bila malipo yoyote. Huduma hizi ni pamoja na, bila kuishia kwa hizi tu, tafsiri ya mdomo, tafsiri ya maandishi na vifaa vya kusikia. Unaweza kuomba huduma hizi na/au vifaa vya kusikia kwa kupigia simu Aetna Better Health Member Services kwa nambari **1-833-711-0773 (TTY: 711)**

UKRANIAN: Щоб допомогти вам зрозуміти це повідомлення, за запитом вам безкоштовно може надаватися мовна допомога, послуги перекладу, а також допоміжні засоби й послуги. Такі послуги включають, крім іншого, усний переклад, письмовий переклад та допоміжні засоби. Ви можете замовити ці послуги та/або допоміжні засоби, зателефонувавши в службу підтримки учасників Aetna Better Health за номером **1-833-711-0773 (TTY: 711)**

CHINESE (TRADITIONAL): 為幫助您理解本通知，我們可應您的要求免費提供語言協助、口譯服務以及輔助設備和服務。提供的服務包括但不限於口譯、筆譯以及輔助設備。您可致電 Aetna Better Health 會員服務部，要求獲得這些服務和/或輔助設備，電話號碼為：**1-833-711-0773**（**TTY：711**）

KINYARWANDA: Kugira ngo ufashwe gusobanukirwa neza iri tangazo, ubufasha mu by'ururimi, serivisi z'ubusemuzi n'ibikoresho bifasha abafite ubumuga bwo kutumva na serivisi bijyanye biboneka bisabwe kandi nta mafaranga wishyuzwa. Serivisi ziboneka harimo, ariko ntabwo zigarukira gusa ku, busemuzi, ubusemuzi bw'inyandiko n'ibikoresho bifasha abafite ubumuga bwo kutumva. Ushobora gusaba izo serivisi cyangwa

ibikoresho bifasha abafite ubumuga bwo kutumva uhamagaye Aetna Better Health Member Services kuri **1-833-711-0773 (TTY: 711)**

CHINESE (SIMPLIFIED): 为帮助您理解本通知，我们可应您的请求免费提供语言援助、口译服务以及辅助设备和服务。提供的服务包括但不限于口译、笔译以及辅助设备。您可致电 Aetna Better Health 会员服务部，请求获得这些服务和/或辅助设备，电话号码为：**1-833-711-0773 (TTY: 711)**

په دي خبرتيا د پوهيدو په برخه کي ستاسو سره د مرستي لپاره، د غوښتني په صورت کي د ژبې اړوند مرستې، د ژباړي خدمتونه، او مرستندويې کومکونه او خدمتونه پرتې لې کوم لګښت څخه ځنې لري. په ځنې خدمتونو کې شفاهي ژباړه، لیکلې ژباړه، او مرستندويې کومکونه شامل دي، خو تر دې پورې محدود ندي. تاسو کولی شئ د Aetna Better Health 1-833-711-0773 **(TTY: 711)** غږ خدمات تې په

تلیفون کولو سره د دي خدماتو اولیا فرعي مرستو غوښتنه وکړئ

AMHARIC: ይህን ማሳሰቢያ እንዲረዱት ሊያግዝዎ የሚያስችሉ የቋንቋ እርዳታ፣ የትርጉም አገልግሎቶች፣ እና ተያያዥ ድጋፎች እና አገልግሎቶች ሲጠይቁ እርስዎ ምንም ወጪ ሳያወጡ ማግኘት ይችላሉ። ያሉት አገልግሎቶች የቃል ትርጉም፣ የጽሁፍ ትርጉም፣ እና ተያያዥ ድጋፎች እና ሌሎችን ይጨምራል። እነዚህን አገልግሎቶች እና/ወይም ተያያዥ ድጋፎችን ወደ Aetna Better Health የአባል አገልግሎቶች በ **1-833-711-0773 (TTY: 711)** በመደወል መጠየቅ ይችላሉ።

GUJARATI: આ સૂચનાને સમજવામાાં તમારી મદદ કરવા માટે, ભાષા સહાય, દુભાિષયા સેવાઓ અને વધારાની સહાય અને સેવાઓ િવનાંતી કરવા પર તમારા માટે કોઈપણ ખચ િવના ઉપલબ્ધ છે. ઉપલબ્ધ સેવાઓમાાં મૌિખક અનુવાદ, લેિખત અનુવાદ અને વધારાની સહાયનો સમાવેશ થાય છે, પરાંતુ સેવાઓ એટલા સુધી મયાિદત નથી. તમે Aetna Better Health Member Servicesને **1-833- 711-0773 (TTY: 711)** પર કૉલ કરીને આ સેવાઓ અને/અથવા વધારાની સહાયની િવનાંતી કરી શકો છો.

Appendix G: OhioRise Member Rights

Providers will be aware of and observe the rights afforded to OhioRISE members as follows:
As a member of OhioRISE, patients have the following rights:

- To receive all information and services that OhioRISE must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information is kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To participate with providers in making decisions relating to your healthcare.
- To be able to take part in decisions about your healthcare as long as the decisions are in your best interest.
- To get information on any medical care treatment, given to you in a way that you can understand.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal and state regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say “yes” or “no” to having any information about you given out unless OhioRISE must do so by law.
- To say “no” to treatment or therapy. If you say no, the provider or an OhioRISE care coordinator must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See page 33 of this handbook to learn more.
- To get help free of charge from OhioRISE and its providers if you do not speak English or need help in understanding information.
- To get all written member information from OhioRISE:
    - At no cost to you.
    - In the prevalent non-English languages of members in OhioRISE’s service area.
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To get help with sign language if you are hearing impaired.
- To be told if the healthcare provider you see is a student and to be able to refuse their care.
- To be told of any of the care you might get is experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will).
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To be free to carry out your rights and know that OhioRISE, OhioRISE’s providers or the Ohio Department of Medicaid will not hold this against you.
- To know that OhioRISE must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- To get a second opinion from a qualified provider in OhioRISE’s network. If a qualified provider is not able to see you, OhioRISE must set up a visit with a provider not in our network.