

Service Definitions: Psychiatric Residential Treatment Facility – (PRTF-MI/ID)**Date Created: July 18, 2023****Date Revised: July 10, 2026**

Psychiatric Residential Treatment Facility (PRTF MI/ID) is a highly structured inpatient level of care in a community-based setting for Medicaid eligible persons under the age of twenty-one (21) years. PRTF provides comprehensive and specialized treatment interventions to youth with complex (and often chronic) behavioral health needs and with a co-occurring MI/ID, and their families. Services provided at PRTFs are trauma-informed, occur seven days a week, 24 hours a day, and are conducted under the direction of a physician.

PRTF MI/ID is part of the continuum of community-based mental health services in Ohio, where youth with significant behavioral health and co-occurring MI/ID needs will receive intensive treatment in a residential setting focused on improving the youth's behavioral health condition to the point where this level of care is no longer necessary, and the youth can return to their home or prior care setting.

Recommendations for PRTF should be made by the member's Child and Family Team (CFT) via the member's OhioRISE Care Coordinator (CC) and include a recommendation from a qualified prescribing provider or by an independently licensed clinician, each with behavioral health expertise and direct observation of the youth's condition. In situations where a current inpatient psychiatric hospitalization is the qualifying event for entry into OhioRISE, the treating hospital can recommend PRTF for the new OhioRISE member through their assigned Aetna OhioRISE Transition of Care (TOC) Coordinator. Aetna determines if a youth meets medical necessity criteria.

Clinical Criteria for PRTF-MI/ID**Admission
Criteria**

At the time of admission, youth meets **ALL** criteria: A through K.

- A. The youth meets the age range for the specific PRTF MI/ID program.
- B. The youth has been determined eligible for services by the county board of developmental disabilities.
- C. The youth presents with symptoms consistent with a DSM 5 behavioral health disorder, as well as a co-occurring intellectual or developmental disability, and requires intensive out-of-home therapeutic intervention.
- D. The youth is in need of 24-hour staff supervision due to emotional and/or behavioral challenges in the home and/or community to such an extent that:
 - 1. The psychological or physical safety of the youth or others is at risk; and/or

	2. The youth has been (or is) unable to function in regular community, home, or school activities due to significant symptoms and/or behaviors. The Ohio Children's Initiatives CANS Assessment and/or other relevant clinical information indicate that the youth's presenting treatment needs are consistent with PRTF intensity of service. E. The youth cannot successfully and safely function in a non-clinical setting or less restrictive setting and requires behavior supports and close supervision. Common behavioral issues may include irritability, emotional outbursts, (often due to anxiety, phobias, and compulsions or at times of transition); oppositional behaviors toward tasks of daily living (tactile sensitivities, comprehension problems); resisting requests to change task or shift from one activity to another. Such challenging/risk taking behaviors may manifest as, but are not limited to: 1. Physical aggression and/or property destruction (possibly due to trauma, poor communication skills, etc.) 2. Low frustration level, social isolation, involvement with negative peer groups, etc., which may result in behavior that leads to juvenile justice involvement, home and school disciplinary issues, psychiatric hospitalization; etc. 3. Verbal threats to peers, parents, authority figures, etc. 4. Problematic sexual behavior (possibly due to lack of insight about boundaries / health relationships, misinterpreted social cues, communication limitations, exposure to sexually explicit material, or sexual abuse victimization) that does not require sex offense specific treatment. 5. History of substance use that does not require specialized substance use treatment. 6. Elopement behavior (including AWOL and bolting); 7. Isolated fire play/setting (low risk); fire setting evaluation is required if fire setting behaviors have occurred within the past 2-year period. 8. Minor legal infractions (e.g., truancy, curfew, repeated probation violations, etc.) and/or at risk of involvement in the juvenile justice system due to poor judgment and/or impulse control.
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	F. The youth exhibits receptive and expressive language skills and reasoning skills or exhibits only mild impairment in this area. G. Based upon information provided in a completed clinical assessment, the youth exhibits limitations in his/her functional capacity within school, home, and the community. H. The youth presents as able to benefit from the PRTF-MI/ID services, such as the utilization of direct support, skills training, and therapeutic services delivered at this intensity of service. I. As a result of youth's intellectual/developmental disability and co-occurring behavioral health disorder, the youth is unable to consistently function independently in significant life domains potentially involving: self-care without prompts and limited support, self-direction, capacity for independent living, or economic self-sufficiency. J. Close supervision, monitoring, and targeted clinical/behavioral intervention are indicated to improve the youth's ability to adequately function and work toward proficiency in the identified functional domains. K. PRTF treatment must be recommended by a qualified prescribing provider or by an independently licensed clinician, each with behavioral health expertise and direct observation of the youth's condition.
Exclusion Criteria	Any of the following is sufficient for exclusion from the PRTF MI/ID intensity of service: A. The youth is at imminent risk of causing serious harm to self or others. B. The youth (18 or older) and/or the family/guardian/ caregiver does not voluntarily consent to treatment. C. The youth has a sole diagnosis of an Intellectual/Developmental Disability and there are no co-occurring diagnoses, symptoms, or behaviors consistent with a DSM 5 mental health diagnosis. D. The youth is unable to perform skills of daily living without total supports and requires interventions that go beyond the capability of this setting.

	E. The youth has a medical condition or impairment that would prevent participation in services and that require daily care that is beyond the capability of this setting. F. The youth has one or more medical conditions that requires treatment by an on-site Registered Nurse/LPN 24-hours a day, including but not limited to: oral or nasal suctioning, intravenous medications, tube feeding, dialysis monitoring, or catheterization. G. The youth requires absolute physical assistance with transfers and mobility. H. The youth's cognitive functioning falls below a moderately impaired level and the severity of cognitive impairment does not allow him/her to actively participate in this type of milieu and therapeutic intervention.
Continuing Stay Criteria (Youth Specific)	All of the following criteria are necessary for continuing treatment at this intensity of service: A. The severity of the behavioral/emotional disturbance continues to meet the criteria for the PRTF-MI/ID 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. Treatment 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.

	G. There is documented evidence of active, individualized transition planning.
Continuing 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. D. When clinically necessary, coordination of neuropsychological testing as an additional diagnostic tool to guide the plan of care.
Transition Criteria	The following criteria are for transition (<i>*indicates</i> must be met for transition): 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 are connected with OhioRISE Care Coordination. D. The youth and 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. 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. Youth 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 system and specific therapeutic services (which allow the youth to be maintained in a lower intensity of service treatment 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. K. *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 (7) calendar days of transition.
Service Exclusions	Limitations • Services provided by the PRTF beyond those described may only be provided if authorized in accordance with rule 5160-59-03.1 of the Administrative Code. • Payment for physician, outpatient, and community behavioral health services outside of a PRTF, except for those identified in the child and family-centered care plan as necessary for the youth’s successful transition to a lower level of care, is not allowable when a youth is in a PRTF. This includes:

	○ Outpatient behavioral health services, as defined in Chapter 5160-2 of the Administrative Code; ○ Community behavioral health services, as defined in Chapter 5122-27 and rule 5160-08-05 of the Administrative Code; and ○ Physician services, as defined in Chapter 5160-4 of the Administrative Code, rendered by a physician employed by or under contract with a PRTF. • The costs of medical and ancillary services not provided by the PRTF will not be included in the all-inclusive per diem rate and should be billed as a separate service by the provider of those services. ○ Payment to PRTFs for take-home drugs will be reimbursed according to the provisions of Chapter 5160-9 of the Administrative Code. ○ Transportation to or from a PRTF is not a PRTF service. ○ Care coordination activities provided by a care management entity in accordance with rule 5160-59-03.2 of the Administrative Code will be reimbursed as described in Chapter 5160-59 of the Administrative Code. Educational services are not reimbursable as a PRTF service.
Required Components	PRTF Model Description • Provided seven days a week to youth under 21 years of age • An inpatient level of care provided in a separate non-acute setting: ○ Separate, free-standing building; or ○ In a building with other services, which may include a class one residential facility, however located on a separate floor or in a separate unit or wing • Physician directed including input into the clinical component of an individual plan of care

- Multi-disciplinary
- Time limited with short lengths of stay, with treatment focused on the objectives that are most important for the youth to address to achieve a successful transition to the community
- Able to address the intensive treatment, supervision, and safety needs of the person referred and possess the capacity and expertise to provide targeted treatment services to address the variety of needs of the youth
- Treatment is strengths-based, individualized, and the quantity and frequency of services is adjusted based upon the needs of individuals and the culture of the milieu
- Inclusive of evidence-based treatment services that focus on the strengths of the youth and their family/caregiver
- Consists of appropriate therapeutic, education, and medical services, including referral and coordination of transportation to services that are not provided by the PRTF
- Available to the youth and family/caregiver post transition
- Utilizes performance improvement processes to monitor performance, address problem areas and troubleshoot, and assure provision of quality services

A PRTF shall meet the requirement in Chapter [5122-30](#) of the Administrative Code and be licensed as a class one residential facility:

- Document PRTF services in accordance with Chapter [5122-27](#) of the Administrative Code
- Maintain compliance with applicable state and federal laws and regulations
- Hold and maintain other required licenses or certificates as applicable, e.g., school, dietary, etc.
- Meet the federal emergency preparedness requirements of [42 C.F.R 441.184](#)

PRTF services for individuals under the age of twenty-one (21) must be:

- Provided under the direction of a physician

- Provided by a psychiatric facility that is not a hospital and is accredited by the joint commission, the commission on accreditation of rehabilitation facilities, or the council on accreditation as a behavioral health residential facility
- Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reached the age of twenty-one, before the earlier of:
 - The date the individual no longer requires the services; or
 - The date the individual reaches the age of twenty-two; and
- Certified in writing to be medically necessary (Certification of Need)
 - 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.

Youth and Family Engagement

- PRTF is a youth and family driven service. The youth and family/caregivers are viewed as full participants the treatment team and their needs, preferences and choice are valued and respected.
- The PRTF shall provide the family/caregiver clear communication and explanations related to the youth's service needs at a frequency defined by the youth and their family and/or care plan.
- The youth and their family/caregiver shall be asked directly for their input on and offered choices in their treatment and services. Their input and choices are respected and incorporated into the plan of care whenever clinically and developmentally appropriate.
- The PRTF actively engages the family/caregiver in partnership with the care management entity or care coordination entity.

- The family/caregiver is invited to participate in treatment team meetings regarding the youth, which are held at times convenient to the family/caregiver.
- Families/caregivers are encouraged to be full participants in the youth's ongoing care including participation in clinical appointments. The family / caregiver is invited to participate in family counseling from the time of the youth's placement in the PRTF unless clinically contraindicated and documented or not permitted by the custodial agency or a court order.
- PRTF visitation policies promote face-to-face contact.
- The PRTF makes available and utilizes technology for visitation, clinical services, and treatment team meetings.
- The PRTF supports the family/caregiver in transition planning in collaboration with the Child and Family Team.

Care Coordination, transition planning, and continuity of care

- The PRTF coordinates care with other providers during treatment, as part of transition planning and after treatment.
- The PRTF recognizes that transition to the community is challenging for the youth and family / caregiver and assures that services and supports are in place to support the youth's successful return to the community.
- Individualized transition planning begins within twenty-four hours of admission with a strong focus on family and caregiver education and engagement in the care of youth, and coordination with partnering entities.
- The PRTF partners with the youth and family to engage and utilize natural community supports as part of transition planning.
- The PRTF notifies Aetna as soon as possible after determining the need for discharge before meeting treatment goals. A medical director peer to peer is required before determining a discharge date.
- The PRTF establishes individualized warm hand-offs with community providers and/or partners prior to the transition.

- The PRTF is available to community partners, as well as the youth and family / caregiver at least sixty days post discharge when the youth is transitioned to a community setting, including at least monthly contact with the youth and family / caregiver unless the youth and family / caregiver decline this contact when the PRTF discusses it and offers it as part of discharge planning.
- The PRTF provides written documentation to all participants of the transition plan prior to the youth 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.

CFT Meeting Frequency

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.

Before 60 Days of Transition - CFT/CC + PRTF meeting 1x per month

60 Days before Transition - CFT/CC + PRTF meeting = *3x per month

30 Days before Transition - CFT/CC + PRTF meeting = *3x per month

Individual plan of care and services

- PRTF services must involve “active treatment,” which means implementation of a professionally developed and supervised individual plan of care that is:
 - Developed and implemented no later than 14 days after admission; and
 - Designed to achieve the youth’s discharge from the PRTF at the earliest possible time.
- Individual plan of care.
 - The individual plan of care shall be in writing and developed for each youth to improve their condition to the extent that PRTF care is no longer necessary.

	○ The plan of care must: ▪ Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the youth's situation and reflects the need for PRTF care. ▪ Be developed by a team of professionals specified in paragraph (D) of OAC rule 5122-41-07 in consultation with the youth and their parent / caregiver and legal guardians. ▪ Clearly delineate treatment goals and objectives with specified timelines and benchmarks for success. ▪ Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives. • The plan must be reviewed every thirty days, and more often when clinically indicated by the treatment team and the youth and family/guardian/caregiver to: ○ Determine that services being provided are or were required to be provided in a PRTF, and ○ Recommend changes in the plan as indicated by the youth's overall progress in the PRTF. • Each youth shall receive the following treatment services: ○ Physical health examination by a physician or advanced practice registered nurse within twenty-four hours of admission, including 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. ○ Psychiatrist care on-site, via telehealth, or telephone and including an evaluation within forty-eight hours of admission; and weekly face-to-face consultation by a psychiatrist or other qualified
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	physician; routine and emergency evaluations, and medication and prescription adjustments. • 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. DODD can facilitate linkage with resources if needed. ○ Individual counseling with licensed clinician using adapt techniques for MI/ID for at least ninety minutes weekly. Persons with MI/ID may require shorter length and more frequent sessions due to memory and attention span difficulties. ○ Family/caregiver therapy or other family/caregiver intervention at least once a week and in accordance with the individual plan of care. ○ Medication administration (including de-prescribing as indicated), substance use treatment and family/guardian/caregiver therapy will be adapted for MI/ID. ○ Nursing services available at all times and provided when clinically indicated. ○ Sensory evaluation, Sensory OT, PT, BCBA, and Behavior Support Specialist will have knowledge of MI/ID. The treatment plan will include a Behavior Support Specialists, as well as alternative treatments such as music, art, and recreation ○ Education services according to their individualized educational plan. Must meet the minimum standards as prescribed by the state board of education, whether through a public school or through a charter or non-public (private) school operated by or at the PRTF. The PRTF shall coordinate education services with youth's school district according to Education section in the OhioRISE PRTF Program Manual. 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. ○ Organized recreational activities to support normative developmental experiences that accommodate their individual medical, neurological and physical needs and capabilities.
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	○ 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.
Staffing Requirements	PRTF 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, or ○ 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 children 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 40 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 also provides services to youth with co-occurring substance use disorders, sufficient clinical staff shall be credentialed to provide substance use disorder treatment. • Nursing shall be on-site and on-duty at all times as outlined below. ○ 8:00a.m. to 10:00p.m. shall be a registered nurse ○ 10:00p.m. to 8:00a.m. at least a licensed practical nurse • Sufficient direct care staff, trained to provide care for persons with MI/ID; the staff will be provided MI/ID specific training by DODD and DBH. which may include clinical and nursing staff, to meet all residents' supervisory and care needs. Staffing ratios will be individual-specific and circumstance-based.

	○ During the hours of 8:00a.m. until 10:00p.m., PRTF maintains a staffing ratio of at least one direct care staff for each three residents. The PRTF will always maintain a minimum of two direct care staff on duty, including a practitioner with a scope of practice of at least a registered nurse. ○ During the hours of 10:00p.m. until 8:00a.m., the PRTF maintains a staffing ratio of at least one direct care staff for each six residents. The PRTF will always maintain a minimum of two direct care staff on duty, 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 and other needs. • If there is another residential facility or outpatient services 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 youth. • 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 is available, apart from a certified nurse practitioner. This does not include staff who are registered or certified by an Ohio state licensing board, e.g., a registered social work assistant or certified chemical dependency counselor assistant.
Approval and Utilization Review	Prior Authorization • The member's OhioRISE Care Coordinator must submit all PRTF Request Forms through FamilyCare Central portal. • A new PRTF Request Form must be completed in its entirety and contain all required clinical and non-clinical information requested. It is compulsory

	for the Aetna Release of Information Form (consent) to be completed according to training, signed by the legal guardian (and member, if applicable), and submitted along with the PRTF Request Form for Aetna to release records to PRTF's during the referral process. • Prior authorization for a youth under the age of thirteen (13) is reviewed and approved by a Medical Director. • Aetna has seven (7) calendar days that begins the day after receipt of a PRTF Request Form for standard non-urgent PA requests to render a determination and notify the requesting OhioRISE Care Coordinator of that determination. • If Aetna is unable to obtain sufficient information to make a determination that may benefit the member during these seven (7) <u>calendar</u> days, Aetna may request an extension of timeframes. This would be done by simultaneous written notification to the member and ODM indicating the number of additional days requested to make the determination (up to fourteen (14) days), and the specific additional information/items needed to do so. • Expedited reviews will be completed within 48 hours. Expedited reviews occur when a delay could seriously jeopardize the member's life, health, or ability to regain maximum function. • The status and determinations on PRTF (and all other prior authorization) requests can be viewed through FamilyCare Central. • Approved prior authorizations expire 90 calendar days after the approval unless the member is currently admitted to a PRTF or admission is pending. • Aetna includes the expiration date on the approved prior authorization and notifies the guardian and the care coordinator of the expiration date ten (10) business days before expiration. • At a minimum, resubmission of a prior authorization must include ○ clinical documentation (e.g. psychiatry notes, hospital discharge summaries, medication lists, therapeutic treatments encompassing the most recent 30 days, and an updated Aetna Release of Information Form (consent). ○ Aetna may also consider clinical information received while the original prior authorization was active including information
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	obtained by Aetna Transition of Care Coordinators during clinical meetings with the youth's team. • For youth who are hospitalized in the immediate fourteen (14) days preceding the expiration of a prior authorization, Aetna considers and may grant an extension of the existing prior authorization for up to ninety (90) days. • For youth admitted to a PRTF and a disruption notice has been issued, if PRTF is still the recommended level of care Aetna considers all available documentation including, but not limited to: • inpatient hospitalization records • clinical service documentation while the youth has been in treatment; • clinical information obtained during the course of concurrent case reviews completed by utilization management; and • information obtained by Aetna Transition of Care Coordinators during clinical meetings with the youth's team. • A prior authorization can be resubmitted at any time within 6 months of a prior approved PRTF request. A new application is required if the previous prior authorization has been expired greater than 6 months. • Aetna authorizes covered and medically necessary PRTF services provided that the following criteria are met: • The member is enrolled and eligible on the date(s) of service. • The services are ordered by a participating or nonparticipating practitioner. • Aetna's notification and prior authorization requirements are met. • Review of the member's clinical information indicates that PRTF level of care is appropriate based on medical necessity criteria. • All denials are determined by an Aetna Medical Director (MDR) and an official Notice of Action/Adverse Benefit Determination (NOA) is issued. • All EPSDT (Healthchek) requests for individuals under 21 must undergo individualized clinical review based on Ohio's medical necessity standards.
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Plans or providers may not deny these requests for technical or administrative reasons (e.g., incorrect code, modifier, form). Instead, they must work collaboratively to resolve such issues and ensure access to the service.

Concurrent Clinical Review

- Concurrent reviews for PRTF are conducted a minimum of every 30 days from admission by telephone or facsimile, and as dictated by the member's clinical condition may occur up to seven (7) days a week.
- The PRTF provides updates to all aspects of the member's treatment including but not limited to: therapy, psychiatric and nursing notes; any assessments/evaluations/lab or imaging studies; interactions with peers and staff; involvement in educational or vocational activities; member's participation in treatment and programming; family/caregiver engagement; progress towards treatment goals; any barriers or incidents; CFT collaboration and transition planning.
- Updated clinical information includes a discharge plan and anticipated discharge needs.
- Continuing stay for any youth under the age of thirteen (13) is reviewed and approved by an Aetna Better Health Medical Director (MDR) at least once every ninety (90) days.

Authorization extension requests that do not meet the above outlined clinical criteria for PRTF level of care are presented to the Aetna Better Health MDR for review. The MDR considers all available information, focusing on the member's current clinical needs, and the information provided by the PRTF. The MDR will then render a determination as to whether the clinical threshold to continue treatment at PRTF has been met based on their assessment of all available information. If the MDR is not able to approve continued stay at PRTF, they will initiate an official Notice of Action/Adverse Benefit Determination (NOA). Only the MDR can reduce or deny a request for coverage.

Medical Necessity Criteria [OAC 5160-1-01](#)

Aetna applies the PRTF criteria outlined in the OhioRISE PRTF Program Manual to determine medical necessity.

Requests for criteria/guidelines can be made via email, phone, or mail. Staff fulfills requests for clinical criteria/guidelines by:

- Distributing only the smallest portion necessary, specific to a member coverage determination
- Including a “Response to Request for Decision Making Criteria” letter that details the request and identifies the specific criteria used in making the determination

Health plan staff document the following in the Utilization Management business application system by the end of the current business day:

- Name of the person requesting the guideline
- Contact information of the requestor
- Date request received
- Date information provided
- Method of delivery of information
- Guideline name and number provided

Transition Planning

The concurrent review staff works in conjunction with the facility (including, but not limited to admissions, rehabilitation) to identify the services required for the member’s transition planning needs. The concurrent review clinician collaborates with the case manager/care coordinator as needed to ensure the transition planning requirements are incorporated into the member’s child and family-centered care plan (CFCP). System of care services are included to address social determinants of health.

Approval, Denial or Reduction in Services

Aetna OhioRISE notifies the requestor within seven (7) days of receipt of the request through written notification via fax or FamilyCare Central the outcome of prior authorization or concurrent review request that result in an approval, denial or reduction of service. Aetna notifies the member or legal guardian within seven (7) calendar days of the receipt of the request through written notification of all denial or reduction in services.

Provider and member notifications communicate utilization management decisions including approvals, denials and reduction in services. Written notifications to members must be at a sixth-grade reading level.

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When there is a denial or reduction in service, the written notification includes:

- The action the health plan has taken or plans to take and the effective date
- The specific reason for the action
- Notification that upon request the provider or member may obtain a copy of the guideline that was used for the denial
- Notification that practitioners/providers can discuss UM denials with a physician or other appropriate reviewer
- Appeal information
- Translation service information

Peer to Peer

Practitioners/providers are notified in the written notification that they may request a peer-to-peer consultation to discuss behavioral healthcare denied authorizations with the medical director reviewer by calling Aetna Better Health. When the denial of authorization is for a service on a member's established child and family-centered care plan, the peer-to-peer consultation is offered to the appropriate clinical representative at the assigned Care Management Entity (CME) who shall serve as the liaison to the member's Child and Family if one has been established. If the requesting provider for the service is not the CME, peer-to-peer consultation is offered to the provider and to the CME who is responsible for the comprehensive child and family-centered plan of care developed by the care plan team in addition to the CME.

Appeal

Members and providers are notified in the denial letter of appeal rights ([OAC 5160-26-08.4](#) and [ORC 5160.34](#)), including the right to submit written comments, documents, or other information related to the appeal.

The denial letter also explains:

- The appeal process including the right to member representation and the timeframes for deciding appeals

	• A description of the next level of appeal, either within the organization or to an independent external organization • The right of the member or provider (with written permission of the member) to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing • A description of the expedited appeals process for concurrent denials • Provider notification that expedited external medical reviews can occur concurrently with the internal appeals process • The circumstances under which expedited resolution is available and how to request The member's right to request continued benefits pending resolution of the appeal, or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services
Additional Requirements	A PRTF must comply with the rules for restraint and seclusion, in accordance with rules 5122-26-16 and 5122-26-16.1 of the Administrative Code. The facility's executive director, chief executive officer, president, or similar position must provide a copy of the attestation given to the Ohio Department of Medicaid, certifying it is compliant with CMS standards governing the use of seclusion and restraint in 42 C.F.R. 483.350 to 42 C.F.R. 483.376. A copy of this attestation must be provided to the department within seven calendar days of executing its agreement with the Ohio Department of Medicaid and annually by July 21st. Care providers for youth with MI/ID 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.Serious occurrence incident notification: • A PRTF must meet the incident reporting requirements of rule 5122-30-16 of the Administrative code for residential facilities. • In addition to the incident notification requirements of rule 5122-30-16 of the administrative code, a PRTF must also report the following serious occurrences in writing to the Ohio Department of Behavioral Health, Disability Rights and

Aetna Better Health via Microsoft Form submission

<mailto:PRTFIMS@aetna.com> who notify Ohio Department of Medicaid via the ODM IMS by the close of business on the next business day following notification/discovery of the incident.

- Youth death, which must also be reported to the CMS regional office in Chicago
 - Suicide attempt or self-harm resulting in a physical injury that is addressed by emergency room treatment, inpatient observation, or hospital admission
 - Health or welfare at risk due to being lost or missing
 - Misappropriation
 - Exploitation
 - Serious injury
 - abuse or neglect, including unauthorized or improper use of restraint, seclusion, or restrictive intervention
- The report must include the name of the youth, a brief description of the occurrence, notifications that were made, actions completed to ensure health, safety, and welfare, and the name, street address and the telephone number of the facility.
- In the case of a minor, the facility must notify the youth's parents/custodian, or legal guardian as soon as possible, and in no case later than twenty-four hours after the incident.
- Staff must document in the youth's record that the serious occurrence was reported in accordance with this paragraph, including the name of the person with the Ohio Department of Medicaid, disability rights Ohio 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, as well as in the incident and accident report logs kept by the facility.
- Critical incidents involving youth with MI/ID will also be reported to DODD and major unusual incidents (MUI) involving youth with intellectual disabilities will also be reported to DODD in accordance with the information on this page: <https://dodd.ohio.gov/health-and-welfare/ui-mui>.

Bed Holds- [5160-59-03.6](#)

Acute Inpatient Needs

The PRTF will coordinate care with the acute inpatient provider and hold capacity to serve that youth upon their return for at least three consecutive days. The PRTF must notify Aetna Better Health OhioRISE of all bed holds within one (1) business day of admission to an acute inpatient facility inclusive of the clinical

	documentation for admission. Maximum allowable bed hold days per occurrence is seven (7) days. Therapeutic Leave Therapeutic leave are overnight passes for which a bed hold day is being requested as part of treatment and transition planning. It is anticipated that 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 leave passes must be requested a minimum of seven (7) days in advance to Aetna Better Health OhioRISE and must include: • Individualized to the treatment needs of each youth. • Goal-directed, and clearly described in the individualized plan how therapeutic passes support the youth attaining their goals. • Planned and no more than three consecutive days at a time. • Include a clear Crisis and Safety plan that is developed in conjunction with the CFT 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 and skill development then adjust the plan as needed. • Maximum number of therapeutic passes of 15 days per PRTF admission. Additional therapeutic pass days can be approved based on clinical need.
Facilities Requirements	PRTF Building and Living Requirements 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 to each youth a single or double occupancy bedroom while meeting all other standards regarding sleeping space in rule 5122-30-14 of the Administrative Code. • 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 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 youth. • Meet the following for the living and dining space of the facility in addition to the standards in rule 5122-30-14 of the Administrative Code: ○ Have a meeting space that is large enough to accommodate all youth at the same time. ○ Have a communal area that provides space and opportunities for small group activities and socializing. ○ Have entertainment or recreational areas, including furnishings, which promotes social engagement. 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 to address the needs for youth with MI/ID.
Billing and Reporting Requirements	The Medicaid per diem reimbursement rate includes all medically necessary PRTF services provided under the direction of a physician, as outlined in the youth’s treatment plan. These services include, but are not limited to: • Room and board; • Physician services, as defined in Chapter 5160-4 of • of the Administrative Code; • Behavioral health services, as described in Chapter 5122-27 and rule 5160-8-05 of the Administrative Code; • The services of PRTF staff as attendants during transportation. When permitted, provision of any service addressed in Chapter 5160-59 of the Administrative Code by telehealth will comply with the appropriate telehealth requirement(s) requirements found in rules 5122-29-31 and 5160-1-18 of the Administrative Code.

Aetna Better Health conducts systematic reviews of service definitions on an ongoing basis to ensure they remain aligned with regulatory requirements, operational expectations, clinical standards, and plan objectives. These reviews support the identification and incorporation of necessary updates, clarification of language, and implementation of changes resulting from policy revisions, stakeholder feedback, and evolving program requirements.