Chapter 7 Section 4

Residential Treatment Center (RTC) Reimbursement

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(b)(4) and 32 CFR 199.1(f)
Revision:

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

How are RTCs to be reimbursed under TRICARE?

3.0 POLICY

3.1 Rate Structure: Facility Rates and Cap Amount

The rate is the per diem rate authorized for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by an approved RTC, and approved by the contractor.

3.1.1 Individual Facility Rates

For RTCs new to the program, one of the following two alternative methods will be used in determining their individual rates:

3.1.1.1 The all-inclusive per diem rate for RTCs operating or participating in the program during the base period of July 1, 1987, through June 30, 1988, will be the lowest of the following conditions:

- The rate paid to the RTC for all-inclusive services as of June 30, 1988, adjusted to include an increase reflecting appropriate annual CPI-U (Consumer Price Index-Urban) update factors up through Fiscal Year (FY) 1997, and Medicare update factors for fiscal years after FY 1997; or

- The per diem rate accepted by the RTC from any other agency or organization (public or private) that is high enough to cover one-third of the total patient days during the 12-month period ending June 30, 1988, adjusted by appropriate annual CPI-U update factors up through FY 1997, and Medicare update factors for fiscal years after FY 1997;

or

- The RTC cap amount.

3.1.1.2 The all-inclusive per diem rates for RTCs which began operation after June 30, 1988, or began operation before July 1, 1988, but had less than 6 months of operation by June 30, 1988, will be calculated based on the lower of the following conditions:

- The per diem rate accepted by the RTC that is high enough to cover one-third of the total patient days during its first 6 to 12 consecutive months of operation adjusted by appropriate annual CPI-U inflation factors up through FY 1997, and Medicare update factors for fiscal years after FY 1997; or

- The RTC cap amount.

Note: A period of less than 12 months will be used only when the RTC has been in operation for less than 12 months. Once a full 12 months is available, the rate will be recalculated. However, no retroactive adjustments will be made if the recalculated rate (based on 12 months of data) is higher than the initial rate (based on less than 12 months of data). The recalculated rate will become effective upon the date both parties sign off on a revised participation agreement. Until such time, the facility will be subject to the provisions and established rate set under the previous agreement.

3.1.2 Cap Amount

The cap amount will be adjusted by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment for fiscal years after FY 1997.

Note: For detailed guidelines on calculation of individual RTC per diem rates and cap amounts, refer to Addendum B.

3.2 All-inclusive Rate Concept

3.2.1 The all-inclusive per diem rate encompasses the RTC's daily charge for all RTC inpatient care and all mental health treatment including:

- Individual and group psychotherapy.

- Family therapy rendered to the parents of the RTC patient within 250 miles of the facility.

- Collateral visits with individuals other than the RTC patient determined necessary in order to gather information or implement treatment goals for the patient.

- Other ancillary services provided by the RTC.

3.2.2 The following are charges for services allowed outside the all-inclusive RTC rate:

3.2.2.1 Geographically Distant Family Therapy. The family therapist may bill and be reimbursed separately from the RTC if the therapy is provided to one or both of the parents residing a minimum of 250 miles from the RTC. Payment for geographically distant family therapy will be cost-shared on an inpatient basis.

3.2.2.2 RTC Educational Services. The RTC may request approval for payment of educational costs on an individual case basis from the contractor when appropriate education is not available from, or not payable by, a cognizant public entity.

3.2.2.2.1 As part of its admission procedures, the RTC must counsel and assist the beneficiary and the beneficiary's family in the necessary procedures for assuring their rights to a free and appropriate public education. There must be documentation in the beneficiary's record to substantiate this intake procedure.

3.2.2.2.2 The RTC must document any reasons why an individual beneficiary cannot attend public educational facilities and, in such case, why alternative educational arrangements have not been provided by the cognizant public entity. Upon request, the RTC should be able to produce a copy of all pertinent correspondence with state or local educational agencies.

3.2.2.2.3 If reimbursement of educational costs is approved for an individual beneficiary, such educational costs shall be shown separately from the RTC's daily costs on the claim form.

3.2.2.2.4 Reimbursement of educational costs shall not exceed the RTC's most-favorable rate to any other patient, agency, or organization for special or general education services, whichever is appropriate.

3.2.2.2.5 When a local school district reimburses authorized educational costs, but its payment does not completely cover the RTC's most-favorable rate, TRICARE shall cover the remaining amount.

3.2.2.2.6 Approval for educational services will be valid during the entire residential treatment center stay; i.e., from admission through discharge or denial of continued stay, whichever occurs first.

3.2.2.2.7 If the RTC fails to request approval of educational costs on an individual case, the RTC may not bill the beneficiary nor the beneficiary's family for amounts disallowed by contractor.

3.2.2.3 Non-Mental Health Services. Otherwise covered medical services related to a non-mental health condition and rendered by an independent provider outside the RTC are payable in addition to the all-inclusive per diem rate. Claims for non-mental health services are to be cost-shared as inpatient if the contractor cannot determine where the services were rendered and the status of the patient when the services were provided.

3.2.2.4 The all-inclusive rate includes charges for the routine medical management of a beneficiary while residing in an RTC. Services provided by medical professionals employed by or contracted with the RTC are part of the all-inclusive per diem rate and cannot be billed separately. These routine

medical services are made available to all children entering the facility and are designed to maintain the general health and welfare of the patient population. Examples of this type of care are:

- Routine health and physical examinations provided by RTC medical staff;
- In-house pharmaceutical services; and
- Other ancillary medical services routinely provided to the RTC population.

3.2.2.5 Claims submitted by the RTC for residential treatment care will be paid based upon the rate established by the participation agreement. All other mental health claims submitted by other providers for services rendered to an RTC patient (except for those services allowed outside the all-inclusive rate in paragraph 3.2.2) will be denied. Other mental health providers may continue to render services to RTC patients under this payment system; however, such providers must look to the RTC for their payment. Noncovered charges for personal items (toiletries and clothing) are excluded.

3.2.3 Since the reimbursement methodology does not provide a direct payment mechanism for professional providers, except as prescribed in paragraph 3.2.2, coverage cannot be extended for professional services rendered in a non-authorized RTC.

3.3 Authorization Requirements

The contractors will provide the following types of preauthorization for all admissions to RTCs.

3.3.1 Preauthorization and Concurrent Review

The contractor shall obtain information necessary for review for residential treatment to assure that the level of care is medically necessary and appropriate. A written decision will be sent to the facility, and parent or guardian.

3.3.1.1 If a patient is Absent Without Leave (AWOL) for a period not to exceed 10 days, the facility must submit a staffing report.

3.3.1.2 If the period of time away from the facility is more than 10 days, admission approval is required including an updated treatment plan and progress report.

3.3.2 Authorization for Geographically Distant Family Therapy

3.3.2.1 All geographically distant family therapy must be authorized and approved by the contractor at the time the treatment plan is submitted. The RTC is required to submit a detailed treatment plan for each TRICARE patient within 30 days of admission. The authorization shall be on file at the contractor before coverage can be extended. (Refer to the TRICARE Policy Manual (TPM), Chapter 7, Section 3.14.)

3.3.2.2 Cost-Share. Payment for geographically distant family therapy will be cost-shared on an inpatient basis.

3.3.3 Authorization for Coverage of Educational Services

A Public Official's Statement (POS) must be submitted to the contractor demonstrating that the school district in which the TRICARE beneficiary was last enrolled refuses to pay for the educational

component of the child's RTC care. The contractor shall review the POSs on a case-by-case basis and make a decision on whether they meet the exception for coverage under the program. The authorization for educational services shall be on file before coverage can be extended.

3.4 Reimbursement of Therapeutic Absences

Therapeutic leave of absence days may not be reimbursed by TRICARE.

3.5 RTC Participation

3.5.1 In order for the services of an RTC to be authorized, the RTC must sign a participation agreement.

3.5.2 The agreement requires the RTC to accept the TRICARE determined rate as payment in full and collect from the beneficiary or the family of the beneficiary those amounts that represent the beneficiary's liability, as defined by 32 CFR 199, and charges for services and supplies that are not a benefit.

3.5.3 Participation agreements include the specific rate established for each RTC, and the billing number that must be used for claims submission.

3.6 Termination of Participation by RTC

The RTC participation agreement (TPM, Chapter 11, Addendum G) sets forth the following provisions for termination of participation under the program:

3.6.1 Notice is not required for changes or modifications to the participation agreement resulting from amendments to the 32 CFR 199 through rulemaking procedures.

3.6.2 Changes or modifications resulting from amendments to 32 CFR 199 will become effective on the date the CFR amendment is effective or the date the agreement is amended, whichever date is earlier.

3.6.3 If the RTC does not wish to accept the proposed changes, it may terminate its participation by giving the agency written notice of such intent to terminate at least 60 calendar days in advance of the effective date of termination.

3.6.4 If the RTC's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed changes/modifications, then the proposed changes/modifications will be incorporated into its agreement for care furnished between the effective date of the changes/ modifications and the effective date of the termination of this agreement.

3.7 Payment for RTC care shall be made by the contractors only for claims from authorized RTCs.

3.8 Annual Updating of RTC Rates

3.8.1 Once a valid rate is established for each RTC from the base year data it becomes the basis for all future rates. The change in mix of third party payor days thereafter will have no bearing on the TRICARE RTC per diem.

3.8.2 RTC rates will be updated by the Medicare inflation factor for hospitals and units exempt from the Medicare PPS.

3.8.3 Contractors will be provided with the rate updates prior to October 1 of each year (i.e., the start of the new federal fiscal year).

3.8.4 All claims reimbursed under the TRICARE RTC per diem payment system are to be priced for each day of service (using the rate in effect on the day of service) regardless of when the claim is submitted. Any adjustments to such claims will also be priced as of the day of service. In order to do this, at least three iterations of per diem rates shall be maintained on the contractor's on-line system. If the claims filing deadline has been waived and the day of service is more than three years before the reprocessing date, the affected claim or adjustment is to be priced using the earliest per diem rate on the contractor's system.

3.8.5 The last three iterations of per diem rates, along with the corresponding cap amounts, will be maintained in on the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement. The rates are updated by the Medicare update factor as noted in Chapter 7, Section 1, paragraph 3.5.3. The rates are effective on October 1 of each year.

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