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**107.01 LEGAL AUTHORITY**

The following federal statutory and regulatory authorities govern these services:

Section 1905 (a)(16) and (h) of the Social Security Act

42 CFR §441.150 through §441.184

42 CFR §483.350 through §483.376

**107.02 DEFINITIONS**

**107.02-01 Abuse or Neglect** is a threat to a child’s health or welfare as defined in22 M.R.S. §4002(1); or Abuse, Neglect, or Exploitation of an adult means those terms as defined in 22 M.R.S. §3472.

**107.02-02** **Caregiver** is an individual who is responsible for the custodial care, and protective oversight and supervision of a youth. Caregivers may include but are not limited to a member’s parents, babysitter, immediate or extended family, other natural supports fulfilling this role, or professional staff providing protective oversight and supervision in a variety of settings.

**107.02-03 Child and Adolescent Needs & Strengths (CANS)** assessment is a multipurpose tool that assesses the needs and strengths of children and adolescents with mental illness, developmental disabilities/intellectual disabilities, and autism spectrum disorders. The CANS may be used 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 services.

**107.02-04 Clinical Staff** means licensed staff, to include the following:

1. Physicians, including psychiatrists
2. Psychiatric Mental Health Nurse Practitioners
3. Registered Nurses (RNs)
4. Licensed Clinical Social Workers (LCSWs)
5. Licensed Clinical Professional Counselors (LCPCs)
6. Licensed Marriage and Family Therapists (LMFTs), and
7. Licensed Psychologists

**107.02-05 Emergency Safety Intervention** means the use of restraint or seclusion as an immediate response to an emergency safety situation.

**107.02 DEFINITIONS (cont.)**

**107.02-06 Emergency Safety Situation** means unanticipated member behavior that places the member or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.

**107.02-07 Functional Behavior Assessment** means a problem-solving process that identifies the individual and environmental variables contributing to occurrences of challenging behaviors for the purpose of designing individualized behavioral interventions.

**107.02-08 Clinical Certification of Need** is the process by which a member demonstrates the medical necessity for treatment in a Psychiatric Residential Treatment Facility (PRTF) setting.

**107.02-09 Mechanical Restraint** means any device attached or adjacent to the member’s body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

**107.02-10 Minor** means an individual under 18 years of age.

**107.02-11 Natural Supports** are individuals who do not share a common residence with the family, who include the relatives, friends, neighbors, and community resources that a family goes to for support.

**107.02-12 Personal Restraint (Physical Restraint)** means the application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. Briefly holding a resident, without undue force, in order to calm or comfort him or her, holding a resident's hand to safely escort a resident from one area to another, or physical cueing in accordance with the member’s treatment plan are not considered a personal restraint.

**107.02-13 Positive Behavioral Support Strategies** means a strengths-based strategy based on individualized assessment that emphasizes teaching a person productive and self-determined skills or alternate strategies and behaviors without the use of restrictive Interventions.

**107.02-14 Psychiatric Residential Treatment Facility** **(PRTF)** means a facility other than a hospital that provides psychiatric services to individuals under age 21, in an inpatient setting, and which meets the requirements of this policy. Psychiatric Residential Treatment Facility means a facility licensed in Maine by the Maine Department of Health and Human Services.

**107.02 DEFINITIONS (cont.)**

**107.02-15 Restraint** means a “personal restraint,” or “mechanical restraint” as defined in this section.

**107.02-16 Seclusion** means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

**107.02-17 Serious Injury** means 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.

**107.02-18 Serious Occurrence** means a member’s death, a Serious Injury to a member, or a suicide attempt by a member.

**107.02-19 Staff** means those individuals with responsibility for managing a resident's health or participating in an emergency safety intervention and who are employed by the facility on a full-time, part-time, or contract basis.

**107.02-20 Time Out** is intended to remove the resident from positive reinforcement of a particular behavior that has negatively impacted him or herself and/or others. Time out may include the loss of access to positive reinforcement within a particular setting and/or the restriction of a resident to a designated area for a period of time for the purpose of providing the resident an opportunity to regain self-control. During a time out, a resident must not be physically prevented from leaving the designated area.

**107.02-21 Treatment Plan** means an active plan of care developed for each member in accordance with the standards of this policy and intended to improve the member’s condition to the extent that inpatient care is no longer medically necessary.

**107.03 INTRODUCTION**

This rule describes the standards for the provision of Psychiatric Residential Treatment Facility (PRTF) services. PRTFs are jointly federally and state regulated, and providers must follow all federal and state requirements to provide this service. This includes standards for staffing of PRTFs, as described in this policy.

The purpose of a PRTF is to provide comprehensive mental health treatment and/or substance abuse treatment to children and adolescents who, due to mental illness, substance abuse, or severe emotional disturbance, meet level of care requirements for a PRTF.

For members who have co-occurring intellectual or developmental disability, all applicable state and federal laws, including Title 34-B of the Maine Revised Statutes must be followed.

In order for a member to qualify for PRTF services, all other community based resources must have been determined to be inadequate to meet the member’s needs. PRTF services are designed to be short term and intensive in nature, with the goal of successfully transitioning the member back to his or her community. The PRTF is expected to actively engage the member’s natural supports to offer culturally competent, medically appropriate treatment designed to meet the individual needs of the member.

* 1. **MEMBER ELIGIBILITY**

**107.04-01 General Eligibility**

To access PRTF services, members must meet all the following criteria:

1. Be under the age of 21.
2. Meets Clinical Certification of Need (CCON) requirements, as set forth in 107.04-02.
3. The parent or legal guardian, when applicable has approved of this level of service; and
4. The member meets all other MaineCare eligibility requirements.
	* 1. **Clinical Certification of Need (CCON) for PRTF Services**
5. CCON Team

**107.04 MEMBER ELIGIBILITY (cont.)**

1. An independent team consisting of the following individuals must complete the CCON for each member seeking care in a PRTF. No member of the team may be employed by or have a consultant relationship with the admitting PRTF. The team must consist of the following individuals:
2. A physician;
3. A licensed master’s level clinician with clinical experience in child psychiatry. Eligible provider types include:
4. LCSW;
5. LCPC;
6. Psychiatric Mental Health Nurse Practitioner;
7. Physician’s Assistant;
8. An individual with specific knowledge of the member’s situation. The parent/guardian (when applicable) or designee must fill this role. This individual may be a current provider, family or community member, case manager, or other individual with relevant knowledge. In the event of multiple providers, only one individual may be designated to serve this role. The parent/guardian will have the opportunity to select this individual to serve on their behalf; and
9. A representative of the Office of Child and Family Services.
10. Certification Requirements
11. The CCON team must unanimously certify all the following:
12. The member has an active psychiatric condition and functional deficits qualifying as a Serious Emotional Disturbance (SED) meeting the criteria below. The member must be reassessed annually at minimum (within twelve (12) months of the last determination) by licensed mental health professional acting within the scope of their licensure to determine if the member continues to qualify as having an SED:
13. Have a primary diagnosis listed in Appendix A with a severity specifier of moderate to severe (when applicable) when applied to the current condition of the youth, as determined by a licensed mental health professional acting within the scope of their licensure,

**107.04 MEMBER ELIGIBILITY (cont.)**

for the previous six (6) month period or must be reasonably predicted to last six (6) months; and

1. The member must also consistently and persistently demonstrate behavioral abnormalities to a significant degree, well outside the normative developmental expectations for the previous six (6) month period or must be reasonably predicted to last six (6) months. Behavioral abnormalities cannot be attributed to intellectual, sensory, or health factors.
2. The member must additionally display at a minimum, four (4) of the following conditions:
	1. failure to establish or maintain developmentally and culturally appropriate relationships with adult caregivers or authority figures;
	2. failure to demonstrate or maintain developmentally and culturally appropriate peer relationships;
	3. failure to demonstrate a developmentally appropriate range and expression of emotion or mood;
	4. disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings;
	5. behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or
	6. behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.
3. Ambulatory (community-based) resources available in the community, including Private Non-Medical Institutions (PNMI), do not meet the treatment needs of the member, as evidenced by one of the following:
4. The youth has behavior that puts the youth at substantial documented risk of harm to self;

**107.04 MEMBER ELIGIBILITY (cont.)**

1. The youth has persistent, pervasive, and frequently occurring oppositional defiant behavior, aggression, or impulsive behavior related to the SED diagnosis which represents a disregard for the wellbeing or safety of self or others; or
2. There is a need for continued treatment beyond the reasonable duration of an acute care hospital and documented evidence that appropriate intensity of treatment cannot be provided in a community setting.

The member need not have accessed or exhausted all other available services; however, the team must make a determination that these other services are inadequate to meet the member’s needs.

1. Treatment of the member’s psychiatric condition requires medical supervision seven days per week and 24 hours per day, on an inpatient basis and under the direction of a physician.
2. Services can reasonably be expected to improve the member’s condition or prevent further regression so that the services will no longer be needed.
3. Additionally, the CCON team must provide documentation of the following:
4. Member’s diagnosis or diagnoses;
5. Summary of present medical finding;
6. Relevant medical, psychiatric, and behavioral history;
7. Mental and physical functional capacity;
8. Prognoses, to the extent determinable;
9. The member’s created or updated CANS assessment; and
10. Documentation describing any community based services previously accessed by the member as well as their efficacy and challenges faced.

**107.04 MEMBER ELIGIBILITY (cont.)**

1. Prior Authorization
2. The CCON documentation must contain relevant information as described in Sections 107.04-02.B (1-2) above, which must be submitted for Prior Authorization (PA) to the Department or the Department’s third-party administrator. Prior Authorization is required for all PRTF services.
3. Copies of the CCON documentation must be submitted to the PRTF upon the member’s admission, and every 60 days thereafter in accordance with the CCON process.
4. Duration of Care
5. PRTF services may continue to be provided as long as medically necessary as determined by the Treatment Plan and described in the CCON.
6. The CCON process must be completed every 60 days to meet federal utilization control requirements.
7. A continued stay Prior Authorization (PA) must be completed every 60 days.
	1. **COVERED SERVICES**

**107.05-01 Active Treatment:** PRTFs must provide active psychiatric treatment, including all the following:

1. Assessment and evaluation, including review of CCON team documents, to be completed in accordance with Section 107.07-07.A.;
2. Medical supervision seven days per week and 24 hours per day;
3. Intensive psychiatric monitoring and intervention, to include medication management and medication administration:
	1. Medication Management sessions must occur at least once per week;
4. Behavioral and/or rehabilitative therapies, the specific modality to be described in the member’s Treatment Plan. Therapy must include at a minimum, the following:

**107.05 COVERED SERVICES (cont.)**

* 1. Individual Therapy, at least two (2) hours weekly;
	2. Group Therapy, at least one (1) hour daily; and
	3. Family Therapy, at least two (2) hours weekly;
1. Comprehensive and individualized discharge planning, to be commenced upon admission to the PRTF and meeting the requirements described in Sections 107.05-04 and 107.07-07 below;
2. Crisis planning and intervention;
3. Development of a Positive Behavioral Support Plan (PBSP) as described in 107.07-08.B;
4. Case management;
5. All transportation services;
6. Personal care, activities of daily living services, and instrumental activities of daily living services, and;
7. Room and board.

**107.05-02 Development and Periodic Revision of the Treatment Plan** as described in Section 107.07-07 of this policy.

* + 1. **Ancillary Services:** When medically necessary, PRTFs must assure the provision of ancillary services to members enrolled in the PRTF. Ancillary services as described below are billed pursuant to their appropriate section of policy and are as follows:
	1. **Occupational Therapy Services** are covered pursuant to regulations outlined in *MaineCare Benefits Manual,* Section 68, Occupational Therapy Services and provided by or under the direction of providers who meet the qualifications in accordance with *MaineCare Benefits Manual,* Section 68, Occupational Therapy Services and acting within his or her scope of practice under Maine State Law.
	2. **Physical Therapy Services** are covered pursuant to regulations outlined in *MaineCare Benefits Manual,* Section 85, Physical Therapy Services and provided by or under the direction of providers who meet the qualifications in

**107.05 COVERED SERVICES (cont.)**

accordance with *MaineCare Benefits Manual,* Section 85, Physical Therapy Services and acting within his or her scope of practice under Maine State Law.

* 1. **Speech and Hearing Services** are covered pursuant to regulations outlined in *MaineCare Benefits Manual,* Section 109, Speech and Hearing Services and provided by or under the direction of providers who meet the qualifications in accordance *MaineCare Benefits Manual,* Section 109, Speech and Hearing Services and acting within his or her scope of practice under Maine State Law.
	2. **Interpreter Services** are covered pursuant to regulations outlined in Chapter I, Section 1.06-3 of the *MaineCare Benefits Manual*.
	3. **Medical Services**: to address any existing or newly diagnosed physical health conditions when medically necessary.
	4. Board Certified Behavior Analyst consultation with Prior Authorization.
		1. **Discharge Planning**
1. Discharge planning must be included in the Treatment Plan and be considered a vital component of the member’s care.
2. The member and the member’s natural supports, including school personnel, and community providers must be considered in the development of the discharge plan. The member’s family or guardian must be involved in the development of the discharge plan.
3. As part of the discharge planning requirements, PRTFs must ensure the member has a minimum of a seven-day supply of prescribed medication and a written prescription for medication to last through the first outpatient visit in the community with a prescribing provider.
4. Prior to discharge, the PRTF must identify a prescribing provider in the community and schedule an outpatient visit. Documentation of the medication plan and arrangements for the outpatient visit must be included in the medical record for the member.
5. If medication has been used during the PRTF treatment of the member, but is not needed following discharge, the reason the medication is being discontinued must be documented in the medical record for the member.

**107.06 NON-COVERED SERVICES**

Include services described in the *MaineCare Benefits Manual*, Chapter I, “General Administrative Policies and Procedures.”

Duplicative services are non-covered services. A listing of duplicative and allowable concurrent services are described in detail in Appendix E.

* 1. **POLICIES AND PROCEDURES**

**107.07-01 Licensing, Certification, and Accreditation**

1. All PRTFs must maintain current CMS certification and state licensure as administered by the Department of Health and Human Services.
2. All PRTFs must maintain current accreditation by one of the following entities:
3. The Joint Commission on Accreditation of Healthcare Organizations, or
4. The Commission on Accreditation of Rehabilitation Facilities, or
5. The Council on Accreditation
6. All accreditation reports, with findings & remediation, must be submitted to the Maine Center for Disease Control and Prevention (CDC).
	* 1. **Enrollment**
7. All PRTFs must maintain enrollment with MaineCare according to the terms of Chapter I Section 1 of the MaineCare Benefits Manual.
8. All PRTFs, upon enrollment with MaineCare, must attest, in writing, that the facility is in compliance with CMS’s standards governing the use of restraint and seclusion. This attestation must be signed by the facility medical director.
	* 1. **Qualified Providers**

PRTF Programs must have appropriately credentialed staff, as described in the roles below, to satisfy the minimum staffing requirement for covered services described in Appendix D. Roles and qualified providers are described as follows:

**107.07 POLICIES AND PROCEDURES (cont.)**

1. Medical Director – is responsible for overall program implementation, individualized treatment planning, interventions, and key decision-making regarding an individual’s treatment. The medical director must be licensed to practice in the State of Maine and be held by at least one of the following:
2. Board-eligible or board-certified psychiatrist, or
3. Licensed Psychologist AND a physician licensed to practice medicine or osteopathy practicing as co-directors to fulfill the above medical director duties.
4. Administrator– is responsible for business oriented decisions regarding the PRTF. The Program Administrator must be at least 21 years of age, have a Bachelor’s Degree from an accredited school and two years of experience in the management and supervision of personnel and children’s care facilities, or comparable training or experience. Duties include, but are not limited to: oversight of day-to-day operations, scheduling, ensuring staff training, and maintaining the physical plant.
5. Clinical Coordinator – is responsible for the oversight of the implementation of a member’s clinical interventions. The Clinical Coordinator will provide supervision, training, and clinical support staff clinician(s). Additionally, the Clinical Coordinator must serve on the member’s team to develop the ITP and must facilitate the member’s discharge and transition to aid in ensuring a successful transition from the PRTF. A clinical coordinator must be held by one of the following:
6. A LCSW with at least two years of experience in the diagnosis and treatment of children with serious behavioral health conditions (experience may include experience gained while obtaining clinical licensure status as an LMSW-CC), or
7. A Licensed Psychologist by the State of Maine.
8. Staff Clinician – is responsible for the implementation of the clinical services offered by the PRTF. The clinical services include at minimum a mixture of individual, group, and family therapy provided at the levels outlined in Section.

A Staff Clinician may be any of the following:

**107.07 POLICIES AND PROCEDURES (cont.)**

1. A fully Licensed Clinical Social Worker (LCSW);
2. A fully Licensed Clinical Professional Counselor (LCPC); or
3. A fully Licensed Marriage and Family Therapist (LMFT).
4. Nurse – is responsible for the support of the behavioral health, wellness, and medical needs of a member receiving PRTF services. There must be a nurse present in the PRTF 24 hours per day, 365 days per year. The Nurse must be either:
5. A psychiatric mental health nurse practitioner or
6. A registered nurse with at least two years’ experience in the treatment of children with serious behavioral health conditions.

F. Nurse Support – is responsible for supporting the Nurse in duties allowable by the scope of their licensure including the administration of medications as well as assistance with personal care activities. The Nurse Support must be either:

1. A Certified Nursing Assistant-Medication Aide (C.N.A.-M) listed on the Maine C.N.A. Registry with no disqualifying annotations and two years of experience as a C.N.A.-M. responsible for the administration of medications as well as assistance with personal care activities; or
2. A Licensed Practical Nurse (LPN) with at least two years’ experience in the treatment of children with serious behavioral health conditions.

G. Direct Care Staff – is responsible for the daily implementation of the direct program. Direct support staff must be present 24 hours per day, 365 days per year. Direct care staff are critical staff required to maintain structure and safety within the program, and to implement a member’s individualized programming. A Direct Care Staff must hold current Behavioral Health Professional certification (BHPs) with at least two years’ experience working as a BHP with a related population.

* + 1. **Treatment Planning Team**

The Treatment Plan must be developed by an interdisciplinary team within the PRTF. This team may also include any Ancillary service providers as medically indicated.

**107.07 POLICIES AND PROCEDURES (cont.)**

The member must be involved in the planning process to the greatest degree possible. The member’s parent or guardian (when applicable) must be involved in the planning process. The team, based on education and experience (including competence in child psychiatry) must be capable of:

1. Assessing the member’s immediate and long-term therapeutic needs, developmental priorities, and personal strengths and liabilities;
2. Assessing the potential resources of the member’s family;
3. Setting treatment objectives; and
4. Prescribing therapeutic modalities to achieve the plan’s objectives.
5. The team must include:
	* 1. The Medical Director;
		2. Clinical Coordinator; and
		3. One of the following:
			1. Registered Nurse with specialized training or one year’s experience in treating mentally ill individuals; OR

* + - 1. A psychologist who has a master’s degree in clinical psychology or who has been certified by the State or by the State psychological association.
		1. **Supervision Requirements**
1. The facility must assign a supervisor to each staff member based on the staff member’s roles and responsibilities.
	1. BHPs must be supervised by a Staff Clinician (LCSW, LCPC or LMFT) for the purposes of treatment plan implementation.
	2. RNs must be supervised by a physician or nurse practitioner.
	3. LPNs and CNA-Ms must be supervised by RNs or nurse practitioners.

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. Staff Clinicians will be supervised by the Clinical Coordinator.
	2. The facility Administrator will provide supervision regarding any administrative or operational issues.
1. Supervisors must meet with assigned staff at least one hour per week, either individually or in a group format. The supervisory sessions must be documented. At least one hour per month must be individual supervision.
	* 1. **Required Disclosures and Informed Consents**
2. At the time of admission, the facility must:
3. Inform the incoming member and, in the case of a minor, the member’s parents or legal guardians, of the facility’s policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the member is in the program;
4. Communicate its restraint and seclusion policy in a language that the member and his or her parents or legal guardians understand and when necessary, the facility must provide interpreters or translators;
5. Obtain an acknowledgement, in writing, from the member, or in the case of a minor, from the parent or legal guardian that he or she (or they) have been informed of and have received the facility’s policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgement in the member’s record ;
6. Provide a copy of the facility policy on the use of restraint or seclusion during an emergency situation to the member and in the case of a minor, to the member’s parents or legal guardians; and
7. Provide contact information, including the phone number and mailing address, for the State Protection and Advocacy Organization.
8. Advise the member and the member’s parent or legal guardians (as applicable) in understandable terms of the member’s rights pursuant to the *Rights of Recipients of Mental Health Services Who are Children in Need of Treatment,* 14-172 C.M.R. ch. 1*,* and provide a copy of these rights to the member and the member’s parents or legal guardians (as applicable). For

**107.07 POLICIES AND PROCEDURES (cont.)**

members 18 years of age and older or who are emancipated minors, also advise the member and the member’s legal guardian (as applicable) in understandable terms of the member’s rights pursuant to the *Rights of Recipients of Mental Health Services,* 14-193 C.M.R. ch. 1, and provide a copy of these rights to the member and the member’s legal guardian (as applicable). The member’s parent/guardian must sign acknowledgement that the member’s rights have been reviewed and the publication has been received.

1. Acquire informed consent for services from the member and his or her parent/guardian, when applicable. Informed consent means sharing, in writing, a description of the services being provided, service goals, service expectations, disclosure of risks and benefits and the roles and the responsibilities of the Provider and the family toward meeting service goals and expectations. Proof of Informed Consent will be documented, and signed by the Provider and the parent/guardian. Additional requirements are as follows:
	1. The Provider shall document in the member’s plan the treatment or service delivery method or model for each service provided to a client, indicating full disclosure to the child, youth, parent and guardian of the risks and benefits of the method or model and alternative methods or models.
	2. The Provider shall review with the member and his or her parent/guardian, when applicable upon intake, its role and responsibility as a mandated reporter of abuse and/or neglect pursuant to 22 M.R.S. §3477 and 22 M.R.S. §4011-A and document this disclosure within the client record.
	3. The Provider shall secure consent from the member and his or her parent/guardian, when applicable, to use the disclosed methods of intervention to treat the identified areas of need in the member’s Individualized Treatment Plan. The Provider shall document the consent within the member’s service record.
	4. The Provider shall consider available Evidence-Based Practices and consider using such practices when clinically appropriate for the member’s condition. Provider staff shall understand and consider empirical evidence, clinical expertise, and the values and preferences of families and youth in implementing treatments.

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. The Provider shall clearly document the target symptoms of the treatment, how they will be measured and improvement determined.
		1. **Provider Documentation Requirements and Member Record**
1. Assessment and Evaluation
	1. The Provider shall conduct an initial assessment and evaluation in accordance with §107.5-1.A within seventy-two (72) hours of admission, with a full comprehensive assessment and evaluation completed within fourteen (14) days of admission to the facility.

* 1. The assessment and evaluation must consist of direct and indirect encounters. Direct encounter shall include a psychological assessment and medical evaluation (to include medication review) directly with the member. Indirect encounters consist of record review and may include conversations with the member’s parent/guardian (as applicable), teachers, other professionals involved, and natural supports (as applicable). Direct and indirect encounters must inform the medical, psychological, social, behavioral and developmental aspects of the member’s situation, and reflects the need for inpatient psychiatric care. Assessment and evaluation will be conducted to the extent necessary to determine the member’s current disposition and treatment recommendations.
	2. Documents submitted to the PRTF by the CCON team in accordance with 107.04-02.B may be used to satisfy parts of the documentation requirements for the initial and/or full comprehensive assessment.
	3. The assessment must contain documentation of the member’s current status, the reason for referral to the service, history, strengths and needs in the following domains: personal, family, social, emotional, psychiatric, psychological, medical, drug and alcohol (including screening for co-occurring services), legal, permanency/housing, financial, vocational, educational, leisure/recreation, transition needs (when applicable), potential need for crisis intervention, physical/sexual and emotional abuse (including

trauma history). The assessment must review cultural needs including issues of literacy and English and language barriers, and the need for interpretation and other needed services. The assessment should also take into consideration the member’s expressed desires.

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. The assessment shall contain documentation of developmental history, sources of support that may assist the member to sustain treatment outcomes including natural and community resources and state and federal entitlement programs. The assessment shall address physical and environmental barriers to treatment and current medications. Domains addressed must be clinically pertinent to the service being provided.
	2. For a member with substance abuse, the documentation must also contain age of onset of alcohol and drug use, duration, patterns and consequences of use, family usage, types and response to previous treatment.
	3. The provider will review the member’s CANS assessment as a part of the full comprehensive assessment and will review the CANS ongoing in coordination with the member’s treatment plan intervals described below in 107.07-07.B.2.
	4. The assessment must be summarized to include a clinical formulation that summarizes the strengths and needs of the member and family (when applicable) that informs treatment, service intensity, and recommendations for service. The formulation will include intended intervention modalities. The assessment must include a diagnosis using the most recent version of the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) or the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC 0-5), as appropriate. The assessment must be signed, credentialed and dated by the appropriate personnel conducting the assessment.
1. Treatment Plan
2. All members must have an active Treatment Plan, which must:
3. Be developed and implemented in a timely manner; an initial treatment plan must be developed and implemented within 72 hours of admission while a more comprehensive treatment plan must be developed and implemented within 14 days of admission.
4. Be developed by the Treatment Planning Team as described in Section 107.07-04 of this policy;

**107.07 POLICIES AND PROCEDURES (cont.)**

1. Be developed based on the Assessment completed in accordance with Section 107.07-07.A;
2. Reflect the needs and strengths identified in the member’s CANS assessment;
3. Be designed to achieve the member’s discharge from inpatient status at the earliest possible time;
4. Describe the functional level of the member;
5. Prescribe an integrated program of therapies, activities, and experiences designed to meet the member’s treatment objectives, and include any orders for:
6. Medications; and
7. Treatments and Therapy; and
8. Social services; and
9. Special procedures recommended for the health and safety of the member.
10. Include plans for continuing care, including review and modification of the Treatment Plan;
11. Include clear short and long-term goals and treatment objectives that are specific, measurable and are time limited to include target dates, and include the frequency, intensity, and duration of each described intervention;
12. Describe the rationale for utilizing the prescribed treatment and services;
13. Specify treatment and service responsibility, including both staff and member responsibilities in meeting the member’s treatment objectives;

**107.07 POLICIES AND PROCEDURES (cont.)**

1. Be developed in consultation with the member, the member’s parents or legal guardians (where appropriate), or others who will be caring for the member following discharge from the PRTF, including but not limited to family, school officials, and community service providers; and
2. Include a list of needs identified in the assessment process that are not addressed in the Treatment Plan and an explanation of why the identified needs are not addressed;
3. Include a discharge plan which must:
	1. Identify individualized discharge criteria that are related to the goals and objectives described in the Treatment Plan;
	2. Identify the individuals responsible for implementing the plan, including staff who can assist the member in making referrals for other resources;
	3. Identify natural and other supports necessary for the member and family to maintain the safety and well-being of the member, and to sustain progress made during the course of treatment;
	4. Be reviewed by the treatment planning team every review meeting and no less than every thirty (30) days;
	5. Identify any service recommendations and reasons for recommending that service;
	6. Address behavior planning, including interventions and resources necessary to carry out the plan without supports; and
	7. Contain a list of resources tailored to the member’s individualized needs and situation necessary for parents, guardians, and natural supports to increase the likelihood of a successful and sustainable discharge.
4. The Treatment Plan must:
5. Be entered in the member’s medical record upon initial completion and upon any alteration;

**107.07 POLICIES AND PROCEDURES (cont.)**

1. Consider any additional assessments in the development of the Treatment Plan;
2. Be reviewed every 30 days, or sooner as clinically indicated by the treatment planning team to:
3. Determine that services being provided are required on an inpatient basis and
4. Recommend changes in the plan as indicated by the member’s overall adjustment as an inpatient;
5. Document plan approval as shown by the signature of the member (when applicable), parent/guardian (when applicable), any staff with credential(s) involved in creating the treatment plan, and the medical director with credential(s). All signatures will be dated at the time of signature. In extenuating circumstances, verbal approval by the parent/guardian may be obtained in lieu of signature which must be documented in the member record with the staff member who received the approval (and signature/date), and the reason why signature could not be obtained;
6. Be provided to the member and the member’s parent/guardian (if applicable) within five (5) working days from the date of final plan approval.
7. Results of any assessments conducted must be included in the member record.
8. Progress Notes:

#### Providers must maintain written progress notes for each service discipline provided by the PRTF, in chronological order. There must be one milieu note per shift and all medication/therapy services (as defined under covered services Section 107.05-01.D) must be documented individually.

#### All entries in the progress note must include the service provided, the provider’s signature and credentials, the date on which the service was provided, the duration of the service, and the progress the member is

**107.07 POLICIES AND PROCEDURES (cont.)**

#### making toward attaining the goals or outcomes identified in the Treatment Plan.

* + 1. **Additional Treatment Standards**

In addition to the requirements detailed above, providers must follow all the Treatment Standards described below:

1. Family Centered Practice
2. The treatment shall be tailored to return the member to a family when possible and to a community. The Provider shall include and support family members as extensively as possible from the beginning of the admissions process through discharge, transition and aftercare. Families shall be full partners in all aspects of the member’s treatment, barring any limitations on participation. The focus of treatment shall be on helping families acquire the skills necessary to solve problems, meet needs, and attain desired goals. Individualized Family Therapy goals shall be included in the Treatment Plan.
3. It is the responsibility of the PRTF Provider to work with the member and his or her family to continually pursue effective levels of engagement with families, which include extended family members and natural/informal supports.
4. Planning with families shall make every effort to mobilize both informal and formal resources in support of families. Informal/natural supports include identification of the member and family’s personal resources including their specific skills, capacities or attributes. The PRTF staff shall work as a part of the team in exploring these resources for families.
5. The Treatment Planning Team shall address family readiness and the specific supports needed to ensure placement stability and success.
6. The PRTF Provider will have a family-centered policy including the following components, and will maintain records documenting training of all staff in the policy. The family-centered policy shall:

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. Ensure family involvement in all aspects of the program (medical appointments, school communication, daily living, daily programming, etc.);
	2. Illustrate family’s right to visitation and treatment participation in the PRTF setting;
	3. Expectations of family treatment & daily living participation; and
	4. Define exceptions when limits are placed on family participation, including but not limited to protect the member’s welfare, as a result of a protection from abuse or other court order, or a member age 18 years and older or an emancipated minor who does not consent to family participation.
1. The PRTF Provider will provide parent with supports and treatment interventions including psycho-educational, preventive, and supportive services as indicated by assessments. The focus will be on enhancing the parents’ coping mechanisms and providing them with the tools to move towards self-sufficiency through involvement in normal parenting activities and participating in positive behavioral supports and management techniques. The program will actively engage parental involvement and provide ongoing opportunities for parent to engage within the daily life activities of the member in the PRTF setting. Sibling involvement in treatment, visitation, and shared activities should be a part of the family treatment.
2. Documentation of parental presence and participation in treatment and typical daily parenting activities, as well as sibling involvement shall be maintained in the member’s record. It is the responsibility of the PRTF Provider to document its attempts and strategies for family engagement and to overcome barriers to family participation in treatment.
3. Behavioral Support and Management Standards

The PRTF shall practice positive behavior support strategies. Interventions are designed to modify member behavior should be individualized, respectful, developmentally appropriate, related to the issue at hand, flexibly applied, and designed to help the child master age and developmentally appropriate skills.

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. All individualized positive behavior support plans shall be based on a Functional Behavioral Assessment (FBA) by a qualified clinician or Board Certified Behavioral Analyst, with specific training in FBAs.
	2. All individual positive behavioral support plans shall be monitored, reviewed, and adjusted on an ongoing basis based on the member’s behavior and response to treatment. Review shall not be limited solely to the required 30-day Treatment Plan review.
		1. Each behavioral plan shall include strategies that encourage the use of adaptive and pro-social behaviors with the goal of preventing aggressive behavior and de-escalating behavior before it becomes necessary to use more restrictive measures. The member’s trauma history shall be considered in determining the most effective means to de-escalate behavior.
	3. Behavioral interventions shall not be used as punishment, a form of discipline, or for the convenience of staff.
	4. All staff will be trained in appropriate de-escalation techniques. Staff shall be provided ongoing trainings and supervision around their use to ensure fidelity to the model chosen by the provider.
1. Any use of outside resources to intervene with psychiatric or behavioral occurrences must be reviewed and approved by the Medical Director prior to the intervention. The approval, including rationale, must be documented in the member record. This includes, but is not limited to referring a member to psychiatric hospitalization and requesting police intervention.
	* 1. **Education, Training Requirements and Background Checks**
2. Required Background checks:

The following is required for all staff working in a PRTF;

* 1. Background checks must be completed in accordance with the facility’s licensing requirement 10-144 C.M.R Ch. 36;

**107.07 POLICIES AND PROCEDURES (cont.)**

* 1. Additionally, all background checks must be performed at hire and every two years, at minimum, thereafter;
	2. Any potentially adverse findings must be vetted by the provider and documented in the staff’s personnel record.
1. The facility must require staff to have initial and ongoing training, education and demonstrated knowledge of:
2. Techniques to identify staff and member behaviors, events, and environmental factors that may trigger emergency safety situations;
3. The use of non-physical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and
4. The safe use of restraint and the safe use of seclusion, including the ability to recognize and respond to signs of physical distress in members who are restrained or in seclusion.
5. Certification in the use of cardiopulmonary resuscitation (CPR), including periodic recertification, is required. Certification and staff competency in the use of CPR must be reviewed on an annual basis.
6. First aid certification is required. Certification must be reviewed on an annual basis.
7. Staff trainings must be provided by individuals who are qualified by education, training and experience to provide such training.
8. Staff training must include training exercises in which staff members successfully demonstrate, in practice, the techniques they have learned for managing emergency safety situations.
9. Staff must be trained and demonstrate competency before participating in an emergency safety intervention.
10. Staff must demonstrate their competencies and proficiencies in the skills described in subsection (B) above every six months.

**107.07 POLICIES AND PROCEDURES (cont.)**

1. The facility must document in the staff personnel records that the training and demonstration of competency were successfully completed. Documentation must include the date training was completed and the name of persons certifying the completion of training.
2. All training programs and materials used by the facility must be available for review by CMS, the Office of MaineCare Services, Maine CDC, and the Office for Child and Family Services.

**107.07-10 Reporting of Serious Occurrences**

1. PRTFs must report each Serious Occurrence to:
2. The Office of MaineCare Services;
3. The Office of Child and Family Services (OCFS);
4. Maine CDC; and
5. The Department’s State Protection and Advocacy Agency.
6. Reports must be made by the close of business the next business day following a Serious Occurrence.
7. The report must include the name of the member involved in the serious occurrence, a description of the occurrence, and the name, street address, and telephone number of the facility.
8. If the member involved is a minor, the facility must notify the member’s parents or legal guardians as soon as possible, and in no case no later than 24 hours after a Serious Occurrence.
9. Staff must document in the member’s record that the serious occurrence was reported to the agencies as required in this provision, including the name of the person to whom the incident was reported.
10. A copy of the report must be maintained in the member’s record, as well as in the incident and accident report logs maintained by the facility.

**107.07 POLICIES AND PROCEDURES (cont.)**

1. In the event of a member death, the following additional reporting and documentation must be made:
2. Facilities must report the death of any member to the Centers for Medicare and Medicaid Services (CMS) regional office no later than close of business the next business day after the member’s death; and
3. Staff must document in the member’s record that the death was reported to the CMS regional office.
4. In certain circumstances, additional reports must be made to Child Protective services for youth under 18 years old per 22 M.R.S. §4011-A, or Adult Protective Services for individuals 18 years and older per 22 M.R.S. §3477.
	1. **MEDICATION PRO RE NATA (PRN)**
		1. PRN medication orders are written on an “as needed” basis for the treatment of a member’s medical or psychiatric condition;
		2. PRN medication orders can only be issued if developed as part of the member’s Treatment Plan;
		3. PRN medication orders must be signed and dated by authorized licensed practitioners and must include detailed behavior-specific written instructions, including symptoms that might require use of such medication, exact dosage, exact time frames between dosages, and the maximum dosage to be given in a 24-hour period;
		4. The PRTF may only administer a PRN medication order for antipsychotic-type psychotropic medication when the PRTF also has an order prescribing routine scheduled and administered doses of the antipsychotic-type psychotropic medication for the member;
		5. PRN medication orders shall not be used as a form of restraint and shall not be written in anticipation of an emergency safety situation. PRN medication cannot be given in response to a member’s aggressive behavior, in order to restrict a member’s movement or given to prevent the resident from acting out violently;
	2. **REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION**

**107.09-01 General Requirements**

Restraint and Seclusion may be utilized by the provider and must be done in adherence with 42 C.F.R. part 483 Subpart G, the Maine Rights of Recipients of Mental Health Services, and the Rights of Recipients of Mental Health Services who are Children in Need of Treatment. Restraints or Seclusion. When there are conflicting provisions in these sources, the provision that provides the member the most protection applies. Restraint and seclusion may only be employed under the following circumstances:

1. When the intervention is absolutely necessary to protect the member from causing serious physical harm to self or others. Restraint or seclusion must not be utilized solely to address the comfort, convenience, or anxiety of staff, or as a form of coercion, discipline, or retaliation;
2. The intervention is the least restrictive emergency safety intervention necessary to resolve the emergency safety situation after other methods have been proven ineffective or inappropriate;
3. The restraint or seclusion is performed only by staff with specific training in these interventions. These interventions are applied in a manner that is safe, proportionate, and appropriate to the severity of behavior, and the member’s chronological and developmental age, size, gender, physical conditions, psychiatric conditions, medical conditions, and personal history. The restraint or seclusion must not result in harm or injury to the member and must be used only:
	1. To ensure the safety of the member or others during an emergency safety situation; and
	2. Until the emergency situation has ceased and the member’s safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired; and
4. Restraint (including physical and mechanical restraints) and seclusion must not be used simultaneously; and
5. Locked seclusion is prohibited. The member may not be confined alone to any area with the door locked, barred, or held shut by staff.

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

1. For minor members, the Treatment Planning Team must decide and document in the Treatment Plan whether to allow restraints to be employed on a particular member in the event of an emergency safety situation and where the requirements of this section are met

**107.09-02 Orders for Restraint or Seclusion**

* 1. The restraint or seclusion must be ordered by a physician or a nurse practitioner who is acting under the guidance of the team physician. When the team physician is available, only he or she may order restraint or seclusion. In the event that the provider ordering restraint or seclusion is not the treatment planning team physician, the ordering provider must consult with the member’s treatment planning team physician as soon as possible and inform him or her of the emergency safety situation that required the member to be restrained or placed in seclusion and document in the member’s record the date and time the team physician was consulted. The order must be the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
	2. An order for restraint or seclusion may be given after an examination by a physician or nurse practitioner. In the event neither are available, a registered nurse, acting in consultation with and in accordance with protocol approved by the Medical Director, may conduct the examination and approve the emergency safety intervention.
	3. An order for restraint or seclusion must not be written as a standing order or on an as-needed (PRN) basis. An order for restraint or seclusion may be given only during or immediately after the emergency safety situation arises.
	4. The order must include:
1. The name of the ordering physician, or nurse practitioner permitted to order restraint or seclusion;
2. The date and time the order was obtained;
3. The reason for the restraint or seclusion;

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

1. The emergency safety intervention ordered, including the authorized length of time for the intervention and the conditions under which the member may be sooner released; and
	1. Each order for restraint or seclusion must adhere to the following:
2. Be limited to no longer than the duration of the emergency safety situation;
3. Under no circumstances exceed four (4) hours for members ages 18-21; two (2) hours for members ages 9-17; or one (1) hour for members up to age 9; and
4. The order must be signed by the ordering physician, or nurse practitioner in the member’s record as soon as possible.
	1. If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse, while the emergency safety intervention is being initiated by staff, or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted to order restraint or seclusion must verify the verbal order in a signed written form in the member’s record. The physician or other licensed practitioner permitted to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention;
	2. Under no circumstances may prone restraints be ordered or used. Additionally, providers must not initiate or sustain any restraint that may hinder chest and abdomen movement.

**107.09-03 Monitoring of the Member**

Monitoring of the Member During and Immediately Following Restraint

1. Clinical staff trained in the use of restraints must be physically present, continually assessing and monitoring the physical and psychological well-being of the member and the safe use of restraint throughout the duration of the emergency safety intervention.
2. Every member placed in restraint shall be released as necessary to eat, drink, bathe, toilet and to meet any special medical orders. Members in restraint shall have each extremity examined and the restraint loosened, sequentially,

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

no less frequently than every fifteen (15) minutes. In instances in which blanket wraps are utilized for restraint, the member will be released and examined no less frequently than every hour.

1. A special progress/check sheet shall be maintained for each use of restraint. In addition to documenting the requirements of this provision, a description of the member’s behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes.
2. If the emergency safety situation continues beyond the time limit of the order for the use of restraint, a registered nurse must immediately speak with the ordering physician or nurse practitioner permitted to order restraint or seclusion to receive further instructions.
3. A physician, nurse practitioner, RN or LPN trained in the use of emergency safety interventions must evaluate the member’s well-being immediately after the restraint is removed.

Monitoring of the Member During and Immediately After Seclusion

Clinical staff trained in the use of seclusion must be physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the member in seclusion. Video monitoring does not meet this requirement.

Every member placed in seclusion shall be released, unless clinically contraindicated, at least every two (2) hours to eat, drink, bathe, toilet and to meet any special medical orders.

A special progress/check sheet shall be maintained for each use of seclusion. In addition to documenting the requirements of 107-09.03.B.2 above, a description of the member’s behavior as observed shall be noted on the special progress/check sheet every fifteen (15) minutes

A room used for seclusion must:

1. Allow staff full view of the member in all areas of the room; and

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

1. Be free of potentially hazardous materials, objects, or conditions such as unprotected light fixtures, phone cords, and electrical outlets.

If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse must immediately speak with the ordering physician or nurse practitioner permitted to order restraint or seclusion to receive further instructions; and

A physician, nurse practitioner, RN, or LPN trained in the use of emergency safety interventions must evaluate the member’s well-being immediately after member is removed from seclusion.

**107.09-04 Examination Following Use of Restraint or Seclusion**

1. Within thirty (30) minutes of the initiation of the emergency safety intervention, the team physician, or nurse practitioner must conduct a face-to-face of the physical and psychological well-being of the member. If the examination is not able to occur within thirty (30) minutes, the reason why must be documented in the member’s record. The examination may be in person, or by phone in consult with a registered nurse. Documentation of the physician’s or nurse practitioner’s examination must be entered into the member’s record. When a telephonic consult occurs, the physician, or nurse practitioner must examine the member in person within the following time constraints:
	* + - 1. Within one (1) hour of when the registered nurse requests an examination;
				2. Within one (1) hour of when information relayed is suggestive of causes leading to physical harm to the member;
				3. Within one (1) hour if an examination has not yet occurred during the member’s stay; or
				4. Within six (6) hours in all other circumstances.
2. Thereafter, the need for a member’s continuation in the emergency safety intervention shall be re-evaluated every two hours by a nurse. The nurse shall examine the member in person. For a member subject to an order of seclusion, the examination may be conducted outside the seclusion area; the nurse shall note the clinical reasons for selection of the examination site. For a member subject to

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

an order of restraint, the examination may be conducted with the member free of restraints; the nurse shall note the clinical reasons for selecting whether the member is examined in or free or restraints. The nurse shall assess the member to determine whether the intervention is absolutely necessary to protect the member from causing serious harm to self or others. If the nurse finds these conditions are still met, then the emergency safety intervention may be continued if the physician’s or nurse practitioner’s order has not yet lapsed. Should the member not need continued seclusion or restraint, the nurse shall release the member even if the time frame of the original order has not yet lapsed. Documentation of the nurse’s examination must be entered into the member’s record.

1. In addition to the above criteria, examinations conducted under this section include, but are not limited to:
2. The member’s physical and psychological status, including vital signs;
3. The member’s behavior;
4. The appropriateness of the intervention measures; and
5. Any complications resulting from the intervention.

**107.09-05 Use of Time Outs**

1. A member in time out must never be physically prevented from leaving the time out area;
2. Time out may take place away from an activity or from other members, such as in the member’s room (exclusionary), or in the area of activity of other members (inclusionary);
3. Staff must monitor the member while he or she is in time out.

**107.09-06 Documentation of Restraint and Seclusion**

1. Documentation regarding the use of restraint and seclusion must be kept within the member record; and must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation of the restraint or seclusion must include all the following:

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

1. Each order for restraint or seclusion as required in Section 107.09-02 above;
2. The time the emergency safety intervention actually began and ended;
3. The time and results of the examinations as required in Section 107.09-04 above;
4. The emergency safety situation that required the member to be restrained or put into seclusion;
5. The name(s) of the staff involved in the emergency safety intervention;
6. The outcome of the situation; and
7. The member’s vital signs.
8. If the member is a minor or has a legal guardian:
9. The facility must notify the parents or legal guardians of the member who has been restrained or placed in seclusion as soon as possible after the initiation of the restraint or seclusion. Families or guardians may not waive this requirement.
10. The facility must document in member’s record that the parents or legal guardians have been notified of the emergency safety intervention, including the date and time of notification and the name of the staff providing the notification.

**107.09-07 Post-intervention Debriefings**

1. Within 24 hours after the use of restraint or seclusion, staff involved in an emergency safety intervention and the member must have a face to face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the member. Other staff may participate in the discussion when it is deemed appropriate by the facility. The member’s parents or legal guardians, as applicable, must be given the opportunity to participate in the discussion, unless clinical staff have determined that participation would be detrimental to the member. The facility must conduct such discussion in a language that is understood by the member’s parents or legal guardians. The discussion must

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

provide both the member and the staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the member, or others that could prevent the future use of restraint or seclusion.

1. Within 24 hours after the use of restraint or seclusion, all staff involved (including any clinical staff involved) in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a separate debriefing session (to not include the member) that includes, at a minimum, a review and discussion of:
2. The emergency situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention; and
3. Alternative techniques that might have prevented the use of restraint or seclusion; and
4. The procedures, if any, that staff are to implement to prevent any recurrence of the use of restraint or seclusion; and
5. The outcome of the intervention, including any injuries that may have resulted from the use of restraint or seclusion.
6. Staff must document in the member’s record that both debriefing sessions took place and must include in that documentation the names and signatures of staff who were present for the debriefing, the names of staff that were excused from the debriefing (and the reason for the non-presence of the staff), and any changes to the member’s treatment plan that result from the debriefings.

**107.09-08 Medical Treatment for Injuries Resulting from an Emergency Safety Intervention**

Members requiring Third Party Treatment of Medical and Psychological Conditions are subject to the following requirements:

1. Staff must immediately obtain medical treatment from qualified medical personnel for a member injured as a result of use of a restraint or seclusion.
2. The PRTF must have affiliations or written transfer agreements in effect with one or more hospitals enrolled with MaineCare that reasonably ensure that:

**107.09 REQUIREMENTS FOR USE OF RESTRAINT AND SECLUSION (cont.)**

1. A member will be transferred from the facility to a hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;
2. Medical and other information needed for care of the member in light of such a transfer will be exchanged between the institutions in accordance with state medical privacy law (including 22 M.R.S. §1711-C and 34-B M.R.S. §1207), including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and
3. Services are available to each member twenty-four hours a day, seven days a week.
4. Staff must document in the member’s record all injuries that occur as a result of the use of restraints or seclusion, including injuries to staff resulting from the intervention.
5. Staff involved in the use of restraint or seclusion that results in injury to a member or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries.

**107.10 WAIVERS**

**107.10-01 Waiver Criteria.** In certain circumstances, DHHS may authorize waivers of Specific PRTF Requirements. All waiver requests must be submitted to the Office of Child and Family Services, and approvals must be obtained in writing prior to initiating any waiver request. Federally mandated requirements are not waivable under any circumstance. Any approved waiver request must be clearly documented in the member’s record.

**107.11 REIMBURSEMENT**

**107.11-01 Principles of Reimbursement.** The PRTF Principles of Reimbursement are specified in the *MaineCare Benefits Manual*, Chapter III, Section 107.

For each MaineCare provider enrolled as a participating Psychiatric Residential Treatment Facility, the Department will determine a prospective per diem rate for routine and fixed costs, as determined under Chapter III, Section 107, Principles of Reimbursement for Psychiatric Residential Treatment Facilities. Medical, clinical,

**107.11 REIMBURSEMENT (cont.)**

and direct care services are reimbursed per diem as described in Chapter III, Section 107, Principles of Reimbursement for Psychiatric Residential Treatment Facilities

Providers are required to obtain separate MaineCare provider number(s) for each PRTF. Upon completion of the provider’s fiscal year, the providers shall submit to the Department, a cost report for each PRTF that has been assigned a provider number(s) in accordance with Chapter III of the Principles of Reimbursement.

1. In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek from any other sources payment for the rendered service prior to billing the MaineCare Program.
2. Psychiatric Residential Treatment Facilities may not accept or receive payment for covered services in addition to the MaineCare payment.

**107.12 BILLING INFORMATION**

Providers must bill in accordance with the Department's billing Instructions for the UB-04 Claim Form. Billing instructions are available at: <http://www.maine.gov/bms/provider.htm>.

**Appendix A**

Qualifying Diagnoses

|  |  |  |
| --- | --- | --- |
| **Category** | **Diagnosis** | **ICD-10** |
| **Schizophrenia Spectrum** | Schizophrenia | F20.9 |
| Moderate and Severe Modifier | Paranoid schizophrenia | F20.0 |
|   | Disorganized schizophrenia | F20.1 |
|   | Catatonic schizophrenia | F20.2 |
|   | Undifferentiated schizophrenia | F20.3 |
|   | Residual schizophrenia | F20.5 |
|   | Schizophreniform disorder | F20.81 |
|   | Schizoaffective disorder, bi-polar type | F25.0 |
|   | Schizoaffective disorder, depressive type | F25.1 |
|   | Other Schizoaffective disorders | F25.8 |
| Bipolar and Related Disorders | Bipolar I disorder, current episode manic w/out psychotic features, moderate | F31.12 |
|   | Bipolar I disorder, current episode manic w/out psychotic features, severe | F31.13 |
|   | Bipolar I disorder, current episode manic, severe with psychotic features | F31.2 |
|   | Bipolar I disorder, current episode depressed, moderate | F31.32 |
|   | Bipolar I disorder, current episode depressed, severe, w/out psychotic features | F31.4 |
|   | Bipolar I disorder, current episode depressed, severe, with psychotic features | F31.5 |
|   | Bipolar I disorder, current episode mixed, moderate | F31.62 |
|   | Bipolar I disorder, current episode mixed, severe, w/out psychotic features | F31.63 |
|   | Bipolar I disorder, current episode mixed, severe, with psychotic features | F31.64 |
|   | Bipolar I disorder in partial remission, most recent episode manic | F31.73 |
|   | Bipolar I disorder, in partial remission, most recent episode depressed | F31.75 |
|   | Bipolar I disorder, in partial remission, most recent episode mixed | F31.77 |
|   | Bipolar II disorder | F31.81 |
|   | Other bipolar disorder | F31.89 |
|   | Cyclothymic Disorder | F34.0 |
| Depressive Disorders | Major depressive disorder, single episode, moderate | F32.1 |
|   | Major depressive disorder, single episode, severe w/out psychotic features | F32.2 |
|   | Major depressive disorder, single episode, severe with psychotic features | F32.3 |
|   | Major depressive disorder, single episode, in partial remission | F32.4 |
|   | Major depressive disorder, recurrent, moderate | F33.1 |
|   | Major depressive disorder, recurrent, severe w/out psychotic symptoms | F33.2 |
|   | Major depressive disorder, recurrent, severe, with psychotic symptoms | F33.3 |
|   | Major depressive disorder, recurrent, in partial remission | F33.41 |
|   | Disruptive mood dysregulation disorder | F34.8 |
| Anxiety Disorders  | Panic Disorder | F41.0 |
|   | Generalized anxiety disorder | F41.1 |
| Personality Disorder | Borderline Personality Disorder |   |
| Trauma and Stressor Related Disorders | Posttraumatic stress disorder | F43.10 |
|   | Posttraumatic stress disorder, acute | F43.11 |
|   | Posttraumatic stress disorder, chronic | F43.12 |
| Dissociative Disorder | Dissociative identity disorder | F44.81 |
| Disruptive, Impulse-Control, and Conduct Disorders | Oppositional defiant disorder | F91.3 |
|   | Intermittent Explosive Disorder | F63.81 |
| NeuroDevelopmental Disorders | Attention Deficit Hyperactivity Disorders | F90-F90.9 |

**Appendix B**

CANS Domains

1. **Child Behavioral / Emotional Needs:**

Two or more ratings of ‘3’ or;

Three or more ratings of at least a ‘2’ on the following:

Psychosis / Thought Disturbances

Depression

Anxiety

Impulse/Hyperactivity

Oppositional Behavior

Conduct

Anger Control

Substance Use

1. **Child Risk Factors:**

Two or more ratings of ‘3’ or;

Three or more ratings of at least a ‘2’ on any of the following:

Self-Injurious Behavior

Suicide Risk

Reckless Behavior (other Self Harm)

Danger to Others

Sexual Aggression

Runaway

Delinquent Behavior

Fire Setting

Intentional misbehavior

Bullying Others

1. **Caregiver Needs:**

Two or more ratings of ‘3’ or;

Three or more ratings of ‘2’ on any of the following:

Supervision

Involvement with Care

Knowledge of Child’s Needs

Organizational Skills

Social Resources

Residential Stability

Physical

Mental Health

Substance Abuse

Developmental

Family Stress

**Appendix C**

Required Minimum Staffing Requirement

The PRTF must employ staffing to adequately meet the needs of the program, and must minimally meet the following staffing requirements:

Medical Director – on site: 1 Full Time Equivalent (FTE)

Facility Administrator – on site: 1 FTE

Clinical Coordinator – on site: 1 FTE

Clinician – on site: 1 FTE per 5 members

Nurse – on site: 1 FTE per 10 members awake, 1 FTE per 20 members asleep

Nurse Support – on site: 1 FTE per 20 members awake

Direct Care – on site: 1 FTE per 2 members awake, 1 FTE per 4 members asleep