Mental Hygiene Administration
COMAR Clarifications
April 16, 2008
(Corrected June 2008)

COMAR 10.21.16 – Community Mental Health Programs – Application, Approval, and Disciplinary Processes

General

Q1. How long do programs have to come into compliance with the new regulatory requirements (i.e., COMAR 10.21.16, 10.21.17, 10.21.20, and 10.21.21)?

A. For the regulations that went into effect on January 14, 2008 (i.e., COMAR 10.21.16, 10.21.17, 10.21.20, and 10.21.21), programs have 90 days from March 1, 2008 (i.e., May 31, 2008) to come into compliance. The effective date for COMAR 10.21.29, Psychiatric Rehabilitation Programs for Minors was April 10, 2006.

.01 Scope

No questions.

.02 Definitions

No questions.

.03 Approval Requirements

No questions.

.04 Application Process

Q2. Who is the lead CSA if a program operates in multiple jurisdictions?

A. The CSA in the jurisdiction where most of the program's services are rendered; most often the CSA that processed the original application. This is for purposes of administrative issues, such as required reports, etc. Having a lead CSA does not change the requirements regarding referrals for and authorization of Residential Rehabilitation Program (RRP) or Supported Employment (SE) services. As is the current process, referrals and authorization for these services are directed to the appropriate CSA.

Q3. Can a program choose the lead CSA it wants?

A. No.

Q4. The CSA is reviewing the business plans and making determinations about financial matters for new providers. What are the guidelines for an adequate business plan?

A. MHA will be providing additional guidance in this area.

Q5. When is an application modification required?

A. It is required whenever a program wants to add a program location, close a program location, or move its program from one location to another. OHCQ approval is required prior to the program expansion or relocation.

Q6. Does the program need to submit a whole new application or can the program send a letter to inform the Department and the CSA if they are adding a site, closing a site, or moving their location?

A. Programs need to submit an application modification form to OHCQ, with a copy to the CSA. In addition, the program needs to notify in writing MAPS-MD provider relations and Medical Assistance provider relations of the new address. The program also needs to supply OHCQ with the applicable fire inspection certificate/occupancy permit that is required by the local jurisdiction and an effective date for the expansion/relocation. When a program is actually adding a program site (as opposed to moving from one location to another), more detailed information is required regarding type of services to be offered at the additional location, hours of operation, compliance with staffing requirements, etc. In addition, OHCQ may visit the site. Once the site is approved by OHCQ, OHCQ will notify MAPS-MD, MA, and MHA of the approval in writing.

Q7. Where can the "application modification form" be found?

A. The form is available from OHCQ (410-402-8060).

Q8. Are separate MA numbers needed for each program location/site? Are separate MA numbers needed for each program type, even when offered at the same location?

A. Yes to both. Challenges with respect to acquiring additional/new MA numbers should be directed to MHA (Dan Roberts at 410-402-8300).

Q9. If our agency has an existing office location in Anne Arundel County and plans to open a separate office location in Baltimore County, which jurisdiction would be the lead CSA and should be notified of the intent to open a new office site?

A. While the lead CSA would be Anne Arundel County, the application modification should be submitted to OHCQ and both CSA jurisdictions.

Q10. Will an agency that intends to relocate to a different office location within the same building be required to submit an application modification?

A. Yes; the program needs to submit an application modification form to OHCQ, with a copy to the CSA. In addition, it should notify MAPS-MD provider relations and Medical Assistance (MA) provider relations in writing of the new address. MA provider relations (410-767-5370) will determine if new MA numbers need to be issued in this type of situation.

Q11. If a program that is approved as an OMHC wants to submit an application for approval as a PRP, how can it demonstrate compliance with the staffing requirements (i.e. the program cannot actually afford to hire staff until it is approved and has an MA number)?

A. It is acceptable to submit the program's proposed staffing plan to OHCQ, but then the program must also submit the actual staff names and credentials, as applicable, to OHCQ prior to beginning services.

.05 Program Service Plan

Q12. When is a program service plan (PSP) required?

A. It is required only during the initial application process, although elements of the PSP are incorporated into the application modification form attachments for programs that are requesting to provide services at an additional program site.

.06 Evaluation of Application

No questions.

.07 Temporary Approval
No questions.

.08 Approval of a Program
No questions.

.09 Waivers and Variances

Q13. Are you doing away with variances?
A. No. Some of the currently approved variances will no longer be needed because of changes made through the regulatory amendments; however, the concept of variances has not been eliminated.

Q14. If a variance is still applicable, but the COMAR citation has changed, does the program need to re-apply for the variance?
A. No; all currently approved variances that are still applicable continue to be approved.

Q15. How is a variance request submitted?
A. Programs must use the MHA variance request form, which can be found on the MHA Web site (www.dhmh.state.md.us/mha) under MHA forms, when requesting a variance. Written variance requests should be submitted to MHA (attn. Stacey Diehl), with copies to the CSA and OHCQ. The variance panel reviews the request and makes a recommendation to MHA's Director. The program will receive written notification of the decision.

.10 Deemed Status

Q16. If a program is on deemed status, how are program relocations/moves handled?
A. Submit the application modification to MHA (attn. Sharon Ohlhaver), which is responsible for the deemed status process, OHCQ, and the CSA. The program should also notify MAPS-MD provider relations and MA provider relations in writing.

.11 Program Inspection and Investigation by the Department
No questions.

.12 Denial, Emergency Suspension of Approval, and Disciplinary Action
No questions.

.13 Program Request for Discontinuation of Operations
No questions.

.14 Program Request for Discontinuation of Approval
No questions.

.15 Initiation of Receivership
No questions.

.16 Procedures for Hearing
No questions.

COMAR 10.21.17 – Community Mental Health Programs – Definitions and Administrative Requirements

.01 Scope
No questions.

.02 Definitions

Q1. What is the definition of "recovery?"

A. "Recovery refers to the process in which people are able to work, live, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery." (from *The President's New Freedom Commission on Mental Health*)

.03 Authorization and Payment

Q2. Must a program provide services to individuals with Medicare?

A. No; however, if the program accepts individuals with Medicare, it must be a Medicare provider and comply with all Medicare requirements, especially with respect to "incident to" service rules and billing.

Q3. If the client has MA and Medicare (i.e., dually eligible), but the provider is not an approved Medicare provider, can Medicaid be billed first?

[A. Only if the provider did not know that the individual had Medicare at the time of the service delivery. It is MHA's expectation that providers serving dually eligible (MA/MC) individuals become a Medicare provider.]

A. Correction June 2008: No; it is MHA's expectation that providers serving dually eligible (MA/MC) individuals become a Medicare provider.

Q4. Are there any new rules regarding billing for OMHC services rendered by LGSWs or LCPCs for persons with dual eligibility for Medicare and Medical Assistance? Can we currently bill for their services?

A. MHA does not set the reimbursement rules for Medicare. Since Medicare is the first source payee, the program must comply with Medicare billing rules, especially with respect to "incident to" service delivery/billing. For example, Medicare requires that a physician must be on-site at the time billable services are rendered. Programs can contact Trail Blazers, Medicare fiscal intermediary, for clarification of Medicare requirements (866-539-5591).

Q5. Is there guidance for billing OMHC services provided by a student? Do you bill through the supervisor or the student?

A. Bill for these services the same way other billing is done. OMHC services are billed by CPT code, not by the individual staff person who provided the service. A student rendering services in an OMHC must be pursuing a degree at an accredited college or university toward state licensure as a mental health professional and delivering services as part of a formal fieldwork placement through the accredited college or university. The student must also comply with the applicable professional licensing laws with respect to supervision requirements and be appropriately screened, oriented to the program's policies and procedures, and supervised.

.04 Consent for Services, Orientation, and Advance Directive for Mental Health Services

Q6. It is too difficult to orient individuals to all that is required in this section of the regulations, especially if the individual is in crisis or experiencing psychotic symptoms upon intake.

A. It is very important to orient individuals to the program's policies in all the areas listed in this section of the regulations. If, for clinical reasons, it cannot be done as required "on or before the date that an individual receives service," this should be documented in the individual's record and the program should then cover the orientation items as soon as possible.

Q7. Are we required to have the most recent version of the "Advance Directives for Mental Health Services" in each individual's medical record?

A. No. The requirements for an Advance Directive for Mental Health Services can be found in Health General §5-602. Sample forms and information that can be used as a guide may be found on the following Web sites: MHA (www.dhmh.state.md.us/mha); Bazelon Center (http://www.bazelon.org/issues/advancedirectives); and, soon to be available for selected counties, the Network of Care Web site (www.networkofcare.org – click on "Behavioral Health," then "Maryland"). At minimum, a written advance directive for mental health services must be:

1. Dated and signed by the declarant (individual receiving services); and
2. Dated and signed by 2 witnesses. (The individual's Healthcare Agent cannot be a witness, and at least one witness cannot be an heir of the individual receiving services. Furthermore, if appointing a Healthcare Agent, the agent MAY NOT be an owner or employee of the healthcare facility where the individual is receiving care, or the relative of the owner or operator of the facility, unless otherwise qualified to be a surrogate decision maker or was appointed agent before the individual received care or treatment from the provider.)

Q8. In lieu of a Mental Health Advance Directive, would a relapse prevention plan suffice?

A. Yes, if the relapse prevention plan covers the applicable requirements of an Advance Directive (see Q7 above).

Q9. At what age is an Advance Directive for Mental Health Services required?

[A. Age 18+, unless clinically contraindicated.]

A. Correction June 2008: While the regulations state "age 16 years old or older," developmentally it may be more appropriate to use the age 18 in many instances. The regulations will be amended in the future to reflect this correction to age 18. In the meantime, programs should use their clinical judgment to assess the clinical and developmental appropriateness of discussing advance directives with an individual in the 16-18 year old age group.

.05 Advisory Committee

Q10. What is the definition of "governing body?"

A. A definition for "governing body" can be found in the definitions section of the regulations [10.21.17.02.B(23)]; however, the regulations no longer contain governing body requirements. Programs must have an advisory board that meets the requirements of this section of the regulations. If the program has a governing body that meets the requirements of this section of the regulations, a separate advisory committee is not required.

Q11. Regarding the consumer representation on the Advisory Board, does the limitation section prohibit programs from compensating consumers for their time, expense, travel, etc. to serve on committees, governing bodies, etc.?

A. No; compensating consumers for their time, expense, travel, etc. to serve on various program committees is permissible.

Q12. How can a program verify whether an individual complies with the limitation section of the advisory committee section of the regulations, especially the part about affiliation with a program that has had its license or approval revoked in the previous 10 years?

A. The program needs to verify this to the best of its ability (i.e., exercise due diligence).

.06 Collaboration with Core Service Agency (CSA)

Q13. Do hospital-based HSCRC cost-regulated outpatient services need to submit the wage and benefit summary to the CSRRC (i.e., does the staffing survey pertain to hospital-based programs)?

A. No.

.07 Program Model

No questions.

.08 Records

Q14. Are electronic records/signatures acceptable?

A. Yes, as long as the records, including signatures and dates, are HIPAA compliant and as long as the records are accessible for review. Programs must use a software package that has been verified as HIPAA compliant. (see COMAR 10.21.17.09C(6)(b) for the federal HIPAA citation)

.09 Policies and Procedures

Q15. What section of the regulations refers to the training to be provided to staff regarding fraud, etc.?

A. The requirement is 10.21.17.09A(4)(m).

Q16. What are the applicable State and federal statutory/regulatory citations regarding fraud and abuse? What needs to be covered in the training on fraud, etc.?

A. All providers must provide a general orientation to educate employees, contractors, and agents regarding compliance with state and federal regulations, and policies and procedures for detecting and preventing incorrect billing, fraud, or abuse. In addition, the provider should educate their employees, contractors, and agents, regarding the Federal False Claims Act. See Section 1902(a)(68)of the Social Security Act.

Q17. Please clarify which staff must have the criminal background check investigation that is required by COMAR 10.21.17.09C(1)(f)(i-ii).

A. All staff who provide services to minors (all program types) and all staff who provide services to adults in group homes must have a criminal background investigation.

Q18. How often are criminal background checks required for staff employed by the program?

A. There is no statutory requirement for ongoing criminal background checks. MHA, however, recommends that the program establish a policy to check on a regular basis

(i.e., a minimum of every 2 years). This provides protection for the individuals served and the program itself.

Q19. What if the criminal background check reveals that a person had been charged with or convicted of a crime?

A. The statute (Family Law Article, §5-560 to 5-568) does not prohibit an individual from being hired, nor does it require a program to fire the individual. The program, however, has the responsibility to review the circumstances of the alleged crime/conviction and how it was resolved, and then make a determination about whether to hire (or continue employment) of someone with a criminal record. While programs approved under these regulations are not Residential Child Care programs, MHA recommends that programs adopt, at a minimum, the major prohibitions contained in COMAR 14.31.06.05 (e.g., a conviction for child abuse or neglect, spousal abuse, rape, sexual assault, homicide, or any crime against children).

Q20. Is there a statute of limitation on the type of criminal charge it was?

A. No; the program should review and make a decision about anything identified by the criminal background check.

.10 Discharge from Services

No questions.

.11 Human Resource Development

Q21. Are there requirements, mandates, or maximum number for OMHC or PRP caseload sizes?

A. No; however, the program should have a mechanism to assign, review, and evaluate caseload sizes, based on the needs of the individuals served (e.g., complexity of needs, frequency of service, type of service, etc.).

Q22. Can the 8 hours of continuing education be in-house training and CEUs?

A. Yes.

Q23. Eight hours of continuing education is not very much, considering all of the things on which staff need to be trained.

A. Eight hours is the minimum requirement. While MHA encourages programs to offer more than the minimum requirement, it is also aware of the potential cost to the program to do so.

Q24. How should continuing education be documented?

A. The program can choose how to document staff orientation and continuing education. Two possible options are to include the training documentation in each staff person's personnel file or to keep a separate training file. Training documentation should contain a brief content description/outline and a record of attendance, including signatures of the attendees.

Q25. Is it true that only one person certified in CPR and first aid has to be on duty at the facility at any time?

A. Yes; however, for multi-facility programs, you need such a person on duty at each facility site. Furthermore, programs are reminded that these are minimum standards and that exceeding the minimum standards may be preferable. For example, while it is not necessary to have certification in order to provide services in an individual's home or in

an RRP residence, programs should evaluate the needs of the individuals served and determine if it seems prudent to have additional certified staff.

Q26. Can an OMHC hire an MSW, who is not yet licensed, to provide clinical treatment services?

A. No; individuals must either be licensed or otherwise authorized under an appropriate licensure board in order to provide or bill for clinical treatment services.

Q27. Is there guidance for billing OMHC services provided by a student?

A. Bill for these services the same way other billing is done. OMHC services are billed by CPT code, not by the individual staff person who provided the service. A student rendering services in an OMHC must be pursuing a degree at an accredited college or university toward state licensure as a mental health professional and delivering services as part of a formal fieldwork placement through the accredited college or university. The student must also comply with the applicable professional licensing laws with respect to supervision requirements and be appropriately screened, oriented to the program's policies and procedures, and supervised.

Q28. Does the student's supervisor need to be on-site while the student is rendering services?

A. No; however, there must be processes for supervision and observation of the student on a regular basis.

Q29. May a program use other types of students than what is described in this section of the regulations? For example, can an undergraduate student do a fieldwork placement in a PRP?

A. Yes. This is an oversight in the regulations; MHA did not intend to prevent PRPs from offering fieldwork placements to undergraduate students.

Q30. Do students' notes need to be co-signed?

A. Yes; in addition, the student's signature should indicate the student status (e.g., Jane Doe, SW student/intern).

.12 Quality Management (QM)

No questions.

.13 Reports of Death

Q31. Have instructions for reporting deaths changed?

A. No; the reporting form is available on MHA's Web site (www.dhmh.state.md.us/mha) under forms.

Q32. To whom should reports of death be sent?

A. The statute requires the program to send reports of death to MHA, the local Health Officer, and the Maryland Disability Law Center (MDLC), which is under contract as the designated state protection and advocacy agency. In addition, while not required by statute, the program should submit a copy of the death report to the CSA, as requested.

Q33. Why do reports of death need to be sent to the CSA?

A. While the statute does not require this, it is often the CSA that does any follow-up that may be requested by the DHMH Mortality Review Committee.

Q34. Does the CSA need to follow-up if the CSA receives reports of deaths where an autopsy was ordered?

A. Possibly; this will depend on the circumstances of the death. MHA will notify the CSA when additional information is needed.

Q35. Who is the Health Officer on DHMH Form 4364 B under "Notifications?"

A. Each local jurisdiction (e.g., County) has its own Health Officer. See the DHMH Web site (www.dhmh.state.md.us) for a listing of Health Officers.

Q36. On DHMH Form 4364, what about the need to report the death to the local police and get a Police Report Number when the police "refuse" to take the call?

A. Reporting deaths to the local law enforcement agency is required by statute. If the local law enforcement agency "refuses" to take the call, this should be so noted, including the name of the individual to whom the program spoke, whenever possible.

Q37. If the program's client dies in a hospital, does the program still need to inform the police? This involves a lot of work for clinicians, who sometimes need to go in person to file a police report of death.

A. Yes.

Q38. Do the client's residential program and also the client's OMHC both need to complete a death report?

A. Yes, the statute requires both programs to complete a death report. Additionally, one program versus the other may have access to more complete information.

Q39. Does the program need to report missing persons to MHA?

A. No; however, depending on the situation, the program should inform the CSA and the local law enforcement agency, as appropriate.

.14 Staff Credentials, Competencies, and Privileges

Q40. What is primary source verification of licensure?

A. This is when the program verifies directly with the applicable professional Board that an individual is licensed and can usually be done on-line. The program should print out the licensure verification and place it in the individual's personnel file.

Q41. Is a copy of the license that the individual supplies good enough?

A. No.

Q42. Is there a cost for verifying licenses with the licensure boards?

A. No; the program can go on-line to verify licensure and does not need to pay a fee.

Q43. It seems to me that the primary source verification of an individual's licensure status through the Maryland Board of Professional Counselors and Therapists was not free and could not be performed on-line. Do you know anything about this?

A. The Maryland Board of Professional Counselors and Therapists now has an on-line system, which is free of charge, for verifying licensure.

Q44. Does primary source verification need to be done for licensure renewals?

A. Yes.

Q45. Does the program need to do primary source verification of current licensed employees or just new hires?

A. Primary source verification needs to be done for all licensed employees. For new hires, this must be done at the time of hiring and at each subsequent licensure renewal interval. For current licensed employees, this must be completed by the next licensure renewal at the latest and for all subsequent licensure renewal intervals. This should result in all primary source verifications being completed for currently licensed employees by no later than December 31, 2009.

Q46. Does the program need to do primary source verification of educational requirements, such as high school diplomas, transcripts from colleges and universities, etc.?

A. No; primary source verification is not required for the educational requirements, although the program may decide to do so. The program should have, however, some evidence (e.g., copy of diploma, transcript, etc.) that the minimum educational requirements have been met.

.15 Rights

Q47. The seclusion and restraint prohibition needs to be spelled out much more clearly; especially what constitutes "restraint."

A. Seclusion and restraint are prohibited in community programs.

Q48. Can a community program use mechanical restraints?

A. No; mechanical restraints cannot be used in community programs.

.16 Complaints

No questions.

.17 Grievances

No questions.

COMAR 10.21.20 – Community Mental Health Programs – Outpatient Mental Health Centers

.01 Scope

Q1. Are there any ramifications of the name change of these regulations from Outpatient Mental Health Clinic (OMHC) to Outpatient Mental Health Center (OMHC)?

A. No.

.02 Definitions

No questions.

.03 Approval

Q2. How long does a new provider, which is not approved under any other MHA Community Program regulations, need to operate as a group practice before applying to become approved as an OMHC under these regulations?

A. For a minimum of one (1) year.

.04 Program Model

Q3. What is meant by the word "facility?"

A. A "facility" for purposes of these regulations is a site whose primary purpose is to provide outpatient mental health treatment services, and is typically space that is rented/owned by the program. A program can still offer off-site services in the client's home, school, health center, senior center, etc., and these are not considered facility program sites. [definition from Health General Article 10-102 (e) Facility – "(1) Except as otherwise provided in this title, 'facility' means any public or private clinic, hospital, or other institution that provides or purports to provide treatment or other services for individuals who have mental disorders. (2) 'Facility' does not include a Veterans' Administration hospital."]

Q4. What is meant by the phrase "multi-site facility?"

A. A multi-site facility means a program that operates more than one program location that meets the above description (e.g., operates more than one facility location in different parts of the same county or operates facility locations in more than one county).

Q5. If a therapist renders services at a health center, is that an OMHC billable service?

A. Yes; however, that would be considered an OMHC "off-site" service, not an OMHC facility-based service.

Q6. Are schools considered "off-site" service sites?

A. Yes.

Q7. Is a weekly review of the ITP now required?

A. No, the weekly review of the ITP, which is referred to in this section of the regulations, is only required for the Intensive Outpatient Program (IOP) service constellation. IOP is an optional, not a required, service for OMHCs.

Q8. For IOP services, what is meant by "short-term?"

A. Approximately 30-60 days.

Q9. For IOP services, does the ITP review need to be done weekly for Medicare, dually-eligible (Medicare/Medicaid), and privately insured clients (Medicare has a less stringent ITP review requirement for individuals receiving IOP services)?

A. No; the IOP weekly ITP review requirement is only for those individuals who are billed through the PMHS. It is acceptable to follow the Medicare and private insurance billing requirements for those individuals who have Medicare or private insurance or who have dual eligibility.

.05 Eligibility, Screening, Enrollment, and Orientation

Q10. What are the new time frames regarding screening assessments for new OMHC referrals?

A. There has been no change for individuals referred from an inpatient facility; a screening assessment must still be completed within five days for those individuals. For all others, the program director, in collaboration with the medical director, must establish a procedure to review clinical acuity. Once clinical acuity is determined, the program must establish a date for a screening assessment and inform the client of the date for the screening assessment or, if there will be a delay in the screening assessment, a tentative timeframe for services and alternative services that may be available.

Q11. For referrals from an inpatient facility, is the screening assessment time frame requirement five working days or five calendar days?

A. Regulation 10.21.20.05B(1)(a) specifies five (5) working days.

Q12. If you schedule everybody for their first appointment within 5 working days of referral, is it necessary to document a review process for clinical acuity?

A. No; assessment of clinical acuity is only required for individuals for whom a screening assessment cannot be scheduled within 5 working days of receipt of referral.

.06 Evaluative Services Provided

Q13. Is there funding to purchase the required co-occurring assessment tools?

A. No; funds are not available, but some tools are free of charge.

Q14. Which instruments on the substance abuse screening tool list are free (i.e., in the public domain)?

A. See attached list.

Q15. Is the OMHC required to do a "full-blown" substance abuse assessment?

A. No; however, if the substance abuse screening indicates that additional follow-up (i.e., additional substance abuse assessment or treatment) is needed, the program must either provide the needed services or refer the individual for the needed services.

Q16. At what age does the substance abuse screening need to be completed?

A. Use clinical judgment; the attached list of screening tools indicates the population for which the tool is intended (e.g., adults, adolescents, etc.).

Q17. For adolescent intakes, does the OMHC need to do a formal substance abuse screening?

A. Yes, using an age-appropriate scientifically validated substance abuse screening tool.

Q18. Is there a "grandfathering" period for substance abuse screening, or do programs need to "go back" and screen all individuals already receiving services?

A. The regulation amendments require a substance abuse screening assessment to be done on admission. For individuals already receiving services, the substance abuse screening assessment is to be done no later than the next scheduled ITP review; although programs may choose to conduct the screening assessment sooner, if clinically indicated.

Q19. What, if any, training will be made available for staff to become competent to provide substance abuse screening assessments?

A. MHA plans to provide additional training in the area of co-occurring disorders; however, programs should follow any guidelines/instructions that accompany the screening assessment tools themselves and seek additional training as needed.

Q20. What is the criteria for a primary Axis I diagnosis of substance abuse versus a secondary diagnosis?

A. Refer to the DSM-IV-TR. For individuals with co-occurring substance abuse and mental illness who are being seen within the MCO, the MCO will treat the substance abuse and the low severity mental illness. For individuals in the OMHC with co-occurring substance abuse and mental illness, the OMHC will treat the mental illness and the low severity substance abuse. The OMHC service is to be performed by a licensed mental health professional who has demonstrated competencies to provide treatment to individuals with co-occurring disorders.

Q21. Is there a substance abuse screening tool that has been scientifically validated for use with geriatric individuals?

A. Yes; the *Alcohol Use Identification Test (AUDIT)*, and its shorter version, *AUDIT-5*; and the *MAST-G* (geriatric) and its shorter version, *Short MAST-G*.

Q22. Does the provider need to obtain documentation of the physical exam?

A. No, the provider is no longer required to obtain a copy of the individual's physical examination. However, the provider is required to review the individual's somatic status, refer the individual to a primary care provider as indicated, and maintain ongoing collaboration and coordination with the individual's primary care provider as indicated. Programs may still choose to request copies of the physical examination for individuals with complex medical issues.

.07 Treatment Planning and Documentation

Q23. What do you consider a visit for purposes of determining when to do the initial ITP?

A. It includes all clinical assessment, evaluation, and treatment services.

Q24. Do you have to document in a contact note that an individual's treatment plan review has been completed or will the ITP review itself suffice on its own?

A. Yes, document in a contact note in addition to the individual treatment plan; this will establish the actual date the individual and therapist developed the ITP and will further demonstrate the individuals' participation in the ITP and ITP review process.

Q25. What do the individual treatment plan reviews have to look like; is the form in APS CareConnection® acceptable?

A. The ITP in APS Care Connections® meets the COMAR ITP and ITP review documentation requirements; however, a program can also choose to use its own format, as long as it includes all the regulatory requirements.

Q26. Is a weekly review of the ITP now required?

A. No, a weekly review of the ITP is only required for the Intensive Outpatient Program (IOP) service constellation. IOP is an optional, not a required, service for OMHCs to offer.

Q27. Are monthly progress summary notes still required for OMHCs?

A. No; although programs may choose to continue to document monthly progress note summaries. The monthly progress summary note requirement was eliminated because the requirements for contact notes for each contact have been significantly increased in order to comply with Medicaid documentation requirements.

Q28. What exactly should the OMHC contact note contain?

A. Refer to 10.21.20.07B(1) for the list of requirements.

Q29. The content for OMHC contact notes is very cumbersome, especially the progress toward goals in every contact note for individuals who make only a very little progress from contact to contact. Can such a note be done quarterly instead of for every contact?

A. No.

Q30. Does a contact note need to be written when an assessment is completed, or is the assessment document itself sufficient?

A. No, a contact note does not need to be written, as long as the assessment itself is clearly dated.

Q31. Does the physician's contact note for a "medication only" visit (CPT code 90862), which is a code without a specific time limit, need to have the start time and either end time or duration of the visit?

A. No; however, the note needs to describe the service that was rendered.

Q32. When was the requirement for a monthly progress summary note discontinued for OMHCs?

A. When the regulations became effective on January 14, 2008.

.08 Treatment Services

Q33. If the OMHC has staff who are capable of providing substance abuse treatment as an adjunct to the individual's mental health treatment, does the OMHC need to be approved under the AADA regulations as a substance abuse provider?

A. No. For individuals with co-occurring substance abuse and mental illness who are being seen within the MCO, the MCO will treat the substance abuse and the low severity mental illness. For individuals in the OMHC with co-occurring substance abuse and mental illness, the OMHC will treat the mental illness and the low severity substance abuse. The OMHC service is to be performed by a licensed mental health professional who has demonstrated competencies to provide treatment to individuals with co-occurring disorders.

Q34. Does the substance abuse counseling that is provided in an OMHC as a part of the integrated treatment for an individual with a co-occurring disorder need to be done by a licensed substance abuse counselor (i.e., LGADC or LCADC)?

A. Not necessarily. The service is to be performed by a licensed mental health professional who has demonstrated competencies to provide treatment to individuals with co-occurring disorders. Providing treatment for co-occurring disorders means that the licensed mental health professional integrates the substance abuse treatment within the mental health treatment in each session that is billed through the PMHS.

Q35. What if it becomes clear that the individual's substance abuse diagnosis is the primary diagnosis and the mental health diagnosis is secondary? Can the program provide treatment, if it has staff who is competent to do so? Who is billed? Does the program then need to be approved as a substance abuse provider?

A. The PMHS does not reimburse for services that are for substance abuse treatment only. As discussed in the answer to Q34, the PMHS will reimburse for treatment when the licensed mental health professional integrates the substance abuse treatment within the mental health treatment in each session that is billed through the PMHS. The integrated treatment must be provided by a licensed mental health professional who has demonstrated competencies to provide treatment to individuals with co-occurring disorders. When the individual's needs are primarily substance abuse, the individual should be referred to the MCO or other substance abuse treatment provider for substance abuse treatment. If the program itself is capable of providing primary substance abuse treatment that is not billed through the PMHS, it should consult with the Alcohol and Drug Abuse Administration (ADAA: 410-402-8600) regarding whether it needs to be approved under ADAA regulations.

Q36. Will there be training provided regarding "co-occurring disorders?"

A. Yes, MHA is planning to provide additional training in this area. In addition, programs are encouraged to seek and receive training in this area, since a large percentage of individuals served in the PMHS have co-occurring disorders.

Q37. What are the options for providing the 24/7 on-call and crisis intervention coverage, especially in rural areas where it is cost prohibitive?

A. The agency should collaborate with the CSA and possibly consider providing this service through a written shared service agreement with another OMHC or crisis response agency.

Q38. Can a clinician perform telephone crisis consultation while the OMHC is open?

A. The program must have the capacity, when clinically indicated, to provide crisis services "face-to-face" during the 40-hours the OMHC is open. In addition, the program must provide on-call and crisis services by telephone during the hours the OMHC is not open (either through the OMHC or by written agreement with another OMHC or mental health crisis service provider). Instructing individuals in crisis (via an answering machine message) to go to the emergency room or to call 911 is not sufficient.

.09 Support Services

No questions.

.10 Program Staff

Q39. Are Registered Nurses considered "licensed mental health professionals?"

A. While the licensing boards do not use the term "licensed mental health professional," MHA considers a registered nurse to be part of the "multidisciplinary licensed mental health professional staff" required by the OMHC regulations. In addition, MHA is requiring RNs rendering services in OMHCs to agree to acquire the credential of RN-C or RN-BC in psychiatric/mental health nursing within approximately 18 months of hire. Registered nurses who are licensed as either an APRN/PMH or a CRNP-P are already licensed at the advanced practice level and do not need any additional certification to meet the requirements for a "licensed mental health professional."

Q40. If a program employs both an LGADC/LCADC and an LGPC/LCPC, does this meet the requirement for two (2) different mental health professions?

A. No; these are all licensed through the Board of Professional Counselors and Therapists and, thus, are all considered the same professional discipline.

.11 Multi-Facility Programs

Q41. Define "multi-site facility."

A. More than one facility site.

Q42. Does each multi-facility program site need to be open 40 hours per week?

A. No.

Q43. Is it required that each location of a multi-facility program offer evening and weekend hour?

A. No, not necessarily; although the days and hours that services are offered should be responsive to the needs of the individuals served.

Q44. If an OMHC operates 3 OMHC sites (i.e., 1 primary location and 2 additional secondary locations), are the minimum requirements one 20 hour-per-week program director, one 20 hour-per-week medical director, and one clinical coordinator for each of the 2 additional secondary locations for half of the time that the additional location is open?

A. Yes; although the program needs to evaluate and provide the amount of administrative and clinical oversight that is needed at each additional secondary location.

Q45. Since the medical director's time is valuable and expensive, how frequently does he/she need to provide on-site consultation (i.e., what does "routine basis" really mean)?

A. At a minimum of monthly.

Q46. For providers operating multiple OMHC sites, does there need to be a psychiatrist at each OMHC site?

A. Yes, a psychiatrist must be available on-site at each multi-facility OMHC location according to the needs of the individuals served.

Q47. How many hours per week does the psychiatrist need to be on-site at each additional program location?

A. The number of hours is not specified in the regulations; it is guided by the needs of the individuals served at each additional OMHC location.

Q48. Can the representatives of the two mental health professions required in this regulatory section be licensed at the graduate level (e.g., are an LGPC and LGSW sufficient)?

A. Yes; however, individuals must be supervised in accordance with the applicable licensure board requirements.

Q49. Who can serve as the clinical coordinator for a multi-site facility?
A. The individual must be a licensed mental health professional who can practice independently (e.g., LCSW-C, LCPC, APRN/PMH).

Q50. Can the clinical coordinator role be shared by two individuals?
A. No; one individual must fulfill that role at each additional multi-facility site.

Q51. Are services provided in a school considered a separate "multi-facility program site," needing to meet the requirements of this regulatory section?
A. No, schools are considered off-site service locations.

Q52. If a clinician visits a person's house, is that considered off-site or is that considered a "facility?"
A. Off-site.

Q53. Does each multi-facility program site need a separate MA provider number?
A. Yes.

Q54. Do additional program sites need to be in the same county as one another?
A. No.

Q55. Are there any restrictions on how far away an additional facility site can be?
A. No.

Q56. For programs that are trying to build a client base at a second site, it is cost prohibitive to hire a second licensed mental health professional until the census warrants it. Are there any exceptions to the two mental health professional requirements in this situation?
A. No; the multi-disciplinary team is a requirement of OMHCs. OMHCs are reimbursed at a higher rate because OMHCs provide more comprehensive services (such as treatment services provided by an array of licensed mental health professionals, coordination of services and supports, individual treatment planning by a multidisciplinary treatment team, clinical oversight and direction of a medical director, and treatment planning by a multidisciplinary team) than individual practitioners.

COMAR 10.21.21 – Community Mental Health Programs – Psychiatric Rehabilitation Programs for Adults

.01 Scope
No questions.

.02 Definitions
No questions.

.03 Approval
No questions.

.04 Program Model

Q1. Why is there such an emphasis on eliminating goals that are "maintenance-oriented," especially if a person is doing fairly well, but still wants/needs the services and supports that the program provides?

A. Since PRP services are reimbursed by Medicaid, CMS is reviewing and auditing States to assure that services are medically necessary and rehabilitative. The expectation is that an individual in need of PRP services has an individual plan that identifies the services and strategies needed to facilitate the individual's achievement of his/her rehabilitation goals. PRPs need to prepare individuals to achieve goals by developing greater skills in the areas of self-sufficiency, wellness self-management, and independence to support the individual's recovery. The program needs to work with individuals to develop natural supports in the community, and skills for work and independent living, as appropriate.

.05 Eligibility, Screening, and Initiation of Service

Q2. If an individual is obtaining mobile treatment services, can he/she also obtain psychiatric rehabilitation program services?

A. No, but there can be a transition period, which must be authorized through MAPS-MD, between services.

Q3. What are the new requirements regarding the time frames for screening assessments and initial IRPs?

A. The program now has 10 days to conduct a screening assessment (not necessarily face-to-face) and to inform the individual if he/she has been accepted for services. Once PRP services are initiated, the program has an additional 30 days to conduct a comprehensive rehabilitation assessment and develop the initial IRP with the individual.

Q4. Does a separate screening assessment need to be done if the comprehensive rehabilitation assessment is done within 10 days?

A. No.

.06 Evaluation and Planning Services

Q5. Do individuals served in PRPs and RRPs need an annual physical examination?

A. No, the provider is no longer required to obtain a copy of the individual's physical examination. However, the provider is required to review the individual's somatic status, refer the individual to a primary care provider as indicated, and maintain ongoing collaboration and coordination with the individual's primary care provider, as indicated.

Programs may still choose to request copies of the physical examination for individuals with complex medical issues.

Q6. Do programs need to request a variance in order to maintain an integrated PRP/OMHC record?

A. No; however, the program needs to be sure it is complying with the record documentation requirements of both regulatory chapters.

Q7. Are monthly progress summary notes still required for PRP records?

A. Yes, at a minimum of each month, a PRP progress note or a contact note must include the elements of a monthly progress summary note. This is because programs are not required to document an assessment of progress toward goals in each contact note.

Q8. Are electronic records and signatures permitted?

A. Yes, as long as the records, including signatures and dates, are HIPAA compliant and as long as the records are accessible for review. Programs must use a software package that has been verified as HIPAA compliant. (see COMAR 10.21.17.09C(6)(b) for the federal HIPAA citation)

Q9. Does COMAR 10.21.21.06C(4)((d)(ii) mean that a signature of the psychiatrist is required for the IRP?

A. No; the psychiatrist's signature is required only if the individual is receiving medication prescribed through the OMHC and if the plan is an integrated ITRP.

.07 Rehabilitation and Support Services Provided

No questions.

.08 Residential Rehabilitation Program (RRP) Managed Intervention plan (MIP)

Q10. Is the MIP required for all individuals in an RRP?

A. No; the MIP is for individuals in RRPs who may be at risk of losing their housing or other services due to problem behaviors or problems that are not addressed in the IRP.

Q11. Is the MIP completed only when the individual is in the process of an unplanned discharge?

A. No, the MIP is a proactive effort for individuals in RRPs who are at risk of an unplanned discharge.

.09 Supported Housing Services for Adults

No questions.

.10 Staff Qualifications and Responsibilities

Q12. Can orientation be included in the 40 hours of PRP training that is required before a staff person can independently provide PRP services?

A. Yes.

Q13. Can on-line training be included in the 40 hours of PRP training that is required before a staff person can independently provide PRP services?

A. Yes, part of the required 40 hours of training may be offered on-line.

.11 Required Program Staff

Q14. What are the requirements for a rehabilitation specialist? Can a rehabilitation specialist who does not meet the new credential requirements continue in that role?

A. The rehabilitation specialist is not a new requirement; however, some of the requirements for serving in that capacity have changed. The rehabilitation specialist is responsible for overseeing services in the PRP and must serve in that capacity for a certain number of hours per week, depending on the size of the program. If the individual who occupied the rehabilitation specialist position at the time the regulations were promulgated does not meet the new credential/licensing requirements, the program may submit a variance request to MHA.

Q15. Can an RN be the PRP's rehabilitation specialist?

A. Yes.

Q16. Does an RN in the rehabilitation specialist position need to be an RN-C or RN-BC?

A. No; while this may be preferable, it is not required.

Q17. Can a person licensed as an LGMFT/LCMFT be the PRP's rehabilitation specialist?

A. Yes.

Q18. If a program operates more than one PRP site, does each site need to meet the program director and rehabilitation specialist requirements?

A. No; the requirements are based on the total number of individuals served at all locations. However, the program needs to evaluate and provide the amount of administrative and programmatic oversight that is needed at each additional site.

Q19. If a PRP serves both adults and minors, what are the program director and rehabilitation specialist requirements?

A. See the December 3, 2007 clarifying memorandum on this subject.

.12 Ratio

Q20. What is the maximum caseload size for a rehabilitation specialist or for a direct care PRP staff person?

A. Maximum caseload sizes are not specified; however, the program should have a mechanism to assign, review, and evaluate caseload sizes, based on the needs of the individuals served (e.g., complexity of needs, frequency of service, type of service, etc.). There is an average 1:10 staff-to-client ratio requirement that must be met for on-site PRP activities and off-site PRP services in a group.

COMAR 10.21.29 – Community Mental Health Programs – Psychiatric Rehabilitation Programs for Minors

.01 Scope
No questions.

.02 Definitions
No questions.

.03 Approval
No questions.

.04 Program Model

Q1. What types of services are permitted to be offered in a PRP for Minors?

A. Services that promote social, coping, self-help, and communication skills, as well as basic living and organizational skills, are permitted. This excludes educational tutoring, transportation, camp, etc. There is a PRP Best Practices subcommittee that will further define/describe these concepts and develop ways to measure interventions that promote skill acquisition.

Q2. What does the concept of resiliency mean as it related to PRP Services for Minors?

A. Resiliency is the ability to develop or enhance protective factors that can be utilized in times of stress or adversity. It is seen as the youth equivalent of "recovery." MHA will be further developing a working definition of resiliency that will be related to program outcomes.

.05 Eligibility, Screening, and Initiation of Service

Q3. At what age is someone considered to be a "minor?"

A. Up to age 18.

Q4. When the "minor" turns 18 and continues to meet the medical necessity criteria for PRP services, does he/she have to be transferred to a PRP for Adults?

A. Not necessarily. In a rare situation, a minor could continue to receive services from a PRP for Minors if he/she is still in high school and there are clinical reasons, documented by the individual's primary treating clinician, that this is the most appropriate PRP service. In addition, there needs to be an ongoing assessment of the individual's clinical, developmental, and functional progress either to support that it is appropriate for the individual to continue to receive services from a PRP for Minors or to transition to a PRP for Adults. Programs should also consider developing services that are specifically designed to meet the needs of transition-age youth, ages 16+ through 24.

Q5. Can the minor be referred for PRP services by the PRP's rehabilitation specialist?

[A. No; the referral for PRP services must be made by the licensed mental health professional who is providing ongoing outpatient mental health treatment services to the minor.]

A. Correction June 2008: No; the referral for PRP services must be made by the licensed mental health professional who is providing inpatient, residential treatment center, or outpatient mental health treatment services to the minor.

Q6. What if the program cannot meet the time frame for a face-to-face screening assessment in the 5 working days as required?

A. The program should document in the record why the screening assessment is late. If this is a regular problem, then the program needs to address it systemically.

.06 Evaluation and Planning Services

No questions.

.07 Rehabilitation and Support Services Provided

No questions.

.08 Discharge from Services

No questions.

.09 Program Staff

Q7. Can an RN be the PRP's rehabilitation specialist?

A. Yes.

Q8. Does an RN in the rehabilitation specialist position need to be an RN-C or RN-BC?

A. No; while this may be preferable, it is not required.

Q9. Can a person licensed as an LGMFT/LCMFT be the PRP's rehabilitation specialist?

A. Yes.

Q10. What are the additional experience requirements for the program director and rehabilitation specialist?

A. The regulations require the program director to have a minimum of three (3) years of experience working with emotionally disturbed youth and the rehabilitation specialist to have a minimum of two (2) years direct care experience working with emotionally disturbed youth.

Q11. If a program operates more than one PRP site, does each site need to meet the program director and rehabilitation specialist requirements?

A. No; the requirements are based on the total of number of individuals served at all locations. However, the program needs to evaluate and provide the amount of administrative and programmatic oversight that is needed at each additional site.

Q12. If a newly hired direct service staff has prior experience working in a PRP for Minors, does that individual still need 60 hours of on-the-job direct PRP supervision before providing services without direct supervision?

[A. Yes.]

A. Correction June 2008: Yes. It is preferable that the majority of these 60 hours include face-to-face supervision involving youth receiving PRP services. Supervision may occur in a variety of settings, including individual, group, community and in-home rehabilitation services that reflect the program's routine service delivery. The other portion of the on-the-job supervision may include working with the direct care staff on skills such as crisis response, de-escalation techniques, understanding child development, and documentation related to interventions and outcomes. It would not include hours related to program orientation and policies. All supervision must be documented in the personnel

chart in a clear format that shows hours, activities, and where supervision was provided.

Q13. Which PRP staff are eligible to provide the 60 hours of on-the-job direct PRP supervision?

A. The program director, rehabilitation specialist, or another direct service staff who has been providing PRP services independently at the program for a minimum of 6 months.

Q14. Does the one year work experience in a supervised mental health setting that is required for direct service staff need to be with children/adolescents?

A. No, although it is preferable.

Q15. If a PRP serves both adults and minors, what are the program director and rehabilitation specialist requirements?

A. See the December 3, 2007 clarifying memorandum on this subject.