STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Mental Hygiene Administration
Spring Grove Hospital Center – Dix Building
55 Wade Avenue – Catonsville, MD 21228
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

POLICY IMPLEMENTATION MEMO

TO: All Providers

FROM: Susan Steinberg, Esq.
Deputy Director, Community Programs and Managed Care
Mental Hygiene Administration

DATE: November 8, 2005

SUBJECT: 90801

Effective December 15, 2005, only one initial diagnostic interview (90801) may be rendered as part of the unmanaged 12 visits. If an additional initial diagnostic interview is required, the service must be specifically authorized. Claims will not pay for more than one 90801 without specific authorization. The following circumstances are examples of when specific authorizations for 90801 are required:

1) If there is a significant change in the patient's condition then an additional 90801 may be authorized. Reasonable clinical judgment will be applied by MAPS-MD to determine whether the service will be authorized.
2) If the consumer is admitted to a crisis bed then a second 90801 may be requested and approved. It is assumed that sufficient clinical need has been met based on the request for the crisis bed authorization.
3) Consumer selects a different provider.
4) A second 90801 may be requested and approval given during the initial diagnostic/evaluation period if the second 90801 is to be provided by a different rendering provider. The different rendering providers may be part of the same OMHC or independent of each other. The primary consideration is that one of the providers is physician and the other is a non-physician.
5) Prior to psychological testing performed by a psychologist.

MAPS-MD will be modifying CareConnection®, the authorization system, to create a new level of care that corresponds to any 90801 authorized beyond the first 90801 that is part of the unmanaged 12 outpatient visits (100 and 110 in CareConnection®). The authorization type in CareConnection® will be 111 for Medicaid recipients and 112 for the uninsured consumers.

Web Site: www.dhmh.state.md.us

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Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor — S. Anthony McCann, Secretary

To: All Residential Treatment Centers:

From: Brian Hepburn, M.D
Director

Re: Active Treatment within RTC

Date: October 20, 2005

Attached please find a clarifying policy regarding what constitutes and is reimbursable by the Public Mental Health System as "Active Treatment" for a Medicaid recipient admitted to a residential treatment center.

If you have any questions, please contact Al Zachik, Director, Child and Adolescent Services, 410-402-8487.

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Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary
Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

CHANGES IN PLACE OF SERVICE OR BILLING ADDRESS

The Mental Hygiene Administration has been informed by the Maryland Medical Assistance Administration that provider numbers are site specific and are not to be transferred to another address. This applies all providers enrolled in the Public Mental Health System.

If you open a new location you must contact Maryland Medical Assistance Administration, Provider Relations (410-767-5340) to obtain a new provider number for the new location. This generally means that the first seven digits of your provider number will remain the same, but that the last two numbers will be incremented by one. If you are not closing your current location you need to clearly state that you are requesting an additional provider number when speaking with the Medical Assistance Administration. You will also need to advise MAPS-MD, (1-800-888-1965, x3128) of the new provider number and location.

Programs inspected by and approved by the Office of Health Care Quality must also contact the OHCQ (410-402-8060) concerning the new location and provider number.

Providers are advised that they must have the new provider number and, if applicable, have contacted the OHCQ prior to providing services at the new location. Providers must also be in compliance with all applicable regulations (COMAR, MA, etc) on the first date that they provide services to consumers at the new location.

If you are changing your billing address / check address (pay to address) only, you need to have that information updated by the Maryland Medical Assistance Administration. When communicating with Medical Assistance make sure that you clearly state that you are changing your pay to address only. The billing address change will be sent by Medical Assistance to MAPS-MD.

The Mental Hygiene Administration can not make these changes for you. You must directly contact Provider Relations at the Maryland Medical Assistance Administration; Provider Relations at MAPS-MD; or the Office of Health Care Quality.

Please contact Ray Lewis at the Mental Hygiene Administration (410-402-8451) if you have any questions.

April 18, 2005

MENTAL HYGIENE ADMINISTRATION

Active Treatment:

1. Means the implementation of an individual plan of care for the treatment of a recipient of Maryland Medical Assistance admitted to a residential treatment center that:

    a. was developed and implemented within 14 days of admission;
    b. is designed to achieve the recipient's discharge from inpatient status at the earliest possible time;
    c. meets the procedural and content requirements of 42 CFR §441.155; and
    d. was developed by an interdisciplinary team of mental health professionals that met the qualifications specified in 42 CFR §441.156.

2. May include mental heath services rendered during the school day only when those services are an integral component of an individual plan of care (Individualized Treatment Plan) that meets the requirements of Section 1, above, and are:

    a. Directly provided by a licensed mental health professional* or a registered/certified art, music or movement therapist with specialized training in meeting the therapeutic needs of patients of residential treatment centers;
    b. directed by a physician or licensed mental health professional;
    c. designed to improve the patient's behavioral health status and aid in the recipient's recovery from a specific clinical diagnosis;
    d. Integrated with the educational services provided to the recipient; and
    e. Included in the individual plan of care (Individualized Treatment Plan), in which the clinical interdisciplinary team has determined that the child requires 24 hour a day residential placement in order to receive appropriate treatment and education.

* = a licensed mental health professional is someone who is legally authorized/permitted to render clinical services under a Practice Act of an appropriate licensure board.

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To: All Group Providers
All Individual Practitioners

From: Brian Hepburn, M.D.
Director, Mental Hygiene Administration

Re: Number of Services

Effective date March 1, 2005

The Public Mental Health System will reimburse Group Providers and Individual Practitioners for a single therapy session per service date. If two individual therapies sessions are provided then the billing should reflect the cumulative time provided to the consumer. It is anticipated that two therapy sessions on a single service date would be a rare occurrence. The total time should be billed as a single service combining the total time as prescribed below.

90804 Individual therapy, 20 - 30 minutes
90805 Individual therapy, 20 – 30 minutes with medical management and evaluation
90806 Individual therapy, 45 – 50 minutes
90807 Individual therapy, 45 - 50 minutes with medical management and evaluation

There has been no change in the qualifications of the provider for medical evaluation and the actual rendering provider should be included on the claim form.

Only one therapy session per day will be paid by the PMHS. There is no change in the authorization process or in the medical necessity criteria.

Under no circumstances should providers bill for CPT codes 90805 or 90807 in conjunction with 90862. These combinations will be regarded as an attempt to bill more than once for the same service.

Toll Free 1-877-4MD-DHMH • TTY for Disabled - Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.state.md.us

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To: All Outpatient Mental Health Clinics

From: Brian Hepburn, M.D.
Director, Mental Hygiene Administration

Re: Number of Services

Effective date March 1, 2005

The Public Mental Health System will reimburse Outpatient Mental Health Clinics (OMHC) for a maximum of two therapy sessions per service date. In addition, an OMHC may be reimbursed for pharmacological management (CPT Code 90862) on the same date of service.

If two individual therapies sessions are provided then the billing should reflect the cumulative time provided to the consumer. It is anticipated that two therapy sessions on a single service date would be a rare occurrence. The total time should be billed as a single service combining the total time as prescribed below.

90804 Individual therapy, 20 - 30 minutes
90805 Individual therapy, 20 – 30 minutes with medical management and evaluation
90806 Individual therapy, 45 – 50 minutes
90807 Individual therapy, 45 - 50 minutes with medical management and evaluation

One individual therapy and one family therapy session may be provided and billed on the same date of service. Individual and family therapies may be provided and billed on the same date of service but family and group therapies may not be billed on the same date of service. There is no change in the authorization process or in the medical necessity criteria.

Under no circumstances should providers bill for CPT codes 90805 or 90807 in conjunction with 90862. These combinations will be regarded as an attempt to bill more than once for the same service.

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Policy Implementation Memo

TO: All PRP Providers

FROM: Susan Steinberg, Esq.
Deputy Director, Community Programs and Managed Care
Mental Hygiene Administration

DATE: October 7, 2005

SUBJECT: Co-payments for PRPS

Co-payments amounts for Psychiatric Rehabilitation Program (PRP) services have been established based on the minimum service levels required for the authorized service. The co-pay amount is not affected by the actual number of services delivered in the month. The co-pay amount does not increase if services are delivered above the minimum level and does not decrease if the billed amount in any month is cascaded downwards. This memo clarifies the PRP billing memo issued February 17, 2005 related to claims with dates of service after April 1, 2005.

Concerns regarding this policy should be directed to the Mental Hygiene Administration. Claims and payment questions should be directed to MAPS-MD Claims Customer Services at 800-888-1965.

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To: All Psychiatric Rehabilitation Programs (PRP)

From: Brian Hepburn, M.D.
Executive Director

Re: **Child & Adolescent PRP- Medical Necessity Criteria**

Date: January 31, 2005

The Mental Hygiene Administration, with input from Maryland Disability Law Center, and various stakeholders, has clarified the Medical Necessity Criteria for Children and Adolescents requesting services of a Psychiatric Rehabilitation Program (PRP). Attached please find the medical criteria to be utilized by the Public Mental Health System effective February 1, 2005. All current authorizations will be honored.
All requests for PRP services for children and adolescents submitted on February 1 or after must meet the new criteria.

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POLICY IMPLEMENTATION MEMO

To: All Inpatient Psychiatric Facilities

From: Brian M. Hepburn, M.D.
Director, Mental Hygiene Administration

Date: July 12, 2005

Re: Authorizations for Care

Please Distribute to your Billing and Utilization Management Offices.

This is to remind all hospitals that pursuant to COMAR 10.09.06.06, Medical Care Programs Hospital Services, Preauthorization Requirements, in order to receive Medicaid reimbursement for mental health treatment the service must be preauthorized.

MAPS-MD authorizes inpatient care for hospital level care. It is the responsibility of the provider to contact MAPS-MD for preauthorization, continued-stays reviews (concurrent) and discharges. Given the emergency nature of an admission, the provider has up to 24 hours to seek initial authorization of the admission. However, all concurrent reviews must be requested prior to the provision of the additional days of care.

MAPS-MD has been receiving requests for initial or concurrent reviews weeks to months after the date of service for individuals with Medicaid eligibility upon admission. This is in violation of COMAR. **Effective September 1, 2005, MAPS-MD will not review days of care that are not timely requested. Without an authorization for the days of care, MAPS-MD will deny the claim.**

Retrospective reviews are only permitted if:
1. Consumer becomes Medicaid eligible after care has been provided.
2. Due to incorrect or insufficient information provided by Consumer at time of admission, provider was not aware of Medicaid eligibility.

MAPS-MD will provide courtesy reviews for individuals admitted without insurance or for whom Medicaid eligibility is questionable. Courtesy reviews provide an authorization for care that can be used when the consumer receives Medicaid eligibility. The Mental Hygiene Administration strongly encourages the use of courtesy reviews to “authorize” services, rather than the submission of medical records for a retrospective review. By obtaining courtesy reviews and “authorizations,” the hospital may submit claims in a more timely manner upon receipt of notification of the consumer’s eligibility for Medicaid.

Any provider seeking an exception to the above policy must submit the request in writing to Susan Steinberg, Deputy Director, Community Programs and Managed Care, 55 Wade Avenue, Dix Building, Catonsville, Md 21228

Cc: Cheryl Collins, Executive Director, MAPS-MD
Susan Steinberg, Deputy Director, MHA

:

ATTACHMENT TO THE DHMH MEMO
RE: Claims submission for inpatient psychiatric care- Public Mental Health System
January 7, 2005

INSTRUCTIONS FOR RETRACTION OF OVERPAYMENTS

- Providers should not return the overpayments to MHA or MAPS-MD at this time.
- Retractions will be taken against new claims payment in the January 31, 2005 check run.
- Payment will be retracted for all inpatient claims that are subsequent bill types (112, 113 and 114). The initial bill will not be retracted.
- To request an adjustment of the retraction, the provider must adjust the original inpatient claim to bill for the entire inpatient stay.
- If overpayments are not recouped in full in the January 31, 2005 check run, providers should send a check for the overpayment to:

  MAPS-MD
  P.O. Box 7061
  Silver Spring, MD 20907-7061

- The checks should be made out to MAPS-MD.
- The following information must accompany the repayment:
  - Claim Number
  - Consumer Identification Number
  - Date of Service
  - Revenue Code
  - Number of Units
  - Amount Paid
- If you have questions, please contact Claims Customer Service at 800-888-1965 menu option 5.

Medical Necessity Criteria
Child & Adolescent Psychiatric Rehabilitation Program Services (PRP)

Effective: FEBRUARY 1, 2005

I. Criteria for Admission

Psychiatric Rehabilitation Services (PRP) are for children and adolescents who have serious mental illness or emotional disturbance who have been referred by a licensed professional of the healing arts based on a screening, assessment, or ongoing treatment of the individual. The services must be goal directed and outcome focused. The services are time limited interventions provided only as long as they continue to be medically necessary to reduce symptoms of the individual's mental illness or to reduce the functional behavioral impairment that is a result of the mental illness and to restore the individual to an appropriate functional level. A clinical evaluation and the ongoing mental health treatment plan must indicate that the individual has a primary DSM-IV TR diagnosis that is causing the significant symptoms or serious functional behavioral impairment to be addressed by the rehabilitation services.

To assure that PRP services are both clinically indicated and meet medical necessity criteria there must be written documentation by the treating licensed mental health professional supporting the diagnosis, domains of dysfunction, and expectation of what PRP services would achieve.

In making a determination of whether to authorize or reauthorize PRP services, the Administrative Services Organization (ASO) will consider information presented regarding the following factors or criteria justifying the need for PRP services but will consider any other clinical information provided by a referring professional that in his or her professional judgment justifies the need for a child to receive PRP services for reasons *other* than those listed below:

A. Factors or Criteria Justifying the need for PRP Services

1. The youth's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community). Based on the clinical evaluation and ongoing treatment plan, PRP services are indicated and are expected to reduce the symptoms of the youth's mental illness or the functional behavioral impairment that is a result of the mental illness.

2. The impairment as a result of the youth's mental illness results in:

    a) A clear, current threat to the individual's ability to be maintained in his or her customary setting, or

    b) An emerging / pending risk to the safety of the individual or others, or

c) Other evidences of significant psychological or social impairment such as inappropriate social behavior causing serious problems with peer relationships and/or family members.

3. The individual, due to dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.

4. Either:

a) There is clinical evidence that the current intensity of outpatient treatment will not be sufficient to reduce the youth's symptoms and functional behavioral impairment resulting from the mental illness and restore him or her to an appropriate functional level, or prevent clinical deterioration, or avert the need to initiate a more intensive level of care due to current risk to the individual or others.

or

b) For individuals transitioning from an inpatient, day hospital or residential treatment setting to a community setting there is clinical evidence that PRP services will be necessary to prevent clinical deterioration and support successful transition back to the community, or avert the need to initiate or continue a more intensive level of care.

5. The individual's disorder can be expected to improve through medically necessary rehabilitation or there is clinical evidence that this intensity of rehabilitation is needed to maintain the individual's level of functioning; and

6. The individual is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.

B. PRP Service Requirements:

1. In order for rehabilitation services to be safe for an individual, Outpatient mental health services and social supports should be identified and available to the individual outside the program hours and the individual or the individual's parent/guardian should be capable of seeking them when needed when the individual is not attending the rehabilitation program.

2. The rehabilitation program must have a documented crisis response plan both inside and outside of program hours coordinated with the primary mental health clinician treating the individual that indicates clear responsibility for the mental health clinician and rehabilitation program.

3. The individualized service plan requires that services are rendered by a multidisciplinary team of professionals and support staff supervised by a licensed mental health professional and should be signed off by the licensed mental health professional. The Individual Rehabilitation Plan (IRP) must be carried out in accordance with the Child and Adolescent PRP regulations. The team, where appropriate, also shall seek input from teachers and other child serving agencies involved with the individual.

4. Family / Caregiver participation is required in the establishment, delivery and evaluation of the rehabilitation services provided.

II. Continued Stay Factors or Criteria for Continued PRP Services

The following criteria shall be met:

A. Clinical evidence and an evaluation of previously identified rehabilitation goals and interventions needed to improve individual outcomes indicate a persistence of the original problems or an emergence of additional problems that necessitate ongoing PRP services. If original problems persist, the individual's multidisciplinary team including the PRP provider, the individual's primary clinician and family / caregiver must evaluate why the problem persists and what, if any, overall plan of care modifications are necessary to improve outcomes.

B. For continued stay approval, the admission criteria above and any other clinical information provided by a referring professional that in his or her professional judgment justifies the need for a child to continue to receive PRP services will be considered. The need for continued PRP services should be supported by the individual's primary mental health clinician and family / caregiver.

C. There must be documented evidence that the individual is improving with rehabilitation services.

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December 30, 2005

Billing Clarification for Mobile Treatment Services (MTS).

Mobile Treatment Services (MTS) are paid through a monthly rate that is reimbursed through Medicaid or with state general funds through the public mental health system. The expectation is that consumers will be seen, at a minimum, for four face to face contacts in a month. The four visits is a minimum requirement as the Mental Hygiene Administration (MHA) expects the MTS to provide additional contacts as needed. Since MTS targets individuals who previously have not engaged in mental health treatment, services are expected to be delivered in community settings.

Can I count my unsuccessful outreach visits towards the required 4 visits?
The MTS provides outreach to individuals to facilitate the individual's acceptance of services and treatment. Occasionally, the MTS team goes to meet with an individual and the individual is not at home or may refuse to see the team. In these instances MHA has said that the program may count the attempted visits toward the four visits required per month. The MTS is to document in the medical record the unsuccessful outreach attempts to see the consumer.

What counts as a visit? If the team provides a home visit in the morning and the after noon is this counted as one visit?
Answer: It is routinely counted as one. The expectation with MTS is that individuals have not utilized Mental Health services and need an intensive treatment and rehabilitation team intervention. Therefore, the MTS should see the consumer at least weekly. However, there may be exceptions due to the clinical needs of the individual. Routinely seeing an individual through combined visits on the same day and counting the visits towards the minimum would not be considered adequate to manage the needs of the individual. If it occurs and MTS believes there is clinical justification to support seeing the person twice in a day, it must be documented in the record. MHA would see this as a rare occurrence, or would expect additional visits.

Does an office visit count as a face to face encounter?
Answer: MTS are expected to be in the community. However some services may be provided in an office location. If there are special groups such as substance abuse support group facilitated by the MTS team this may be counted toward the four visits. This may be a part of the process to transition individuals to more traditional services. If the individual is able to routinely come into the office then one would question the need for MTS. Again, it is imperative that documentation support the office visit.

If an intake is conducted mid month and the person is seen for services in the first month a couple of times, is that person's service billable?

Answer: Yes a minimum of two face to face contacts have been made and this is documented. This applies only to the intake month.

What if an intake is completed the last week of the month can the agency bill?
Answer: Yes a minimum of two face to face contacts have been made and this is documented

If a person is seen three times then disappears and a worker goes to the home a couple of times without success as well as making calls etc., can this be billed?
Answer: Yes as long as efforts to make contact are documented

When a person enters a hospital or jail for a period of time under 30 days and MTS visits the person in the institution to provide support, linkage, and discharge planning, and the person is released in under 30 days, with four face-to-face contacts, can we bill for the month?
Answer: If the person is in the hospital or jail for less than 15 days that month and the MTS visits the person to maintain continuity of care it may count the visits towards the minimum four provided the MTS makes at least 2 face to face visits in the community.

If a person decides to leave services mid month and proper discharge planning occurs, is that month a billable month?
Answer: Yes as long as least two visits were provided.

May a MTS program see more than one family member?
Answer: Yes, as long as each family member meets medical necessity criteria for the service and the MTS provides a separate and distinct intervention for each family member. Separate medical records should be maintained, and the contact properly documented.

May two family members be seen by the same team member at the same time?
Answer: Yes, however, this would be seen as rare. Separate medical records should be maintained, and the contact properly documented in each consumer's record.

December 30, 2005

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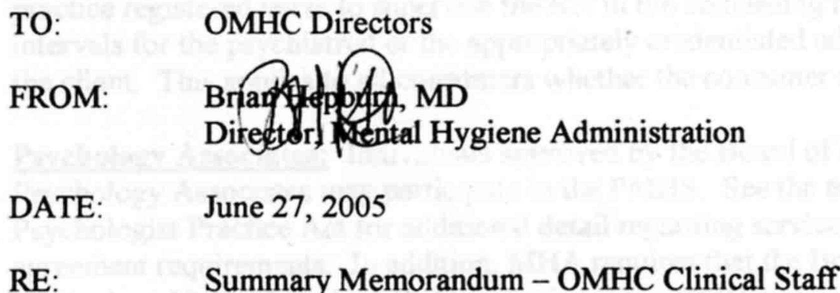
MEMORANDUM



TO: OMHC Directors

FROM: Brian Hepburn, MD
Director, Mental Hygiene Administration

DATE: June 27, 2005

RE: Summary Memorandum – OMHC Clinical Staff

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This memorandum is intended to summarize the clarifications that have been made by the Mental Hygiene Administration (MHA) over the past several months regarding the provision of clinical services in Outpatient Mental Health Clinics (OMHC) that are approved under COMAR 10.21.20, Outpatient Mental Health Clinics, and reimbursed by the Public Mental Health System (PMHS). All staff rendering clinical services must first be legally permitted under a Practice Act of an appropriate licensure board (i.e., Physician, Social Work, Psychology, Nursing, Professional Counselors and Therapists) to render specific services. Approved OMHC programs are reminded that, in addition to verifying the appropriate staff credentials of all clinical staff, they are required to have a process for granting clinical privileges and providing clinical supervision, based on the individual staff member's competency to provide the service. Additionally, providers billing Medicare must comply with Medicare billing rules.

Although many of these have been distributed previously, enclosed again are the letters of clarification that the Mental Hygiene Administration (MHA) has received from several of the professional Boards. OMHCs and individual staff members should refer to the various professional Practice Acts for additional clarification and detail. To prevent disruption in services, MHA is working with OMHCs on transitioning existing unlicensed staff to licensed status in certain specified circumstances pursuant to provider-specific MHA approved transition plans.

Students: Students in a formal training program, directed at obtaining a license in a mental health field through a college/university and approved by the appropriate licensure board, may participate in the PMHS (i.e., provide billable services) with appropriate supervision in an OMHC. In addition, the appropriately licensed healthcare supervisor must, on an established interval, observe the student and consumer during a therapeutic service. For greater detail, see the memorandum, dated March 17, 2005, "Provision and Reimbursement of Services by Individuals in Training Programs." A provider may not bill for service provided by a student in an individual or group practice.

Registered Nurses: As clarified in the enclosed letters, dated September 5, 2004 and April 5, 2005, from the Maryland Board of Nursing (MBON), it is within the scope of practice for a registered nurse to perform supportive counseling. MHA, however, will only reimburse OMHCs for the RN-C and RN-BC (i.e., those RNs who have additional certification in psychiatric and mental health nursing) performing this service. As stated in the April letter from the MBON, "there will need to be regularly planned periodic intervals established for the psychiatrist or an appropriately credentialed advanced practice registered nurse to supervise the RN in the counseling role, and planned periodic established intervals for the psychiatrist or the appropriately credentialed advance practice RN to assess/reassess the client. This applies to all consumers whether the consumer receives medication or not."

Psychology Associates: Individuals approved by the Board of Examiners of Psychologists as Psychology Associates may participate in the PMHS. See the enclosed information from the Psychologist Practice Act for additional detail regarding services that can be rendered and supervisory agreement requirements. In addition, MHA requires that the Board-approved supervising psychologist be employed by and credentialed to practice at the OMHC.

Professional Counselors: Licenses issued by the Board of Professional Counselors and Therapists are: Licensed Clinical Professional Counselor (LCPC), Licensed Clinical Marriage and Family Therapy (LCMFT), Licensed Clinical Alcohol and Drug Counselor (LCADC), Licensed Graduate Professional Counselor (LGPC), Licensed Graduate Marriage and Family Therapy (LGMFT), and Licensed Graduate Alcohol and Drug Counselor (LGADC). See the enclosed letter, dated March 7, 2005 from the Board of Professional Counselors and Therapists, regarding services that can be rendered and supervisory requirements. In addition, MHA requires that the Board-approved supervisor be employed by and credentialed to practice at the OMHC.

Social Workers: Licenses issued by the Board of Social Work Examiners are: Licensed Social Work Associate (LSWA), Licensed Graduate Social Worker (LGSW), Licensed Certified Social Worker (LCSW), and Licensed Certified Social Worker-Clinical (LCSW-C). See the enclosed letter, dated September 8, 2004 from the Board of Social Work Examiners, regarding services that can be rendered and supervisory requirements. Note that the only service that can be rendered in an OMHC by an LSWA is a screening assessment. In addition, MHA requires that the supervising LCSW-C be employed by and credentialed to practice at the OMHC.

Transition Plans: In a memorandum ("Transition Plan Guidelines," March 14, 2005) to all OMHC providers, OMHCs were directed to assess the credentials of all OMHC staff providing clinical services and, if applicable, submit a transition plan to MHA by April 22, 2005. Those transition plans are in the process of being reviewed and each OMHC will receive a response indicating whether or not its transition plan has been accepted or if additional information is needed.

In general, for OMHC transition plans that indicated that individuals 1) were employed by the OMHC prior to April 1, 2005 and 2) are either in the process of obtaining education to sit for a licensure or certification examination or waiting to take a scheduled licensure or certification examination, MHA may grant the OMHC permission for those specific individuals to participate in the PMHS (i.e.,

provide billable services) ***on a time-limited basis that will be clearly specified by MHA in its letter back to the OMHC***. As a condition of this time-limited permission, the OMHC has an obligation to ensure that each transition plan employee is on target to obtain the required Maryland State licensure/other Board authorization/or additional certification within the approved timeframe. Upon notice that an employee will not be able to meet the approved deadline, the employee may no longer render clinical services in the OMHC and the OMHC may no longer bill the PMHS for services rendered by the employee. The OMHC must maintain documentation to support the employee's commitment and ability to obtain the appropriate licensure or certification within the approved timeframe (e.g., signed employee commitment statements, copy of letter from the applicable Board stating what courses are needed, copy of transcripts showing courses being taken, etc.).

OMHCs may not hire any new clinical staff members who do not already meet appropriate licensure/certification requirements.

Please contact Susan Steinberg at 410-402-8451, if you have any questions.

Enclosures:

Memorandum, "Provision and Reimbursement of Services by Individuals in Training Programs," March 11, 2005
Memorandum, "Delegation of Psychotherapy and Assessments," Board of Physicians, February 4, 2005
Letter from Board of Professional Counselors and Therapists, March 7, 2005
Letter from Board of Social Work Examiners, September 8, 2004
Letters from Board of Nursing, April 5, 2005 and September 20, 2004
Excerpt from the Psychology Practice Act

c: CSA Directors
MHA Management Committee
Herb Cromwell, CBH
Bill Dorrill, OHCQ
Sharon Ohlhaver, MHA

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MEMORANDUM

TO: OMHC Directors

FROM: Brian Hepburn, MD
Director

RE: Policy Clarification - Nurses in Outpatient Mental Health Clinics **(REVISED)**

DATE: November 2005

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The practice of nursing is governed by the *Nurse Practice Act* (Annotated Code of Maryland, Health Occupations Article, Title 8; and COMAR Title 10, Subtitles 27 and 39). In addition, the State of Maryland, Board of Nursing provided the Mental Hygiene Administration (MHA) with following specific clarification regarding the scope of practice of the registered nurse performing counseling:

> "It is within the scope of practice of the registered nurse (not specifically a RN, C) to perform counseling – which is a supportive approach that encourages and assists the client in problem solving strategies to address day to day pragmatic issues. While the registered nurse is able to provide counseling – there will need to be regularly planned periodic intervals established for the psychiatrist or the appropriately credentialed advanced practice nurse to supervise the registered nurse in this counseling role; and planned periodic established intervals for the psychiatrist or the appropriately credentialed advanced practice nurse to assess/reassess the client. This would apply to all clients whether the client receives medication or not." (paragraph 2, letter from the Board of Nursing to MHA, dated April 5, 2005)

In addition to the above clarification regarding scope of practice provided by the Board of Nursing, the Mental Hygiene Administration (MHA) sets forth the following clarifications regarding payment of services through the Public Mental Health System (PMHS) for nurses rendering services in Outpatient Mental Health Clinics (OMHCs), which are regulated under COMAR 10.21.20, Outpatient Mental Health Clinics:

1. COMAR 10.21.20.08 sets forth the program staff requirements for a multidisciplinary team in an OMHC. A registered nurse (RN) may be considered part of the multi-disciplinary team.

2. An OMHC may bill the Public Mental Health System (PMHS) for the following services performed by an RN or LPN, as permitted by the Nurse Practice Act:

- 36415 Routine venipuncture (blood draw); see COMAR 10.27.20, Management of Infusion Therapy by the Registered Nurse and the Licensed Practical Nurse
- 90782 Therapeutic injection

3. An OMHC may bill the PMHS for the following services performed by a RN-C or RN-BC (certification in Psychiatric and Mental Health Nursing through the American Nurses Credentialing Center); Certified Registered Nurse Practitioners with a Psychiatry specialty, CRNP-P; and Certified Advanced Practice Registered Nurse/Psychiatric Mental Health, APRN/PMH:

- 90804, 90806 (individual therapy, which includes individual supportive counseling)
- 90846, 90847 (family therapy, which includes family supportive counseling)
- 90849 (multi-family group therapy, which includes group supportive counseling)
- 90853 (group therapy, which includes group supportive counseling)

4. An OMHC may bill the PMHS for the above supportive counseling services performed by an RN who has not yet received, but is pursuing, the additional certification. The OMHC shall be responsible for ensuring that the RN is pursuing the additional certification. Supervision is further defined as actual observation of supportive counseling sessions by the supervisor on a regular basis to ensure the quality of services being delivered. The following certification timelines apply:

- If the RN was hired before October 1, 2005, the RN has stated in writing an intention to receive the certification by December, 2006, per the OMHC's specific transition plan that was approved by MHA. **(Note: This extends the previous deadline by 6 months)**
- If the RN is hired after October 1, 2005, the RN has stated in writing an intention to receive the additional certification within 18 months of hire.

5. An OMHC may bill the PMHS for medication management (90862) or therapy with medication management (90805, 90807), if performed by a Certified Registered Nurse Practitioner with a specialty in Psychiatry (CRNP-P), as permitted by the Board of Physicians and the Board of Nursing.

6. An OMHC may bill the PMHS for diagnostic interview (90801), if performed by a Certified Registered Nurse Practitioner with a specialty in Psychiatry (CRNP-P) or an Advanced Practice Registered Nurse/Psychiatric Mental Health (APRN/PMH).

Attachments: Maryland Board of Nursing letters dated September 20, 2004 and April 5, 2005 (sent in October mailing)

cc: CSA Directors
MHA Management Committee
Herb Cromwell, CBH
Bill Dorrill, OHCQ
Sharon Ohlhaver, MHA

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POLICY EXCEPTION MEMORANDUM

DATE: January 18, 2005

TO: Becky Rau
MAPS-MD

FROM: Raymond C. Lewis, Chief, Office of Managed Care Operations
Mental Hygiene Administration

RE: **AUTHORIZATION OF ADMISSION PHYSICAL EXAMINATIONS FOR INPATIENT SERVICES AND FOR PARTIAL HOSPITALIZATION PROGRAM SERVICES - PEM# 05-152**

Whenever a physical examination is required for admission for inpatient services or for partial hospitalization services, and when the consumer is authorized for admission, MAPS-MD is to also authorize one (1) physical examination per episode of care. CPT codes 99251 through and including 99255 may be used by the provider in submitting claims for payment. These codes for initial inpatient consultation are limited to physicians only.

Please reprocess any claims described above which were previously denied by MAPS-MD. If necessary, please contact the provider to resubmit the claims. Claims which deny for any reason other than authorization are <u>not</u> to be paid. The provider may correct and resubmit any claims which are denied provided that the corrected claims are <u>received</u> by MAPS-MD within sixty (60) days of the date of the denial or nine (9) months of the date of service, whichever is later. Claims not previously submitted must be <u>received</u> by MAPS-MD within nine (9) months of the date of service. Claims which are resubmitted at MAPS-MD's request must be <u>received</u> by MAPS-MD within nine (9) months of the date of service or sixty (60) days the date of the request from MAPS-MD, whichever is later.

cc: Dr, Gayle Jordan-Randolph
Ms. Susan Steinberg
Mr. Dan Roberts
file

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Mental Hygiene Administration
Spring Grove Hospital Center – Dix Building
55 Wade Avenue – Catonsville, Maryland 21228
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor –– S. Anthony McCann, Secretary

PRP Billing Clarification –Revised 6-2005

PRP and Assisted Living:
The MHA has determined that Assisted Living and psychiatric rehabilitation program (PRP) services may be duplicative in nature. Individuals contract with an Assisted Living (AL) provider for assistance with activities of daily living and other independent living skills supports. Therefore, PRP services delivered within the AL facility would be compensated through AL and would not be eligible to receive reimbursement for PRP under the Public Mental Health System. An agency may provide facility based PRP services, at a separate location accessible (i.e. open to the public and not the AL residence), to individuals who reside in Assisted Living,

PRP and Medical Day Care:
Currently, the Medicaid regulations (COMAR 10.09.70) prohibit a PRP provider from billing on-site MA-covered PRP services on the same day as MA-covered Medical Day Care services. Similarly, under a monthly rate structure, a PRP provider would not be able to bill the separate on-site PRP rates for consumers who are receiving MA-covered Medical Day Care services that same month. However, the provider may bill the blended rates for that month as long as the minimum service requirements are met by providing only off-site services. If a consumer is not receiving on-site PRP, then the consumer may be eligible for Medical Day Care services. Off-site PRP services may not be delivered at the Medical Day Care site.

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QMB/SLMB

Effective March 1, 2005

The Mental Hygiene Administration (MHA) does not receive federal fund participation (FFP) for claims submitted for QMB and SLMB. These individuals receive services at 100% State dollars, and are considered uninsured by MHA. Therefore, effective March 1, 2005, a provider seeking authorization for services for a QMB or SLMB individual must follow the protocol for obtaining services for a non-insured individual. Example: PRP services must be approved by the Core Service Agency. Services to this population are not an entitlement and are subject to the availability of funds, in addition to a finding of medical necessity.

Authorizations received prior to March 1st, that extend past March 1st, will be honored. Upon expiration of the authorizations, the provider will be required to follow the procedure of obtaining authorizations for a non-insured individual.

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Rate Increase/Enhanced Client Support

Revised July 29, 2005

Goal: Support and maintain individuals in least restrictive setting, to provide supports to discharge individuals with long term stays from state psychiatric hospitals, and to facilitate the individual's recovery to achieve greater independence with community living

"Enhanced support" (ECS) means short-term, in-home services provided, in addition to other services to an individual, by a program that is approved by the Administration, to support the individual to remain in the community. Services are currently reimbursed in the fee-for-service system through procedure code S5150.

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Plan: Cost Neutral

1. Retain Short Term ECS through Fee for Service, not to exceed 10 days per episode.

Authorization through the CSAs and seek, at a later time, Medicaid reimbursement for the service. There will be a maximum benefit of 30 days in a fiscal year per individual.

2. Increase rates for Intensive Residential Rehabilitation Program (RRP) beds (1440 beds) proposed effective July 1, 2005 by $ 265 per month. The proposed new rate is $2,845. Approximately $4,500,000 in FFP and SGF.

The rate increase is needed to support RRPs to provide service to individuals with serious mental illness who have multiple needs and may require intensive staff support to remain in the community. This rate increase is to provide staff support at a minimum of 40 hours per week in the RRP with capacity for 24 hour staff availability for these individuals.

3. Support acceptance of challenging and consumers with multiple needs.

The CSA will screen all referrals for RRP and forward eligible referrals to RRP providers. If the provider rejects the referral, the CSA will review the decision and the rationale. All attempts will be made to negotiate with the provider and other mental health service providers to support the individual's access to RRP services.

Every six months, the CSA will forward to MHA, data on the number of referrals accepted and rejected by each RRP. The dispositions will be categorized according to reason for rejection, and if the CSA concurred with the decision. The purpose of the data collection is to identify a fair evaluation of a provider's rates of referral acceptance and rejection. However, the following situations that may result in a rejection will not be factored into the bed reallocation process. These reasons are listed below:

1. Present danger to self or others,

2. Forensic history that included recent harm to others
3. Significant medical complications
4. Current mix of residents may create a dangerous/unhealthy environment
5. Active drug use – illegal activity
6. Sexual Assault, Pedophilia, and
7. Fire setters
8. Severe incontinence that can not be managed with support

Examples of rejections that may lead to bed reallocation may include rejecting the individual who is not independent in community living skills (unable to cook, manage money), forensic history, currently working, etc. The CSAs will work with providers to assist the provider through training, in creating a program of acceptance of all referrals and supports individuals with challenging behaviors. The CSA may assist providers to negotiate with consumers regarding the requirements for payment of services. Since the system must facilitate access to RRP for all individuals meeting eligibility criteria, MHA will consider reallocation of RRP beds only as a last resort.

The CSA will send this data to MHA every 6 months. MHA will evaluate the data on an annual basis. Based upon this data, providers who have a history of not accepting referrals may have the number of RRP beds reduced in order to reallocate RRP beds to other providers who demonstrate a high acceptance, retention, and transition to independent living rate for consumers. Providers will have the option to appeal to MHA to review the decision to reallocate RRP beds.

4. Provide assistance to individuals experiencing special challenges

For individuals experiencing challenges in the RRP, the RRP is to contact the CSA and develop a Managed Intervention Plan (MIP) to coordinate services and supports to facilitate the consumer's tenure in the RRP and the consumer meeting his/her goals. The CSA will review the plan. If the plan is not successful, RRPs shall notify the CSA in advance before terminating or suspending services. (This is in current RRP draft)

5. Maintain a reserve fund of up to $1,000,000 for special needs clients

For providers accepting individuals with multiple and special needs discharged from a state hospital with a length of stay greater than 6 months, MHA will reserve funds to provide additional compensation. MHA will identify individuals in state hospitals that are eligible for these funds. MHA will contract with the CSAs to purchase services for these individuals. The CSAs will develop proposals that include a process (transition plan) to work with patients in state hospitals reluctant or fearful of leaving in order to be successfully discharged. Proposals may include individuals without insurance or who will be ineligible for Medicaid, services to support complex medical needs (such as unstable diabetes, hypertension,, oxygen dependent) , additional supports for individuals with forensic histories, other housing options such as assisted living, supported housing with mobile treatment or assertive community treatment services, etc. Based upon procurement requirements, CSAs will award funds to providers. Providers and CSAs will develop transition plans to target long stay patients for this initiative

In addition, MHA, through the CSAs, will review requests for additional funds for individuals with extraordinary needs currently in the RRP who need additional targeted service. Providers will submit a request to the CSA. The CSA will review and if validated, approve the request, and forward to MHA for determination. If MHA approves, the CSA contract will be modified for the new service.

POLICY IMPLEMENTATION MEMO

Re: Targeted Case Management for Children and Adolescents

Service Description: Targeted Case Management Services (TCM) are for children and adolescents who frequently require hospitalization, are at risk for out-of-home placement due to their inability to manage their mental illness or basic personal needs. Services include: assessment of the individual's needs, planning and coordination of needed services, linking the individual to services, monitoring receipt of services and advocating on behalf of the individual. It does not include direct therapy, and is not for the sole purpose of providing transportation to appointments. The Case Manager may attend conferences and meetings held on behalf of the child and family by other service providers, e.g. school system, Department of Social Services.

Case Management as adjunct to Outpatient Mental Health Center services (OMHC) or Psychiatric Rehabilitation Program (PRP) services:
A child/adolescent receiving services from OMHC or PRP should be receiving some case management as part of the OMHC or PRP service. These services include but are not limited to assistance in securing entitlements, coordination of services and liaison with external services (somatic). *However, Case Management may be authorized on a case-by-case basis, based upon the current needs of the child/adolescent, precipitating events, and other resources available to the child.*

Medical Necessity Criteria: The child/adolescent:

1. Has a serious emotional disturbance (SED)
2. Displays a functional impairment that substantially interferes with or limits the individual's role or functioning in the family, school or community activities
3. Is at risk of requiring a higher level of care if necessary services are not delivered
4. At time of initial eligibility determination, meets at least one of the following:
    a. Transition from hospital or RTC placement;
    b. Requested repeat hospitalizations within 30 days;
    c. Redirected from an emergency room to less intensive level of care more
    d. than once in a 3-month period;
    e. Admission to a state facility totaling 60 days within the past 2 years;
    f. History of medication non-compliance;
    g. Minimal support system, or in danger of out-of-home placement;
    h. Multiple diagnoses such as: SED/substance abuse, SED/ MR, or complex
    i. clinical issues;
    j. Difficulty in accessing vital outpatient services; or
    k. High profile case.

Guidelines for Continued Care: The following must be met.

1. Evidence of attempts to support the individual in accessing necessary services without the assistance of the case manager have not been successful, and
2. The individual continues to be at risk of needing a higher level of care if current services do not continue to be available.