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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: Public Mental Health System Providers

FROM: Brian Hepburn, M.D.
Executive Director, Mental Hygiene Administration (MHA)

RE: Reimbursement for outpatient mental health treatment for Medicare (MC)/ Medicaid (MA) Eligibility - Revised

DATE: September 3, 2008

Due to federal and state enforcement, MHA will no longer reimburse Medicare covered services for Medicare beneficiaries. Providers shall meet Medicare requirements when serving individuals with Medicare/Medicaid and Medicare/Uninsured Eligibility. This includes all requirements for physician on site, appropriate service providers, and other Medicare requirements. MHA does not have the ability to override these requirements. For services not covered by Medicare, such as psychiatric rehabilitation program services, MHA will continue to reimburse providers for eligible recipients

One exception will be for individuals currently receiving outpatient mental health services prior to September 1, 2008. Providers may re-bill for Medicaid payments which are automatically retracted when the consumer receives backdated Medicare eligibility. The claim(s) must be resubmitted on paper with approval from MHA or MHA's designee.

Claims for dually eligible (MC/MA) consumers who begin treatment on or after September 1, 2008, must be submitted to Medicare for payment, regardless of the effective date of the Medicare coverage. These claims may not be submitted for PMHS reimbursement.

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MEMORANDUM

TO: Outpatient Mental Health Center (OMHC) Providers

FROM: Brian Hepburn, M.D.
Executive Director, MHA

RE: Referral to OMHC for inmates with serious mental illness released by Department of Corrections (DOC)

DATE: October 14, 2008

In 2007, the Maryland State Legislature passed House Bill 281 to address the needs of inmates with serious mental illness. One of the requirements in that bill is to have an initial assessment completed for prisoners "with a serious mental illness who are within 3 months of release." The intent is to enable community case managers statewide to work with DOC inmates with serious mental illnesses prior to release in order to link them with medically necessary community mental health services and related supports; and provide every inmate with mental illness released from a State or local correctional facility, a timely appointment with a mental health provider, so that psychiatric medications and treatment can be continued without a lapse.

On October 15, 2008, a new process will become effective for DOC staff. Core Service Agencies (CSAs) will be working with the DOC to schedule appointments at OMHCs.

With the legislative mandate, Department of Public Safety and Correctional Services (DPSCS) and Mental Hygiene Administration (MHA) have identified the following process that will go into effect on October 15, 2008. OMHC appointments will begin for inmates being released December 1, 2008 or later.

1. As soon as an inmate who is diagnosed with a serious mental illness has been identified for release from a Maryland State Prison, a DPSCS social worker will complete the Community Mental Health Referral Form (CMHR). The form summarizes an inmate's demographic, criminal, medical, and psychiatric history and takes the place of the initial screening assessment required by COMAR 10.21.20.05B.

2. With the inmate's consent, the DPSCS social worker will complete and fax the CMHR form, and supporting documentation to the CSA located in the jurisdiction where the inmate will be residing.

3. This will occur at least 30 days prior to the inmate's release.

4. Once the inmate is within 30 days of discharge, the DPSCS social worker will assist the inmate in applying for all appropriate benefits such as Medicaid, Primary Adult Care, and SSI and SSDI.

5. Upon receipt of the CMHR Form, the CSA staff will contact a local OMHC provider to refer the individual. The OMHC should schedule appointments for assessment and diagnosis (COMAR 10.21.20.06A) and, if applicable, medication services (COMAR 10.21.20.08E). The appointments may be on the same day or different days, as determined by staff availability. However, appointments must occur within 30 days of the inmates release to ensure that the person does not run out of medications. Once the OMHC appointments are scheduled, the CSA staff will complete the appointment verification form and fax it back to the DPSCS social worker.

6. When providing OMHC services, a 90801 may be billed on the same day as a 90862, however; these services must be provided by different professionals.

7. The DPSCS will work with the inmates to ensure that they keep their first appointment at the OMHC.

The MHA and DOC are required to track inmate referrals, provider participation, and report back to the legislature with data. Your cooperation in this effort is vital. If you have any questions, please contact your local CSA Director.

Thank you.

CC: MACSA Directors
MHA Management Committee
MAPS-MD
Linda Raines
Lisa Cuozzo
Susan Steinberg

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TO: Public Mental Health System (PMHS) providers

FROM: Brian Hepburn, M.D.
Executive Director

RE: Compliance with Medicaid Requirements and billing the PMHS

DATE: October 22, 2008

This memorandum is to provide clarification on Medicaid rules and regulations regarding delivery of services and submission of claims. All providers in the PMHS, including programs regulated under COMAR 10.21 Community Mental Health programs and independent providers, are required to comply with these requirements.

Compliance Issues

Documentation: In order to receive reimbursement for services, providers shall deliver services according to all applicable federal and state rules and regulations. Medicaid reimbursement is paid for medically necessary services only. Services shall be documented in order to validate payment. Documentation shall include: the date and time of the service, reason for the service, the type and description of services delivered, progress towards goals, and signature of the individual providing services including the signer's credentials. Additional reference may be found in the applicable chapters of COMAR 10.21.17, 10.21.19, 10.21.20, 10.21.21, 10.21.29, 10.09.59, 10.09.36, and 10.09.70.

Up-coding: There have been providers who are not billing correctly. MHA has found indications of patterns of up-coding (billing a code for a higher rate than justified by the service performed) by some providers. As a result, MHA's Office of Compliance will initiate focused audits of services provided over the last three years. Please review your billing practices to make sure you are billing with the correct service codes. If you find an incorrect amount that has been billed please provide written information to: Ms. Audrey Chase, MHA, Director, Office of Compliance, 55 Wade Avenue, Catonsville, Maryland 21228. If MHA's or MAPS-MD's investigations find a pattern of up-coding, the result may be sanctions, financial penalties, reporting to licensing boards, and or referral to the Medical Fraud Control Unit.

Medical Assistance (MA) Provider Numbers:

In order to receive reimbursement within the PMHS a program must be approved by the Office of Health Care Quality (OHCQ) under the specific COMAR 10.21 Community Mental Health Program

chapter, or if an independent practitioner, licensed under the respective Health Occupations Board. Once these conditions are met, a provider submits a completed and signed Medical Assistance provider application along with the approval letter from OHCQ to Medicaid Provider Enrollment for a Medicaid Provider number.

MHA Regulated programs, require a separate MA Provider Number for each service and each location. The approval for each service and each location is provided by OHCQ when all applicable requirements are met.

- When an existing program delivers a new service, an application is sent to OHCQ for review and approval. Once approved for the new service, the provider must file a completed MA provider application to MA Program Provider Enrollment Unit with the approval letter for the new service.

- When a program is opening an additional location, notification is sent to OHCQ for review and approval. When approved, OHCQ will issue an approval letter for the new site or new service; the provider must file a completed MA Provider application with the Maryland MA Program Provider Enrollment Unit with the approval letter for the new site.

- When an existing program plans to relocate, the program is to send a letter, in advance of the relocation, regarding the change in location to OHCQ for review and approval. The existing MA provider number will continue to be used for the relocated service. However, the provider must send a copy of the approval letter from OHCQ to MA Provider Enrollment Unit so the new address may be updated.

- If an organization has separate Tax Identification Numbers or if an organization changes their tax identification number, a separate MA Provider number is required. Therefore, the provider must file a MA Provider application with the Maryland MA Program Enrollment Unit with the new tax identification number.

Group Practices and Physician Groups: Group practices are only to include licensed mental health professionals who are authorized under health occupations to practice independently. Physicians are to have either an individual MA provider number or a physician group practice MA number. If you have a physician currently in your group practice under one MA group practice provider number, a new MA Provider application is to be submitted to MA Provider Enrollment Unit for a separate MA Provider number for the physician.
All applications are to include a copy of the licenses of the indivduals in the practice. Only licensed mental health professionals authorized to practice independently may provide mental health services and receive reimbursement in the PMHS.

If you have further questions please contact Lissa Abrams, Deputy Director, MHA at abramsl@dhmh.state.md.us.

Thank you.

Cc: William Dorrill
Michelle Lehner
Lissa Abrams
Audrey Chase

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TO: PMHS Providers

FROM: Brian M. Hepburn, M.D., Executive Director, MHA

DATE: July 8, 2008

RE: MAPS-MD response time for non-urgent authorization requests

While MAPS-MD makes a reasonable attempt to review all non-urgent authorization requests within 24 hours, the time frame for some reviews may be extended to 72 hours.

COMAR §10.09.70.07 allows for the extension of this time frame with documented clinical rationale. Acceptable clinical rationale may include, but is not limited to, the complexity of the case, the need for additional discussion with the provider or the need for peer-to-peer review between the provider and a Physician Advisor.

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Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

June 10, 2008

Dear Director of Mental Hygiene Administration's Community Mental Health Program:

This is to update you on new Mental Hygiene Administration (MHA) requirements and policy clarifications for the public mental health system (PMHS). This includes additional clarifications to: MHA regulations for COMAR 10.21.16, 10.21.17, 10.21.20, 10.21.21, and 10.21.29.; payment for services to individuals meeting MHA's uninsured criteria; and requirements for services to dually eligible Medicare/Medicaid recipients.

Effective September 1, 2008 the following requirements are to be implemented by all PMHS providers

1. MHA is requiring documentation and verification of all individuals who are requesting or have been determined eligible for uninsured Public Mental Health System (PMHS) benefits. The enclosed form shall be completed at the time of request and updated annually.

2. Due to federal and state enforcement, MHA will no longer reimburse for services, except Psychiatric Rehabilitation Programs (PRP) services, for individuals with Medicare. Providers shall meet Medicare requirements when serving individuals with Medicare/Medicaid (MC/MA). This includes all requirements for physician on site, appropriate service providers, and other Medicare requirements. According to the CMS publication "MNL Matters #SEO441" which can be accessed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf., Medicare will allow "incident to" billing by therapists not recognized as independent practitioners, (e.g. LCPC) if the physician is on site. MHA does not have the ability to override these requirements. Licensed mental health professionals currently treating consumers with MC/MA shall seek approval to become Medicare providers.

3. For all new requests for PRP service for adults and every six months thereafter, referral by a mental health professional will be required. This is the same requirement for PRP services to minors Referrals may be from the individual's treating mental health professional, discharge referral from a hospital, or other mental health program. The program's rehabilitation specialist shall not refer the individual to the PRP.

If you have any questions please contact Ms. Lissa Abrams, Acting Deputy Director, MHA on abramsl@dhmh.state.md.us or Sharon Ohlhaver, Chief, Quality Management Community Programs sohlhaver@dhmh.state.md.us.

Thank you for your cooperation and attention to these requirements.

Sincerely,

Brian Hepburn, M.D.
Executive Director

Enclosures: Uninsured Documentation Form
PRP for Minors Regulation Clarification
COMAR –Corrections and Additional Clarifications (June 2008)

cc: Maryland Association of Core Service Agencies
MHA Management Committee
Sharon Ohlhaver, MHA
William Dorrill, OHCQ
Jennifer Hubert, MAPS-MD
Lisa Hadley, M.D., MAPS-MD
Nancy Calvert, MAPS-MD

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Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

TO: Psychiatric Rehabilitation Program (PRP) Directors

FROM: Brian Hepburn, M.D.

RE: Clarification of PRP Program Director and Rehabilitation Specialist Requirements

DATE: December 3, 2007

For Psychiatric Rehabilitation Programs (PRP) that render services to both adults and minors, the following is intended to clarify the regulatory requirements regarding program director and rehabilitation specialist:

- If the total program enrollment (counting both adults and minors) is less than or equal to 100, the program must comply with the more stringent requirements for program director and rehabilitation specialist specified in COMAR 10.21.29, Psychiatric Rehabilitation Services for Minors. For example, if the program serves 60 adults and 20 minors for a total of 80 individuals, it must meet the program director and rehabilitation specialist requirements specified in COMAR 10.21.29 for programs serving 30-100 enrollees.

- If the total program enrollment (counting both adults and minors) is greater than 100, the program must ***independently*** comply with the program director and rehabilitation specialist requirements in ***both*** COMAR 10.21.21, Psychiatric Rehabilitation Programs for Adults ***and*** COMAR 10.21.29, Psychiatric Rehabilitation Services for Minors. For example, if the program serves 60 adults and 60 minors for a total of 120 individuals, it must meet the program director and rehabilitation specialist requirements specified ***both*** in COMAR 10.21.21 for programs serving 30-100 enrollees ***and*** COMAR 10.21.29 for programs serving 30-100 enrollees.

If you have any questions, please contact Susan Steinberg, Deputy Director of Community Programs and Managed Care, at 410-402-8451.

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 <u>proposed</u> staffing plan to OHCQ, but then the program must also submit the actual staff names and credentials, as applicable, to OHCQ <u>prior</u> to beginning services.

<u>.05 Program Service Plan</u>

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.

<u>.06 Evaluation of Application</u>

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 <u>and</u> 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.

<u>.11 Multi-Facility Programs</u>

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.

Mental Hygiene Administration
COMAR – Corrections and Additional Clarifications
June 2008

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Corrections to COMAR Clarifications (document dated April 16, 2008)

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

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

Q9. COMAR 10.21.17.04C requires programs to provide individuals, age 16 years old or older, information related to making an advance directive for mental health services; however, Q9 of the April 16, 2008 COMAR Clarifications states that the required age is 18. Please clarify.

A. 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.

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

Refer also to *POLICY CLARIFICATION: PRP FOR MINORS (COMAR 10.21.29) (revised June 2008) for more complete policy clarifications*.

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 inpatient, residential treatment center, or outpatient mental health treatment services to the minor.

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 (i.e., on their own/independently)?

A. 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.

Additional COMAR Clarifications

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

.12 Quality Management

Q1. Are providers required to track and/or report incidents when a consumer is attacked by another consumer?

A. The regulations do not specify all the types of incidents that a program should track; however, attacks could come under the category of "unfavorable service-related outcomes." With respect to reporting, the individual who has been attacked has the prerogative to report it to the police and press charges. The program should report all serious incidents to the CSA. Reporting of incidents to OHCQ is not required; however, OHCQ will review the program's quality management policies/processes during site visits.

.14 Staff Credentials, Competencies, and Privileges

Q2. Is it acceptable to the state if the program develops a policy, approved by its Board of Directors/Governing Body/Advisory Committee that prohibits individuals charged with abuse from working at the program under any circumstances until the charges have been dismissed?

A. Programs are responsible for developing a policy that describes the process to review such situations and to make a determination that is in the best interests of the consumers served. The regulations do not require programs to fire individuals who have legal charges, since being charged is not the same as being convicted.

Q3. Does 10.21.17.14D require that the Board of Directors/Governing Body/Advisory Committee be involved in each decision, at the individual staff level, regarding the capacity in which a staff member may continue to provide services until legal charges of abuse are resolved?

A. The intent of this section of the regulations is for the Board of Directors/Governing Body/Advisory Committee to be involved in developing and approving the policies/processes that the program should use when a staff person is charged with a crime that involves abuse. It was not the intent of MHA to require the Board of Directors/Governing Body/Advisory Committee to be involved in each individual staff decision, although the program may choose to do so.

.17 Grievances

Q4. This section of the regulations seems to cite COMAR 10.09.70.09 incorrectly. Please clarify.

A. This is a regulation citation error that is being corrected. The correct regulation citation for individual consumers who want to file a grievance regarding denial of services based on eligibility or medical necessity criteria is COMAR 10.09.70.08.

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

.06 Evaluative Services Provided

Q1. Can a LGPC perform a psychiatric assessment and render a psychiatric diagnosis?

A. MHA defers to each of the professional Boards regarding scope of practice. According to a letter, dated March 7, 2005, from the Board of Professional Counselors and Therapists: "All levels may perform psychiatric assessment and diagnosis. A Board-approved supervisor must supervise graduate counselors and therapist." Any questions regarding this should be directed to the Board of Professional Counselors and Therapists at 410-764-4732.

Q2. If a consumer is referred to the OMHC from a substance abuse program (i.e., the consumer already has a substance abuse diagnosis), is the program still required to perform a co-occurring substance abuse screening assessment?

A. No; a co-occurring substance abuse screening assessment would be unnecessarily redundant for this type of referral. A more important consideration in this scenario is ensuring that the mental health/substance abuse treatment is coordinated (see requirements in COMAR 10.21.20.08D).

.08 Treatment Services

Q3. Regarding the on-call/crisis intervention services required during hours when the OMHC in not open, is it sufficient for the program to have an answering machine message directing individuals to call 911 or go to the local emergency room?

A. No. OMHCs are required to 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.

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

.05 Eligibility, Screening, and Initiation of Service

Q1. Are PRPs required to conduct substance abuse screening assessments?

A. No.

.06 Evaluation and Planning Services

Q2. Does the program need to document whether a service was rendered on-site or off-site?

A. Yes, required contact note documentation includes the location of service.

.10 Staff Qualifications and Responsibilities

Q3. Where can the PRP direct care staff get the required 40 hours of training?

A. The program itself is responsible for developing and providing the training required by this section of the regulations; however, the training may be provided by an outside source competent to provide the training.

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

Answers to questions 1-2 above are also applicable to programs approved under COMAR 10.21.29. COMAR 10.21.29 training/supervision requirements are discussed in Q12 on the first page of this document.

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

TO: PMHS Providers

FROM: Brian Hepburn, M.D., Director, MHA

RE: Provider Contact Information - Update

DATE: January 21, 2008

In order to facilitate important provider communication from the PMHS and MAPS-MD, please complete the "Voluntary Provider Registration" form as soon as possible. This will provide both the MHA and MAPS-MD with current and accurate contact information to better serve you. The registration form can be accessed at:

http://www.surveymonkey.com/s.aspx?sm=kAE51WCrmwxwhf_2f5y9Fhnw_3d_3d

Additional provider types have been added to the survey, effective January 21, 2008

Thank you for your timely cooperation.

Lissa Abrams, Director
Office of Adult Services
Mental Hygiene Administration
Spring Grove Hospital Center
Catonsville MD 21228

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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

April 18, 2008

Dear Community Mental Health Providers:

In February 2008, representatives from the Mental Hygiene Administration (MHA) conducted a series of forums across the state to review amendments to COMAR 10.21.16, 10.21.17, 10.21.20, and 10.21.21. In addition, COMAR 10.21.29, Psychiatric Rehabilitation Programs (PRP) for Minors, and general compliance issues were reviewed.

While many questions were answered during the forums, some required further review and clarification. The following questions and answers, compiled from all the forums, provides most of the needed clarifications. There are a few remaining items that, once finalized, will also be provided.

Since only the major changes to the regulations were reviewed at the forums, programs should review the regulations in their entirety. In general, programs are required to be in compliance with the new amendments by May 30, 2008; although a few "phase-in" exceptions are noted in some of the clarifications.

MHA has met with Office of Health Care Quality (OHCQ) and will be meeting with the MAPS-MD auditors to review the changes.

If you have any questions please contact Sharon Ohlhaver, Chief, Quality Management, Community Programs on sohlhaver@dhmh.state.md.us or Lissa Abrams, Acting Deputy Director on abramsl@dhmh.state.md.us.

Thank you for your continued commitment to providing quality services to the citizens of Maryland.

Sincerely,

Brian Hepburn, M.D.
Executive Director

Enclosures:
COMAR Clarifications, dated April 16, 2008
Co-occurring Disorders Screening and Assessment Tools, dated April 8, 2008

c: MACSA Directors
MHA Management Committee
Mr. William Dorrill
Ms. Jennifer Huber
Sharon Ohlhaver

University of Maryland Evidence-Based Practice Center
Thomas Godwin, COD Consultant/Trainer
tgodwin@psych.umaryland.edu

CO-OCCURRING DISORDERS (COD) SCREENING AND ASSESSMENT TOOLS

April 8, 2008

I. SCREENING TOOLS

Combined Mental Health and Substance Use Focus:

AC-Co-Occurring Disorders Screen – Adults, http://faculty-staff.ou.edu/C/Andrew.L.Cherry-1.Jr/AC-CODscreen.htm - (no cost but permission must be obtained)

Global Appraisal of Individual Needs –Quick (GAIN-Q) – Adults, Adolescents, http://www.chestnut.org/li/gain - (cost entails $100 for 5-year license, unlimited agency use)

Global Appraisal of Individual Needs –Short Screen (GAIN-SS) – Adults, Adolescents, http://www.chestnut.org/li/gain - (no cost)

Massachusetts Youth Screening Instrument (MAYSI-2) – Adolescents, http://www.prpress.com/books/maysi2.html - (cost entails $75.00 to purchase manual)

Mentally Ill Drug and Alcohol Screening (MIDAS) – Adults, http://www.ohiosamiccoe.cwru.edu/library/media/clinicaltool_midas.pdf - (no cost)

Mini-International Neuropsychiatric Interview – (MINI) – Adults, http://www.medical-outcomes.com/indexSSL.htm - (no cost)

Problem Oriented Screening Instrument (POSIT) – Adolescents, http://adai.washington.edu/instruments/pdf/Problem_Oriented_Screening_Instrument_for_Teenagers_188.pdf - (no cost)

Problem Oriented Screening Instrument for Parents (POSIP) – Parent, http://adai.washington.edu/instruments/pdf/Problem_Oriented_Screening_Instrument_for_Parents_409.pdf - (no cost)

Substance Use Focus:

Addiction Severity Index - Lite (ASI - Lite) – Adults, http://www.who.int/substance_abuse/research_tools/addictionseverity/en/ - (no cost)

Alcohol Dependence Scale (ADS) – Adults, Adolescents, http://eib.emcdda.europa.eu/html.cfm/index3583EN.html - (cost is $15.00 for manual)

Alcohol Use Disorders Identification Test (AUDIT) – Adult, African American, Hispanic, Offenders, College Student populations, http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf - (no cost)

Alcohol Use Disorders Identification Test – C (AUDIT-C) – Adults, Adolescents, http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf - (no cost)

Brief Michigan Alcoholism Screening Inventory (B-MAST) – Adults, http://www.partnersagainstpain.com/printouts/A7012DA5.pdf - (no cost)

CAGE (alcohol) – Adults, Adolescent, http://pubs.niaaa.nih.gov/publications/inscage.htm - (no cost)

CAGE-AID (alcohol and other drugs) – Adults, http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.46449 - (no cost)

CRAFFT – Adolescents, http://www.slp3d2.com/rwj_1027/webcast/docs/screentest.html - (no cost)

Dartmouth Assessment of Lifestyle Instrument (DALI) – Adults, http://dms.dartmouth.edu/prc/instruments/dali - (no cost)

Drug Abuse Screening Test (DAST) – Adults, http://kc.vanderbilt.edu/addiction/dast.html - (no cost)

Michigan Assessment Screening Test for Alcohol and Drugs (MAST-AD), Adults, Adolescents, http://dionysus.psych.wisc.edu/Lit/Articles/WestermeyerJ2004a.pdf - (no cost)

Michigan Alcoholism Screening Test – Geriatric (MAST-G), Geriatric population, http://www.consultgerirn.org/uploads/File/Alcohol%20Use%20Screening%20and%20Assessment.pdf – (no cost)

Rapid Alcohol Problems Screen (RAPS) – Adult, African American, Hispanic populations,
http://adai.washington.edu/instruments/pdf/Rapid_Alcohol_Problems_Screen_201.pdf - (no cost)

Restrained Drinking Scale (RDS) – Adults,
http://books.google.com/books?id=0xReiqa4WzUC&pg=PA45&lpg=PA45&dq=%22Restrained+Drinking+Scale%22+questionnaire&source=web&ots=aXr3NHCt6o&sig=yEZPS9rp70z0I53j1PO-QQ-ZNq0&hl=en#PPA479,M1 - (no cost)

Short Alcohol Dependence Data Questionnaire (SADD) – Adults,
http://www.moderation.org/Questionnaire.shtml - (no cost)

Short Michigan Alcoholism Screening Test - Geriatric (SMASTG) -
http://www.consultgerirn.org/uploads/File/Alcohol%20Use%20Screening%20and%20Assessment.pdf – (no cost)

Simple Screening Instrument – Substance Abuse (SSI-SA) – Adults,
SAMHSA/CSAT Treatment Improvement Protocol 42 (TIP 42),
http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.77099 – (no cost)

Texas Christian University Drug Screen II (TCUDS) – Adults,
http://www.assessments.com - (no cost)

TWEAK – Adults (Women),
http://adai.washington.edu/instruments/pdf/TWEAK_252.pdf - (no cost)

Mental Health Focus:

Brief Symptom Inventory (BSI) – Adults,
http://www.pearsonassessments.com/tests/bsi.htm - (cost is $34.00 for manual, 5 screens for $10.25)

Kessler Psychological Distress Scale (K6 & K10) – Adults,
http://www.hcp.med.harvard.edu/ncs/k6_scales.php - (no cost)

Mental Health Screening Form – III (MHSF-III) – Adults,
SAMHSA/CSAT Treatment Improvement Protocol-42 (TIP-42),
http://www.samhsa.gov/ - (no cost)

II. ASSESSMENT TOOLS

Combined Mental Health and Substance Use Focus:

Addiction Severity Index (ASI) – Adults, http://www.who.int/substance_abuse/research_tools/addictionseverity/en/ - (no cost for instrument, training is highly recommended)

Comprehensive Addictions and Psychological Evaluation (CAAPE), Adults, http://www.changecompanies.net - (cost entails $20.00 for manual, 25 assessments for $67.50)

Global Appraisal of Individual Needs (GAIN) – Adults, Adolescents, http://www.chestnut.org/li/gain/gadm1299.pdf - (cost entails $100 for 5-year license, unlimited agency use)

Practical Adolescent Dual Diagnostic Interview (PADDI), Adolescents, http://www.changecompanies.net - (cost entails $20.00 for manual, 25 assessments for $67.50)

Substance Use Focus:

Alcohol Dependence Scale (ADS) – Adults, Adolescents, http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/10_ADS.pdf - (cost entails $15.00 for test kit)

Diagnostic Interview Schedule (DIS-IV) – 18 years and above, http://epi.wustl.edu/dis/dishome.htm - (not in public domain, costly)

Diagnostic Interview Schedule – C (DIS-C) – Adolescents, http://www.c-disc.com - (not in public domain, costly)

Short Alcohol Dependence Data Questionnaire (SADD) – Adults, http://adai.washington.edu/instruments/pdf/Short_Alcohol_Dependence_Data_Questionnaire_224.pdf - (no cost)

Structured Clinical Interview for DSM-IV Substance Abuse Module (SCID)- Adolescents, http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/64_SCID.pdf - (no cost)

Stages of Treatment Scale - Revised (SATS-R) – Adults, http://dartmouth.edu/dms/psychrc/ - (no cost)

Mental Health Focus:

Structured Clinical Interview for DSM-IV (SCID-I), Adolescents http://www.scid4.org/ – (initial cost entails $154.00 for kit including 5 assessments, $60.50 for additional packages of 5 assessments)

Other Resources:
Good resource for other instruments: University of Washington - Alcohol and Drug Abuse Institute Library: http://lib.adai.washington.edu/instruments/

Mental Hygiene Administration
COMAR Clarifications
April 16, 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 <u>proposed</u> staffing plan to OHCQ, but then the program must also submit the actual staff names and credentials, as applicable, to OHCQ <u>prior</u> to beginning services.

<u>.05 Program Service Plan</u>

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.

<u>.06 Evaluation of Application</u>

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.

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.

.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 Care Connections 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 are 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 requirement 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.

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.

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.

MEMORANDUM

TO: Hospital Providers

FROM: Brenda Rose
Deputy Director
Acute Care Administration

RE: Day Limits
NDC Requirements

Date: July 9, 2008

Please be advised that the Medical Care Program has made modifications to the system that will reflect the elimination of Day Limits beginning with **admission** dates of July 1, 2008 forward. At this time, the Program requires that the DRG Version 24 be used but, as previously discussed, we are working on the process of removing the requirements for the DRGs in Medicaid claims and 3808s.

The Program is moving towards implementation of the National Drug Code (NDC) as required by CMS. The implementation date will be effective with claim submitted for payment September 1, 2008 and have dates of service July 1, 2008 and forward. Billing instructions should be posted to the Web by beginning of next week.

If you have any questions about this notice, please email me at roseb@dhmh.state.md.us.

MARYLAND STATE DEPARTMENT OF HEALTH & MENTAL HYGIENE

DIRECTOR, OFFICE OF ADULT MENTAL HEALTH SERVICES

(Program Manager III – Management Service)

LOCATION: Mental Hygiene Administration
55 Wade Ave
Catonsville, MD 21228

NATURE OF WORK: Reporting to the Executive Director, MHA this is professional, managerial, and supervisory work in the field of mental health. The Office of Adult Services develops, administers, and monitors the statewide continuum of community-based mental health programs and services for adults and older adults; formulates policy, protocols, regulations, and practice guidelines to support systems transformation for improved consumer outcomes; and promotes evidence-based, consumer-directed, and recovery oriented rehabilitation and treatment services and supports that have demonstrated effectiveness and are responsive to consumer needs and preferences. The office plans and directs the: dissemination, implementation, evaluation of Evidence Based Practices (EBP), including Supported Employment, Assertive Community Treatment, Co-occurring Disorders, and Family Psychoeducation, in accordance with established fidelity criteria; development of certain standards for care and regulations for publicly funded mental health services for adults; and, the design and development of specialized programs and services for youth transitioning into adulthood; older adults; individuals in state hospitals, and adults who have sustained a traumatic brain injury (TBI).

MINIMUM QUALIFICATION/REQUIREMENTS: Requires a bachelor's degree and six years of health or human services administrative or professional experience including three years in mental health services and three years at a management or supervisory level.

DESIRABLE QUALIFICATIONS: Five years experience leading and directing recovery based community services for adults with mental illness including experience with Medicaid financing and reimbursement of community based services and including two years experience supervising professional staff.

SALARY: $56,496 - $82,514yr (Negotiable); growth to $90,706yr (Grade 21).

FRINGE BENEFITS: Excellent State of Maryland benefits/leave package.

HOW TO APPLY: Please submit resume or State application form MS-100 by no later than **October 1, 2008** for fullest consideration to:

Mark Townend, Chief of Recruitment
Department of Health & Mental Hygiene
201 W. Preston Street Room 114B
Baltimore, MD 21201

AN EQUAL OPPORTUNITY EMPLOYER

Ref.Pos. # 047941 Issued: 9-10-

08

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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: Public Mental Health System (PMHS) Providers

FROM: Brian Hepburn, M.D.
Executive Director, MHA

RE: Discharge Planning

DATE: November 18, 2008

There have been increased reports of individuals being dropped off at emergency rooms and discharged from community programs without adequate discharge planning while the person is hospitalized. This is not acceptable.

For those individuals with complex clinical, medical, and rehabilitation needs who are at risk of being discharged from your program, please contact the CSA in advance of any discharge actions. CSAs will assist community programs to access consultation in order to plan and coordinate care.

MHA will be requesting hospitals to provide information on programs that discharge individuals during an inpatient stay. While we recognize that occasionally programs are not able to safely and clinically serve an individual, the program is responsible for discharge planning in order for the individual to receive continued care.

It is important that all components of the PMHS collaborate in order to provide the most effective level of service to indivduals with mental illness. Thank you.

aSTATE 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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: Public Mental Health System (PMHS) Providers

FROM: Brian Hepburn, M.D.
Executive Director, MHA Brian Hepburn 6/26/08

Re: Coding Clarification

Date: June 26, 2008

This memorandum is to clarify billing procedures when services are delivered in a hospital. These procedures are effective for claims submitted on or after July 1, 2008.

Service providers may only bill the PMHS for services provided within the Emergency Department (ED) of a General Hospital, if the service is not otherwise included in the hospital's HSCRC rate. Physician charges are not included in the HSCRC rate. A social worker evaluation may or may not be included in the rate. The hospital shall submit written confirmation to MAPS-MD, from the HSCRC, stating that the social worker's service is not included in the hospital's ED rate. The hospital must also attest that all other payers are billed for the social work services. Contact Nancy Calvert at MAPS-MD (410-281-2705) to update the attestations.

Mental Hygiene Administration (MHA) will reimburse a psychiatrist or a social worker at the individual provider rate. It is recommended that Outpatient Mental Health Center (OMHC) psychiatrists and social workers obtain individual or group Medicaid numbers, separate from the OMHC Medicaid number, as soon as possible.

OMHC providers may apply for individual Medicaid provider numbers on-line at:
https://encrypt.emdhealthchoice.org/emedicaid
Group numbers may be requested from DHMH Provider Enrollment (410 767-5340)

The appropriate coding of physician services is critical to the proper billing and payment of these services, and is subject to post-payment audit. A careful review of the coding schema and examples provided in the Current Procedural Terminology (CPT) Code is required. Only one service, per day, per provider type, for a consumer may be paid. There may be one bill for a social worker per calendar day and one bill for physician hospital visits but the Medicaid system will not reimburse for multiple visits of the same 'provider type'.

Consultation

A consultation is a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source. may bill consultation codes for services provided in an ED. Only one unit of service may be billed per ED admission except in extraordinary circumstances. Payment may be paid if the consumer remains in the ED for more than one calendar day and if there is evidence of additional visits by the consulting psychiatrist for the purposes of reviewing care and providing additional treatment. Additional services shall not be billed without evidence in the clinical record of additional treatment or changes in the orders or recommendations of the consulting psychiatrist.

The ED consultation codes may be billed in addition to the social worker evaluation when the consumer receives two distinct services. The hospital clinical record shall include documentation to validate the delivery of distinct services including all relevant findings.

The codes may not be billed to the PMHS if the patient is admitted to the hospital in the care of the psychiatrist and the group practice or the physician bills for initial hospital care (99221-99223)

Consultation CPT Codes to be billed by psychiatrists providing services in the ED:

99241 Office/outpatient consultation for a new or established patient:
The presenting problems are usually self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office/outpatient consultation for a new or established patient:
The presenting problems are usually of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office/outpatient consultation for a new or established patient:
The presenting problems are usually of low severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

99244 Office/outpatient consultation for a new or established patient:
The presenting problems are usually of low severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99245 Office/outpatient consultation for a new or established patient:
The presenting problems are usually of low severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Admission

MHA will reimburse the psychiatrist at the individual provider rate for inpatient services. It is therefore recommended that OMHC physicians obtain individual or group Medicaid numbers separate from the OMHC as soon as possible.

The psychiatrist may use the following CPT Codes to report all evaluation and management services to the consumer related to care of the consumer on the date of admission. The single billed CPT code is inclusive of services delivered in the ED, outpatient setting, physician office, and hospital for the

date of service (s) provided. No other psychiatric evaluation and management services may be billed by the individual psychiatrist, group practice or OMHC.

These CPT Codes may be billed in addition to the social worker evaluation in the ED when the consumer receives two distinct services. The hospital clinical record shall contain documentation to validate the delivery of distinct services including all relevant findings.

99221 Initial hospital care, per day, for the evaluation and management of a patient:
Usually, the problem(s) requiring admission are low severity. Physicians typically spend 30 minutes at the bedside and on the hospital floor or unit.

99222 Initial hospital care, per day, for the evaluation and management of a patient:
Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the hospital floor or unit.

99233 Initial hospital care, per day, for the evaluation and management of a patient:
Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the hospital floor or unit.

Subsequent Hospital Visits (CPT codes 99231 – 99233) and Discharge Day Management (CPT Codes 99238 – 99239) must also be billed using the individual or group provider MA number and not the OMHC MA number.

Social Worker Evaluations in the ED

For services provided in the ED of a hospital approved by MHA per the requirements stated above, a licensed clinical social worker (LCSW-C) may bill for the following service as governed by the Social Work Practice Act. This service may be billed in addition to the psychiatric services listed above when the consumer has received two distinct services. The hospital clinical record shall contain documentation to validate the delivery of distinct services including all relevant findings. Only one unit of service may be billed per ED admission except in extraordinary circumstances. Payment may be paid if the consumer remains in the ED for more than one calendar day and if there is evidence of additional visits by the Social Worker for the purposes of re-evaluation or additional treatment. Additional services shall only be billed when supporting documentation exists in the clinical record to justify the additional evaluation or treatment.

90801 Psychiatric diagnostic interview:
This service includes a history, mental status, and a disposition, and may include a communication with family or other sources. In some circumstances other informants will be seen in lieu of the patient. This service requires authorization through APS CareConnection® within 24 hours of the delivery of the service.

Emergency Department Physicians

Emergency Department physicians (non-psychiatrists) must bill using the Emergency Department Evaluation and Management CPT Codes (99281 – 99285.)

Maryland Register

Issue Date: January 4, 2008

Volume 35 • Issue 1 • Pages 1—104

IN THIS ISSUE

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, this issue contains all previously unpublished documents required to be published, and filed on or before December 17, 2007, 10:30 a.m.

Pursuant to State Government Article, §7-206, Annotated Code of Maryland, I hereby certify that this issue contains all documents required to be codified as of December 17, 2007.

Dennis C. Schnepfe
Administrator, Division of State Documents
Office of the Secretary of State

Final Action On Regulations

Symbol Key

- Roman type indicates text already existing at the time of the proposed action.
- *Italic type* indicates new text added at the time of proposed action.
- *Single underline, italic* indicates new text added at the time of final action.
- Single underline, roman indicates existing text added at the time of final action.
- **[[**Double brackets**]]** indicate text deleted at the time of final action.

Title 10
DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

Subtitle 21 MENTAL HYGIENE REGULATIONS

Notice of Final Action

[07-160-F]

On December 18, 2007, the Secretary of Health Mental Hygiene:

(1) Adopted the repeal in their entirety of Regulations **.01—.12** and new Regulations **.01—.16** under **COMAR 10.21.16 Community Mental Health Programs—Application and Approval Processes**;

(2) Adopted the repeal in their entirety of Regulations **.01—.14** and new Regulations **.01—.17** under **COMAR 10.21.17 Community Mental Health Programs—Definitions and Administrative Requirements**; and

(3) Adopted the repeal in their entirety of Regulations **.01—.08** and new Regulations **.01—.11** under **COMAR 10.21.20 Community Mental Health Programs—Outpatient Mental Health Centers**.

This action, which was proposed for adoption in 34:15 Md. R. 1363—1381 (July 20, 2007), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 14, 2008.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

COMAR 10.21.16.01B: Added to clarify what is know that these regulations do not apply to Therapeutic Group Homes or Federally Qualified Health Centers which are regulated under other chapters. It is not substantive revision.

COMAR 10.21.16.04C(3)(f): This information is needed in order to review the application to determine if the applicant meets the requirements under COMAR 10.21.16.07C(2): The need for this information would be implied from those requirements. It is not a substantive revision.

COMAR 10.21.16.04E: This is a clarifying section. When an applicant submits an application it must list the sites where it will provide services. When DHMH approves the application it is

approved based on those sites. An applicant cannot operate past the approval on the original license. This section gives a benefit to the provider who wishes to open additional sites. Rather than submit a new application the provider can ask for a modification of the original application. It is not substantive revision.

COMAR 10.21.16.10C(1): By regulation and law the Department's designated approval unit would have the right to consult. Adding the unit to this regulation clarifies existing authority and is not substantive revision.

COMAR 10.21.17.02B(60): DHMH has promulgated different chapters to regulate providers of psychiatric rehabilitation programs for adults and children. Adding “for adults, and COMAR 10.21.29 for minors, or both” to this definition reflects the state of the current law. It is not substantive revision.

COMAR 10.21.17.04C: Adding that advanced directives requested are for mental health services and not a general advanced directive reflects what was intended and what is current practice. It is not substantive revision.

COMAR 10.21.17.05B(2): The requirements to take members which reflect the date of the meeting, the members present and the topics discussed is a reflection of current good practices for any committee and certainly one that reviews health care decisions. These requirements could be inferred and are just spelled out. These additional regulatory requirements are not substantive revision.

COMAR 10.21.17.05B(5): By adding the word “if applicable” indicates that for profits providers do not have a charitable purpose to satisfy and that this applies only to nonprofit corporations. Adding the word “annually” clarifies when the review is to occur. This reflects the current good business practices for nonprofit boards. It is not a substantive revision.

COMAR 10.21.17.08B(7): This change combines §B(7) and §B(8). Adding the words “necessary to implement the Department's requirements on the setting of charges and collection of fees” indicates the purpose of this regulation and implements the requirements of other laws. It is not substantive revision.

COMAR 10.21.17.09A(4)(k) and (l): Providers are required to report incidents and have a crisis response plan currently. This regulation clarifies that in order to issue such reports and have such plans, the provider must have written policies to implement this requirement. This could be inferred. These changes clarify the inference. It is not a substantive revision.

COMAR 10.21.17.09A(4)(m): As to additions regarding policies about false claims, please note the explanation below regarding the deletion of Regulation .10. This addition reflects current legal requirements, and could have been anticipated since it was covered in the proposed regulations. It is not a substantive revision.

COMAR 10.21.17.10: This regulation has been deleted in its entirety and added under Regulation .09A(4)(m). This is correct since it is a requirement about having a policy informing

employees of the laws and regulations regarding fraud and abuse. Redundant language has been deleted regarding inclusion in the employee handbook. All employees must be informed of all policies. Thus, having a requirement to put this information in an employee handbook was duplicative. This is not a substantive revision.

COMAR 10.21.17.12C: The addition of the words “which may be a component of the QM” reduces the redundancy of having the provider produce two different documents where one can serve the same purpose. This is not a substantive revision.

COMAR 10.21.17.12C(2)(b): Referencing an existing requirement contained in Regulation .14 helps the provider by not having to consult two legal sources. It reduces the burden on the provider without changing the intent of the regulation. This is not a substantive revision.

COMAR 10.21.17.12C(3): Adding the word “evaluates” spells out what is inferred by the intent of this regulation. There is no purpose in collecting information, i.e. tracking, if the information is not evaluated. This is not a substantive revision.

COMAR 10.21.17.13: This completely new regulation gives the provider more information and notice regarding the statutory reporting requirements. It assists the provider by providing by providing forms which will make the report uniform and inform them of what is needed. This is not a substantive revision.

COMAR 10.21.17.16D(1): The language is clarifying that this is a requirement and that the CSA where applicable must be notified. Collaborating with the CSA is a current requirement. This language specifies that the provider must consider involving the CSA when there are complaints. This is not burdensome to the provider. This is not a substantive revision.

COMAR 10.21.17.16F: The words “presents a serious risk” interpret what was meant by “poses a danger”. It was intended that the provider take action only when there is a serious risk, which means a danger. Changing the word “final decision” to “recommendations of the CSA etc.” also clarifies what was intended and was currently occurs. The provider must make the final decision. This is not a substantive revision.

COMAR 10.21.20.06B: The addition of the word “Screening” clarifies what was intended and what is the current practice. This is not a substantive revision. Also, adding the words, “if available” reflects the reality that there are not tools for every age. This is not a substantive revision.

COMAR 10.21.20.07A(1): The addition and deletion of the words in this regulation are related to assuring that this Medicaid services is interpreted as intended, i.e. to meet medical needs and is not a service that is not directed at the mental illness with which the individual presents. This is not a substantive revision.

COMAR 10.21.20.07A(3)(f): The addition of the Certified Registered Nurse Practitioner (CRNP) corrects an unintended omission. Since CRNPs can fulfill this function failure to list them would have been to limit their practice. This was not intended. Having more practitioners

who can deliver these services benefits the providers and consumers. This is not a substantive revision.

COMAR 10.21.20.07B(2): Any proper documentation by a provider would include significant changes or events, including hospitalization, that affect the individual's treatment. Making clear that this is part of professional and required record keeping places the provider on notice of only what the provider should know. This is not a substantive revision.

COMAR 10.21.20.11A: The addition of the words “application modification as outlined in COMAR 10.21.16.04E” clarifies what was meant by the words “requirements of this chapter” which are being deleted. This is not a substantive revision.

10.21.16 Community Mental Health Programs—Application, Approval, and Disciplinary Processes

Authority: Health-General Article, §§10-901 and 10-902, Annotated Code of Maryland

.01 Scope.

A. This chapter outlines the process for application for, denial of, and disciplinary action on, the approval for a program to be eligible to receive State or federal funds for providing community mental health services.

B. This chapter does not apply to programs approved under COMAR 10.21.07 Therapeutic Group Homes or Federally Qualified Health Centers.

.04 Application Process.

A.—B. (proposed text unchanged)

C. Application. An applicant for approval of a program shall:

(1)—(2) (proposed text unchanged)

(3) Include in the application, at a minimum, the following information:

(a)—(e) (proposed text unchanged)

(f) Disclosure of:

(i) Any license or approval revocation within the previous 10 years by the Department or other licensing agency;

(ii) Whether the program, or corporation or entity associated with the program, has surrendered or defaulted on its license or approval for reasons related to disciplinary action, within the previous 10 years; and

(iii) Any corporate officer who has served as a corporate officer for a corporation or entity that has had a license revoked, or has surrendered or defaulted on its license or approval for reasons related to disciplinary action within the previous 10 years;

[[*(f)***]]** *(g)*—**[[***(g)***]]** *(h)* (proposed text unchanged)

(4) (proposed text unchanged)

D. (proposed text unchanged)

E. Application Modification.

(1) A program that proposes to change its program sites by adding, closing, or moving locations shall submit an application modification, on the form required by the Department, to the Department's designated approval unit.

(2) If the Department's designated approval unit approves the application modification, the existing program approval shall extend to the additional site, as applicable.

.10 Deemed Status.

A.—B. (proposed text unchanged)

C. Evaluation of Request for Initial Deemed Status or Renewal of Deemed Status. Within 60 calendar days of receipt of the request under §A or B of this regulation:

(1) The Administration, in consultation with the CSA or lead CSA, and the Department's designated approval unit:

(a)—(c) (proposed text unchanged)

(2) (proposed text unchanged)

D.—E. (text unchanged)

10.21.17 Community Mental Health Programs—Definitions and Administrative Requirements

Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland

.02 Definitions.

A. (proposed text unchanged)

B. Terms Defined.

(1)—(59) (proposed text unchanged)

(60) "Psychiatric rehabilitation program (PRP)" means a program approved under COMAR 10.21.21 for adults, and COMAR 10.21.29 for minors, or both.

(61)—(84) (proposed text unchanged)

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

A.—B. (proposed text unchanged)

C. Advance Directive for Mental Health Services. For individuals who are 16 years old or older, the program director shall:

(1)—(4) (proposed text unchanged)

.05 Advisory Committee.

A. (proposed text unchanged)

B. Responsibilities of the Advisory Committee. The advisory committee shall:

(1) (proposed text unchanged)

(2) Maintain documentation of the meetings, including:

(a) Date;

(b) Members present; and

(c) Summary of the topics discussed;

[[*(2)***]]** *(3)*—**[[***(3)***]]** *(4)* (proposed text unchanged)

[[*(4)***]]** *(5)* **[[***Annually***]]** *If applicable, annually review whether the program is satisfying its charitable mission.*

C.—D. (proposed text unchanged)

.08 Records.

A. (proposed text unchanged)

B. Contents of Record. When an individual is enrolled in a program, the program shall maintain a record of, at a minimum:

(1)—(6) (proposed text unchanged)

[[*(7) When required, financial information necessary to implement the Department's requirements on the setting of charges and collection of fees;***]]**

[[*(8)***]]** *(7) Documentation of* **[[***the***]]** *verification of the individual's financial information, or, if the individual is a minor, the minor's parent's financial information necessary to implement the Department's requirements on the setting of charges and collection of fees;*

[[*(9)***]]** *(8)*—**[[***(16)***]]** *(15)* (proposed text unchanged)

.09 Policies and Procedures.

A. The program shall have and maintain written policies that, at a minimum include:

(1)—(3) (proposed text unchanged)

(4) The policies and procedures for:

(a)—(h) (proposed text unchanged)

(i) If the program provides services in a facility, a disaster and emergency evacuation plan; **[[***and***]]**

*(j) According to federal and State requirements, safety precautions, infection control, and communicable disease control***[[.]]** *;*

(k) Incident reporting;

(l) Crisis response plan; and

(m) Information about any State and federal laws pertaining to civil or criminal penalties for false claims and statements and whistle blower protections, including the necessity for preventing and detecting fraud, waste, and abuse.

B.—C. (proposed text unchanged)

[[.*10 Employee Education About False Claims Recovery.*

A. All programs approved to receive funds under any Mental Hygiene Administration regulations shall establish written policies for all employees of the program, including managerial employees, and of any contractor or agent of the program that provide direct care or billing services, that provide detailed information about the:

(1) False Claims Act established under 31 U.S.C. §§3729—3733;

(2) Administrative remedies for false claims and statements established under 31 U.S.C. Chapter 38; and

(3) Any State laws pertaining to civil or criminal penalties for false claims and statements, and whistle-blower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

B. A program shall include:

(1) As part of its written policies regarding the False Claims Act, detailed provisions regarding he program's policies and procedures for detecting and preventing fraud, waste, and abuse; and

*(2) In any employee handbook for the program, a specific discussion of the rights of employees to be protected as whistle-blowers.***]]**

[[.*11*]] .*10*—[[.12]] .*11* (proposed text unchanged**)**

[[.*13*]] .*12* *Quality Management (QM).*

A.—B. (proposed text unchanged)

C. Risk Management (RM). The program director shall develop and, at least every 3 years, review a written RM plan, which may be a component of the QM plan, that:

(1) (proposed text unchanged)

(2) Includes a mechanism by which the program director reports:

(a) (proposed text unchanged)

(b) The death of an individual, as **[[***provided under Health-General Article, §10-714, Annotated Code of Maryland***]]** *as outlined in Regulation .14 of this chapter; and*

(3) Tracks and evaluates incidents reported under §C(1) and (2) of this regulation and complaints filed under Regulation .16 of this chapter to determine trends.

D. (proposed text unchanged)

.13 Reports of Death.

Upon notification of the death of any individual in a State funded or operated program or facility, the administrative head of the program or facility shall:

A. Report the death according to the provisions of Health-General Article, §10-714(a), Annotated Code of Maryland; and

B. Use the form required by the Administration.

.14—.15 **(**proposed text unchanged**)**

.16 Complaints.

A.—C. (proposed text unchanged)

D. A program shall include in the complaint process required by §A of this regulation the procedures for registering and responding to the complaints in a timely fashion, which:

(1) **[[***Include a specific standard, monitored by the program for compliance, directing that***]]** *Require a complaint to be reviewed by the program and, if applicable, the CSA, within 30 calendar days of the program's receipt of the complaint;*

(2)—(7) (proposed text unchanged)

E. (proposed text unchanged)

F. Unless the individual **[[***poses a danger***]]** *presents a serious risk to self or others, the program shall postpone taking action until* **[[***a final decision is made***]]** *the recommendations of the CSA and the Administration have been made, if applicable.*

.17 (proposed text unchanged***)***

10.21.20 Community Mental Health Programs —Outpatient Mental Health Centers

Authority: Health-General Article, §§10-901 and 10-902, Annotated Code of Maryland

.06 Evaluative Services Provided.

A. (proposed text unchanged)

B. Co-Occurring Substance Abuse Screening Assessment. The face-to-face diagnostic assessment conducted under §A of this regulation shall include **[[***an***]]** *a screening assessment, using a scientifically validated, and if available, age appropriate tool, to determine whether the individual has a co-occurring substance abuse disorder.*

C.—D. (proposed text unchanged)

.07 Treatment Planning and Documentation.

A. Individual Treatment Plan (ITP).

(1) Initial ITP.

(a) Not later than the fifth visit after an individual is enrolled in an OMHC and based on the assessment conducted under Regulation .05B of this chapter, the treatment coordinator and the individual, **[[***or***]]** *and if the individual is a minor, the minor's parent, guardian, or primary caretaker if appropriate, shall develop an ITP in collaboration with:*

*(i)—(ii) (*proposed text unchanged*)*

(b) The ITP shall include, at a minimum:

(i) (proposed text unchanged)

(ii) The individual's presenting needs, **[[***wants,***]]** *strengths,* **[[***and***]]** *recovery, and treatment expectations and responsibilities;*

*(iii) (*proposed text unchanged*)*

(iv) A description of how the needed and desired **[[***skills and supports***]]** *treatment will help the individual to manage the individual's psychiatric disorder and to support recovery;*

*(v)—(vi) (*proposed text unchanged*)*

*(c) (*proposed text unchanged*)*

*(2) (*proposed text unchanged*)*

(3) Signature of the ITP and Reviews.

(a)—(e) (proposed text unchanged)

(f) If the individual is receiving medication prescribed through the OMHC, an OMHC psychiatrist, or Certified Registered Nurse Practitioner in psychiatry, whomever prescribes the medication, shall sign the plan and reviews.

(4)—(5) (proposed text unchanged)

B. Continuing Evaluation and Treatment.

(1) (proposed text unchanged)

(2) The treatment coordinator shall document any significant changes or events, including hospitalizations, that affect the individual's treatment.

[[*(2)***]]** *(3) (*proposed text unchanged*)*

.11 Multi-Facility Programs.

A. An OMHC program that operates multiple sites shall assure that each additional site adheres to the **[[***requirements of this chapter***]]** *application modification as outlined in COMAR 10.21.16.04E.*

*B.—D. (*proposed text unchanged*)*

JOHN M. COLMERS
Secretary of Health and Mental Hygiene

Subtitle 21 MENTAL HYGIENE REGULATIONS

10.21.21 Community Mental Health Programs — Psychiatric Rehabilitation Programs for Adults

Authority: Health-General Article, §§10-901 and 10-902,
Annotated Code of Maryland

Notice of Final Action

[07-189-F]

On December 18, 2007, the Secretary of Health and Mental Hygiene adopted amendments to Regulation **.01**, the recodification of Regulation **.02-1** to be Regulation **.03**, the amendment and recodification of Regulations **.03—.06**, and **.06-1** to be Regulations **.04—.07** and **.09**, new Regulations **.08** and **.10—.13**, and the repeal of existing Regulations **.07** and **.08** under **COMAR 10.21.21 Community Mental health Programs—Psychiatric Rehabilitation Programs for Adults**. This action, which was proposed for adoption in 34:16 Md. R. 1452—1458 (August 3, 2007), has been adopted with the nonsubstantive changes shown below.

Effective Date: January 14, 2008.

Attorney General's Certification

In accordance with State Government Article, §10-113, Annotated Code of Maryland, the Attorney General certifies that the following changes do not differ substantively from the proposed text. The nature of the changes and the basis for this conclusion are as follows:

Regulation .05B(1)—(3): This revision combines two provisions regarding screening and initiation of service into the same 10 day period. This is not a burden on the provider, gives the provider more flexibility, and does not burden the consumer since much of the work of initial

intake can be done without a face-to-face screening. Placement in the right program is not based on the initial referral but on the subsequent assessment. Notice is given to the consumer and no rights are taken away. This is not a substantive revision.

Regulation .05B(1)(b): Adding the words to “determine whether rehabilitation services are medically needed by the individual” make clear that such services must address the individual's disability and mental illness. This is not a substantive revision.

Regulation .06C(4)(a)—(d) and (5): The revisions and additions in these regulations are clarifications. The addition of “ITRP” which was an unintended omission which burdens neither provider or consumer. This is not a substantive revision.

Regulation .06D(3): This new language sets forth what is already required in proper documentation of services. Any medical record must include significant changes, events, including hospitalizations that affect the individual's rehabilitation. This does not burden the provider. It gives them clear notice of what is required. This is not a substantive revision.

Regulation .07B(3)(a): Changing the language clarifies that rehabilitation is about developing skills that have been lost or are lacking as a result of a mental illness. This is what was intended. The revised language is clearer. This is not a substantive revision.

Regulation .07B(3)(g): Adding that wellness management is part of rehabilitation program services is making clear what has always been implied. Once the program works with an individual to achieve skills to cope with the individual's mental illness the program works with the individual to make sure the skills will remain. This is what is meant by wellness management. It is an integral part of the program. This language simply states underlying assumptions. This is not a substantive revision.

Regulation .07F(2): Changing the word “contact” to “to assist the individual to access” again is a clarification of the purpose of the program. The program is not to take care of the individual's needs. The program helps build skills that permit the individual to take charge of handling the individual's mental illness. This is a clarification that is understood in the field, does not burden the provider, and benefits the consumer. This is not a substantive revision.

Regulation .08B: Changing the language that states “In order to prevent the” to “For an individual at risk of an” clarifies that no provider can control any individual's behavior. Rather the provider works with the individual through developing a MIP to assist the individual in meeting the individual's treatment goals, which include not leaving the program before the goals are reached (i.e. unplanned discharge). This change does not burden the provider and it benefits the consumer by recognizing the consumer's independence. This is not a substantive revision.

Regulation .09C(2)(b): Deleting this paragraph does not burden the consumer. The program does not supply the consumer's needs. The program assists consumers in caring for their own needs, including food and household goods. This requirement is set for in COMAR 10.21.21.06C(1). This is not a substantive revision.

Regulation .10C(1): Adding the word “independently” makes clear what happens in practice now. Staff must be trained before staff can work with a consumer. This is not a substantive revision.

Regulation .11B(2)(a), C(2)(a), D(2)(c): These changes are necessary to make the citations to COMAR accurate. This is not a substantive revision.

Regulation .12A: After this regulation was published MHA discussed it with some providers. The providers believed that the language as written did not reflect practice and clarification was needed. The change reflected current practice to have an overall ratio in the on-site facility rather than just for groups. The change gives the providers greater flexibility to maintain a 1:10 ratio in order to work 1:1 with a consumer when needed and then have staff also run a group activity. The change is clarifying and benefits the consumer while giving the provider flexibility. This is not a substantive revision.

.*05* Eligibility, Screening, and *Initiation of Service*.

A. (proposed text unchanged)

B. Screening.

[[(1)**]]** Within **[[**5**]]** *10* working days of receipt by the program of *a complete* referral for PRP *services* **[[**,*staff*]]:

(1) Staff assigned by the program director shall conduct a **[[**face-to-face**]]** screening assessment to **[[**:

(a) Assess the individual's:

(i) Rehabilitation services *wants and* needs;

(ii) Willingness to participate in PRP services; and

(iii) Residential rehabilitation program (RRP) service wants and needs, when appropriate; and

(b) Determine the program's ability to address the *wants and* needs identified in §B(1)(a)(i) and (*iii*) of this regulation**]]** *determine whether rehabilitation services are medically needed by the individual*.

(2) If, following the screening assessment under §B(1) of this regulation, the program director determines that the program's services are not appropriate for an individual who has been referred, the program director shall, in writing **[[**, promptly**]]**:

(a)—*(c)* (proposed text unchanged)

(3) **[[**Within 5 working days of the screening assessment conducted under §B(1) of this regulation, unless**]]** *Unless* the program director has notified the individual of the determination under §B(2) of this regulation, the program director shall notify the individual whether the program:

(a)—(c) (proposed text unchanged)

(4) (proposed text unchanged)

C. (proposed text unchanged)

.06 **Evaluation and Planning Services.**

A.—B. (proposed text unchanged)

C. Individual Rehabilitation Plan (IRP).

(1)—(3) (proposed text unchanged)

(4) Signature of the IRP or ITRP and Reviews.

(a) The following shall sign that they agree with the IRP **[[***and***]]** *or ITRP and reviews:*

(i)—(ii) (proposed text unchanged)

(b) With proper consent, family or others designated by the individual, including the individual's caregivers, may sign the IRP **[[***and***]]** *or ITRP and reviews.*

(c) If the individual is unwilling to sign agreement with the IRP **[[***and***]]** *or ITRP and reviews, the individual's rehabilitation coordinator shall:*

(i) Verify the individual's verbal agreement with the IRP **[[***and***]]** *or ITRP and reviews; and*

(ii) (proposed text unchanged)

(d) In addition, for an ITRP, at least two licensed mental health professionals, who collaborate about the individual's treatment, shall sign the **[[***IRP***]]** *ITRP and ITRP reviews, including:*

(i)—(ii) (proposed text unchanged)

(5) Upon completion of an IRP **[[***or***]],** *ITRP, or review, an individual's rehabilitation coordinator shall assure that the individual is offered a copy of the plan or review and document the individual's receipt or decline of the offer in the individual's medical record.*

D. Continuing Evaluation.

(1)—(2) (proposed text unchanged)

(3) If not documented in §D(1) or (2) of this regulation, the rehabilitation coordinator shall document any significant changes or events, including hospitalizations, that affect the individual's rehabilitation.

[[(3)**]]** *(4)* (proposed text unchanged)

.07 **Rehabilitation and Support Services Provided.**

A. (proposed text unchanged)

B. Rehabilitation *and Recovery* Activities.

The program director shall ensure that the program provides rehabilitation activities directed toward the *individual's recovery and the improvement or* restoration of skills, including:

(1)—(2) (proposed text unchanged)

(3) Independent living skills, including:

(a) **[[**Maintenance of the individual's living environment**]]** *Skills necessary for housing stability*;

(b)—(d) (proposed text unchanged)

(e) Accessing available entitlements *and resources;* **[[***and***]]**

(f) (proposed text unchanged)

(g) Wellness self-management; and

(4) (proposed text unchanged)

C.—E. (proposed text unchanged)

F. On-Call and Emergency Response. The program director shall assure that:

(1) (proposed text unchanged)

(2) All relevant staff shall **[[***contact***]]** *assist the individual to access, as appropriate, the OMHC, mobile crisis, residential crisis services, hospitals, and other service providers that are designated to provide crisis and emergency care and treatment.*

G. (proposed text unchanged)

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

A. (proposed text unchanged)

B. **[[***In order to prevent the***]]** *For an individual at risk of an unplanned discharge* **[[***of an individual***]]***, the rehabilitation coordinator, in collaboration with the individual, shall prepare a MIP that includes:*

(1)—(2) (proposed text unchanged)

C. (proposed text unchanged)

.09 **Supported Housing Services for Adults.**

A.—B. (proposed text unchanged)

C. Accessing and Sustaining Housing. The program director shall ensure that the program provides, as needed by and acceptable to the individual, services that are directed at:

(1) (proposed text unchanged)

(2) Developing or restoring appropriate basic living skills and supports to keep housing, such as:

(a) (proposed text unchanged)

[[(b) *Maintenance of* an adequate supply of food and household goods;**]]**

[[(c)**]]** *(b)*—**[[**(e)**]]** *(d)* (proposed text unchanged)

(3) (proposed text unchanged)

.10 Staff Qualifications and Responsibilities.

A.—B. (proposed text unchanged)

C. Psychiatric Rehabilitation Direct Care Staff. The program shall employ psychiatric rehabilitation direct care staff who:

(1) Have 40 hours of PRP training before independently providing PRP services;

(2)—(3) (proposed text unchanged)

.11 Required Program Staff.

A. (proposed text unchanged)

B. If a PRP has fewer than 30 enrollees, the PRP shall employ either:

(1) (proposed text unchanged)

(2) A program director who is responsible for the duties of the program director and the duties of a psychiatric rehabilitation specialist, if the program director:

(a) Has the qualifications described under **[[***Regulation .11B(1)(a)***]]** *Regulation .10B(1) of this chapter;*

(b)—(c) (proposed text unchanged)

C. If a PRP has 30—100 enrollees, the PRP shall employ either:

(1) (proposed text unchanged)

(2) A program director who is responsible for the duties of the program director and the duties of the psychiatric rehabilitation specialist, if the program director:

(a) Has the qualifications described under **[[***Regulation .11B(1)***]]** *Regulation .10B(1) of this chapter;*

(b)—(c) (proposed text unchanged)

D. If a PRP has more than 100 enrollees, the PRP program shall employ:

(1) (proposed text unchanged)

(2) A psychiatric rehabilitation specialist or specialists and staff assigned to administrative duties as follows:

(a)—(b) (proposed text unchanged)

(c) If the program director has the qualifications described under **[[***Regulation .11B(1)***]]** *Regulation .10B(1) of this chapter:*

(i)—(ii) (proposed text unchanged)

.12 Ratio.

A. The program shall maintain an average ratio of at least one rehabilitation staff member serving each ten individuals who are receiving **[[***group***]]** *on-site PRP services,* **[[***either at the PRP facility or off-site***]]** *or receiving off-site PRP services in a group.*

B. (proposed text unchanged)

JOHN M. COLMERS
Secretary

Husband and Wife Convicted of Defrauding State Medicaid Program of $900,000

BALTIMORE, MD (March 11, 2008) – Attorney General Douglas F. Gansler today announced the conviction of Tammy D. Smith and Anthony H. Smith, husband and wife, both of Huntshire Road in Randallstown on nine counts of felony Medicaid fraud and nine counts of felony theft. Each count of theft carries a maximum sentence of 15 years and each count of Medicaid fraud caries a maximum sentence of five years incarceration. Sentencing has not yet been scheduled.

The evidence in the case established that Tammy Smith, a clinical social worker, and her husband, who handled her billing, submitted thousands of false claims to the Maryland Medicaid program for therapy services that were not performed at all or were different than the services billed for. For example, Ms. Smith billed for services she claimed to have performed on several days when she was a hospital inpatient. She also billed for nine months of multiple therapy services a week for a patient she never saw and who was in the hospital at the time the services were allegedly rendered. She also claimed to have provided up to 42 hours of service on a single day and more than 24 hours of service per day on 27 separate occasions.

During the trial, several former employees testified that they were told to falsify billing documents in an effort to bill a higher rate to Medicaid. In addition, several former patients testified that they did not receive the services that were billed to the Medicaid program by the Smiths. The evidence also established that Ms. Smith billed for thousands of 75 minute therapy sessions that were not performed at all or were actually only 20 to 30 minute sessions. The State established that from January of 2000 through December of 2003, Medicaid paid the Smiths nearly $900,000. Although required to do so by the Medicaid regulations, the Smiths failed to document over $700,000 of those services.

“My Office will pursue criminally any provider who tries to defraud the State Medicaid program,” said Attorney General Gansler, noting that the Medicaid program is one of the largest items in the State budget. “This kind of fraud hurts both needy patients by wasting Medicaid’s strained resources and the State itself by stealing from the taxpayers.”

The case was prosecuted by the Attorney General’s Medicaid Fraud Control Unit with the assistance of the Mental Hygiene Administration and the Medicaid Program, both of which are part of the Department of Health and Mental Hygiene.

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

To: All Program Providers

From: Susan Steinberg
Deputy Director

Re: Medicaid Number

Date: January 7, 2008

Please be advised that each program participating in the Public Mental Health System must have a unique Medicaid Provider number. If a program provides the same service, i.e. PRP in different locations, then the Program will have one base Medicaid number, with different suffixes for each location. Medicaid will provide the different suffixes. If a program provides different services at the same location, i.e. PRP and OMHC, then the provider will need separate, unique provider numbers for each program.

In addition, each program site must be approved by Office of Health Care Quality.

Failure to have OHCQ approval for each site may lead to suspension of payments. Failure to have unique Medicaid numbers, may lead to problems with obtaining claims payment.

Mental Hygiene Administration
Documentation for Uninsured Eligibility Benefit

Consumer Name _____

ID _____

Adddress _____

Program _____

Date Form Completed _____

REQUIREMENTS

☐ The consumer requires treatment for a mental health diagnosis(es) covered by the PMHS.

☐ The consumer is financially needy.

☐ The consumer has a verifiable Social Security Number

☐ The consumer has applied for Medical Assistance (MA), Social Security Insurance (SSI), or Social Security Disability Insurance (SSDI) if they have an illness/disability for a period of 12 months or more (or are expected to have an illness/disability for a period of 12 months or more.)

☐ The CSA has approved the eligibility span due to the urgent need for the service.

AND the consumer meets one of the following criteria:

☐ The consumer's income is 116% of FPL.

☐ The consumer has received services in the PMHS in the past two years.

☐ The consumer is currently receiving SSDI for mental health reasons.

☐ The consumer is homeless within the state of Maryland.

☐ The consumer was released from prison, jail or a Department of Correction facility within the last 3 months.

☐ The consumer was discharged from a Maryland-based psychiatric hospital within the last 3 months.

☐ The consumer is receiving services as required by an order of a Conditional Release.

Individuals may only receive PMHS uninsured benefits if the provider has documented that the consumer is not eligible for MA, SSI, SSDI, or any other public benefit program and includes, in the individuals medical record, documentation from MA or Social Security stating the reason for ineligibility.

Check all that apply:

☐ Application submitted to DSS for Medicaid eligibility determination.

☐ If yes, indicate date application submitted, outcome, (e.g. denied due to disability determination, income, other) and the rationale if denied.

Application submitted date: _____ Outcome: _____

Rationale of denial: _____

☐ Application not submitted to DSS because the individual has SSDI in excess of Federal Poverty Level (FPL).

☐ Application submitted to all other public entitlement programs. If yes, indicated the program, date of application and outcome.

Program _____ Application submitted date: _____

Outcome: _____

☐ For individuals not eligible for Social Security or Medicaid, application submitted for Primary Adult Care (PAC) Waiver.

Application submitted date: _____ Outcome: _____

☐ For individuals working who are determined disabled by Social Security or Disability determination, application submitted for Employed Individuals with Disabilities (EID).

Application submitted date: _____ Outcome: _____

☐ Application submitted to Social Security Administration.

Application submitted date: _____ Outcome: _____

☐ Individual does not have private insurance.

☐ Individual has private insurance but has exhausted all benefits.

☐ Individual has SSDI/Medicare and a serious mental illness and requires service such as PRP to prevent or divert hospitalizations, incarceration or homelessness.

MHA Overview and Question and Answer Session for Changes to:
Chapters 10.21.16, 10.21.17, 10.21.20, 10.21.21, and 10.21.29

Registration Form

Please check-off which location you wish to attend: All locations 1:30 pm–4:30 pm

1. Western Maryland
_____**Monday**, **February 11, 2008**
Allegany Community College
12401 Willowbrook Road, S.E.
Cumberland, MD 21502

2. Eastern Maryland Region
_____**Tuesday, February 12, 2008**
Chesapeake College
Wye Mills Campus – Historic Wye Mills
Routes 50 and 213
Wye Mills, MD 21679

3. Central Maryland
_____**Wednesday, February 13, 2008**
Oakland Mills Interfaith Center - The Meeting House
5885 Robert Oliver Place
Columbia, MD 21045

4. Central Maryland
_____**Tuesday, February 19, 2008**
Oakland Mills Interfaith Center - The Meeting House
5885 Robert Oliver Place
Columbia, MD 21045

5. Southern Maryland
_____**Wednesday, February 20, 2008**
Bowie State University
14000 Jericho Park Road
Bowie, MD 20715

6. Central Maryland
_____**Wednesday, February 27, 2008**
Essex Community College
7201 Rossville Boulevard
Baltimore, MD

This form must be received by **FEBRUARY 6, 2008**

(pre-registration is required - there is no fee for this meeting)

Please Check one:

□ Consumer
□ Family member
□ CSA Representative
□ PRP Administrator/Director
□ PRP Staff Member
□ Other_____
□ OMHC Administrator/Director
□ OMHC Clinician

Name _____
(please print or type)

Agency_____

Address _____

Phone _____ E-mail _____ _____

If hearing interpreter or other special accommodations are needed, call Wendy Baysmore at (410) 646-7758 by Thursday, January 31, 2008.

Send completed form to: **Peggie Butler-Watson, MHSTC, 3700 Koppers Street, Suite 402, Baltimore, Maryland 21227, or Fax (410) 646-7849.**

- PM snack will be provided.

Directions: Will be forwarded in a confirmation email upon receipt of registration form.

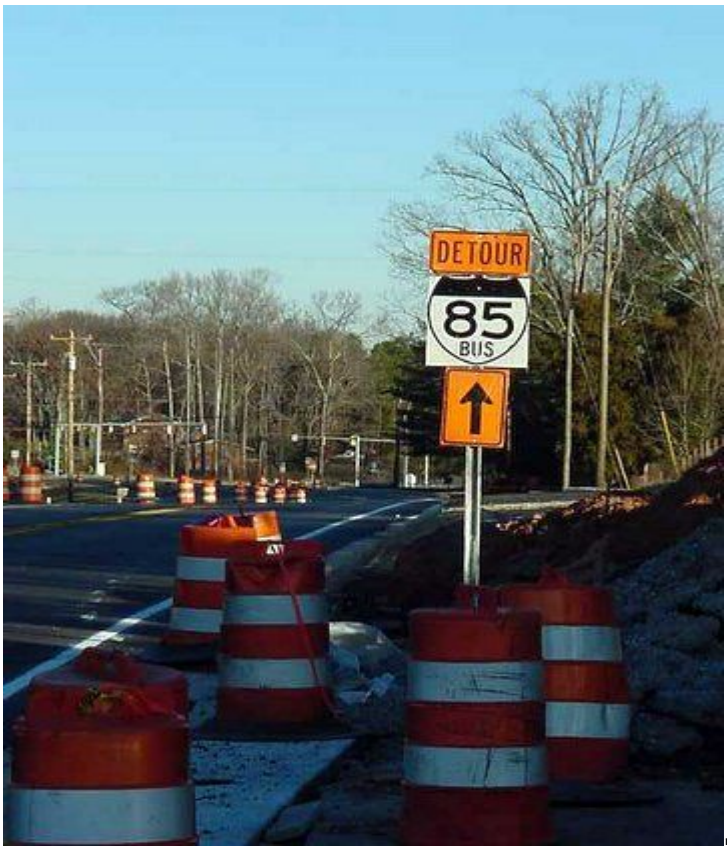
PLEASE SAVE THE DATE!!

JUNE 27, 2008

Maryland Mental Hygiene Administration (MHA)/
Maryland Division of Rehabilitation Services (DORs)
2008 Annual Conference

Detours Ahead on the Road to Recovery: Finding Employment without Getting Lost

Lisa Mistler, MD, Assistant Professor of Psychiatry, Dartmouth Medical School



Conference location remains to be determined. For more information, please contact Steve Reeder, MHA at 410-402-8476 or sreeder@dhmh.state.md.us

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor - John M. Colmers, Secretary

MEMORANDUM

From: Susan Tucker
Executive Director
Office of Health Services

Date: December 24, 2007

RE: NDC Extension

The Medical Care Programs has received notice that the Center for Medicaid and State Operations has approved our request for an extension on the requirement to meet the January 1, 2008 deadline for reporting the NDC on outpatient claims. The approval of the extension is limited to claims submitted on the UB04. Compliance with the January 1, 2008 deadline will be required on those professional claims submitted on the CMS 1500 claims. The extension is granted for the outpatient claims until June 30, 2008.

The Medical Care Program appreciates your continued participation and support towards resolving the issues that challenge us in becoming fully compliant with the NDC reporting requirements. We will continue to meet to discuss these issues after the first of the year.

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

January 10, 2008

Dear Public Mental Health System Provider,

In the spring of 2008, the State of Maryland will launch a Mental Health and Human Services web site called Network of Care (NOC). The Maryland Network of Care is an online information center for individuals, families, and mental health providers concerned with mental and emotional wellness. It is funded by the Maryland Mental Health Transformation State Incentive Grant to provide a means for communities to respond to the behavioral and mental health needs of their citizens through access to mental health providers, support groups, and personal advocacy resources in their local communities.

The Network of Care enables online access to services and information available within each county, including: an updated list of service providers by behavioral/mental health category; federal and state laws/legislation related to mental health issues; a library containing more than 30,000 articles, fact sheets and reports produced by the leading experts and organizations in the field of behavioral health; and a comprehensive listing of both low-cost and private insurance providers. Please go to the website, http://networkofcare.org, from the menu select **Mental/Behavioral Health,** select **Maryland** from the drop-down list, on the bottom of the window select a county such as **Anne Arundel, and** select **Services** from the side menu.

As a Public Mental Health System (PMHS) provider, it is important that you are included on the NOC. **Therefore, I am requesting that you please complete the attached form and return it to by February 10, 2008 to:**

Anne Arundel County Mental Health Agency, Inc.

P. O. Box 6675, MS 3230

1 Truman Parkway, Suite 101
Annapolis, MD 21401

Thank you for your help in making the Network of Care a comprehensive listing of services available to consumers, families, and the general public. If you have questions about the project or the form, please call Ruth Ehrensberger at 410-222-7858.

Sincerely,

Brian Hepburn, M.D.
Executive Director

Daryl Plevy
Project Director, Maryland Transformation Grant

NETWORK OF CARE PROVIDER LISTING FORM

I. **Name:** _____ _____ _____
Last **First** **Middle Initial**

_____
Address #1. Street **City** **State** **Zip**

_____ _____ _____
Phone **Fax** **Email Address**

Agency: _____ _____
Company Name **Contact Person**

_____
Address #2: Street **City** **State** **Zip**

_____ _____ _____ _____
Phone **Fax** **Email Address** **Web Site Address**

Additional Locations? (List on Page 5)

Please choose the NOC County sites you would like to be listed under:

- ☐ Allegany, Garrett, Washington
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Calvert, Charles, St. Mary's
- ☐ Caroline, Somerset Wicomico
- ☐ Carroll, Frederick
- ☐ Cecil, Harford
- ☐ Howard
- ☐ Montgomery
- ☐ Prince George's

II. **Days of Operation With Hours of Operation (Circle):**

- ☐ Monday a b c d:_____
- ☐ Tuesday a b c d:_____
- ☐ Wednesday a b c d:_____
- ☐ Thursday a b c d:_____
- ☐ Friday a b c d:_____
- ☐ Saturday a b c d:_____
- ☐ Sunday a b c d:_____

EXAMPLE:
a. 8:00 a.m to 12 noon
b. 12:00 noon to 4 p.m.
c. after 4 p.m to _____
d. Other: _____

Insurance (Check All That Apply):

- ☐ Medical Assistance
- ☐ Medicare
- ☐ PAC
- ☐ Private:_____
- ☐ MD Psychiatrist
- ☐ MD Other: _____
- ☐ Psychologist
- ☐ Marital & Family

List Licensed Staff with Type of License
(Check All That Apply to Practice Group):

- ☐ LCPC
- ☐ LCSW-C
- ☐ Psychiatric Nurse
- ☐ OTR
- ☐ Other: _____

COMAR Service Codes - As licensed, or approved by the State of Maryland (Check All That Apply):

III. Mental Health:

- ☐ Case Management, 10.09.45
- ☐ Crisis Beds,10.21.26
- ☐ EPSDT, 10.09.23
- ☐ Home Health, 10.9.04
- ☐ Intensive Outpatient-MH, 10.21.20
- ☐ Mental Health Group Homes, 10.21.04
- ☐ Mental Health Vocational Program, 10.21.28
- ☐ Mobile Treatment, 10.21.19
- ☐ Outpatient Mental Health Center, 10.21.20
- ☐ Psychiatric Rehabilitation, Adult, 10.21.21
- ☐ Psychiatric Rehabilitation, Child, 10.21.29
- ☐ Psychiatric Day Treatment, 10.21.02
- ☐ Respite, 10.21.27
- ☐ Residential Rehabilitation, 10.21.22
- ☐ Residential Treatment Center, 10.09.29
- ☐ Therapeutic Group Home, 10.21.07
- ☐ Therapeutic Nursery Program, 10.21.018
- ☐ Traumatic Brain Injury, 10.09.46
- ☐ Other:_____

Substance Abuse:

- ☐ Early Intervention, 10.47.02.03
- ☐ Outpatient Treatment Srvs, 10.47.02.04
- ☐ Intensive Outpatient & Partial Hosp. Srvs, 10.47.02.05
- ☐ Res. Srvs. – Halfway Houses, 10.47.02.06
- ☐ Res. Srvs – Long Term Residential Care, 10.47.02.07
- ☐ Res. Srvs – Therapeutic Community, 10.47.02.08
- ☐ Res. Srvs– Med Monitored Intensive Inpatient Tx, 10.47.02.09
- ☐ Detoxification Srvs, 10.47.02.10
- ☐ Medication-Assisted Tx, 10.47.02.11
- ☐ Education Programs, 10.47.04
- ☐ STOP 10.47.05
- ☐ Treatment to Work 10.47.06
- ☐ Other: _____

Psychiatric Hospitals:

- ☐ Acute General
- ☐ Private Psychiatric (IMD)
- ☐ State Psychiatric Hospital

Languages:

- ☐ American Sign
- ☐ English
- ☐ Korean
- ☐ Spanish
- ☐ Other _____

IV. PROVIDER INFORMATION

Techniques/Theoretical Orientation - Choose up to Six:

- ☐ Analytical
- ☐ Behavioral
- ☐ Cognitive
- ☐ Cognitive Behavioral
- ☐ Dynamic
- ☐ Dialectical Behavioral
- ☐ Eclectic
- ☐ Existential
- ☐ Family Systems
- ☐ Family Therapy
- ☐ Freudian
- ☐ Gestalt
- ☐ Hypnosis
- ☐ Jungian
- ☐ Play Therapy
- ☐ Reality
- ☐ Religious Oriented Counseling
- ☐ Rational Emotive
- ☐ Solution Based
- ☐ Transactional Analysis
- ☐ Transpersonal
- ☐ Other _____

_____

Specialties (Check All That Apply):

- ☐ ACOA
- ☐ Acupuncture
- ☐ Acute Crisis & Evaluation
- ☐ Adolescent Issues
- ☐ ADHD
- ☐ Adoptions
- ☐ Anger Management
- ☐ Anxiety/Panic/Phobic Disorders
- ☐ Biofeedback/Relaxation
- ☐ Bipolar/Mood Disorders
- ☐ Blindness
- ☐ Child Issues
- ☐ Co-Dependency
- ☐ Compulsive Gambling
- ☐ Conduct Disorders
- ☐ Co-Occurring, MH & Substance Abuse
- ☐ Couples/Marital
- ☐ Critical Incident Stress Debriefing
- ☐ Cultural/Ethnic Issues
- ☐ Deafness
- ☐ Death/Dying/Terminal Illness
- ☐ Dementia/Alzheimer's
- ☐ Depressive Disorders
- ☐ Developmental Disorders
- ☐ Employee Assistance Program
- ☐ Eating Disorders
- ☐ ECT
- ☐ EMDR
- ☐ Elder Issues
- ☐ Forensics
- ☐ Grief/Bereavement
- ☐ HIV/AIDS
- ☐ Infant/Pre-School Disorders
- ☐ Mediation
- ☐ Medications (Psychopharmacology)
- ☐ Men's Issues
- ☐ Mental Retardation
- ☐ Neurological
- ☐ Neuropsychological Assessment
- ☐ Pain Management
- ☐ Parenting
- ☐ Personality Disorders
- ☐ Physical/Sexual Abuse-Child
- ☐ Physical/Sexual Abuse Adult/Elder

Specialties (Check All That Apply) Cont'd:

- ☐ PTSD
- ☐ Psychological Testing-Adult
- ☐ Psychological Testing-Child
- ☐ Rape
- ☐ Schizophrenia/Psychosis
- ☐ Sexual Dysfunction
- ☐ Sex Offenders Treatment
- ☐ Sexual Orientation/Preference Issues
- ☐ Sleep Disorders
- ☐ Sports Pyschology
- ☐ Substance Abuse
- ☐ Traumatic Brain Injury
- ☐ Veteran's Issues
- ☐ Women's Issues
- ☐ Other:_____

_____

Methods:

☐ Individual ☐ Group☐ Couples/Family

Age Group Specialty:

- ☐ 0-5
- ☐ 6-12
- ☐ 13-17
- ☐ 18-21
- ☐ 22-64
- ☐ 65+

Accessibility:

- ☐ ADA Compliant
- ☐ Within 100 Yards of Public Transportation
- ☐ Provide Transportation (Specify Conditions) _____
- ☐ Off Hours Coverage (Explain): _____
- ☐ Other Special Arrangements (Explain: _____
- ☐ Can accept urgent referrals (within one working day). Explain: _____

Sex & Ethnicity of Provider:

- ☐ Male
- ☐ Female

- ☐ Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ African American
- ☐ Hispanic
- ☐ Native American
- ☐ White
- ☐ Multi-Racial
- ☐

Other: _____

Summary (Briefly explain how you would like your Agency/Practice to appear in the listing).

_____

_____

_____

_____

Additional Locations:

#3. Agency: _____ _____
Company Name **Contact Person**

_____
Address #3. Street **City** **State** **Zip**

_____ _____ _____
Phone **Fax** **Email Address**

#4. Agency: _____ _____
Company Name **Contact Person**

_____
Address #3. Street **City** **State** **Zip**

_____ _____ _____
Phone **Fax** **Email Address**

#5. Agency: _____ _____
Company Name **Contact Person**

_____
Address #3. Street **City** **State** **Zip**

_____ _____ _____
Phone **Fax** **Email Address**

#6. Agency: _____ _____
Company Name **Contact Person**

_____
Address #3. Street **City** **State** **Zip**

_____ _____ _____
Phone **Fax** **Email Address**

Maryland Psychiatric Research Center
Outpatient Research Program
Clinical Care Program

February 21, 2008

The provision of high quality clinical care services is one of the Outpatient Research Program (ORP) missions. Patients are cared for in a clinical program that is personal and individualized.

The Process

The process begins with an approximate two-month, in-depth evaluation performed by a licensed clinical social worker and clinic psychiatrist to clarify diagnosis and assess decisional capacity. For admission, patients must be between the age of 18 and 45 and have a schizophrenia or schizoaffective diagnosis, and they must be capable of understanding and appreciating the research nature of the clinic.

As part of their appreciation, prospective patients must understand that participation in research protocols is expected of them during their clinic stay. It is this level of competency that is required of a patient when they agree to be treated in the ORP. Patients remain in the ORP for an indefinite amount of time.

Diagnostic consultation is provided as a service to the community for patient and families who wish for clinical information but are not interested in research clinic participation.

The process of obtaining informed consent for a specific research protocol does not begin until the staff has an understanding of the patient's symptoms, behaviors and life circumstances. For patients who are not interested in ORP clinic admission, diagnostic consultation is provided as a service to the community. Fees are not collected for clinical services, as these are funded through University of Maryland, state and federal grants.

Components of Treatment

- In-depth evaluation and diagnostic formulation
- Evening hours and Saturday appointments available on request for those employed
- Physical examination and primary care services performed by Nurse Practitioner
- Weekly group therapy by licensed clinical social workers with individual sessions provided, as needed
- Psychiatric medications dispensed on premises
- Psychiatrist available as needed
- 24 hour emergency, on-call service, covered by clinic staff
- Transportation provided as needed
- Regularly scheduled family education and support groups

- Utilization of modern brain imaging, neuropsychological testing, and other assessment techniques, when indicated.
- Clinical care to the approximately 100 patients seen in the clinic, weekly.

The goal is to improve social and occupational functioning, reduce symptoms, increase autonomy, and prevent hospitalization. The ultimate aim of treatment is to help each patient attain an optimal level of functioning at home and in the community. Clinical care follows the procedures outlined in the Outpatient Program Policy and Procedure Manual which meet DHMH/ MHA regulations.

Primary Clinical Goals

- maximizing independent living, working, and social life
- helping the patients and their families manage the effects of the illness with minimal disruption in their lives
- preventing hospitalization
- The clinical staff is comprised of experienced psychiatrists, psychologists, social workers, nurses, and pharmacist who work together as a multidisciplinary team

The program is licensed by the state of Maryland as an Outpatient Mental Health Program (OMHP) and is visited regularly by the Department of Mental Health and Hygiene to maintain this OMHP status. Fees are not collected for clinical care, as clinical services are funded through University of Maryland, State and federal grants.

Referrals or Questions may be directed to:
Christine Brown,Project Research Coordinator
MPRC- Outpatient Research Program
410-402-7878
cbrown@mprc.umaryland.edu

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: Public Mental Health System (PMHS) Providers of Partial Hospitalization Programs/Day Treatment Programs

FROM: Brian Hepburn, M.D.
Executive Director, Mental Hygiene Administration (MHA)

RE: Changes in Benefit Coverage

DATE: November 20, 2008

This memorandum is to provide clarification regarding coverage for services for individuals who are uninsured in the Public Mental Health System (PMHS). Mental Hygiene Administration (MHA) is limiting coverage of Partial Hospitalization Programs/Day Treatment (PHP/DT) regulated under COMAR 10.21.02 to Medicaid recipients only. If individuals who meet the PMHS uninsured eligibility criteria need intensive short-term services, the individual is to be referred to Outpatient Mental Health Centers (OMHC) for Intensive Outpatient Services (IOP).

Partial Hospitalization Programs /Day Treatment (PHP/DT) are short-term intensive mental health treatment services often provided as a diversion to inpatient psychiatric care. As such, the service should be similar to the daily treatment provided for inpatient care to consumers who meet medical necessity criteria for PHP/DT level of care. MHA and MAPS-MD are analyzing the use of PHP/DT to determine if it is being used as an intensive treatment intervention.

Effective January 5, 2009, MHA is directing MAPS-MD to closely review and monitor authorizations for PHP/DT to assure that the services provided are short-term intensive goal-directed treatment services to ameliorate acute psychiatric symptoms.
In addition, the PMHS will only reimburse Medicaid eligible recipients for PHP/DT. This excludes Primary Adult Care (PAC) recipients since PHP/DT is not an eligible benefit.

If you have any questions please contact Lissa Abrams, Deputy Director, MHA on 410-402-8451.
Thank you.

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

TO: PMHS Providers

FROM: Brian Hepburn, M.D., Director, MHA

RE: Provider Contact Information

DATE: December 27, 2007

In order to facilitate important provider communication from the PMHS and MAPS-MD, please complete the "Voluntary Provider Registration" form as soon as possible. This will provide both the MHA and MAPS-MD with current and accurate contact information to better serve you. The registration form can be accessed at:

http://www.surveymonkey.com/s.aspx?sm=kAE51WCrmwxwhf_2f5y9Fhnw_3d_3d

Thank you for your timely cooperation.

MENTAL HYGIENE ADMINISTRATION
POLICY CLARIFICATION: PRP FOR MINORS (COMAR 10.21.29)
(revised June 2008)

Please note: The most recent version of COMAR 10.21.29, PRP for Minors, was not circulated at the winter 2008 trainings. Please refer to the latest amendments dated February 12, 2007, which may be accessed at www.dsd.state.md.us.

Facility (COMAR 10.21.29.04A): This regulation requires a designated and separate on-site location where, based on consumer choice and the clinical needs of the youth being seen, PRP services shall be provided to a youth and their family, including space that can accommodate group rehabilitation services for a minimum of 6 youth. The PRP on-site facility may include designated space in a larger mental health organization. The hours of operation shall be posted for the public. The PRP is required to have office space where medical records can be locked.

Eligibility for Services [COMAR 10.21.29.05A(1)(a)(i) and (ii)]: This regulation requires that all youth receiving PRP services must be referred for PRP services by a licensed mental health professional who is providing inpatient, residential treatment center, or outpatient mental health services to the minor; and must currently be in and remain in active mental health treatment. "Active mental health treatment" is defined as being seen for treatment ***at least twice a month*** and must be clearly documented in the youth's record. In addition, the youth must meet the Medical Necessity Criteria (MNC) for PRP services for minors.

Evaluation and Planning Services (COMAR 10.21.29.06): As part of the rehabilitation assessment and planning processes, ongoing contact between the clinician treating the youth and the PRP provider need to be documented to assure integration of services as part of the overall plan of care for the youth. PRP services need to be goal-directed and outcome-focused. The parent or primary caregiver needs to be actively involved in both the identification and evaluation of the PRP services. Additionally, the regulations require IRPs to be reviewed every 3 months, even when the authorization period may be for six months.

Program Director and Rehabilitation Specialist [COMAR 10.21.29.09F and G(1)]: The requirement for the number of hours of program director and rehabilitation specialist's time varies depending on the number of youth enrolled in the program. For programs that provide PRP services to both minors and adults, the total number of individuals in the program guides the staff requirements (see "Clarification of PRP Program Director and Rehabilitation Specialist Requirements," dated December 3, 2007). Credential and supervision requirements/ privileges of the rehabilitation specialist are determined by the applicable professional licensing board.

Direct Care Staff Qualifications and Training [COMAR 10.21.29.09G(2)]: Direct care staff must have, ***at a minimum***, one year of work experience in a supervised mental health setting. Meeting the additional educational requirements specified in the regulations (i.e., 30 college credits, AA degree, or BA/BS degree in a health-related field), however, is preferable.

In addition, direct care staff must have 60 hours of on-the-job direct PRP supervision (working with minors) before being able to provide PRP services without direct supervision (i.e., on their own/independently). 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.

Staffing Ratios (COMAR 10.21.29.O9H): The required 1:6 staff-to-client ratio is intended for group PRP activities only, either on-site or off-site (i.e., there must be at least 1 PRP rehabilitation staff member for every 6 youth in a group rehabilitation service). There are no restrictions for the caseload size for PRP direct care staff, although caseload size should be guided by the needs of the youth being served.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Office of Systems, Operations & Pharmacy
Medical Care Programs

Charles E. Lehman
Executive Director

Maryland Medical Assistance Program
General Provider Transmittal No. 69
September 30, 2008

TO: Physicians, Hospitals, Clinics, Nursing Homes, Intermediate Care Facilities for people with Mental Retardation, Residential Treatment Centers for Children under age 21, Nurse Practitioners

FROM: Charles E. Lehman, Executive Director
Office of Systems, Operations & Pharmacy

SUBJECT: Continuity of Mental Health Medication During Hospital to Community Transition for Maryland Medicaid and HealthChoice Patients

****

The source of payment for prescription medications changes when a patient is discharged from an acute care facility or a mental health inpatient service. To minimize the risk of interrupting the patient's drug regimen, the discharge planning process should include a survey of the particular medications ordered and identification of the patient's prescription drug insurance coverage.

This step in the discharge planning process is particularly critical for Medicaid patients with prescriptions for mental health medications because:

- Medicaid patients typically do not have the ability to pay cash for their prescriptions; and
- Continuity of drug regimen prevents relapse of symptoms and re-hospitalization.

The Maryland Medicaid Pharmacy Program has no formulary as such, but rather has established a Preferred Drug List (PDL) to insure the availability of efficacious, safe and cost effective drug options. The following classes of mental health drugs are included on the PDL: anticonvulsants, stimulants and related agents, antidepressants (SSRIs and others), atypical antipsychotics and sedative hypnotics.

In planning for discharge of Medicaid patients to the community with orders for an Atypical Antipsychotic medication, the prescriber should check the prescriptions against the current PDL. If the prescribed medication has clinical criteria and/or requires Prior Authorization (PA), the prescriber should obtain the PA before discharge. Currently, Zyprexa® is the only Atypical that is a Tier 2 drug (due to clinical criteria) and requires a PA.

Information about the status of drugs on the PDL can be found in several ways:

- telephone 800-932-3918 anytime, 24 hours a day, 7 days a week;
- visit website http://www.dhmh.state.md.us/mma/mpap/druglist.html; or
- consult Epocrates®, a free, online or downloadable reference at http://www.epocrates.com/. Epocrates® also gives information about any quantity limits or other restrictions that may apply to a particular drug.

Prior to discharge, the prescriber must personally call **800-932-3918** to obtain a PA. The prescriber need not provide a justification or meet any special conditions or criteria. Preauthorization requests can be processed at any time, 7 days a week, 24 hours a day, and will last one full year. Phone requests for PA are effective immediately. A PA can also be obtained using a fax form (see attached) which the prescriber must personally sign. A separate form is required for each prescription. It may take up to 24 hours for fax submissions to become effective.

Attachment (1)

37663

Maryland Pharmacy Program
Request for Rx Prior Authorization
Preferred Drug Program

Request Date ☐☐ / ☐☐ / ☐☐☐☐

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State ☐☐

Zip Code ☐☐☐☐☐ - ☐☐☐☐

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber DEA # ☐☐ - ☐☐☐☐☐☐

Person Completing Form _____

Drug Requested: (Use one form per drug)

Check if generic is not acceptable ○ (Prescriber must complete DHMH Medwatch Form)

Strength _____ Dosage Form _____ Quantity _____ Directions _____

1. Diagnosis for use of this medication? _____

2. Why have you chosen to use a drug that is not a preferred drug nor a recommended Tier 1 drug?

○ Inadequate response to alternatives ○ Allergy to alternates ○ Adverse event with alternatives

Select all that apply

○ Other (describe) _____

The Preferred Drug List allows the State to provide recipients quality drugs that are safe and cost-effective.
Current list of non-preferred drugs requiring PA is available at
http://providersynergies.com/services/documents/MDM_PDL.pdf

Signature of Prescriber _____ Date ☐☐ / ☐☐ / ☐☐☐☐

FAX TO: Maryland Pharmacy Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

37663

Revised - February 06, 2008

MENTAL HEALTH SYSTEMS
IMPROVEMENT COLLABORATIVE
HOWARD H. GOLDMAN, M.D., Ph.D.
Director
Training Center
Evidence-Based Practice Center
Systems Evaluation Center

UNIVERSITY OF MARYLAND
SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY

DIVISION OF SERVICES RESEARCH

May 5, 2008

Dear Colleagues,

On Thursday, June 5, 2008, the Mental Hygiene Administration, Office of Special Needs Populations, and the Mental Health Services Training Center, University of Maryland, Baltimore will present a ***Shelter Plus Care 101 Training.***

The purpose of this one day training is to provide information about the Shelter Plus Care Housing Program. This training will educate providers and consumers on homeless services and how to access rental assistance through the Department of Housing and Urban Development (HUD), a funded Shelter Plus Care Housing Program through the Mental Hygiene Administration.

The training will be held at the Temple Oheb Shalom located at 7310 Park Heights Avenue, Baltimore, Maryland 21208. To register, please complete the enclosed registration form and mail it to LaToya Scott with a check for $25.00 made out to Baltimore Mental Health Systems, Inc. Or, if you'd prefer, you may fax the registration form and mail the check or bring the check with you to the training. We are also accepting electronic payments from state agencies; your electronic payment should be sent to "Baltimore Mental Health Systems" and must include this statement: **"Please reference BMHS-TC47.**

Goals and Objectives:

This training will provide a basic overview of the Mental Hygiene Administration's Shelter Plus Care Housing Program and the application process. The Shelter Plus Care training will discuss: the eligibility criteria for the Shelter Plus Care Housing Program; provide a step by step overview of the application process and required documentation; provide information on how to develop consumer focused and consumer driven service plans and documenting supportive services; provide strategies for locating housing that meet HUD's Housing Quality Standards; and provide strategies for working with landlords and consumers to prevent eviction and termination.

Agenda for the day:

8:30 – 9:00	Registration/Continental Breakfast
9:00 – 9:15	Welcome and Introductions *Marian V. Bland*, Director, Office of Special Needs Populations Mental Hygiene Administration
9:15 – 10:30	Overview of Shelter Plus Care: Purpose, Goals, Eligibility Criteria, Application Process I – Initial Application *Marian V. Bland*, Office of Special Needs Populations
10:30 – 10:45	Break

10:45 – 12:30	Application Process Part II: Housing Placement and Renewals Billing and Administrative Policies
12:30 – 1:15	Lunch (Provided)
1:15 – 2:30	Developing Consumer Friendly Service Plans *Clarissa Netter,* Director, Office of Consumer Affairs, MHA *Mary Raki,*Case Manager for Johns Hopkins Case Management Program
2:30 – 3:30	Strategies for Locating Housing and Working with Landlords Tips for Finding Housing within Housing Quality Standards *Carolyn Ames,* Executive Director of Community Housing Associates
3:30 – 4:15	Other Pertinent Shelter Plus Information; Question and Answers *Marian Bland,* MHA Office of Special Needs Populations
4:15	Adjourn - Evaluations

If you have any questions regarding the program, please contact Wendy Baysmore, Assistant Director at 410-646-7758.

Sincerely,

Eileen Hansen, MSSW
Director
Mental Health Services Training Center

cc: Marian Bland
Wendy Baysmore
LaToya Scott

Directions to Temple Oheb Shalom

7310 Park Heights Avenue
Baltimore, Maryland 21208
(410) 358-0105

From Downtown – Baltimore City:
Take 83 North to Northern Parkway Exit West underneath the overpass (2nd exit). Take Northern Parkway to Park Heights Avenue and turn right onto Park Heights Avenue. Stay on Park Heights Avenue until you get to the 7300 block. The Temple will be on your left.

From Frederick, Hagerstown and Points West: Take 70 East, get off at Exit 91B (the sign says 695 to 95 New York and Towson). Get off at Exit 21 (Park Heights Avenue–129 South) turn right onto Park Heights Avenue. Pass three traffic lights (last light is at Slade Avenue) and approximately 200 yards after the third light you will see Temple Oheb Shalom on the right.

From Washington: Take I-95 North to I-695 West (Baltimore Beltway). Follow I-695 to Exit 21. Turn right onto Park Heights Avenue, pass three traffic lights and proceed approximately 200 yards after the third light (at Slade Avenue). You will see Temple Oheb Shalom on the right.

PARKING – FOR ALL INSTRUCTIONS: Take the first driveway entrance for parking.

(Tear off and keep top portion)

This form must be received by **Wednesday, May 28, 2008**

Shelter Plus Care 101 Training.

Shelter Plus Care

Thursday, June 5, 2007

(pre-registration is required)

Name _____
(please print or type)

Agency _____

Address _____

Phone _____

E-mail _____

If hearing interpreter or other special accommodations are needed, call Wendy Baysmore at (410) 646-7758 by Monday, May 26, 2008.

☐ Continuing Education Credit (social worker, psychologist, licensed professional counselors)

☐ Certificate of Attendance (nurses and all other disciplines)

Registration fee is $25 per attendee. Payment options are: Cash, Check or Electronic payment. Electronic payment must be sent to Baltimore Mental Health Systems, Inc.; **reference code BMHS-TC47.**

Make checks payable to ***Baltimore Mental Health Systems.*** Send the check, along with this completed form to: **LaToya Scott, MHSTC, 3700 Koppers Street, Suite 402, Baltimore, Maryland 21227. Fax (410) 646-7849 Phone (410) 646-7758.**

Individuals receiving public entitlements may attend this conference for $5. If this fee represents a hardship, call Wendy Baysmore at (410) 646-7758.

Certificate for 6.25 Continuing Education Units or 6.25 Continuing Education Credit Hours of Category I will be awarded upon completion of this training and of a completed evaluation. The Mental Health Services Training Center is authorized by the Maryland Board of Examiners of Psychologists as a sponsor of Continuing Education Units, and by the Maryland Board of Social Work Examiners as a sponsor of Category I Continuing Education. The Center maintains responsibility for this program. A Certificate of Attendance will be made available for all other disciplines.

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

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Michelle A. Gourdine, M.D., Deputy Secretary, Public Health Services – Brian M. Hepburn, M.D., Executive Director

TO: PMHS Providers

FROM: Lissa Abrams

DATE: February 5, 2008

RE: **IMPORTANT REMINDER REGARDING REGIONAL TRAININGS on Amendments to COMAR Regulations, 10.21.16, 10.21.17,10.21.20 OMHC, 10.21.21 PRP, and 10.21.29 Child PRP**

MHA is offering a series of trainings on Recovery for providers serving adults and an Overview and Question and Answer sessions on the recently adopted changes to COMAR regulations affecting all regulated programs in the Public Mental Health System.

The morning sessions, from 9:00 AM -12:15 PM, are on recovery and are targeted to OMHC and PRP providers serving adults.

The afternoon sessions, from 1:30 P.M -4:30 PM, are on the COMAR regulation amendments and are open to all MHA regulated programs serving adults, children, and adolescents.

Advance registration is required for morning, afternoon, or both sessions.

The deadline for registration is February 6, 2008. If necessary this will be extended

Please see the attached for additional information and registration forms.

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

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
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: PMHS Providers

FROM: Lissa Abrams
Deputy Director, MHA

RE: Uninsured Eligibility Form

DATE: August 26, 2008

****

Due to the number of questions MHA has received concerning the uninsured eligibility form, additional written clarification will be provided by September 30, 2008. Providers are encouraged to complete the form to the best of their ability for new clients entering the system. The additional clarification will assist providers as they complete this document to assure that consumers have applied for all applicable entitlements.

Thank you.

STATE OF MARYLAND
DHMH

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Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary
Brian M. Hepburn, M.D., Executive Director

TO: Public Mental Health System (PMHS) Providers

FROM: Lissa Abrams
Deputy Director, Mental Hygiene Administration (MHA)

RE: Clarification on Completing "**Documentation for Uninsured Eligibility Benefit Form**"

DATE: October 24, 2008

This memorandum is to provide additional clarification to the requirements for requesting and completing documentation for MHA's uninsured eligibility benefit. MHA has revised the form that provides documentation to validate the individual's eligibility. However, if you have already completed the former uninsured eligibility benefit form, it is not necessary to complete the revised form until the individual's annual eligibility is due to be reviewed.

MHA has prioritized services for indivduals who are uninsured when the individual has a psychiatric diagnosis, is in need of mental health services, and is financially needy. Uninsured eligibility is provided to individuals near federal poverty level or who have other documented financial hardships.

In addition, the individual must meet one of the following conditions:

The consumer has received services in the Public Mental Health System (PMHS) in the past two years;
The consumer is currently receiving SSDI for mental health reasons;
The consumer is homeless within the state of Maryland;
The consumer was released from prison, jail or a Department of Correction facility within the last 3 months;
The consumer was discharged from a Maryland-based psychiatric hospital within the last 3 months;
The consumer is receiving services as required by an order of a Conditional Release; or
if the individual has an urgent need for outpatient mental health services and has been approved by the Core Service Agency (CSA).

The uninsured benefit for individuals who have Medicare includes services not covered by Medicare, such as Psychiatric Rehabilitation Programs (PRP), Residential Rehabilitation Programs (RRP) Mobile Treatment Services (MTS), Supported Employment, and Assertive Community Treatment (ACT).

In order to assure that individuals most in need who are uninsured receive the uninsured benefit, MHA is implementing the following procedures.

Initially, and annually thereafter, for every individual who is uninsured, programs shall document that applications have been made for all applicable benefits. Programs are to assist consumers by reviewing all potential public benefit programs and referring individuals accordingly. The "Documentation for Uninsured Eligibility Benefit" Form is to be kept in the individual's medical record. It is not to be submitted to MHA or MAPS-MD unless specifically requested. When medical records are reviewed during audits performed by MHA, MAPS-MD, Office of Health Care Quality (OHCQ), or the Core Service Agency (CSA), the auditors will review the record to see if the form has been completed for indivduals with uninsured eligibility spans.

The forms are to be completed for all uninsured individuals in all types of PMHS services and programs by the program requesting eligibility on behalf of the consumer. This includes, but is not limited to: PRP, RRP, MTS, Outpatient Mental Health Centers (OMHC), services rendered by individual practitioners, Supported Employment programs, etc.

For OMHCs, with the individual, review benefits and refer the individual to either case management services or to the applicable benefits office. PRP and RRPs are required to assist consumers apply. Consumers may attest and document the attestation that they have submitted applications for various benefit programs. It is not expected that programs will receive copies of all applications.

Programs will continue to provide information to MAPS-MD when requesting an uninsured eligibility span. This process will not change. The "Documentation for Uninsured Eligibility Benefit" form will validate the individual's continued need for the uninsured benefit.

For individuals who are uninsured, who are employed, and are requesting authorization for PRP services, MAPS-MD will direct the provider to refer the individual to Maryland Department of Disabilities Employed Indivduals with Disabilities (EID) Outreach program in order for the program to apply for EID on behalf of the individual. Before an uninsured request is determined, MHA is requiring an EID application be submitted. Exceptions will be granted only for an urgent care and referrals from state hospitals.

For veterans of Afghanistan and Iraq residing in rural areas of Maryland, MHA will provide gap services, outpatient treatment and crisis intervention services until the Veterans Administration benefits are activated and available. This does not apply to individuals with insurance benefits.

If you have any questions please contact me at abramsl@dhmh.state.md.us. Thank you for your attention to this matter.

Enclosure: **"Documentation for Uninsured Eligibility Benefit Form" Revised November 2008**
cc: CSA Directors
MHA Management Committee
OHCQ – Mental Health Unit
Jennifer Huber, MAPS-MD

STATE OF MARYLAND

DHMH

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Mental Hygiene Administration
Spring Grove Hospital Center – Dix Building
55 Wade Avenue – Catonsville, Maryland 21228

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Brian M. Hepburn, M.D., Executive Director

TO: PMHS Providers

FROM: Brian Hepburn, M.D.
Executive Director, Mental Hygiene Administration (MHA)

RE: IMPORTANT Public Mental Health System (PMHS)
Updates and Changes

DATE: December 23, 2008

This memorandum is to update you on proposed changes and to clarify rules regarding payment of services within the PMHS. MHA is assuring that all state and federal requirements are followed in order for the PMHS to pay for services.

1. All services except emergency care require pre-authorizations, COMAR 10.09.70, 10.21.17, and 10.21.25. There will be no exceptions granted.

2. Services covered by Medicare or other insurers will not be reimbursed by the PMHS, COMAR 10.21.25 and 10.21.17.

3. MHA has instructed MAPS-MD to post the ACH deposits on Thursdays beginning, January 8, 2009 for checks dated January 5, 2009.

4.MHA has determined that MAPS-MD may authorize PRP and Mobile Treatment on a case by case basis when the service is required in order to meet an individual's complex clinical needs to prevent hospital level of care or out of home placement.

I appreciate your attention to this important information. These are difficult and uncertain times but we are committed to providing mental health care to Maryland citizens in need.

Thank you.