

6.12. Mental Health – Psychiatric Rehabilitation Program (PRP)

DESCRIPTION OF SERVICES

Psychiatric rehabilitation program (PRP) services are provided by a program approved under COMAR 10.21.21. PRP services provide rehabilitation and support for participants to develop and enhance their community and independent living skills. Services may be provided at a PRP facility (onsite); at a residence, job, or another appropriate location in the community (off-site); or at a combination of the two (blended onsite and off-site).

The following are four different levels of care that a participant may be authorized to receive:

1. **Community PRP (authorized as PR1, billed as U2):** Services provided to:
 - a. Children in foster homes in which psychiatric services are not part of the day rate
 - b. Participants ages 18-21 (transition age youth [TYA])
 - c. Adults under legal guardianship

Services are provided to participants at a minimum of two encounters per month.

2. **Supported/Independent Living PRP (authorized as PR2, billed as U3):** Services provided to adults who are their own legal guardian. Services are provided to participants at a minimum of two encounters per month.
3. **Residential – General Support PRP (authorized as PR3, billed as U4 or U6):** Services provided to participants receiving PRP services with staff that is available on-call 24/7 and provides, at a minimum, three face-to-face contacts per participant, per week, or 13 face-to-face contacts per month.
4. **Residential – Intensive Support PRP (authorized as PR4, billed as U5 or U7):** Services provided to participants receiving PRP services with staff that is available on-call 24/7 and provides, at a minimum, daily support onsite in the residence with a minimum of 40 hours per week, up to 24 hours a day, seven days a week.

Information specific to PRP services provided to participants living in a residential program are discussed in Section 6.13. Information regarding PRP services available to participants in supported employment services is discussed in Section 6.6.

SERVICE RULES

PRP providers must complete an individualized rehabilitation plan (IRP) according to the requirements of COMAR 10.21.21.

The Core Service Agency (CSAs) reviews and approves applications for the PRP services associated with general and intensive levels of RRP services. The CSA manages any waiting list in their jurisdiction for intensive and general levels of RRP services. The CSA also manages transitional PRP services for participants stepping down from state hospitals or crisis beds to a RRP level of care.

Beacon Health Options, Inc. (Beacon) makes the medical necessity determinations for all levels of PRP and RRP services, except those of transitional PRP. Beacon makes all initial determinations on the level of the service and whether the service will be onsite, off-site, or blended.

A unit of PRP services is one month. Each level of PRP service stipulates a minimum number of face-to-face encounters to be provided. The expectation is that the program will provide services at the frequency and intensity indicated by the participant's presentation and as stated in the IRP.

The monthly case rate is based on a minimum number of encounters per month for a maximum of 30 encounters per month.

In the event the provider does not meet the service level minimum encounters for the authorized level of service, but does meet the minimum encounters for a lower level of service, the provider will bill using the originally authorized modifier, but will bill at the lower "allowed charge." It is the responsibility of the provider to ensure that the billed amount corresponds to the level of service that has been delivered. Please refer to the PRP billing cascade available at:

http://maryland.valueoptions.com/provider/claims_finance/PMHS_PRP_Cascade.pdf. Additionally, COMAR 10.21.25.09 describes the number of encounter requirements.

A provider may bill the blended rate for supported living (PR2/U3) or community services (PR1/U2) only if:

1. The participant is not receiving PRP services from another provider.
2. The program operates an onsite PRP facility which is owned or rented, open to the public, and is where PRP services (individual and group) are provided on a regular basis.
3. The program receives authorization to provide both on-site and off-site services.

The provider who meets the above criteria may provide only onsite or off-site services and submit claims for the blended rate. The provider must provide services based upon the needs of the participant as documented in the IRP, but may deliver only onsite or off-site services. The provider must document in the medical record that the participant has the choice to receive both onsite and off-site PRP services, and elected to only receive either onsite or off-site services. Requirements for billing the blended rate for PRP participants receiving residential services are listed in Section 6.

The Maryland Behavioral Health Administration (BHA) requires all PRPs participating in the Public Behavioral Health System (PBHS) to submit all encounter data, regardless of whether the number of encounters goes beyond the minimum required for reimbursement levels. For details, please see: http://maryland.valueoptions.com/provider/alerts/2013/011113_PRP_Billing_Clarification.pdf.

The encounter data will verify the number of face-to-face contacts, by date of service, when the PRP provided services to a participant during the month. There can only be one onsite encounter and one off-site encounter submitted on any given day.

Off-site encounters must be a minimum of 15 minutes and onsite encounters must be a least 60 minutes in duration. Interactions with participants for less than these time limits shall not be submitted to support the monthly PRP claim.

Multiple onsite encounters of less than the minimum duration, which occur on the same day, may be added together in order to meet the minimum time requirement. The time spent providing multiple off-site encounters on the same day may also be added together in order to meet the minimum time requirement for off-site services.

The encounters for participants receiving the community level (PR1/U2 and PR2/U3) of care must occur on at least two days.

Encounters that occur at a nursing home, hospital, or other institution shall not be submitted in order to support the monthly PRP claim.

Transportation is not a PRP service and shall not be submitted as an encounter. The time spent transporting the participant shall not be included in calculating the duration of an encounter. Additionally, attendance at an IEP meeting is not a PRP service or encounter.

BHA will not authorize or pay for PRP for a child residing in a therapeutic group home, or therapeutic foster care setting if similar support services are part of the per diem rate of that youth in placement. There may be limited reimbursement for a child residing in a regular group home. These residential settings are responsible for promoting the skills required for daily living and may at times need to provide intensive support or supervision to youth in their care.

BHA will not authorize or reimburse a provider for onsite only PRP services for a participant who is receiving Medicaid-covered medical day care services during the same month. However, the provider may submit the blended rate PRP services provided to a participant also receiving medical day care as long as the minimum service requirements are met by providing only off-site services. The off-site PRP services may not be delivered at the medical day care program.

Participants receiving PRP services are expected to receive basic case management functions, such as assistance in securing entitlements, transportation to appointments, coordination of services, and liaison with external services (somatic, substance use, and mental health) within the provision of PRP services. Therefore, requests for targeted case management or mobile treatment for participants enrolled in PRPs will not be approved.

Onsite services provided by two different PRP programs, as well as off-site services provided by two different PRP programs, is a duplication of services and is not allowed.

No more than one transitional PRP service per day, for a minimum requirement of four PRP services, while a participant is in a state psychiatric hospital or crisis bed may be authorized, as medically necessary. These visits must be pre-authorized by the CSA and are paid out of State general funds.

Participants authorized for RRP services receive, at a minimum, off-site PRP services in the RRP residence. Off-site PRP services cannot be reimbursed to providers if services are provided in an adult day care center. For off-site PRP services to be covered, the participant must be seen in their own home or outside of hours spent in the adult day care center.

When a service begins onsite at the PRP facility, goes off-site, and then returns to the PRP facility, it is considered an onsite service. For example, the PRP provides a cooking group and the PRP staff take the group to the supermarket for supplies and then return to the PRP facility. This is an onsite PRP service. The service does not count as both an onsite and off-site service.

All adult and child/adolescent PRP services must be referred to by the licensed mental health provider who is treating the participant. There also has to be at least one coordination of care activity with the licensed, treating, and referring mental health professional every six months. For details, please see: http://maryland.valueoptions.com/provider/alerts/2012/042512-PRP_Care_Coordination.pdf.

ADDITIONAL REQUIREMENTS FOR PROVIDERS WHO SERVE CHILDREN AND ADOLESCENTS

PRP services should be designed to promote positive peer interaction, effective communication, self-help skills, completion of age-appropriate activities of daily living, frustration tolerance, etc. It is expected that the services will be designed and developed to address the individual rehabilitative needs of each child and adolescent, while taking into account the stressors evolving from the environment at home or in school.

Providers of PRP services for children and adolescents must document progress on age-appropriate self-care and social skills, and should address any barriers to improvement in the participant's overall functioning.

Children and adolescents placed in a crisis bed program may attend a PHP or PRP during the day, depending upon the clinical needs of the participant. Services are authorized separately based on the participant's needs and medical necessity.

PRP services are not to be utilized for family therapy. Off-site PRP services delivered in a child or adolescent's home shall remain focused on the participant's rehabilitative skills development, assisting the participant and his/her family to identify appropriate activities to reach and maintain identified goals.

PARTICIPANT ELIGIBILITY

Those who are eligible for PRP services are participants with federally-funded Medicaid and Dual Eligible Medicare and Medicaid, or those who were receiving PRP services when they lost their federally-funded insurance. Upon pre-authorization, State funded Medicaid and the uninsured eligible participants are eligible for PRP services only when they meet the medical necessity criteria and have been discharged from:

1. A state hospital and are on conditional release
2. An acute care hospital or institution for mental disease within the last six months
3. An RRP bed within the last six months
4. Jail or incarceration within the last six months

For details, please see Beacon's Maryland service class grid at:

http://maryland.valueoptions.com/provider/clin_ut/ValueOptions-Maryland-Service-Grid.pdf.

Please also see the BHA memo on State only funded PRP at:

http://maryland.valueoptions.com/provider/alerts/2012/092412-Uninsured_PRP_Services_Memo.pdf.

PROVIDER ELIGIBILITY

PRP services may only be performed by PRPs approved according to COMAR 10.21.21. PRP providers must have an active Maryland Medicaid provider number and a signed provider agreement with BHA.

CLAIMS PROCESS

Claims for encounter data shall be submitted to Beacon Maryland within 30 days of the end of the billing month.

Claims need to be submitted on a CMS 1500 form through EDI-371, or entered directly into the Beacon system through the direct claim submission process. The billing/payment code for either PRP or RRP services is always H2018, choosing the correct modifier for the level of service. The modifiers are:

MODIFIER CODE	MODIFIER DESCRIPTION
U2	PRP for all children (up to the age of 18) adults ages 18-21 in a TAY-designated PRP, or adults with a legal guardian. Legal guardians are appointed through the legal system. A participant who still lives with his parents at the age of 18 (or older) but there is no legal guardian is an adult (use U3).
U3	PRP for adults with no legal guardians.
U4	A RRP client in the general level of care who is either on or off-site
U5	A RRP client in the intensive level of care who is either onsite or off-site
U6	A RRP client in the general level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity
U7	A RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in an onsite or off-site capacity

It is imperative that providers choose the correct modifiers when submitting the requests for authorization. In summary, the rules for submitting the H2018, the case rate for PRP include the following:

- H2018 is the code for billing the PRP monthly case rate.
- H2018 must be billed with the appropriate modifier and place of service.
- Only one H2018 per participant/per provider may be billed each month.
- The charge submitted for the service should equal the amount shown on the cascade document for the modifier and place of service.
- Providers must obtain an authorization for this service.
- Claims must be submitted within 12 months of the date of service, in accordance with the timely filing requirement. Ideally, providers should wait to bill the H2018 until the appropriate number of H2016 encounters have been met. This is not a required billing practice, but alleviates reconciliation issues that occur when H2018s are billed without supporting H2016 encounters (see encounter processing below).

Each PRP/RRP service requires the provider to see the participant in one of the three settings listed above. These services are considered an encounter. Encounters are billed as an H2016. These must also be submitted on a CMS 1500 form through EDI-371, or entered directly into the Beacon system through the direct claim submission process. These “claims” will not be paid, but the encounters will be tracked to reconcile payments made against the H2018.

Encounters (H2016) must be submitted with a billed amount of \$1.00. The “clean” claims will appear as “prepaid.” The H2016 claims will be reconciled to the payments made against the H2018.

Per the attached Maryland Department of Health and Mental Hygiene (DHMH) memo, it is essential and required that providers submit all, not just the minimum, number of encounters:

http://maryland.valueoptions.com/provider/alerts/2012/021012-PRP_Encounter_Submission_and_Reimbursement.pdf.

Although PRP services (H2018) can be billed in advance of all supporting encounter data (H2016) being submitted, it is required that the minimum number of encounters be rendered prior to submitting the H2018 claim. As always, all supporting encounter data (H2016) must be submitted in support of the billed services by the end of the month following the month in which services were rendered. For example, encounters for January 2015 must be submitted by February 28, 2015. Encounters are to be billed with no modifier; however, the claim must indicate where the service was rendered. If the service was rendered onsite, the place of service is 52. If the service was rendered off-site, the place of service is 15. These are the only two acceptable place of service codes that can be used when submitting encounters.

In summary, the rules for submitting the H2016, the encounter data for PRP including the following:

- Do not submit a modifier with the H2016 code (exception: reporting transitional PRP encounters which require the U8 modifier).
- Each encounter must be a separate line item on the claim form. Only one unit may be entered for each encounter.
- All encounters for the month must be submitted by the end of the month following the month in which the service was rendered, e.g., encounters for March 2015 must be submitted by April 30, 2015.
- Submit \$1.00 as the billed charge for H2016 (any amount greater than zero will be accepted); \$1.00 will show as a “prepaid amount” on the provider voucher.
- The place of service code for H2016 must be either 15 or 52, off-site or onsite, respectively.
- H2016 may be billed on the same claim form as the H2018 or on separate claim forms.
- H2018 is not included in the count of supporting encounters.

A link to the Beacon Provider Alert that contains this information is:

http://maryland.valueoptions.com/provider/alerts/2010/122710-PRP_Billing_Encounter_Submission-Corrected.pdf.

Claims for unauthorized services will be denied.