CHAPTER 1

WELCOME TO THE MARYLAND PUBLIC BEHAVIORAL HEALTH SYSTEM

Overview

In accordance with state legislation, the Maryland Department of Health and Mental Hygiene (DHMH), Medicaid Office of Health Services and the Behavioral Health Administration (BHA) implemented a new integrated Public Behavioral Health System (PBHS) effective January 1, 2015. The Medicaid Office of Health Services and BHA oversee and have the authority over the PBHS, which includes policy development, state-wide planning, resource allocation, and continuous quality improvement strategies. ValueOptions® is the Administrative Service Organization contracted with DHMH to assist with the management of the PBHS.

The following manual should be used as a reference guide when a provider needs specific information. Additional sections or revisions will be placed on the ValueOptions® Maryland website, http://Maryland.ValueOptions.com. If you cannot find an answer to your questions, please refer to the Key Contacts list under Section 1.4 of this manual.

1.1 Introduction

Maryland Medicaid, the Behavioral Health Administration, and ValueOptions® Maryland welcome you to the network of providers for the Maryland Behavioral Health System
(PBHS). As a provider participating in the PBHS, you will be working with us to provide quality behavioral health services that are efficient and economical to individuals who qualify under the Maryland PBSB. We are excited about the opportunity to work with you in achieving treatment, rehabilitation and recovery goals for the participants of the PHSB.

Participation in this provider network requires providers to have an active Maryland Medical Assistance (MA) number and a National Provider Identifier (NPI). Providers will not receive authorization or payment for services until they have an active Maryland MA number and an NPI. Information on how to obtain a Maryland Medicaid number can be found in Section 2.1 of the ValueOptions® provider manual.

This manual describes the requirements for providers to participate in the Public Behavioral Health System including eligibility, service requirements, and authorization procedures to serve as a resource to answer general questions providers may have. It is by no means all-inclusive. We encourage you to share with us suggestions and updates regarding its content. Providers can send communications regarding the manual to marylandproviderrelations@valueoptions.com

Maryland Medicaid, BHA, and ValueOptions® Maryland share a commitment to continuous quality improvement that involves an ongoing review of our regulations, processes, and procedures. As the PBHS continues to develop, additions and clarifications to this manual will be published. All applicable supplements and revisions and changes to provider information will be available on the ValueOptions® Maryland Website (http://Maryland.ValueOptions.com). Once again, we welcome you as a provider in the Maryland PBHS and look forward to a successful collaboration.
1.2 Responsibilities

Everyone plays a role in the successful management and implementation of a system as vast and complex as Behavioral Health services. Maryland’s goal in integrating services is to build on the existing strengths of the public behavioral health programs and the Medicaid program in order to improve services for individuals with co-occurring conditions; expand access to appropriate mental health and addiction services; capture and analyze data regarding overall population health, and the use and cost of care for behavioral health services; expand public health initiatives, and reduce the cost of care through prevention, utilization of evidence-based practices, and an added focus on encouraging prevention and reducing unnecessary or duplicative services. To this end, the Department, the ASO, and Providers have unique responsibilities as follows.

The responsibilities of the Department of Health and Mental Hygiene, specifically Maryland Medicaid and the Behavioral Health Administration are outlined below:

- Developing and evaluating policies, drafting regulations and overall administration of behavioral health services to participants in Maryland
- Establishing provider rates and setting the benefit design standards including the amount, duration and scope requirements
- Setting medical necessity standards
- Establishing utilization review and prior authorization criteria
- Ensuring a process for clinical reviews and consumer appeals
- Setting provider participation, compliance, integrity, and audit standards and methods
- Developing claims and encounter data submission standards
- Establishing and managing other data and reporting standards
• Monitoring the ValueOptions contract and performance in Maryland.

**The responsibilities of ValueOptions® Maryland are outlined below:**

- Manage behavioral health services for Medicaid participants, eligible uninsured individuals and some grant funded services
- Maintain on-line authorization applications and preauthorize non-emergency care
- Have 24-hour access for clinically related calls
- Refer individuals to qualified service providers
- Conduct utilization reviews of services
- Process claims and remit payments
- Assist with the evaluation of the PBHS via provider and participant satisfaction surveys
- Audit providers for quality of documentation and correct billing processes
- Train providers, participants and advocates via webinar and regional forums on topics of interest to the behavioral health community; such as deaf services, evidence-based practices and other programs available to assist participants in their recovery efforts.
- Conduct provider and participant forums (such as the Quality Steering Committee) to obtain feedback regarding the performance of the PBHS
- Define and evaluate performance, outcomes, effectiveness, efficiency, and cost effectiveness of mental health and substance use disorder related services and systems
- Collect and analyze behavioral health and health-related information

**The responsibilities of Providers are outlined below**

- Exercise sound clinical judgment
• Work with participants to provide quality services that meet the participants’ goals and needs
• Cooperate and collaborate with ValueOptions® Maryland concerning appropriate clinical care for participants
• Obtain preauthorization/authorization/registration for appropriate services
• Engage in responsible management of behavioral health care by adhering to ethical and professional standards
• Maintain a high standard of medically necessary, efficient and cost-effective care that addresses each participant’s individual needs
• Work with ValueOptions® Maryland Care Managers and participants to achieve participant satisfaction with services regulations, policies and procedures
• Involve participants in treatment/service planning
• Deliver the principles of recovery and resiliency in treating participants.
• Coordinate treatment with other involved health care providers.
• Promote innovation and best practices in services and systems.
• Help participants to obtain appropriate benefits
• Honor each participant’s right to dignity and confidentiality
• Comply with local, state, and federal laws and regulations
• Comply with federal, State, Medicaid and Medicare rules as well as with PBHS

1.3 Key Contacts

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<tbody>
<tr>
<td>Provider Enrollment</td>
<td>(410) 767-5340</td>
</tr>
<tr>
<td>Recipients’ Relations</td>
<td>(800) 492-5231</td>
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<tr>
<td>EVS (eligibility verification)</td>
<td>(866) 710-1477</td>
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<tr>
<td>Provider Relations</td>
<td>(800) 445-1159</td>
</tr>
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Copyright 2015: http://maryland.valueoptions.com/index.htm
The following are websites where additional contact information may be found.

Department of Health and Mental Hygiene (DHMH):
http://www.dhmh.maryland.gov/pdf/DHMH_Contact_Us_1.pdf

ValueOptions® Maryland
http://Maryland.ValueOptions.com
CHAPTER 2

PARTICIPATION IN THE STATE PUBLIC BEHAVIORAL HEALTH SYSTEM

General Description

Any practitioner who is authorized under the Health Occupations Article, according to Maryland state regulation (COMAR), to provide behavioral health services (inclusive of both specialty mental health service providers or substance use disorder service programs), a provider who is approved or licensed under the Maryland Department of Health and Mental Hygiene Administration Regulations, HSCRC regulated services, or Federally Qualified Health Centers, may be a provider in the Public Behavioral Health System.

Providers can access information regarding participation in the Public Behavioral Health System (PBHS) at: http://www.dhmh.maryland.gov/mha/SitePages/infoforproviders.aspx

All providers are required to regularly review ValueOptions® Maryland and the Department of Health and Mental Hygiene’s Behavioral Health Administration
website for Policy and Procedure updates or changes. It is the responsibility of the provider to be informed of all information affecting the delivery and payment of PBHS services. Providers may also access their local Core Service Agency (CSA) and/or Local Addiction Authority (LAA) for issues regarding local services and supports. A complete list of CSA and LAA are listed within the ValueOptions® Maryland website at http://maryland.valueoptions.com/

2.1 Participation in the Public Behavioral Health System Network (All Providers)

The PBHS requires all providers to be in good standing. All providers delivering Medicaid reimbursed services are required to have an active Medicaid number. Providers delivering more than one type of approved or licensed service, under the Behavioral Health Administration regulations, COMAR 10.21 and 10.47 require a separate Medicaid and NPI number for each Medicaid service and service location (e.g., separate numbers for Opioid Maintenance Treatment Programs and Outpatient Mental Health Centers and Psychiatric Rehabilitation Programs).

If a provider wishes to confirm whether they have an active Medicaid number they may do so by contacting: marylandproviderrelations@valueoptions.com. For providers approved under COMAR 10.21 or 10.47, BHA regulations delivering non-Medicaid services, a separate provider agreement between the provider and BHA is required after the program receives OHCQ approval. ValueOptions® Maryland will pay providers based on this provider agreement. ValueOptions® Maryland does not credential or contract directly with PBHS providers.
In order to become a provider within the PBHS, providers must first enroll in Maryland Medicaid. To receive a State of Maryland Department of Health and Mental Hygiene Medical Care Program Provider Application, contact DHMH Provider Enrollment: 410-767-5340. On-line Provider Enrollment in the PBHS can be accessed at: https://encrypt.emdhealthchoice.org/emedicaid

Providers must then register with ValueOptions® Maryland through the ProviderConnect System in order to complete authorizations to submit claims for reimbursement. To register with ValueOptions® Maryland providers should call 1-800-888-1965 and follow the prompts provided.

All PBHS providers are credentialed and contracted by the DHMH. The provider information in the DHMH system (MMIS II) is downloaded to ValueOptions® Maryland weekly. Providers are required to comply with state and federal laws and regulations, including all applicable Medicaid and BHA regulations. All services require preauthorization except emergency services, no exceptions will be granted.

Note: The MA number must be a valid provider type and status. See Appendix D, State Approved Medicaid Provider Types for the PBHS.

2.2 Change of Status or Address

Because ValueOptions® Maryland does not credential providers, we do not update provider information in our authorization and claims systems. It is the responsibility of the provider to notify DHMH as soon as possible, but no later than
30 days after the effective date of the change. Behavioral Health Programs, Groups, and Outpatient Mental Health Clinics should contact DHMH.BHenrollment@Maryland.gov to obtain direction of what is required by Medicaid to update the provider record. Individual practitioners can update their records by contacting the DHMH, Provider Enrollment Department, at (410) 767-5340. Provider Enrollment must be made aware of any of the following changes:

- Provider’s name and the name(s) of the provider’s practice, facility, and program.
- Tax identification number and billing information.
- Street address(es), city, state, and zip.
- Telephone number(s), fax number(s), beeper or pager numbers, and e-mail addresses.
- Copies of new or updated licenses, authorizations, or program approvals.

ValueOptions® Maryland will update its systems to reflect the information changes made through Provider Enrollment. Please note that changes to a provider’s information could take up to 3 weeks to populate in the ValueOptions® Maryland system.

2.3 Provider Terminations

Notifications

A provider must notify the DHMH Provider Enrollment (410-767-5340) within 24 hours upon the occurrence of any of the following:
• Revocation, suspension restriction, termination, or relinquishment of any of the provider’s licenses, authorizations, program approvals, or accreditations, whether voluntary or involuntary.

• Any indictment, arrest, or conviction for felony charges or a criminal charge other than traffic offenses.

• Revocation, suspension, restriction, termination or relinquishment of medical staff membership or clinical privileges at any healthcare facility.

Voluntary Termination

If a provider decides to no longer participate in the PBHS, the provider must notify DHMH Behavioral Health Unit by emailing: DHMH.BHenrollment@Maryland.gov, or call Provider Enrollment directly at 410-767-5340, and must also contact ValueOptions® Maryland Customer Service (1-800-888-1965, option 3).

Involuntary Termination

If a provider loses his/her licensing, certification, approval, or otherwise becomes ineligible, DHMH will inform the provider that he/she is terminated from participation in the PBHS. ValueOptions® Maryland receives provider terminations in the weekly downloads from DHMH.

2.4 Out-of-State Emergency/Urgent Care (Medical Assistance Benefit Only)

A participant may receive care from a non-registered provider in an emergency or urgent situation when traveling out-of-state.
If the provider does not have an active Maryland Medicaid number, the individual or organization must apply for one to receive claims reimbursement. An NPI is also required. Please see section 2.1 for additional information on how to enroll in Maryland Medicaid and register within the ValueOptions® Maryland System.

2.6 Participant Referral

Description

Medicaid (MA) and Non-Medicaid participants who contact, or are referred to, ValueOptions® Maryland for behavioral health services, will be referred to a provider or providers according to the policies outlined below.

Policies

Open Referral Process

Referrals may be initiated by the participant, the participant’s primary care provider (PCP), a family member, or legal guardian.

Participant Choice

The Department of Behavioral Health and Mental Hygiene values participant choice. Participant wishes and needs drive the referral process. Participants will be given a choice of providers.

Participant Preferences
Participant preferences can be identified in the following areas:

- Provider location
- Transportation to provider office
- Provider office hours
- Gender of provider
- Culture and communication

Participant Needs

Participant needs will be identified in at least the following areas:

- Clinical
- Child or adolescent
- Geriatric
- Deaf or hard of hearing
- Language
- Veterans
CHAPTER 3

UNINSURED ELIGIBLE CONSUMERS

Mental Health

Uninsured Eligible consumers are individuals for whom the cost of medically necessary and appropriate community based mental health services will be subsidized by the Behavioral Health Administration (BHA) because of the severity of mental illness and financial need. Depending on the availability of state funding, services may be provided to consumers who meet specific eligibility guidelines.

Providers can verify a consumer’s eligibility or initiate a request for Uninsured Eligibility through ProviderConnect or by calling ValueOptions Maryland Customer Service Team at (800) 888-1965. ValueOptions Maryland will process Uninsured Eligibility requests via ProviderConnect and immediately assign a consumer identification number.

Uninsured Eligibility requests for consumers who are not automatically granted eligibility for mental health services by meeting the criteria will be forwarded electronically to the appropriate Core Service Agency (CSA) for an eligibility determination.

The Uninsured Eligibility Spans will be for three months for new requests and when spans are eligible for renewal. Individuals must meet financial need criteria of income of no more than 250% of federal poverty level and other required conditions. Providers are
required to maintain appropriate documentation in the medical record.

Coverage Groups

Uninsured “Eligible Uninsured” Consumers

This population may be served in the Public Behavioral Health System (PBHS) if all of the following are met:

Requirements:
In order to request an uninsured eligibility span, the provider is required to document and verify the consumer meets all six uninsured eligibility criteria. The criteria are:

- The consumer requires treatment for a behavioral health diagnosis(es) covered by the PBHS
- The consumer has a verifiable Social Security Number
- The consumer has applied for Medicaid (MA the Health Care Exchange Social Security Income (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 12 months or more). If the consumer is not eligible for MA, SSI, or SSDI, documentation from MA or Social Security stating the reason for ineligibility must be provided and maintained in the consumer’s medical record.
- The consumer is a Maryland Resident
- The consumer meets the financial criteria (250% of federal poverty level and not covered by Medicaid (MA) or other insurance. (The service provider is responsible for collecting and maintaining documentation from the consumer that validates the consumer’s financial need. This may include documentation of
application and outcome for benefits, pay stubs, other income, etc. to document that the consumer meets the financial criteria)

- The individual meets US citizenship requirement.

Exceptions to the documentation requirement may be made by BHA under extenuating circumstances. The exceptions are related to the type of crisis and type of service. If a consumer is in immediate need for services (such as acutely suicidal) or the consumer's symptoms prevent that person from being able to provide information and they are being seen by an Assertive Community Treatment team, mobile crisis team, residential crisis program, or other outpatient setting, documentation criteria may be waived.

If an individual is in immediate need of services, the consumer will be given an uninsured span of one month. If at the end of the first month, the consumer still is in crisis and documentation is still not available, the provider may request another month by completing the registration for the uninsured span again. If at the end of the second month, the provider again requests an uninsured eligibility span without the documentation, the request will be denied and the provider must submit a written request to the Core Service Agency (CSA) to demonstrate the need for continued services in spite of the missing documentation. If the CSA approves, then an uninsured eligibility span is established. If at any point during this process, the provider updates the uninsured consumer’s eligibility record with the missing documentation, the uninsured eligibility span is established for three months from the initial begin date of the uninsured span.

Additionally, there are other exceptions to documentation if the consumer meets other criteria. These criteria are:

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• If the individual meets all of the above criteria except item 2 and one of the following:
  • Under age 19
  • Released from prison, jail or Department of Corrections facility within the last three months
  • Is pregnant
  • Is an injection drug user
  • Has HIV/AIDS
  • Was discharged from a Maryland-based psychiatric hospital within the last three months
  • Was discharged from a Maryland-based medically monitored Residential Treatment Facility within the last 30 days (American Society of Addiction Medicine Level 3.7)
  • Is requesting services required by HG 8-507 order or referred by drug or probate court
  • Is receiving services as required by an order of Conditional Release
  • If an individual meets all criteria except items 2 and 5 and is currently receiving SSDI for mental health reasons.
  • If an individual meets all criteria except items 2 and 4 and is homeless within the state of Maryland
  • If an individual meets all criteria except items 2, 3 and 5 and is a veteran
  • If a Non-US citizen, the exception process will be used which requires approval from the CSAs

For mental health consumers this will result in an uninsured span which will determine payment by ValueOptions.
Substance Use Disorder

For substance use disorder (SUD) consumers, this will result in an uninsured span for data collection purposes only. No funding for uninsured consumers is available with ValueOptions at go-live. SUD consumers may also receive mental health services under the uninsured span. Providers may obtain funding for uninsured services from local grants.

BHA is requiring providers to maintain documentation in the medical record to validate the individual's uninsured eligibility. ValueOptions and BHA will be monitoring requests for uninsured eligibility spans and providers without documentation may be audited. Failure to maintain all supporting documentation may result in a retraction of funds. A list of the types of documentation that should be submitted is listed below:

Uninsured Eligibility Documentation Requirements

In order to request an uninsured eligibility span, the provider is required to document and verify the person’s uninsured eligibility. BHA is requiring providers to maintain documentation in the medical record to validate the individual’s uninsured eligibility. The documentation is to include, at a minimum, the following:

1. Maryland Residency
   a. photo ID (driver’s license or state MVA identification) or
   b. utility bill, lease, or notation in the record that the consumer is homeless

2. 250% of Federal Poverty Level (any of the following)
a. SSI award letter or recent pay stubs or
b. If no income, then consumer must sign a “no income statement”

3. Application for Benefits (either of the following)
   a. Copy of the application submitted for benefits or
   b. Since not all applications submitted receive an acknowledgement, a notation in the record that the consumer went to the benefits office with the provider and applied for MA, SSI or SSDI, or other applicable entitlement. This requires the consumer’s signature.

4. As applicable, if consumer received PBHS Services in the Past Two Years
   a. Authorization forms, medical records, or claims paid.

5. As applicable, if consumer was released from Prison, Jail or Department of Correction within the last three months
   a. Copy of release papers or notation in the record

6. As applicable, if consumer was discharged from a Maryland-based Psychiatric Hospital within last three months
   a. Discharge summary note or
   b. Aftercare plan

7. As applicable, if consumer was discharged from a Maryland-based medically monitored Residential Treatment Facility (American Society of Addiction Medicine Level 3.7) within the last 30 days
   a. Discharge summary note or
   b. Aftercare plan

8. Services required by HG 8-507 order or referred by drug or probate court
   a. Copy of court order

9. Services required by an order of Conditional Release
   a. Copy of Conditional Release order
Insured “Uninsured Eligible” Consumers

This population may be served in the PMHS if the following conditions are met:

- The consumer meets all the requirements listed under the Uninsured “Uninsured Eligible Consumer” section.
- The consumer is a Medicare beneficiary, Medicare does not cover this service, and the individual does not have other insurance to cover this service such as Psychiatric Rehabilitation (PRP), Residential Rehabilitation Programs (RRP), Mobile Treatment Services, Supported Employment, and Assertive Community Treatment (ACT).
- The consumer’s commercial mental health insurance benefits are exhausted.

For the OHMCs, with the individual, review benefits and refer the individual to either case management services or to the applicable benefits office. PRP and RRP 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.

For individuals who are uninsured, who are employed, and requesting authorization for PRP services, ValueOptions Maryland will direct the provider to refer the individual to Maryland Department of Disabilities Employed Individuals 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, BHA is requiring an EID application be submitted. Exceptions will be granted only for an urgent care and referrals from state
For veterans in Maryland, BHA will provide gap services, outpatient treatment and crisis intervention services until the US Veterans Administration benefits are activated and available.

Financial data must be reviewed annually, documented and maintained in the consumer’s medical record.

Others

All other situations will be reviewed on a case-by-case basis by the Core Service Agency (CSA), and/or the Behavioral Health Administration (BHA).

Application/Registration Process

All providers should first access ProviderConnect or call ValueOptions Maryland Customer Service Team (1-800-888-1965) to verify current consumer eligibility before providing services and/or submitting claims to ValueOptions Maryland.

Requests for services for Uninsured Eligible consumers can come from the provider or the consumer by accessing the web based application or by calling the ValueOptions Maryland Customer Service line at 1-800-888-1965. ValueOptions Maryland will conduct a preliminary assessment and registration over the web based application or the phone to establish if the consumer is eligible to receive services in the PMHS. If the
consumer appears to be eligible, the consumer will be assigned an uninsured eligibility span in ValueOptions Maryland system. A provider may then request authorization for services.

If VO denies the request, due to the individual not meeting the minimum criteria, the provider may request a review by the CSA for an exception to the criteria due to an urgent care or special exception need.

The provider may call or FAX a request for urgent care using the designated forms to the CSA of the consumer’s county of residence.

The CSA will review the request to determine if an urgent care need is met and an exception will be granted. Rationale for the exceptions is to include discharge/release or diversion from a state hospital or other inpatient setting or detention center.

If the CSA denies the request, the CSA notifies the provider.

If CSA approves the exception, the CSA forwards “STATE OF MARYLAND - REQUEST FOR REIMBURSEMENT FOR NON-MEDICAID OUTPATIENT SERVICES” form (if member number, Medicaid ID is available, include) and sends to ValueOptions.

The “MARYLAND: PROVIDER REQUEST TO CSA FOR URGENT CARE FOR UNINSURED” form will not be sent to VO but retained by the CSA.

No later than 2 business days, VO will enter the consumer information into its system (expectation is within 24 hours). VO will update the form with the consumer ID and
email back to the CSA with a copy to the provider. The form requires the provider’s email address be included.

Uninsured requests in which the consumer does not have a primary mental health diagnosis or is not a Maryland resident will be denied without opportunity for exception.

When VO completes a courtesy review, another type of funding stream “MCOU” is assigned. This is not considered an uninsured eligibility span.

The provider must inform the consumer that documentation will be required. The documentation should include validation of the consumer’s financial status. This documentation should be maintained in the consumer's medical record.

**Copayments**

The BHA requires a co-payment be collected for outpatient mental health treatment and psychiatric rehabilitation program services Uninsured Eligible individuals. The amount of the copay is deducted from the approved rates and is dependent upon the availability of state funds.

**Certification Period**

The certification period begins on the date that eligibility is granted and lasts for three months. In order to assure that individuals most in need who are uninsured receive the uninsured benefit, the following procedures must be done initially and every 3 months as needed. (“Documentation for Uninsured Eligibility Benefit Form”).

ValueOptions® Maryland Provider Manual  
Uninsured Eligibility Services

The following services may be available to Uninsured Eligible consumers served in the PBHS [coordination of benefits (COB) is required for commercial coverage only]:

- Outpatient Mental Health Clinic Services (OMHCs) – except for Intensive Outpatient Services
- Outpatient Office Services (non-OMHCs)
- Psychiatric Rehabilitation Program Services (PRP) - On-Site and Off-Site
- Residential Rehabilitation Program Services (RRP) ****
- Respite Services
- Residential Supported Employment Services***
- Crisis Services**
- Mobile Treatment Services**
- Enhanced Support Services

COB for both Medicare and commercial insurance is not required for the following services:

- Supported Employment
- Residential Rehabilitation Program Services Respite Services
- Enhanced Support
- Psychiatric Rehabilitation Program Services Occupational Therapy*

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*Consumers must meet additional criteria to qualify for these services.

**No copays apply to these services.

***The income derived from the individual’s supported employment will not be included in the income verification.

****Consumers are required to contribute to cost of care for RRP.

Recertification Process

If the consumer has had any changes during the 3-month period, the consumer or provider must report to ValueOptions® Maryland any changes which may impact eligibility.

The PBHS requires every provider to request that each consumer/applicant apply for any Medicaid benefits or EID for which he/she may be eligible.

Note: Requests for Uninsured Eligibility will not be backdated unless the consumer has an open authorization with an end-date beyond the end-date of the consumer’s current Uninsured Eligibility span. Backdating of uninsured eligibility spans will be allowed in the following scenarios:

- The consumer was discharged from a hospital will backdate to discharge date.
- The notification of termination of Medicaid is within 30 days of the requested uninsured start date.
- The consumer is receiving care in a Designated Hospital Diversion Programs.
CHAPTER 4
GENERAL PROVIDER INFORMATION

4.1 Provider Registration

In order for a provider to become participating provider for the Maryland Public Behavioral Health System (PBHS), a provider must initially enroll in the Maryland Medicaid program. To enroll in Medicaid, a provider needs to complete the provider application found here:

https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

Once enrolled in Maryland Medicaid, a provider will be given a Medicaid ID number. Providers will use that number to register with ValueOptions and will then be assigned a six-digit ValueOptions® ID number for billing and payment. Upon receipt of a provider’s Medicaid ID number, a provider should contact ValueOptions® customer service department at (800) 888-1965 to make sure they are also enrolled with ValueOptions®.

For providers that are providing services on a grant basis to Maryland participant’s with substance use disorder (SUD), a provider should contact their local addiction authority to find out the requirements for participation and whether funding is available for the service to be delivered (see maryland.valueoptions.com for a listing of the local addiction authorities).
4.2 Provider Training

ValueOptions® provides monthly training for providers and their staff. Trainings include:

- How to access and use ProviderConnect for both mental health and substance use disorder providers
- Billing rules
- Psychiatric Rehabilitation Provider (PRP) ProviderConnect and billing

ValueOptions® also offers specialized trainings/webinars for providers and these sessions will also be listed on the ValueOptions® web site. The training schedule can be found on the maryland.valueoptions.com web site under the Provider tab.

4.3 Provider Information

Provider Alerts

ValueOptions® emails Provider Alerts. Provider Alerts are important informational documents that announces important information on changes within the PBHS, system down time, DHMH announcements and important regulatory guidance. Providers should register for Provider Alerts by sending an email to: marylandproviderrelations@valueoptions.com. The subject line should read “Provider Alerts” and the provider’s email address should be in the body of the email. All Provider Alerts are also posted on the Maryland.valueoptions.com web site.

Newsletter

*Coming soon: ValueOptions® publishes a quarterly newsletter with information useful to both providers and to your participants. This new feature highlights new clinical
innovations, upcoming events within the State, news for participants as well as innovations happening within our provider community. If you have any ideas for the newsletter, please send your comments to: marylandproviderrelations@valueoptions.com.
CHAPTER 5

INFORMATION TECHNOLOGY

ValueOptions® provides a suite of services and applications that offer providers real-time access to the tools necessary for handling most administrative transactions as well as request services for members. At the core of this is ProviderConnect which accelerates provider’s workflows by delivering an interactive Web-based system for collaborative business processes.

5.1 ProviderConnect

ProviderConnect is a secure, password protected site where participating providers conduct certain online activities with ValueOptions® directly twenty four (24) hours a day, seven (7) days a week (excluding scheduled maintenance and unforeseen systems issues). Currently, participating providers are provided access to the following online activities:

- authorization or certification requests for all levels of care,
- concurrent review requests and discharge reporting
- single and multiple electronic claims submission
- claim status review for both paper and electronic claims submitted to ValueOptions®
- verification of eligibility status
- submission of inquiries to ValueOptions® Provider Customer Service,
- updates to practice profiles/records
- electronic access to authorization/certification letters from ValueOptions® and
provider summary vouchers.
For additional information on how to access these features in ProviderConnect, visit the ProviderConnect Helpful Resources page at http://www.valueoptions.com/providers/Provider_Connect.htm.

Log On to ProviderConnect

To log on to ProviderConnect:
1. Access the following URL: maryland.valueoptions.com.
2. Click on the ‘For Providers’ link.
3. Click Log In.
4. Enter your User ID and Password.
5. Click Log In.
6. Carefully read the User Agreement and then click I Agree.

Note: ProviderConnect permits submitters belonging to providers with the same NPI to use a single login for accessing multiple accounts.

New User Registration

If you are a new user, you must first register in order to access ProviderConnect.
1. Click Register.
2. Complete the fields on the Provider Online Services Registration screen.

Note: Within ProviderConnect, a red asterisk (*) indicates a required field.

- Enter the provider’s first name.
- Enter the provider’s last name. (required)
- Enter the person’s name to contact at the office.
• Enter the provider number. (required) (Contact National Networks at 800.397.1630 to obtain a Provider ID number if needed. The Provider ID number is assigned by ValueOptions®.)

• Enter the provider’s Federal ID or Social Security Number.

• Enter and verify the provider’s primary e-mail address. (required)

• Enter the provider’s secondary e-mail address.

• Enter the provider’s complete phone number, omitting dashes. (required)

• Enter the provider’s complete fax number, omitting dashes.

• Enter and confirm a password. (required) Passwords must contain at least:
  - One number (0-9) and,
  - One upper case letter (A-Z) and,
  - One lower case letter (a-z) and,
  - One of the following special characters:

```
!  #  $
~  "  %
&  ,  ( 
)  *  +
```
• Passwords must be between 8 and 20 characters, cannot contain spaces, and are case-sensitive.

• Create a security question and answer. (required)

3. Click Submit.

You are required to change your password every 90 days.
5.2 Clearinghouses

Electronic claim submission is also accepted through clearinghouses. When using the services of a clearinghouse, providers must reference ValueOptions®’ Payer ID, FHC & Affiliates, to ensure ValueOptions® receives those claims.

5.3 PaySpan® Health

ValueOptions® providers/participating providers must use PaySpan Health, the largest healthcare payment and reimbursement network in the United States, for electronic fund transfer. PaySpan Health enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

5.4 ValueOptions® Electronic Data Interchange (EDI) Claims Link for Windows® Software

The EDI Claims Link for Windows® application is another tool providers or their designated representatives have to submit HIPAA compliant electronic claims. This tool requires installation on a computer and creation of a database of providers and members. Refer to the EDI Claims Link for Windows User Manual located on ValueOptions.com

5.5 Maryland.ValueOptions.com

ValueOptions®’ website (Maryland.ValueOptions.com) contains information about ValueOptions® and its business. Links to information and documents important to providers are located here at the Provider section, including additional information pertaining to ValueOptions®’ E-commerce Requirement. Access to ProviderConnect and Achieve Solutions® is available here as well. ValueOptions®’ Notice of Privacy of Practices regarding use of the website is
located on the website.

Please note, the ValueOptions.com and Maryland.ValueOptions.com Terms and Conditions, including but not limited to limitations on liability and warranties, apply to the installation and use of, and any technical assistance related to the installation or use of this software. Technical assistance includes but is not limited to any guidance, recommendations, instructions or actions taken by ValueOptions® or its employees, including where such activity is performed directly on your system, device or equipment by a ValueOptions®, Inc. employee or other representative.

5.6 Achieve Solutions®

Achieve Solutions® is an educational behavioral health and wellness information website. This website is educational in nature and is not intended as a resource for emergency crisis situations or as a replacement for medical care or counseling.
CHAPTER 6
SERVICE DESCRIPTIONS

06.01 Mental Health – Inpatient Hospital Psychiatric Services

Service Coverage

Inpatient psychiatric care involves skilled psychiatric services in a hospital setting. The care delivered includes both medical and nursing care, and is expected to be delivered on a 24-hour basis, including weekends. For individuals not certified for involuntary admission, and in areas where Residential Crisis Services (RCS), Hospital Diversion Programs or CSA crisis response system are available, ValueOptions® Maryland shall request these levels of care be explored, when appropriate, before authorization for an inpatient stay is given.

Service Rules

ValueOptions® Maryland authorizes inpatient care for hospital level care. It is the responsibility of the provider to complete an authorization request for an admission and continued-stay reviews. It is also the provider’s responsibility to enter a discharge when the participant completes inpatient treatment.

Clinical information that supports Medical Necessity Criteria for inpatient level of care must be provided. Required clinical information includes the current need for treatment, precipitating event(s), treatment history, medications, substance use history, and risk assessment.
If medical necessity is demonstrated, ValueOptions® Maryland will authorize a specified number of days. If ValueOptions® Maryland has authorized a hospital stay for a Medical Assistance (MA) recipient and the discharge diagnosis is a PBHS-covered psychiatric diagnosis, the claims will be paid for the authorized days.

**Aftercare Planning:** Aftercare planning is expected to begin at the time of admission (see Maryland State Law COMAR 10.21.05).

Providers of inpatient services are expected to work collaboratively with the participants, parents and/or the legal guardians of the participant to develop a discharge plan that will provide stability and adequate behavioral health treatment services. As the types of services and treatment programs vary from jurisdiction to jurisdiction, the provider should seek assistance from the appropriate CSA or LAA. This is determined by the participant’s place of residence or jurisdiction that maintains legal custody, e.g., for a Baltimore County participant hospitalized in Howard County, the provider should seek assistance from the Baltimore County CSA/LAA.

It is important to note that the day of discharge is not a reimbursable day for the hospital. For example, if the participant is admitted on March 1 at 11:45 p.m., March 1 is a covered day. If the participant is discharged on March 12 at 4:00 p.m., March 12 is not a reimbursable day. The last date listed on the authorization is not considered an authorized day for reimbursement purposes.

Only one psychiatric professional fee, from a psychiatrist or nurse practitioner, per psychiatric inpatient day is covered. An additional authorization is not needed.

In an emergency room and during an inpatient stay, the PBHS will cover and pay for
diagnostic testing and consults that are related to the psychiatric treatment of the individual. For participants who are considered for hospitalization ValueOptions® Maryland may request a crisis team evaluation, or diversion to a crisis facility, for a short-term admission, when available and appropriate.

When an uninsured adult participant, who requires inpatient care, presents at an Emergency Department (ED) of a hospital with a psychiatric unit, that hospital must admit the participant to a bed on the hospital’s psychiatric unit or arrange for disposition to another inpatient setting as required under Emergency Treatment and Active Labor Act (EMTALA). The expectation is that individuals will be admitted to these facilities without regard to ability to pay. If a person, in need of psychiatric inpatient care, is in an ED which has a psychiatric unit, the hospital is obligated to admit the person if the hospital has a bed. If a person, in need of psychiatric inpatient care, is in an ED without a psychiatric unit, the ED finds the bed and refers the person for admission.

A participating hospital that has specialized capabilities, or facilities such as psychiatric hospitals, SHALL NOT refuse to accept an appropriate transfer of an individual (from a hospital in the United States) who requires such specialized capabilities or facilities IF the hospital has the capacity to treat the individual, 42 CFR §489.24(f). This provision applies to any participating hospital (those that accept Medicare and thus Medicaid) regardless of whether the hospital has a dedicated ED, §489.24(f)(i).

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment providers (e.g. substance use treatment) when clinically indicated, with appropriate release of information.
Administrative Days

Administrative days for participants in inpatient settings awaiting Residential Treatment Center (RTC) or Nursing Home placement can be approved by ValueOptions® Maryland.

Consultations/Inpatient Therapy

Psychiatrist fees must be billed separately from the hospital charges. A non-attending psychiatrist or nurse practitioner must bill the initial inpatient consultation visit using CPT Codes 99251, 99252, 99253, 99254, or 99255 and subsequent consultations, using CPT Codes 99232, 99233, 99231, 99238, 99239.

Individual therapy by a psychiatrist or nurse practitioner in an inpatient setting must use CPT Codes 90832 for a 30-minute session, CPT Codes 90834 for 45-minute sessions, and CPT Code 90837 for 60-minute sessions.

A psychiatrist performing a psychiatric consultation on a non-psychiatric unit for a participant who was admitted for a somatic (medical) diagnosis should use inpatient consultant CPT Codes 99251, 99252, 99253, 99254 or 99255. The initial consultation does not require preauthorization. Subsequent consultation must be billed using CPT Codes 99232, 99233, 99231, 99238, 99239. These services do not require preauthorization.

Service Eligibility
Participants with Medical Assistance are eligible for this benefit. This is not a covered service for Uninsured Eligible participants.

When an Uninsured Eligible participant presents with a major illness that requires hospital level care, the institution providing that care is expected to assist the family with an application for Medical Assistance.

If an uninsured participant is reasonably expected to become eligible for Medical Assistance, the provider should request a “Courtesy Review” from ValueOptions® Maryland. Reminder: If the participant remains in the hospital beyond the number of days initially authorized, the provider should request a courtesy review for the additional days.

Service Providers

Hospitals licensed and regulated by the state of Maryland that are approved Medicaid providers are eligible for reimbursement for services.

Hospitals located outside the state of Maryland, who possess an active Maryland Medicaid provider number and who are treating psychiatric emergencies, are also eligible for reimbursement.

Authorization Process

Provider may obtain initial authorization for inpatient psychiatric services via electronic submission via ProviderConnect, or via telephone to the Engagement Center. ValueOptions® Maryland Care Managers are available 24 hours a day, 7 days a week, to
review telephonic requests for initial authorizations.

Providers obtain additional authorizations through the electronic submission of a Continuing Review Authorization Request via ProviderConnect. The provider must submit a Continuing Review Authorization Request prior to the expiration of the previous authorization time span.

If a ValueOptions® Maryland Care Manager is not able to authorize the service as medically necessary, the request for services will be referred to a ValueOptions® Maryland Physician Adviser for review (see Chapter 10, Grievances and Appeals).

Non-psychiatrist physicians or nurse practitioners will be reimbursed by the PBHS for one History and Physical per admission, and authorization is not required. Claims should be submitted to ValueOptions® Maryland, using CPT codes 99251-99255. The Managed Care Organization (MCO) is responsible for all other non-psychiatrist physician or nurse practitioner consultations which are not related to the psychiatric diagnosis. Authorization by the MCO may be required. The participant’s Primary Care Physician or the MCO Special Needs Coordinator should be contacted.

Discharge planning is expected to begin on admission. Discharge information must be entered in ProviderConnect.

Claims Process

Claims for unauthorized days will be denied.
6.2 Mental Health – Residential Treatment Services

Service Coverage

A Residential Treatment Center (RTC) offers 24-hour inpatient care in a facility licensed under Maryland Law (COMAR 10.07.04). An RTC provides children and adolescents who have long-term and serious emotional disturbance with residential care in a structured therapeutic milieu and provides a range of diagnostic and therapeutic mental health services. RTC treatment focuses on maximizing a participant's development of appropriate living skills. RTC is a very intense level of care and can only be provided when therapeutic services available in the community are insufficient or have failed to address the participant's need.

Discharge planning must be considered prior to placement in an RTC and the discharge plans must be actively reviewed throughout the treatment process. Active discharge planning requires effective collaboration with the participant, the participant's family (or legal guardian), and other appropriate agencies or service providers.

Before admitting a youth to RTC, ValueOptions® Maryland (the State of Maryland’s ASO) and the Core Service Agencies (CSAs) are responsible for assuring that the participant has received the maximum benefit from any available,
appropriate, community-based services. The overall focus of the RTCs, ValueOptions® Maryland, and the CSAs is to help children, adolescents, and their families develop skills to manage the symptoms of their mental illness and to live successfully in the community.

The Department of Social Services (DSS), the Department of Juvenile Services (DJS), the Department of Human Resources (DHR), and any other agency involved in the care and supervision of the participant, and/or the parents/guardians are expected to contribute toward the development and implementation of a discharge plan.

Service Rules

A Federally-mandated Certification of Need for services (CON) is required for Medical Assistance (MA) participants at the time an application for an RTC admission is made. The CON is time-sensitive in that all of the elements of a CON must be dated within 30 days of the participant entering the RTC. There is no standardized CON form; each provider uses its own format and all formats will be accepted if they each recommend an RTC placement and if they include:

1. A Psychiatric Evaluation, which must be completed by a board-certified psychiatrist, and must include a summary of the participant’s:
   a. Presenting problem
   b. Current psychiatric symptoms and behaviors
   c. Treatment, medication, family and education history
   d. All applicable diagnoses
   e. A clear recommendation that the participant be placed in an RTC

2. A Psychosocial Evaluation must be completed by a licensed mental
health professional. Any psychosocial evaluation completed by an LGSW or LGPC must be cosigned by a licensed mental health professional. The Psychosocial Evaluation may include the components delineated in the Psychiatric Evaluation but will provide further detail regarding:

a. The presenting problem
b. Family involvement
c. Religious, social, educational and legal history
d. The writer of this evaluation must also clearly recommend participant placement in an RTC

3. History and Physical Examination (H&P), signed by a physician or CRNP, that attests that the participant is medically appropriate and cleared for RTC placement

The CON must be sent to both the CSA and ValueOptions® Maryland. An authorization request (whether it be the initial or subsequent) for RTC services must be made to ValueOptions ® Maryland through the on-line, ProviderConnect system. Initial requests must be made prior to admission. If a medical necessity review for continued treatment is not reviewed before the authorization period expires, treatment is not authorized and the facility will be denied payment for unauthorized days.

Persons requesting RTC may send updated CON documentation if the original CON is drafted more than 30 days prior to admission. Any updated and abbreviated psychosocial, psychiatric, H&P addendums should be sent to VO and the CSA. The updated CON should refer to the prior CON evaluations and reiterate that the participant continues to need residential placement. Whenever
possible, the updated CON should be submitted along with a copy of the original CON documentation.

The outcome of the RTC placement should be to return the participant to a home-like environment. If this is not a reasonable expectation, alternatives to RTC placement should be investigated. It should be expected that there will be a minimum of weekly family involvement. This may include, but is not limited to, family attending sessions in the RTC, RTC staff going with the participant to the home, or telephonic therapy.

Emphasis is placed on keeping children and adolescents who need residential treatment services in Maryland-based RTCs. When an out-of-State placement appears indicated, the CSA and the local coordinating council will need to be involved.

It is the responsibility of the RTC to ensure that the information contained in the CON accurately reflects the medical necessity of the RTC admission.

The RTC must contact ValueOptions® Maryland when a previously non-MA participant has applied for MA and has been determined eligible.

The last date listed in the ValueOptions® Maryland ProviderConnect authorization is not considered an authorized day for reimbursement purposes. For example, in an authorization from April 1 to May 1, May 1 is not considered an authorized day.

Psychological testing performed while a participant is being treated in an RTC is included in the RTC daily rate.

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RTC's will be reimbursed for overnight Therapeutic Leave of Absence (TLOAs) of less than 72 hours. A TLOA that lasts longer than 72 hours requires preauthorization by ValueOptions® Maryland. Any TLOAs of 72 hours or more will not be paid for. TLOAs may be allowed when the provider identifies specific goals for this type of service planning and while the participant continues to meet medical necessity criteria for continued RTC stay. TLOAs include, but are not limited to, situations such as:

1. An admission to inpatient psychiatric bed
2. An admission to an inpatient medical bed
3. Home or Transitional visits to practice symptom management techniques developed in residence

There are no reimbursable Administrative days for care in an RTC beyond the point in time where the participant no longer meets the medical necessity criteria for continued stay. Authorization for payment is denied when a participant no longer meets the Medical Necessity Criteria for residential treatment services.

Active discharge planning with a participant's family, legal guardian and/or agency representative is expected to begin at the time of admission. This plan is to be routinely reevaluated with the participant, family, guardian and/or agency representative (as specified in Maryland Law, COMAR 10.21.05). All interested parties (i.e. the participant, family, custodial agent, and local school system, etc.) should be kept apprised of the participant's progress toward meeting the discharge goals. When the ValueOptions® Care Manager determines that the participant may, soon, no longer meet medical necessity criteria, a time-limited authorization may be given to operationalize a discharge plan. The provider should contact the
participant's CSA to assist with accessing community-based mental health services.

ValueOptions® Maryland will do a Courtesy Review for the medical necessity of RTC services when the participant has not yet been granted Medicaid eligibility. However, the responsible parties must apply for Medicaid, immediately, to the Maryland State Department of Human Resources (DHR). ValueOptions® Maryland will not pay for any medically necessary services until the participant has been granted Medicaid eligibility. When newly or previously Medicaid eligible, the responsible parties are required to work with the State’s Eligibility Determination Division to change the Medicaid eligibility from a Community-Based Medicaid to a Long-Term Care Span. To do so, the provider must submit the following form:

- DES 1000 Form
  @ https://mmcp.dhmh.maryland.gov/longtermcare/docs/DES-1000.pdf
- 9708 Application
  @ https://mmcp.dhmh.maryland.gov/eid/Documents/9708A%20form.pdf

The DES form to the ValueOptions® Maryland Clinical Director and the 9708 form to the Eligibility and Determination Division of DHMH. The DES is to confirm the start date of the authorization/admission. Once confirmed, the Clinical Director will sign and return the DES 1000 form to the RTC provider to process with the State. The 9708 is a financial eligibility application.

The applicable Maryland Health General Article:
- Standards of Institutionalized services article 19-308)
The applicable Code of Maryland (COMAR) Titles:

- Conditions of participation (10.09.29.03)
  [http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.29.03.htm](http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.29.03.htm)

- Preauthorization requirements (10.09.29.06)
  [http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.29.06.htm](http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.29.06.htm)

**RTC Special Issues**

Although some participants in RTCs may present significant management challenges, enhanced support services are not an option available in an RTC. All services provided by the RTC must be included in the RTC rate. Participants with another primary insurer (i.e. a commercial plan, TRICARE, etc.) should seek treatment in RTC facilities that are credentialed by (in-network with) that insurer. Admission to a non-participating facility, for any payer, does not make Medicaid the primary payer.

Information regarding participants' plans and progress toward discharge goals is to be shared with the Child and Adolescent Coordinator at the CSA for that participant's county of residence. Should issues arise which interfere with activating the discharge plan, the CSA Child and Adolescent Coordinator is to be contacted for assistance ([http://www.marylandbehavioralhealth.org/core-service-agency-directory](http://www.marylandbehavioralhealth.org/core-service-agency-directory)).

The mental health service provider is expected to exchange information and coordinate care with the participant's primary care physician and other treatment providers when clinically appropriate.
Service Eligibility

Participants under the age of 21 who have Medicaid are eligible for RTC service.

Some participants with a private insurance carrier may find it necessary to seek Medicaid when fiscal or time period limitations on their private policies have been exhausted. These participants will be reviewed by ValueOptions® Maryland at the time of the MA application. Prior to admission to an RTC, the participant should be referred to their CSA for possible diversion services. The result of this review should determine if community services can meet the required level of treatment or if the participant should be referred for the RTC level of care.

Service Providers

All RTCs must have a Maryland or other state license to provide Residential Treatment Services. The RTC must also have an active Maryland MA provider number.

Authorization Process

The RTC requesting authorization must enter an authorization request in ValueOptions® ProviderConnect system to activate an RTC review. Required information must supplement the information in the previously submitted CON and should include at least the following:

1. All applicable diagnoses – Maryland PBHS-eligible diagnoses can be found here:
2. Current need for treatment
3. Precipitating event(s)
4. Treatment history
5. Current (and history of) medications
6. Substance use history
7. Risk assessment
8. History of out-of-home, mental health placements
9. History of non-mental health, out of home placements
10. Attempts (and outcomes) of increasingly intensive, community-based services

Prior to the expiration of any initial or continued stay authorization period, the RTC must request authorization for additional days through the ValueOptions® Maryland ProviderConnect system. If the participant still meets the medical necessity for continued stay, ValueOptions® will continue to authorize RTC services.

Treatment at this level of care requires family involvement. This must be documented in the medical record. If this does not occur, there may be questions regarding whether Medical Necessity Criteria are being met and about the efficacy of residential treatment.

This authorization process continues until the participant is discharged.

**Billing Codes**

RTCs must bill using the reimbursement rates approved by the Maryland Department of Health and Mental Hygiene. Revenue code 100 or 101 must be used.

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Claims should be submitted to ValueOptions® Maryland, only after authorization has been received, the individual is Medicaid-eligible, and a long-term care span has been secured through the DES 1000 application process. Claims are submitted on UB-04 forms. Claims must specify an ICD-9 code (not the DSM 5 code) for reimbursement.

Laboratory services are covered as outlined in Chapter 13 of the Provider Manual.

Prior to payment, the state of Maryland requires ValueOptions® Maryland to review all claims for inpatient services at RTCs to determine if a Long-Term Care Span has been properly opened. A Long-Term Care (LTC) Span is required when the participant meets the state's definition of an institutionalized participant. In general, a participant becomes institutionalized when he/she is admitted to a facility for more than one calendar month. The span is specific to the facility, participant and the time period of the admission. The LTC Span allows the state to establish eligibility and to ensure that claims for services, other than those rendered by the RTC, are valid prior to payment. Most participants will become a "family of one" when the definition of institutionalization is met. The state may determine that renewable assets exist and that a "share amount" should be deducted from each monthly payment. The change in membership for the admitted participant may also result in membership changes for their family. To establish a LTC span, the RTC must complete the DES 1000 form and submit it to the Waiver Unit at the State Department of Human Resources.

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It is equally important that facilities close the span when the participant leaves the facility. If the participant is transferred to another facility (regardless of the length of stay), the RTC must close the existing LTC Span and then reopen the span if the participant later returns to the RTC. Unless the span is closed, the other facility may not be able to bill MA. The participant may be eligible for additional MA services in the community.

Please refer to Chapter 17 for specific instructions on claims procedures for RTCs.

Claims for unauthorized days will be denied.

The RTC daily rate is established according to federal guidelines and is intended to cover all services a participant may require, including but not limited to, psychological and other specific types of testing and forensic and psychosexual evaluations. Likewise, the occasional need for intensive supervision of some participants is included in the determination of the annual provider rate of care.

If the services requested do not meet medical necessity criteria and care is non-authorized, please refer to Chapter 10, Grievances and Appeals.
6.03 Mental Health – Partial Hospitalization Services

Service Coverage

Partial Hospitalization Programs (PHP), also known as Psychiatric Day Treatment Services, must be rendered by a provider approved under Maryland Law (COMAR 10.21.02). This is an outpatient, short-term, intensive, psychiatric treatment service that parallels the intensity of services provided in a hospital, including medical and nursing supervision and interventions. PHP is an alternative to inpatient care when the participant can safely reside in the community. This level of service is a benefit for children, adolescents, and adults (refer to Chapter 7.08 for medical necessity criteria).

Those providers who choose to provide a full-day of PHP services must provide at least 6.5 hours of treatment. Free-standing PHP’s may provide a full day or a half day (minimum of 4 consecutive hours) of treatment.

Service Rules

- Psychological testing for participants enrolled in a PHP requires a separate authorization and must be administered outside of the hours billed for Partial Hospitalization.
• A physician’s service may be billed for a Medicaid recipient, in addition to the Partial Hospital stay, when provided in a hospital setting. One psychiatric visit per day is allowed without a separate authorization.

• Non-hospital based partial programs do not have a provision for this additional physician payment, as it is already included in the Partial Hospital rate.

• For non-hospital staff physicians to be reimbursed for physical examinations, providers must use a CMS (HCFA) 1500 form. The CPT codes accepted for this service are 99241-99245.

• Occupational therapy performed in a hospital or Partial Hospitalization setting, by the staff of these organizations, does not require an authorization. Private occupational therapists or occupational therapy groups require authorization, regardless of location. In order to receive reimbursements through the PBHS, all providers approved under COMAR 10.21.02, must also be Medicare providers, or compliant with Medicare rules if a free-standing PHP.

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment providers (i.e. substance abuse treatment) when clinically appropriate.

**Service Eligibility**

Participants with active Medicaid and participants dually covered under Medicare and Medicaid are eligible for PHP services. The PBHS does NOT reimburse PHP Services rendered to Uninsured Eligible participants.

**Service Providers**
Partial Hospitalization Programs are approved under Maryland Law (COMAR 10.21.02). These services may or may not be hospital-based and have reimbursement rates depending on their site. A multidisciplinary team, including a psychiatrist, nurse, and other professionals, should be available to provide this service.

**Authorization Process**

To obtain initial authorization for PHP services, the provider must submit a pre-authorization request through ProviderConnect. Providers obtain additional authorizations through the submission of a Continuing Review Authorization Request (see ProviderConnect User Manual for directions on completing these authorization requests).

The provider must submit a Continuing Review Authorization Request prior to the expiration of the previous authorization time span. If a ValueOptions® Maryland Care Manager is not able to authorize the service as medically necessary, and agreement regarding an alternative level of care cannot be reached, the request for services will be referred to a ValueOptions® Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect downloads to the provider. (See Chapter 10, Grievance and Appeals.)

Discharge planning is expected to begin at the same time as service delivery. All discharge plans must be submitted in the authorization request.

**Claims Process**

Claims are submitted on a CMS 1500 form or on a UB04 form with the appropriate billing codes.
• Claims must specify an ICD-9 code (not DSM-5 code) for reimbursement.
• Claims for unauthorized PHP days will be denied.
6.04 Mental Health – Emergency Services in a Licensed Hospital Emergency Room

Service Coverage

The service allows for assessment and intervention for a participant who is in an emergency room and appears to be in psychiatric distress. The participant, because of a mental disorder, may present as dangerous to self or others, or is unable to care for him/herself. The participant’s presentation at the emergency room may be voluntary or on the basis of a petition for emergency evaluation.

The participant is expected to have psychiatric symptoms addressed during an emergency room visit and a psychiatric diagnosis as a result of the assessment.

Service Rules

The Public Behavioral Health System (PBHS) does not cover services for participants presenting at an emergency room whose primary diagnosis is not a PBHS-covered diagnosis (see Appendix for excluded diagnoses).

For licensed mental health professionals other than psychiatrists or nurse practitioners to be reimbursed in this venue, the requirements in Appendix of the manual must be met.
Billing Codes

Licensed providers requesting reimbursement from the PBHS will also need their own active Maryland Medical Assistance individual or group number. The provider, NOT the hospital, will be paid for services rendered using a 90791 (or 90792 if the psychiatric diagnostic evaluation includes medical service) CPT code. Outpatient departments of hospitals should use revenue codes for emergency room services.

When Emergency Services are sought for a minor, by an individual other than the parent or legal guardian, e.g., a foster parent, the Department of Social Services caseworker, or a school counselor, permission must be obtained from the parent, legal guardian, or the court, if it is determined that the child or adolescent requires hospitalization. If the parent or legal guardian is unavailable to give permission, and it is determined that the child or adolescent requires hospitalization, then the child must be certified by two physicians in order for him/her to be admitted to a hospital.

Service Eligibility

The mental health service provider is expected to collect history, exchange information, and coordinate care with the participant’s primary care physician and other treatment (e.g. substance abuse treatment, ACT teams, RRPs, other mental health and DDA providers) when clinically appropriate. If the participant in emergency circumstances is thought or known to be eligible for DDA services, the appropriate regional office of DDA should be contacted to arrange rapid evaluation (where available) and to delineate service options. This is a service reimbursable only for participants with Medical Assistance (MA).
Service Providers

Hospitals regulated by the State of Maryland are eligible providers. Out of state hospitals must be active Maryland MA providers and have a signed provider agreement with DHMH in order to provide this service.

Authorization Process

The rendering of medically necessary Emergency Service does not require preauthorization by ValueOptions® Maryland. Once the service has been delivered, claims should be sent to ValueOptions® Maryland.

Reimbursement for Emergency Services pertaining to medical diagnoses for participants enrolled in HealthChoice is the responsibility of the Managed Care Organization (MCO) in which the participant is enrolled.

Claims Process

Claims are submitted on a CMS 1500 form or on a UB04 form with the appropriate billing codes. Claims must specify an ICD-9 code (not DSM-5 code) for reimbursement.
6.05 Mental Health – Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)

Service Coverage

Mobile Treatment Services (MTS) and Assertive Community Treatment (ACT) programs are community-based, intensive, outpatient services rendered by providers approved under Maryland Law (COMAR 10.21.19). MTS/ACT provide intensive, mobile, assertive mental health treatment and support services to participants with mental illness who may be homeless, or for whom more traditional forms of outpatient treatment have been ineffective. Services are provided by a multidisciplinary team, are mobile and are provided in the participant’s natural environment (e.g., home, street, shelters). MTS/ACT are also available for children, adolescents and their families who require more intensive intervention in order to clinically stabilize the child’s or adolescent’s psychiatric condition, to promote family preservation and/or to return functioning and quality of life to previously established levels as soon as possible.

Services provided include psychiatric evaluation and treatment, clinical assessment, medication management/monitoring, health promotion and training, interactive therapies, support with daily living skills, assistance with locating housing, case management, as well as crisis intervention. The duration, frequency and intensity of services provided are determined by a participant’s treatment plan. The goals of MTS/ACT are to connect participants to treatment services in the community,
remediate tenuous living situations, and avert hospitalizations.

Service Rules

Since MTS/ACT targets participants who previously had not successfully engaged in mental health treatment, services are expected to be delivered in community settings. Office visits may be counted under certain circumstances such as Co-occurring Groups, etc.

- The expectation is that participants will be seen, at a minimum, for four face-to-face contacts in a month.
- The four visits are a minimum requirement with the expectation that additional contacts will be provided as needed.
- The MTS/ACT provide outreach to participants to facilitate the participant’s acceptance of services and treatment. Occasionally, the MTS/ACT team attempts to meet with a participant and the participant is not at home or may refuse to see the team. In these instances, the Behavioral Health Administration (BHA) has said that the program may count the attempted visits toward the four visits required per month. The MTS/ACT is to document in the medical record the unsuccessful outreach attempts to see the participant.
- When participants are hospitalized for brief periods of time, MTS may see the participant in the hospital but may not count the visit towards the required four encounters. The minimum four encounters are to be provided only on separate days. If a MTS/ACT team sees a participant in the morning and again in the afternoon, only one encounter per day may be counted.
- ValueOptions® Maryland will contact the MTS/ACT provider for the purpose of service coordination and discharge planning when a participant served by the MTS/ACT site is hospitalized.
- Based on the needs of the participant, a one month overlap of services may be
appropriate in order to transition the participant to more traditional mental health services, e.g. transitioning from Mobile Treatment to OMHC. In some instances a longer transition period may be necessary. In rare circumstances, Mobile Treatment Services may be authorized for participants with complex and unique needs who may also be receiving PRP and/or Case Management Services.

- Permission to treat a minor is required from the legal guardian. Adolescents age 16 and over may consent to treatment for themselves.

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment providers (e.g. substance use treatment) when clinically appropriate.

**Service Eligibility**

Participants with Medicaid (MA), PBHS-eligible Medicare recipients, and Uninsured Eligible participants (see Chapter 3, Uninsured Eligibility) are eligible for MTS/ACT. Adult participants in MTS/ACT must have a Priority Population Diagnosis (see chapter 7.13).

A MTS site identified as an ACT site is eligible to receive evidence-based practice rates of reimbursement after meeting the requirements outlined in the BHA Memorandum entitled “Assertive Community Treatment (ACT) – Evidenced-Based Practice (EBP) Project,” including meeting the required scores to be considered an EBP ACT program.

**Authorization Process**

To obtain initial authorization for MTS/ACT, the provider must submit a pre-authorization request through ProviderConnect (see ProviderConnect Users Guide for
directions on completing an authorization request). If medical necessity criteria are met, Mobile Treatment Services will be authorized by ValueOptions® Maryland (usually in six month increments).

Providers obtain additional authorizations through the submission of a Continuing Review Authorization Request (see ProviderConnect Users Guide for directions on completing an authorization request). The provider must submit a Continuing Review Authorization Request prior to the expiration of the previous authorization time span.

If a ValueOptions® Maryland Care Manager is unable to authorize the service as medically necessary (refer to Chapter 7.13, 7.14 for medical necessity guidelines), the request for services will be referred to a ValueOptions® Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect to the provider (See Chapter 10, Grievances and Appeals).

**Claims Process**

MTS/ACT is authorized in monthly blocks. Regardless of when in the month a request for Mobile Treatment Services is authorized, the first day of the month is used as the beginning date of authorized service. For example, if the service begins mid-month, the provider will receive payment for the full month.

Mobile Treatment Services (MTS) are paid through a monthly rate that is reimbursed through Medicaid or with state general funds.

- Only one monthly fee is reimbursable.
- Providers are to bill with the first date of service the participant was seen using a CMS 1500 form.
• Claims may not be submitted for the monthly fee until the calendar month has ended.

• Claims must specify an ICD-9 code (not DSM-5 code) for reimbursement.

Claims for unauthorized services will be denied.
6.6 Mental Health – Supported Employment (SE) Services

Service Coverage

Supported Employment (SE) services are provided by a Mental Health Vocational Program (MHVP) approved under Maryland Law (COMAR 10.21.28). Before the PBHS pays for SE services, the MHVP-SE must enter into a written agreement with DORS.

Supported employment (SE) provides job development, job coaching, and ongoing employment support services to individuals with serious mental illness (SMI) for whom competitive employment has not occurred, has been interrupted, or has been intermittent. These individualized services are provided to enable eligible individuals to choose, obtain, maintain, or advance within independent competitive employment, within a community-integrated work environment, consistent with their interests, preferences, and skills.

For a description of EBP SE services and service rules, please refer to this section and Section 7.10.

The non-EBP SE service, funded under the Public Behavioral Health System (PBHS), consists of the following reimbursable service phases:
1. **Pre-placement Phase (H2023):** This includes, at a minimum, MHVP assessment, referral to the Division of Rehabilitation Services (DORS), entitlements counseling, and discussion of the risks and benefits of disability disclosure and informed choice. A request for reauthorization of the pre-placement service phase may be approved at the CSA’s discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of reauthorization requests is not guaranteed (1 unit per service authorization span).

2. **Placement in a Competitive Job (H2024) (does not include agency-sponsored employment):** This includes assisting the participant in negotiating with the employer a mutually acceptable job offer and advocating for the terms and conditions of employment, to include any reasonable accommodations and adaptations requested by the individual. A request for reauthorization for the Placement service phase may be approved at the CSA’s discretion, not to exceed three service authorizations per fiscal year, based on a change in individual circumstances or the emergence of a new service need. Approval of reauthorization requests is not guaranteed and the request must reflect the need for a separate and independent job development activity (1 unit per service authorization span).

3. **Intensive Job Coaching Phase (H2024-21) (reimbursed by DORS, special exceptions may be made for PBHS reimbursement):** This includes the use of systematic intervention techniques designed to help the supported employee learn to perform job tasks to the employer’s specifications and
to develop the interpersonal skills necessary to assume the employee role and to be accepted as a full-status employee at the job site and in related community-based settings. Job coaching may also be used as a preventative intervention to assist the individual in preserving the job placement, resolving employment crises and in stabilizing the employment situation for continuing employment. In addition to direct job skills training, job coaching includes related job analysis and environmental assessment, vocational counseling, employer education and advocacy, mobility skills training and other support services as needed to promote job stability and social integration within the employment environment (1 unit per 15 minutes of service).

4. **Ongoing Support Services Phase (non-EBP) (H2026):** This includes proactive employment advocacy, supportive counseling, and ancillary support services, at or away from the job site, to assist the individual in maintaining continuous, uninterrupted, competitive employment and to develop an employment-related support system. This includes encouraging the use of natural supports to the maximum extent possible. This service is not time limited and continues until the individual no longer needs or desires the service (1 unit per month of authorized service)

5. **Psychiatric Rehabilitation Program services to Individuals in Supported Employment (PRP-SE)(S9445):** This includes those psychiatric rehabilitation service interventions needed to assist the individual to restore and to improve coping skills, assertiveness skills, interpersonal skills, and social skills necessary to function adaptively in the work environment or to develop compensatory strategies to minimize the
impact of the individual’s mental illness on his or her behavior while on the job. The service must be provided on the job, unless the individual has chosen not to disclose his or her disability to the employer. At the individual’s request, the service may be performed at a mutually agreed upon community-based location, as indicated in the Individual Rehabilitation Plan (IRP) or disclosure plan. The individual must be competitively employed to receive this service (1 unit per month of authorized service; minimum of 2 encounters for non-EBP providers.)

Service Rules

All SE service recipients within the PBHS must apply for eligibility for DORS-funded job development and job coaching services, within the context of SE program services. In rare instances, when the individual refuses to be referred for DORS services and multiple failed attempts to engage the individual in DORS services have been documented and all other avenues to resolution of issues precluding the individual from accessing DORS services have been exhausted, a waiver of the referral requirement may be granted with CSA approval and supporting documentation.

- The PBHS may authorize payment for intensive job coaching services if funds are available, with CSA approval, when written documentation from the DORS field counselor on DORS letterhead of the DORS denial of service is submitted and sufficient justification exists to support the request. The MHVP provider may submit a request for pre-authorization of intensive job coaching services to the relevant CSA jurisdiction, and specify the estimated number of units of service.
required, based upon the individual’s specific job duties and a corresponding assessment of the expected frequency, intensity, and duration of his or her support needs. The CSA may grant authorizations up to 400 units of service per participant, with one unit of service equal to 15 minutes of service. All DORS service rules apply. The authorization is in lieu of a DORS authorization, when an official denial of service has been received, and is not intended to supplement the DORS authorization of intensive job coaching hours.

- The MHVP provider must secure a competitive placement prior to seeking authorization from the CSA for the placement phase. The CSA will review the placement information to screen out requests for authorization for agency-sponsored employment. Any supported placement or related SE services, occurring in a facility, entity, subsidiary, affiliate, or contract site that is owned, operated or managed by its own approved supported employment program or its umbrella organization, will be considered to be agency-sponsored employment, and will not be eligible for supported employment authorization and reimbursement within the Public Mental Health System (PBHS).

- Ongoing support services or PRP-SE services may not be provided concurrent with intensive job coaching services.

- SE service recipients who acquire third party health insurance as a result of employment, obtained by virtue of receipt of SE services through an approved MHVP, may retain eligibility for SE. The PRP-SE service must meet all applicable requirements for PRP services, as delineated in COMAR 10.21.21. Claims for PRP Services to Individuals in SE must be substantiated by the submission of encounter data which reflects the provision of a minimum of two discrete service encounters per month,
separate and apart from the encounter data submitted to validate other PRP levels of care.

The MHVP must provide one employer contact per month; with proper consent and only if the individual has disclosed the existence of a disability to the employer.

Information regarding PRP services available to participants Supported Employment Services is discussed in EBP services chapter.

Service Eligibility

Services for participants with MA, and Uninsured Eligible participants are eligible for reimbursement for this service. Service authorization is determined by the CSA for adults in the PBHS with a diagnosis of SMI and for TAY with a primary mental health diagnosis, who express an interest in competitive employment and desire to work in the community; demonstrate a work history which has been non-existent, interrupted, or intermittent due to a significant psychiatric impairment; and require supported employment services to choose, to obtain, to maintain, or to advance within competitive employment.

For SE service recipients, income derived from supported employment may be reviewed to determine if the individual has the resources to pay for services or to pay a co-pay, without jeopardizing the individual’s employment. Providers may negotiate with the individual regarding contributing to cost of care.

Participants who are recovering from SMI, or are transitioning from Psychiatric
Rehabilitation Program services, retain access to and eligibility for supported employment program services, as their symptoms abate and functioning improves, as a means to further support, sustain, or extend their recovery from serious mental illness.

Service Providers

SE services may only be performed by an approved MHVP and are regulated according to the provisions of COMAR 10.21.28. PRP-SE services may only be performed by a program jointly approved as a MHVP and a PRP and is regulated according to the provisions of COMAR 10.21.21.

Authorization Process

Mental Health Vocational Program (MHVP) providers must submit the authorization request for SE through ProviderConnect for CSA review within 48 hours of the request. The DORS referral and application are completed coincident with the request for authorization of the Pre-placement Phase. Upon CSA review and approval, SE participants are presumed eligible and to have a most significant disability for DORS services. The MHVP sends an e-mail to the DORS counselor, and the counselor’s supervisor, containing the ProviderConnect authorization number of the participant applying for DORS services and requests an initial interview within 2 weeks.

Based on the CSA’s authorization, ValueOptions® Maryland assigns an authorization number. The provider then submits the claim to ValueOptions® Maryland for reimbursement.
Claims Process

Claims are to be submitted on CMS1500 forms. One unit is billed for each phase, except for the intensive job coaching phase. Claims must specify an ICD-9 code, not DSM-IV-TR code. The number of units billed for intensive job coaching services is **based on the actual number of units authorized**, **up to 400 units, with one unit equal to** 15 minutes of service. Claims submitted with date spans will be denied.

Encounter data must be submitted to establish the actual number of PRP services delivered for PRP-SE. Any claims submitted for PRP-SE in the absence of corresponding encounter data which reflect compliance with the established service minimum of two discrete service counts per month for non-EBP SE providers will be subject to denial of claims payment and subsequent retraction of payment, for claims already reimbursed.

**Claims for unauthorized services will be denied.**
6.07 Mental Health – Respite Services

Service Coverage

Respite Services are provided for adults with Serious Mental Illness (SMI) or children with Serious Emotional Disorders (SED). These services are administered by a program approved and operated under the provisions of Maryland Law (COMAR 10.21.27), and are provided on a short-term basis in the participant’s home or in an approved community-based setting. Services are designed to support participants remaining in their homes by providing temporary relief to the participant’s care-givers.

Respite Services are provided to relieve the care-giver from the stress of care-giving. These services differ from PRP services which target social and activity of daily living training and rehabilitation (see section 6.13). Respite Services differ from Residential Crisis Services, which target acute psychiatric symptoms in a therapeutic milieu (see Section 6.11).

Respite Services must be distinguished from shelter care in the child and adolescent system. While Respite Services are provided on a “short-term basis,” this time limitation generally refers to the length of the participant’s respite care episode, and not to the more extended period of time in which caregivers may
require relief from the stresses of care. Respite Services will be delivered in partial day increments, for weekend breaks, and, in very rare instances, for as much as two weeks.

Service Coverage Examples:

- An adult lives with his or her sibling who helps the participant to perform independent living skills, assist with medication, etc. to manage the participant’s mental illness and support the participant’s recovery. The sibling is scheduled to go out of town on business and needs someone to provide support for the participant. The participant is authorized for Respite Services.

- The parents of a ten-year-old boy who is diagnosed with major depression and oppositional defiant disorder are trying to maintain him in their home. His psychiatric symptoms include temper tantrums, erratic sleep patterns, sporadic acts of cruelty to animals and a labile mood. The parents must provide continuous monitoring of his activities. The case manager has recommended weekend respite two times a month to provide the family with temporary relief from the stressful task of managing their son’s behavioral symptoms.

- The parent of an eight-year-old child who has a serious emotional disturbance requests in-home respite. Respite Services is approved based upon the symptoms the child presents and the burden the parent is under in managing multiple stressors which could eventually lead to the child having a hospitalization or out-of-home placement.
Service Rules

Adult, child and adolescent Respite Services are authorized on a full day, 12-hour minimum, for facility-based respite, or a maximum of 10 hours a day for in-home respite.

Full-day Respite Services are facility-based (i.e. in a licensed foster home, group home, or other facility approved as a Respite Services provider). In-home Respite Services are provided in hourly increments. Enhanced Support Services (see Section 6.08) will not be authorized in conjunction with Respite Service provision for adults, children, or adolescents.

Despite its name, in-home Respite Services may be provided in the community. An approved Respite Services provider, through prearrangement with the caregiver and the participant, may pick up the participant at the participant’s home, school or other location approved by the caregiver, and go to another location, allowing the care-giver to receive a break from the rigors of care-giving in their own home.

Service Eligibility

Participants with Medical Assistance (MA) and Uninsured Eligible participants are eligible for Respite Services.

Service Providers

Services may only be provided by approved Respite Service providers, according
Authorization Process

To obtain authorization for Respite Services, the provider, participant, family member, or advocate must request authorization via from ValueOptions® Maryland. The following clinical information is required: DSM 5 diagnosis(es), current need for respite, including review of the level of caregiver stress, precipitating event, treatment history, medications, substance use history, and risk assessment. If medical necessity is demonstrated, authorizations will be given by ValueOptions® Maryland via ProviderConnect. If medical necessity cannot be determined and an agreed-upon alternative is not possible, ValueOptions® Maryland will refer the case to a ValueOptions® Physician Advisor for review (see Chapter 10, Grievances and Appeals).

For authorizations beyond the initial authorization period, the provider must request a continued stay review via ProviderConnect. ValueOptions® Maryland requires continued demonstration that medical necessity criteria is met for additional authorizations to be granted.

These services must be billed on a HCFA 1500 form (See Chapter 17.00). For dually eligible (Medicare/Medicaid) participants, providers should bill ValueOptions® Maryland directly. It is not necessary to send the claim to Medicare.

Claims Process
Claims must specify an ICD-9 code (not DSM 5 code) for reimbursement.

Claims for unauthorized services will be denied.
6.8 Mental Health – Enhanced Support Services

Service Coverage

Enhanced Support Services provide one-to-one supervision and assistance to an individual experiencing an increase or instability of psychiatric symptoms, based on Medical Necessity Criteria, or individuals transitioning from an inpatient level of care. This service is only provided by a provider of psychiatric rehabilitation program services (PRP), residential rehabilitation program services (RRP) or mobile treatment services. Enhanced Support Services shall be provided in the participant’s place of residence.

Enhanced Support Services are not available for participants in inpatient facilities, RTC settings, or partial hospitalization programs.

Enhanced Support is considered a short term service and will be reimbursed for a maximum of ten days per episode/30 days per calendar year. Services will be authorized as is medically necessary. Enhanced Support Services cannot be authorized in conjunction with Respite Services.

Service Rules
Enhanced Support Services does not cover that provision of personal care services, which may be reimbursable by Medicaid, under a separate funding authority.

A unit of Enhanced Support Services is fifteen minutes of services

Service Eligibility

Participants with MA, PBHS-eligible Medicare recipients, and Uninsured Eligible participants may be eligible for this service.

Service Providers

Enhanced Support Services are limited to approved PRPs, RRPs, and mobile treatment programs.

Authorization Process

Preauthorization is required. To obtain initial authorization for Enhanced Support Services, the provider must submit a preauthorization request through ValueOptions® ProviderConnect for CSA review.

Place the relevant clinical information which substantiates the need for the service in the clinical criteria box of the authorized request. Include, at a minimum, rationale for the request, requested start and end dates for the service and number of hours per day the service is being requested.
Providers obtain additional authorizations through the submission of a Continuing Review Authorization Request (see ValueOptions® User Manual for directions on completing an authorization request). The Continuing Review Authorization Request must be completed prior to the expiration of the previous authorization time span.

If a CSA Care Manager is unable to authorize, as medically necessary, the request for services will be referred to a CSA Physician Advisor for review. The determination will be communicated via ValueOptions® Provider Connect downloads to the provider (see Chapter 10: Grievance and Appeals.)

**Claims Process**

Claims must be submitted on a CMS 1500 form (see Chapter 17). The number of units must equal the number of hours enhanced support was provided (e.g. one unit = one hour, six hours = six units). Each day of service must be on a separate claim form line, and claims must specify an ICD-9 code, not DSM N-TR code.

**Claims for unauthorized services will be denied.**
Service Coverage

Therapeutic Behavioral Services (TBS) are provided by Early and Periodic Screen Diagnosis and Treatment (EPSDT) providers as approved under Maryland Law (COMAR 10.09.34). TBS is a rehabilitative referred service for children and adolescents under 21 years of age.

It is designed to provide rehabilitative treatment interventions to reduce or improve the target maladaptive behavior(s) appropriately through restoration of a participant to their best possible functional level. The services provide the participant with behavioral management skills to effectively manage the behaviors or symptoms that place the participant at risk for a higher level of care. The goal of these services is to restore the participant's previously acquired behavior skills and enable the participant to develop appropriate behavior management skills.

Service Rules

Services are provided by therapeutic behavioral aides who work in the home with both the parent/guardian and the participant. The parent/guardian must be present during all
interventions. Therapeutic behavioral aides are health care professionals or nonprofessionals who are supervised by an individual who is licensed or certified, or otherwise legally authorized to provide mental health services independently. Aides must be trained and supervised by an independently licensed clinician to implement a behavior plan. Aides render services on-site to provide one-to-one behavioral assistance and interventions to accomplish outcomes specified in the behavioral plan.

Behavioral plans are developed after a comprehensive therapeutic behavioral assessment is conducted. The assessment must be conducted with the participant present, and is performed by a licensed or certified health care professional. The assessment must address the medical and behavioral needs for therapeutic behavioral services, and includes the risk of needing placement in a more restrictive living arrangement because of the behavior.

TBS providers shall ensure that therapeutic behavioral aides are trained and supervised in principles of behavior change and childhood development, as well as clinically accepted techniques for decreasing or eliminating maladaptive behaviors.

If the therapeutic aide is not licensed or certified by a health practice licensure board to practice independently, the licensed healthcare practitioner needs to meet at least once every 2 weeks with the aide to review the progress and develop a behavior plan for the participant. At least once a month, the licensed or certified professional needs to observe the participant’s progress with the participant's parent or guardian. They also need to provide a written progress note that is completed for each time period that a therapeutic behavioral aide spends with the participant. This should include the location, date, start-and-end-time of service, and the name of the parent or guardian. A brief description of the service should be provided, including a summary of the participant’s behaviors or symptoms, and the signature of the behavioral aide. The behavioral plan should define
Specific interventions to be used to resolve the behaviors or symptoms, including how the aide will implement therapeutic behavioral services. Goals should be defined so as to demonstrate the decreasing frequency of targeted behaviors, and any alternative behaviors.

TBS must be decreased proportionally when indicated by the participant's progress. It must be discontinued when the targeted outcomes have been reached. If current outcomes are not being achieved, a reassessment should be conducted to obtain new targeted outcomes.

Service Eligibility

Participants with MA, PBHS-eligible Medicare participants, and Uninsured-Eligible participants are eligible for TBS and must be under 21 years of age. The participant’s parent/guardian, or individual who customarily provides care needs to be present during all therapeutic behavioral services to participate in the behavioral plan.

Service Providers

Maryland Law indicates that therapeutic behavioral service providers are either:
(a) A Developmental Disabilities Administration provider meeting criteria set forth in COMAR 10.22.02
(b) An outpatient mental health clinic approved under COMAR 10.21.20
(c) A mental health mobile treatment unit meeting criteria set forth in COMAR 10.09.59 or
(d) A psychiatric rehabilitation program approved under COMAR 10.21.29.

Authorization Process
To obtain initial authorization for an assessment for TBS, the provider needs to submit a pre-authorization request in ProviderConnect. The provider must submit a TBS referral form, signed by a licensed clinician, as well as a recent psychosocial assessment. This may either be a diagnostic evaluation or a psychosocial summary, signed by a licensed clinician. If the clinician is a graduate-level clinician, i.e. LGSW or LGPC, the form must be co-signed by the supervising, independently-licensed clinician, i.e. LCSW-C or LCPC. If the level of care is medically necessary, 4 units of TBS assessment will be authorized by ValueOptions®. TBS units are 15-minute increments of time; therefore, 4 units is equivalent to one hour.

If, after the assessment, the provider feels that the participant would benefit from TBS services, the provider submits a request for TBS service in ProviderConnect, detailing the information obtained from the assessment. If the level of care is medically necessary, TBS will be authorized by ValueOptions®. Hours can vary from 10-40 hours per week, and providers propose the requested hours of service per week that they expect to serve the participant. It is expected that most participants will need about 15-20 hours a week initially, with a decrease in hours in proportion to participant’s progress.

The initial authorization is granted for 56 calendar days. Providers may bill for an additional assessment within two weeks of the end date of the 56 days. Providers obtain authorization for the additional assessment through the submission of a Continuing Review Authorization Request via ProviderConnect. This is not a medical necessity review, so clinical information does not need to be submitted to obtain the assessment authorization request. Four units will be authorized for a one month range, starting on the date of the authorization request submission in ProviderConnect.
If, after the second assessment, the provider feels the participant needs additional TBS services, the provider will submit results of the assessment with a Continuing Review Authorization Request via Provider Connect. If the level of care is medically necessary, TBS will be authorized for 28 or 56 days at the hours requested by the provider, up to 40 hours per week. Authorization may only be given if the therapeutic behavioral service continues to be effective, and progress towards the specified goals is documented.

**Claims Process**

Request for payment of services shall be submitted in accordance with COMAR 10.09.36.04.

TBS providers may not bill for services that are provided in hospitals or crisis residential programs. TBS is not to be used for participants who need services for habilitative, custodial, or activities of daily living.

TBS aides cannot be a member of the participant's immediate family or someone who lives in the participant’s home.

TBS providers may not bill for services that are not conducted face-to-face. TBS providers may not bill for services that are part of another service paid for by the State, such as therapeutic foster care, respite services, broken or missed appointments, or for travel to and from the site of service.

**Claims for unauthorized services will be denied.**
For mental health participants, if the services requested do not meet Medical Necessity Criteria and care is non-authorized, please refer to Chapter 10, Grievances and Appeals.

For developmental disability participants, if the services requested do not meet Medical Necessity Criteria and care is non-authorized, appeals may be sent to the Maryland Department of Health and Mental Hygiene by submitting a written request within thirty (30) days to:

Department of Health and Mental Hygiene
ATTN: Dina Smoot
201 W. Preston Street, Room 127
Code 0413
Baltimore, MD 21201
6.10 Mental Health – Residential Crisis Services

Service Coverage

Residential Crisis Services (RCS) are funded with state general funds and are short-term, intensive, mental health and support services for children, adolescents, and adults in a community-based, non-hospital, residential setting rendered by a provider approved under Maryland Law (COMAR 10.21.26). Services are provided to prevent a psychiatric inpatient admission, to provide an alternative to psychiatric inpatient admission or to shorten the length of inpatient stay. RCS may also be provided in a treatment foster care model. A provider serving adults shall be approved at the alternative mode for Residential Crisis Services. A provider serving children may be approved and reimbursed at the treatment foster care and prevention model.

An approved Residential Crisis Service provider may receive authorizations based on medical necessity. Participants can be admitted to a Residential Crisis Program as an alternative to inpatient hospitalization. However, a participant is not eligible if the individual requires immediate involuntary inpatient psychiatric admission, has a sole diagnosis of substance use, mental retardation or dementia, or is not medically stable.
Service Rules

In general, the only mental health professionals who may bill separately are psychiatrists. However, OMHCs may also obtain pre-authorized service units to continue to follow a participant in a crisis bed. Services by other professionals are included in the Residential Crisis rate and will not be authorized or reimbursed separately.

Residential crisis services are intended to be used on a short-term basis to treat mental health conditions and not to be used solely to meet an individual’s housing needs. Lack of housing is not a reason for using a crisis bed.

A participant may need additional clinical services (i.e., a Partial Hospitalization Program or an on-site Psychiatric Rehabilitation Program) while in either model of Residential Crisis Services. These additional services are authorized separately by ValueOptions® Maryland, and must meet medical necessity criteria. Enhanced support is authorized only in rare circumstances when extreme clinical need exists.

ValueOptions® Maryland will authorize the first 10 days of Residential Crisis Services. After the first 10 days, authorization requests for additional days in a Residential Crisis Program will be reviewed by the CSA in the jurisdiction in which the participant resides. Services provided by psychiatrists or an OMHC are billed separately and are not part of the Residential Crisis rate.
The PBHS will not pay for Residential Crisis Services for individuals with private insurance. The provider is to contact the private insurer directly to seek reimbursement.

**Service Eligibility**

Participants with Medical Assistance, PBHS-eligible Medicare recipients, and Uninsured Eligible participants are eligible for Residential Crisis Services.

**Service Providers**

Residential Crisis Services may only be performed by approved Residential Crisis programs, according to Maryland Law (COMAR 10.21.26).

**Authorization Process**

Before starting the RCS program, if the participant has not been evaluated face-to-face by a physician, then a licensed mental health professional, in collaboration with the participant, needs to conduct an assessment. The assessment should include why the participant needs RCS, documents the diagnosis, if one was provided by the referral source, and, if applicable, any medications that are prescribed for the participant. Within the first 48-hours of the admission, a physician needs to conduct a face-to-face evaluation of the participant.

To obtain initial authorization for Residential Crisis Services, the provider must
submit a pre-authorization request through ProviderConnect, or the authorization request may be called in to the Engagement Center, within 48-hours of the admission. If the medical necessity criteria are met, Residential Crisis Services will be authorized. The initial 10-days of Residential Crisis will be authorized by ValueOptions® Maryland.

Providers obtain additional authorizations, beyond the time span of the initial pre-authorization request, by submitting a Continuing Review Authorization Request through ProviderConnect for CSA review. Continuing Review Authorization Requests are not to be called in to the Engagement Center or the CSA, but submitted via ProviderConnect. The provider must submit the Continuing Review Authorization Request prior to the expiration of the previous authorization time span.

**Claims Process**

Providers must use CMS 1500 forms to submit claims. One unit is billed per day. Claims must specify ICD-9 codes (not DSM 5) for reimbursement.

**Claims for unauthorized services will be denied.**

**Problems and Solutions**

If the request for services does not meet Medical Necessity Criteria and ValueOptions® Maryland or the CSA do not authorize the service, the provider should refer to Chapter 10, Grievances and Appeals.
If the participant has insurance other than Medical Assistance, the provider is expected to bill the primary carrier for Residential Crisis Service and go through all appeals processes with the primary carrier prior to submission to ValueOptions® Maryland.
6.11 Mental Health – Occupational Therapy Services

Service Coverage

Occupational Therapy involves a performance-based assessment and services relating to participant functioning in activities of daily living, cognitive skills, sensory-motor skills, and psycho-social skills. The goal of Occupational Therapy is to maximize the participant's functional independence.

Service Rules

Occupational Therapy can be performed on an inpatient or outpatient basis. It is considered a rehabilitation-oriented service and provided on a short-term basis.

Occupational Therapy is authorized in 15-minute segments.

Reassessments to determine the continuing course of rehabilitation are allowed only for outpatient Occupational Therapy and must be preauthorized by ValueOptions® Maryland.

Occupational Therapy performed in an inpatient unit, a hospital-based partial hospitalization program (PHP), or a hospital-based outpatient program does not
require preauthorization. Occupational Therapy performed in other non-hospital-based settings (e.g., PRP, OMHC) must be preauthorized by ValueOptions® Maryland.

**Service Eligibility**

To see which of the current funds are eligible for Occupational Therapy, please refer to the ValueOptions® Maryland Service Class Grid at:

http://maryland.valueoptions.com/provider/clin_ut/Maryland_Service_Grid.pdf

**Service Providers**

Occupational Therapists licensed by the Maryland Board of Occupational Therapy who have an active Maryland Medicaid provider number and a signed provider agreement with DHMH.

**Authorization Process**

Occupational Therapy performed in an inpatient unit by a hospital-based partial hospitalization program or a hospital-based outpatient program does not require pre-authorization.

To obtain initial an authorization for Occupational Therapy to be performed in a non-hospital based outpatient or PHP setting, the provider must submit a pre-authorization request through ValueOptions® ProviderConnect. As long as the care is medically necessary, Occupational Therapy will be authorized by ValueOptions® Maryland.
Providers obtain authorizations for continued services through the same process of submitting the request through ProviderConnect, prior to the expiration date of the previous authorization time span.

If a ValueOptions® Maryland Care Manager is unable to authorize the service as medically necessary, the request for authorization will be denied. The provider is referred to Chapter 10, Grievance and Appeals, for information on the appeal process.

**Claims Process**

Claims for Occupational Therapy Services must be submitted on a CMS 1500 form. The number of units must be equal to the number of 15 minute increments, (e.g. 45 minutes = 3 units). The exception is CPT Code 97150, Therapeutic Procedures Group, which is billed per group attendee. Claims must specify ICD-9 codes, not DSM 5 codes.

Occupational Therapy Services are not included in the daily rate for private psychiatric hospitals (Institutes of Mental Disease [IMDs]). Consequently, Occupational Therapy Services provided in private psychiatric hospitals must be invoiced by a professional or professional group on a CMS 1500 form.

**Claims for unauthorized services in non-hospital-based settings will be denied.**
CHAPTER 6

6.12 Mental Health – Psychiatric Rehabilitation Program Services (PRP)

Service Coverage

Psychiatric Rehabilitation Program (PRP) services are provided by a program approved under Maryland Law (COMAR 10.21.21). PRP services provide rehabilitation and support to participants to develop and enhance their community and independent living skills, thus enabling/facilitating their recovery or preventing relapse or hospitalization. Services may be provided at a PRP facility (on-site) or at a residence, job, or another appropriate location in the community (off-site).

PRP programs provide a structured environment where rehabilitation activities and services are provided in predominantly group settings. The array of PRP services is the same whether the services are delivered in the community, at a participant’s home, or in a PRP facility.

The expectation of PRP service is to assist the participant to develop the necessary skills to support the participant’s living in the setting of the participant’s choice and to promote community participation. The goal of the service is to use the community environment to teach and promote the development of community living skills.
The following are four (4) 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 (Transitional Age Youth/TAY); (c) Adults under legal guardianship.

2. **Supported/Independent Living PRP (authorized as PR2, billed as U3):** Services provided to adults living alone or with participants who are not legally responsible for their care.

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 (3) 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 RRP services with staff that is available on-call 24/7 and provides at a minimum, daily, on-site, in the residence with a minimum of 40 hours per week, up to 24-hours a day, 7-days a week.

There are also PRP services that can be authorized and provided in conjunction with Supported Employment services received by a participant.

Information specific to PRP services provided to participants living in a residential program will be discussed in section 6.14 of the Provider Manual (Residential Rehabilitation Services). Information regarding PRP services available to participants in Supported Employment Services is discussed in section 6.06 (Supported Employment).
Service Rules

PRP providers must complete an Individualized Rehabilitation Plan (IRP) according to the requirements of Maryland Law (COMAR 10.21.21).

The Core Service Agencies (CSAs) review and approve applications for the PRP services associated with General and Intensive levels of RRP services. The CSAs manage any waiting list in their jurisdiction for Intensive and General levels of RRP services. The CSAs also manage Transitional PRP services for participants stepping down from State Hospitals or Crisis Beds to a RRP level of care.

ValueOptions® Maryland makes the medical necessity determinations for all levels of PRP and RRP services, except those of Transitional PRP. ValueOptions® Maryland makes all initial determinations on the level of the service and whether the service will be on-site, off-site, or blended.

A unit of PRP services is one month.

PRP service providers are required to meet the individual needs of the participant as stipulated in the Individual Rehabilitation Plan (IRP). Each level of PRP service stipulates a minimum number of face-to-face services to be provided. However, 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 minutes/service and visits/month for a maximum of 30 visits/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. Rules and rates for payment regarding submitting partial PRP claims are discussed in the DHMH memo, “PRP Cascade Rate Sheet” and dated July 3, 2013. This memo is available at: [http://maryland.valueoptions.com/provider/alerts/2013/070313PBHS PRP Cascade Update.pdf](http://maryland.valueoptions.com/provider/alerts/2013/070313PBHS PRP Cascade Update.pdf)

COMAR 10.21.52 describes the number of encounters requirements.

A provider may bill the blended rate for Supported Living or Community Services only if:

1. The participant is not receiving PRP services from another provider.
2. The provider is providing both on-site and off-site services in reasonably close proximity to the participant for whom the service is provided.
3. The program operates an on-site PRP facility. A PRP facility is owned or rented, open to the public, operated by the PRP, and is where PRP services (individual and group) are provided on a regular basis. All health and safety codes must be met and documentation provided to the Office of Health Care Quality.
4. The program receives authorization to provide both on-site and off-site services.

The provider who meets the above criteria may provide only on-site 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 on-site or off-site services. The provider must document in the medical record that the participant has the choice to receive both on-site and off-site PRP services, and elected to only
receive either on-site or off-site services. Requirements for billing the blended rate for PRP participants receiving residential services are listed in 6.14 (Residential Rehabilitation Services).

Behavioral Health Administration (BHA) requires all PRPs participating in the public mental health system to submit all encounter data, regardless of whether the number of encounters goes beyond the minimum required for reimbursement levels. For details, see:


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 one-site encounter and one off-site encounter submitted on any given day.

Off-site encounters must be a minimum of 15-minutes and On-site 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 on-site 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.

Only 1 off-site encounter shall be submitted each day. Only 1 on-site encounter shall be submitted each day.
The encounters for participants receiving the community level of care must occur on at least 2-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.

Attendance at an IEP meeting is not a PRP service or encounter.

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

BHA, as a rule, 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 on-site only PRP services for a participant who is receiving MA-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-sit PRP services may not be delivered at the Medical Day Care program.

Participants receiving PRP services are expected to receive from the PRP basic case management functions, such as assistance in securing entitlements, transportation to appointments, coordination of services, and liaison with external services (somatic and mental health) within the provision of PRP services. Therefore, requests for targeted case management for participants enrolled in PRPs will be approved only in very special circumstances.

On-site services provided by two different PRP programs, as well as off-site services provided by two different PRP programs, is generally considered 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 preauthorized by the CSAs 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 on-site 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, the PRP staff take the group to the supermarket for supplies and then return to
the PRP facility. This is an on-site 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 6 months. These referrals and coordination of care activities
must be reflected in the IRP. For details, see:
http://maryland.valueoptions.com/provider/alerts/2012/042512-
PRP_Care_Coordination.pdf.

Additional Requirements for Providers Who Serve Child and Adolescent
Participants

PRP services for children and adolescents must be contained in the participant’s
treatment plan and focus on age-appropriate self-care and social skills. The primary
clinician should identify areas of conflict or deficit in the child or adolescent’s life in
which the acquisition of daily living skills can reasonably be expected to produce
improvement in their overall functioning and adjustment.

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 stresses evolving from their environment at home or in school.
Children and adolescents placed in a crisis bed program may attend a partial hospitalization or psychiatric rehabilitation program during the day, depending upon the clinical needs of the participant. Services are authorized separately based on the participant’s needs and medical necessity.

Off-site PRP services delivered in a child or adolescent’s home shall remain focused on the child or adolescent participant’s rehabilitative skills development; assisting the participant and his/her family to identify appropriate activities to reach and maintain identified goals.

PRP services are not to be utilized for family therapy.

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment providers.

**Service Eligibility**

Those who are eligible for PRP services are those participants with Federally Funded Medicaid and Dual Eligible Medicare and Medicaid participants. State Funded Medicaid and the Uninsured Eligible participants are eligible for PRP services when they meet the medical necessity criteria and have been discharged from:
1. A State Hospital*
2. An acute care hospital or IMD
3. An RRP bed
4. Jail or incarceration*  
   *On conditional release in last 90-days
For details, see:

1. The ValueOptions® Maryland Service Class Grid:
   
   http://maryland.valueoptions.com/provider/clin_ut/Maryland_Service_Grid.pdf

2. BHA Memo on State only funded PRP:
   

**Service Providers**

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

**Claims**

On a CMS 1500 form, through EDI – 37I or entered directly into the ValueOptions® system through the direct claim submission process the billing/payment code for either PRP or RRP services is always H2018. What is important is the correct choice for your modifiers. Please use this guide to correctly enter the modifiers. This information can also be found on the website:


The modifiers are:

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 An RRP client in the general level of care who is either on or offsite
U5 An RRP client in the intensive level of care who is either on or offsite
U6 An RRP client in the general level of care who receives services from a provider who has the capacity to render services in on and offsite capacity
U7 An RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in an on or offsite capacity

It is imperative that providers choose the correct modifiers when submitting the requests for authorization. Please use the above table if you have questions.

The governing rules for submitting the H2018 – the case rate for PRP are:

H2018 is the code for billing the PRP monthly case rate

• H2018 must be billed with the appropriate modifier and place of service
  ○ Please refer to the PRP cascade for descriptions:
• 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 is billed. 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)

It is required that the minimum number of encounters be rendered prior to submitting the H2018 claim.

Each PRP/RRP service requires the provider to see the participant in one of the three setting 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 – 37I or entered directly into the ValueOptions® 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 DHMH Memorandum, it is essential and required that providers submit all, not just the minimum number of encounters. This is posted on our website. For your convenience you may use the attached link to access this memorandum. http://maryland.valueoptions.com/provider/alerts/2012/021012-PRP_Enounter_Submission_and_Reimbursement.pdf

Claims for unauthorized services will be denied.
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, e.g. encounters for January 2014 must be submitted by February 28, 2014. Encounters are to be billed with no modifier; however, you must indicate where the service was rendered. If the service was rendered onsite, the place of service (POS) is 52. If the service was rendered offsite the POS is 15. These are the only two acceptable POS codes that can be used when submitting your encounters.

The governing rules for submitting the H2016 – the encounter data for PRP are H2016, The code for reporting the number of encounters provided per participant/per month:

• Do not submit a modifier with this 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 2014 must be submitted by April 30, 2014.

• Please 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 on-site, 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.
The link for the Provider Alert that contains this information is:
http://maryland.valueoptions.com/provider/alerts/2010/122710-
PRP_Billing_Encounter_Submission-Corrected.pdf.

Please continue to monitor Provider Alerts for the most up to date information related
to PRP and the acceptable billing practices.
6.13 Mental Health – Residential Rehabilitation Services (RRP)

Service Coverage

Residential Rehabilitation Services (RRP) services are provided by a program approved under Maryland Law (COMAR 10.21.22) and provide residential support and rehabilitation for participants who have severe and persistent mental illness (SPMI). Such participants are supported with off-site Psychiatric Rehabilitation Program services that are provided in the RRP residence at either a general or intensive level of support. General support means staff is available, on-call, 24-hours per day, 7-days per week, and provide a minimum of 13 face-to-face encounters for the off-site rate, and 17 face-to-face encounters for the blended rate per participant per month. Intensive support means that staff provide daily off-site services in the residence for a minimum of 40 hours per week, up to 24 hours per day, 7-days per week, with a minimum of 19 face-to-face encounters for the offsite rate, and 23 face-to-face encounters for the blended rate per participant per month. RRP services are provided on-call availability of treatment providers to participants’ 24-hours per day.

RRP is a resource for participants who require extensive support in a structured living environment. It is not a program for those participants who are able to live in housing of their choice with flexible supports. It is also not intended for participants who are simply
homeless or have nowhere else to live.

Service Rules

Expansion of RRP services depends on availability of state general funds. Expansion of RRP services and an increase in level of support requires approval in advance from the Core Service Agency (CSA) in the county where the participant resides.

All service rules that apply to PRP services also apply to RRP services provided to participants living in residential services.

Within the first 30 days of starting RRP services, RRP staff, in collaboration with the participant, need to complete an assessment that includes the need for services, any behaviors that are potentially dangerous to self or others, and the ability to perform basic self-care and to maintain personal safety.

An Individual Rehabilitation plan (IRP) should also be completed within the first 30-days of the start of RRP services. RRP staff should specify the goals of RRP, the frequency of residential services and the intensity of staff support. If the participant's service needs change, the RRP staff need to provide and document in the participant’s record the services required by the change, notify relevant staff of the change initiated, and incorporate this information in the next IRP review.

IRPs should take place at least every 6 months, but as frequently as is needed. The IRP should incorporate the participant's progress toward the accomplishment of previously identified rehabilitation goals, any goal changes, and changes in interventions. Staff should communicate the results of the IRP review to relevant program staff, and, with proper
consent, family or significant others designated by the participant, and any other providers
rendering services to the participant.

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

Providers are required to develop discharge plans for participants. Discharge of
participants from RRPs, who are dropped off at emergency rooms while hospitalized, is
not acceptable. Providers shall instead complete the following procedures: The program
director shall collaborate with the Administration's administrative services organization
(ASO) to arrange for discharge from the program when services are no longer
authorized by the Administration's ASO, or to discontinue residential services to an
participant whose clinical needs exceed the RRP's ability to secure the safety and welfare
of the participant or others. The program director shall maintain clearly written policies
and procedures for the process for discharge from the program, the process for the
temporary suspension from a residence, and the process to discontinue residential
services to an participant whose clinical needs exceed the RRP's ability to secure the
safety and welfare of the participant or others, including the criteria for discontinuation,
and the progressive steps and interventions that the program will enact before
discontinuation.

Enhanced Support is available in certain situations (see Section 6.08) and is authorized by
the CSA via electronic submission via ProviderConnect.
The participant must need, and be willing to participate in, off-site PRP services provided in the RRP residence. Attendance at an onsite PRP program is not a requirement for the participant to receive RRP services.

The PBHS will reimburse for up to 30-days of transition visits, which includes the RRP bed rate and the PRP rate while the participant is in a state psychiatric hospital or a crisis bed. These visits must be preauthorized by the CSA and are paid by state general funds. Additional visits may be authorized by the CSA based on the need of the participant, including participants hospitalized on court order, upon a court finding of “not criminally responsible,” who require extended transition pending court approval of conditional release.

The level of support (general or intensive) needed by the participant is determined by a review of the clinical information submitted by the provider and reviewed and approved or denied by ValueOptions®. The information submitted must meet medical necessity criteria. Additionally, changing the level of support from general to intensive, or vice versa, is based upon a determination of medical necessity and authorization from ValueOptions®.

RRPs are required to have the capacity to provide services based on the participant’s needs. An RRP bed may be held for a maximum of 30 days when a participant is hospitalized and returns to the RRP.

The bed rate may be billed for the time the bed is held. ValueOptions®’ authorization is contingent upon the RRP’s agreement to accept the participant back when the clinical issues or behaviors that precipitated the hospitalization are resolved.
The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment providers (i.e. substance use treatment) when clinically appropriate.

Service Eligibility

Participants with MA, PBHS-eligible Medicare recipients, and Uninsured Eligible participants are eligible for RRP and PRP services as per Chapter 3.

Service Providers

Service providers are RRP s approved by the Department under Maryland Law (COMAR 10.21.22).

Combination of Services

Participants in RRP s are expected to receive basic case management from the RRP. Therefore, participants in RRP will not be authorized for case management services as a separate authorization. RRP staff are also expected to facilitate participants receiving outpatient treatment, so participants in RRP s are not eligible for simultaneous mobile treatment services. Some clinical exceptions may apply. Participants may attend an on-site day program PRP with a provider which is different than where the participant receives the off-site residential services.

Authorization Process
Referral Procedures for Residential Rehabilitation Programs (RRP)

All referrals for RRP must be sent to the CSA of the applicant’s county of origin using ProviderConnect.

The CSA screens referrals for RRP and also determines if other services are needed to support the participant. When other services are needed, the CSA directs the referral source or the applicant to ValueOptions® Maryland. ValueOptions® Maryland may refer and authorize an array of support services. These services may negate the need for RRP or may sustain the applicant until RRP services are available.

The CSA reviews the application within five working days, and if appropriate, refers the applicant to an RRP that has an available bed. After the CSA authorizes an assessment for the RRP, the RRP has 10 working days to evaluate, accept, or deny the applicant.

After the RRP has evaluated and accepted the participant, the RRP electronically submits a ProviderConnect pre-authorization request for the required general or intensive PRP services and RRP bed days for review by ValueOptions®. ValueOptions® reviews the pre-authorization request and approves the Residential PRP services if medically necessary.

For participants in need of RRP who are unable to access the service due to lack of beds, the CSA maintains a waiting list. The CSA reviews and updates the waiting list monthly, checking to see if the participant has been linked to other PBHS services to support the participant, and if RRP is still needed. At all times, the CSA decision is based on the need of the participant. Each CSA has a written policy, approved by BHA that addresses
waiting lists, including prioritizing for state hospital referrals, community referrals, and other services.

The CSA may refer the participant to an out-of-county RRP only for the following reasons:

1. Participant Preference
   A. The participant requests to live in a particular jurisdiction.
   B. The participant’s family has relocated to another county and the participant wishes to be near their family.

2. Provider Capacity: the current RRP agencies in the CSA jurisdiction are at capacity and are not in a position to expand services.

3. Provider Capability: the current RRP agencies in the CSA jurisdiction lack special programming to meet the needs of particular participants referred (for example, deaf, mentally ill substance users).

When the participant meets out-of-county criteria, the participant’s CSA of residence and the CSA of the participant have preferred jurisdiction should act on the request within five days of the request.

To obtain authorization for transitional visits, also known as trial visits, the provider must submit a pre-authorization request through ProviderConnect routed to the CSA queue. The CSA will review and authorize as appropriate.

To obtain initial authorization for Psychiatric Rehabilitation Services and Residential
Rehabilitation Services, the provider must submit a pre-authorization request through ProviderConnect. ValueOptions® collaborates with the CSAs to ensure the CSA is aware of the placement and approves of the requested level of service. Requests submitted in ProviderConnect must be routed to the CSA queue, and will be re-routed to ValueOptions® for medical necessity review. If the level of care is medically necessary, Residential Rehabilitation Services will be authorized.

Providers obtain additional authorizations through the submission of a Continuing Review Authorization Request via ProviderConnect routed to the CSA queue, which will be re-routed to ValueOptions®. The provider must submit a Continuing Review Authorization Request prior to the expiration of the previous authorization time span.

Changes in level of care must be requested via ProviderConnect for medical necessity review. Changes in place of service, i.e. change from blended service to off-site only, do not require a medical necessity review. This type of request can be submitted via ProviderConnect, or called in to the Engagement Center for a change to the authorization’s place of service.

**Appeals Process**

If the services requested do not meet medical necessity criteria and care is not-authorized, please refer to Chapter 10, Grievances, Appeals, and Complaints.

**Claims Process**

One transaction line for each date of service is required. Date spans are not acceptable.
For dually eligible (Medicare/Medicaid) participants, claims may be submitted directly to ValueOptions® Maryland. It is not necessary to bill Medicare.

Only one monthly fee is reimbursable. Providers should bill with the date of the service that met the minimum number of encounters.

Encounters must be submitted as claims, although these claims will not be paid. Claims are submitted on a C1500 form (see Chapter 17).

Claims for unauthorized services will be denied.

If the services requested do not meet Medical Necessity Criteria and care is non-authorized, please refer to Chapter 10, Grievances and Appeals.
6.14 Mental Health – Interdisciplinary Team Treatment Planning Service

Service Coverage

Interdisciplinary Team Treatment Planning meetings are collaborative, face-to-face treatment planning meetings. Based on the initial assessment, the treatment coordinator and the participant, and, if the participant is a minor, the minor’s parent, guardian, or primary caretaker, will develop a treatment plan in collaboration with family or others designated by the participant (with proper consent), and others involved in the participant’s care and other OMHC staff, as appropriate.

The participant is actively engaged in this process and must sign agreement with the plan. If the participant is unwilling to sign agreement with the plan, the participant’s treatment coordinator will verify the participant’s verbal agreement with the plan and document the rationale for the participant’s refusal to sign. If the participant is a minor, the minor’s parent or guardian, or the minor’s primary caretaker, must sign agreement with the plan. With proper consent, family or others designated by the participant, including the participant’s caregivers, may sign the plan. The plan should include the participant’s diagnosis, presenting needs, strengths, recovery and treatment expectations and responsibilities. Also
included should be descriptions of needed and desired treatment and interventions to be provided, as well a description of how the needed and desired treatment will help the participant manage the participant’s psychiatric disorder and to support recovery. Both short-term and long-term treatment goals should be documented, in measurable terms, and with target dates for each goal documented as well.

At least two licensed mental health professionals who collaborate about the participant’s treatment must sign the plan. If the participant is receiving medication management prescribed through the OMHC, whoever prescribes the medication, the OMHC psychiatrist or Certified Psychiatric Nurse Practitioner in psychiatry, must sign the plan.

**Service Rules**

A participant may receive up to two Interdisciplinary Team Treatment Planning meetings per calendar year. Meetings may only be billed only once every 120-days. This service is available for OMHCs only.

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment (e.g., substance use treatment) providers when clinically appropriate.

Participants with Medical Assistance and Uninsured Eligible participants are eligible for Interdisciplinary Team Treatment Planning services.

**Service Providers**
Interdisciplinary Team Treatment Planning meetings are provided by OMHCs approved under COMAR 10.21.20.

Authorization Process

Authorization for this service is **not** required. The provider may bill for one Interdisciplinary Team Treatment Planning meeting every 120-days per participant, but no more than two per calendar year. In order to submit a claim for this service, the participant must be present and seen face-to-face.

Claims Process

Claims are submitted on CMS 1500 forms (See Chapter 17). Dually eligible (Medicare/Medicaid) participants should submit claims directly to ValueOptions® Maryland. It is not necessary to submit these claims to Medicare. Each unit should correspond to the date of service. Only one code (H0032) may be billed per 120 day period, and no more than two per calendar year. Claims must specify ICD-9 code (not DSM 5 code) for reimbursement.
6.15 Mental Health – Case Management Services

Service Coverage

When a participant has a mental disorder that requires professional evaluation and treatment, he/she should be treated at the least intensive setting able to meet the participant’s overall needs. Targeted Case Management (TCM) programs are available to assist participants with gaining access to the full range of available mental health services, as well as to any needed medical, social, financial, counseling, educational, housing, and other supportive services needed in order to maintain stability in the community.

TCM is available to adults, as well as children and adolescents. Each population must meet the State of Maryland’s medical necessity criteria for TCM services (see chapter 7.20 and 7.21). Adult TCM services offer two levels of service intensity, depending on the needs of the participant. TCM providers will need to clearly articulate the requested intensity of services, and rationale, when entering authorization requests in ProviderConnect. Children and Adolescent TCM (also known as Care Coordination Services) providers have three levels of intensity to select, depending on the needs of the participant. Child and Adolescent TCM providers will also need to clearly articulate the requested intensity, and rationale, when entering authorization requests in ProviderConnect.
Service Rules

The TCM service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment (i.e. substance use treatment, therapist, psychiatrist, etc.) providers when clinically appropriate.

- Adult Level I (or Adult General) TCM has a maximum of 2 units of service per month. Level I TCM services are based on the severity of the participant's mental illness. (See Provider Manual, chapter 7, section 21)

- Adult Level II (or Adult Intensive) TCM has a maximum of 5 units of service per month. Level II TCM services are based on the severity of the participant's mental illness. (See chapter 7 section 21)

- One “unit” of TCM service for an adult is any service provided, on any given date of service, where the contact is a minimum of 1 hour of either face-to-face contact with the participant or contacts with stakeholders and service providers on behalf of the participant.

- Child and Adolescent, Level I (or General) TCM has maximum of 12 units of service per month. A minimum of two units of face-to-face contacts with the participant are required. Level I TCM services are based on the severity of the participant's mental illness. (See Provider Manual Chapter 7, section 20)

- Child and Adolescent Level II (or Moderate) TCM services have a maximum of 30 units per month and a minimum of four units of face-to-face contact with the participant. Level I TCM services are based on the severity of the participant's mental illness. (See Provider Manual Chapter 7, section 20).

- Child and Adolescent Level III (or Intensive) TCM services have a maximum of 60 units per month. A minimum of six units of face-to-face contact with the participant are required.
• One “unit” of service for a Child or Adolescent TCM is any service provided, on any given date of service, where the contact is a minimum of 15 minutes of face-to-face contact with the participant, the minor’s parent/guardian, or contacts with stakeholders and service providers on behalf of the participant.

• For Child and Adolescent, Level I and Level II TCM services, four additional units of service above and beyond the monthly maximum may be billed during the first month of service to the participant and every six months thereafter to allow for comprehensive assessment and reassessment of the participant.

• A unit of service for telephonic contact for a Child and Adolescent TCM participant may not be reimbursed unless the provider has delivered at least eight minutes of service.

**Service Eligibility**

Participants with Medicaid (MA) and participants who are dually eligible Medicare/Medicaid recipients are eligible for TCM. The PBHS reimburses TCM services rendered to Uninsured Eligible participants through the assistance/oversight of the participant’s local Core Service Agency (CSA).

**Service Providers**

Case Management Services (TCM), may only be provided and reimbursed by programs approved under Maryland Law (COMAR 10.09.36.03, 10.09.45.04, 10.21.19, 10.21.20, 10.21.21, or 10.21.29).
**Authorization Process**

To obtain initial authorization for TCM services, the provider must submit a preauthorization request through ProviderConnect (see ProviderConnect User Manual for directions on completing an authorization request). If the level of care is medically necessary, TCM services will be authorized for up to 6 months at a time, and at the level of intensity that the participant’s presentation requires. Providers obtain continued stay authorizations through the submission of a concurrent review requests in ProviderConnect (see ProviderConnect User Manual for directions on completing an authorization request). The request must be submitted prior to the expiration of the previous authorization time span.

If a ValueOptions® Maryland Care Manager is unable to authorize the service as medically necessary, the request for services will be referred to a ValueOptions® Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect downloads to the provider. If the services requested do not meet Medical Necessity Criteria and are non-authorized, refer to Chapter 10, Grievances and Appeals for further information.

**Claims Process**

Providers should not submit claims unless the service has been authorized by ValueOptions® Maryland.

- Claims should be submitted on a CMS 1500 form.
- Case Management Assessment (CPT Code H0031) does not require preauthorization.
• Adult TCM is billed as a per day rate (CPT code T1016)
• Child & Adolescent TCM is billed per unit (CPT code T1017).
• Claims must specify ICD-9 codes, not DSM 5 codes.

Claims for unauthorized services will be denied.
6.16 Mental Health – Outpatient Mental Health Services (OMHCs, FQHCs, Hospital Based Clinics, Individual Practitioners, and Private Group Practices)

Service Coverage

Outpatient Mental Health Services such as assessment and evaluation, and individual, group and family therapies are provided by Outpatient Mental Health Centers (OMHCs) regulated under Code of Maryland Regulations (COMAR 10.21.20), and by individual mental health professionals authorized and/or licensed by the appropriate practice boards. OMHCs shall provide services that are age- and culturally-appropriate, coordinated with other components of the delivery system, and focused on recovery and resiliency. OMHCs shall ensure that services are accessible and available at least 40-hours per week, during some weekend and evening hours, and provide emergency coverage, 24-hours per day, 7-days per a week, as regulated under Maryland Law (COMAR 10.21.20). The OMHC must prominently display the hours of operation of the facility or office.

Service Rules

Initial Evaluation/Diagnostic Interview (CPT Code 90791/90792)

The initial evaluation/diagnostic interview session is expected to include face-to-face participant contact, and encompass activities critical to the evaluation process,
such as communicating with the participant and the primary care physician, and ordering laboratory tests when clinically appropriate. By the participant’s second visit, and based on the initial face-to-face diagnostic evaluation, a licensed mental health professional shall formulate and document in the participant’s record, a description of the presenting problem, relevant history, a mental status exam, and a diagnosis and rationale. If this cannot be done, there is documentation of the reason for not formulating a diagnosis, and the plan, including time frame, for formulating a diagnosis. The face-to-face diagnostic assessment should also include a screening assessment to determine if the participant has a co-occurring substance-related disorder.

Only one initial evaluation/diagnostic interview (90791/90792) may be rendered as part of the initial 12, non-OMS services. A maximum of two diagnostic interviews may be rendered as part of the 75-unit bundle of services for OMS participants. An additional 90791/90792 may be requested and approved if the additional 90791/90792 is to be provided by a different rendering provider. The different rendering provider may be part of the same OMHC or practice group, or independent of the OMHC or practice group. The primary consideration is that one of the providers is a physician and the other is a non-physician.

No later than the 5th visit, an Individual Treatment Plan shall be completed with the treatment coordinator and the participant, or, if the participant is a minor, the participant’s parent/guardian.

The PBHS will not reimburse, as the primary payer, for services covered by Medicare for Medicare recipients served by Outpatient Mental Health Clinics (OMHC) or individual practitioners. The PBHS will only reimburse services delivered to
participants who are dually eligible (Medicaid and Medicare) when the service is provided by an independently Licensed Clinical Professional Counselor who is not part of an OMHC after the Licensed Clinical Professional Counselor has explored all other billing options, such as billing according to the Medicare “incident to” provisions, and when the jurisdiction has limited access to other types of mental health professionals.

Eye movement integration therapy (EMI) and eye movement desensitization and reprocessing (EMDR) are not services reimbursed by the PBHS.

All PBHS services require preauthorization except emergency services and some initial psychiatric consults on a medical floor. Please refer to March 2, 2009 memorandum. No exceptions will be granted.

For OMHCs, a diagnosis (not diagnostic impression) needs to be rendered by the participant's second visit by a licensed mental health professional following a face-to-face evaluation (COMAR 10.21.20.06A). Refer to Maryland Health Occupations that govern scope of health care practice. The Social Work licensing regulations stipulate that an LGSW can only provide diagnostic impressions; they cannot render a diagnosis. Refer to Annotated Code of Maryland-Health Occupations Article, Title 19 -19-307(c) (2).

Reasons to request additional 90791s/90792s within the same year of treatment include:

- A significant change in the participant’s condition. Reasonable clinical judgment will be applied by the ASO to determine whether the service is medically necessary.
The participant is admitted to a crisis bed.
The participant selects a different provider.
Prior to psychological testing performed by a psychologist.

Combination of Services

For a description of services which may be reimbursed on the same day, please see COMAR 10.21.25.

A physician who combines a medication management session within a session that also includes individual therapy must use a code which combines both services such as 90792.

Family therapy may be billed for only one member of a family at a time (i.e., CPT codes 90846 or 90847). For example, if two children in a family have mental health diagnoses and are identified participants, authorization and reimbursement will be made for only one child per each family therapy session.

For transition purposes, a participant may be authorized for traditional outpatient services in conjunction with mobile treatment. This overlap of services should not exceed one month.

If more than one outpatient provider is requesting authorization for the same participant, both should document that they are aware of, and coordinating care with the other provider. If the services both providers are requesting are the same (i.e. both providing individual therapy), only one provider will be allowed an authorization.
unless there are clinically extenuating circumstances. If both of the providers are OMS providers, the second provider will need to choose to submit their request through the Non-OMS or Medication Management workflows to secure their authorization. The ValueOptions® system will allow you to enter one authorization as OMS, one authorization as non-OMS and one authorization for medication management electronically. If the participant has a need for anything in excess of the three authorizations, the request must be called in through Customer Service for review telephonically.

Family Psychoeducation (FPE) is a reimbursable service under the Public Behavioral Health System only if the agency/provider is an approved Outpatient Mental Health Center and approved by BHA as an approved Evidence Based Practice (EBP) program. FPE is targeted to participants with serious mental illness and their families or significant others. It is a multi–family group that provides education and support. FPE is not age-restricted and is available to both Medicaid participants and Uninsured Eligible participants. The groups meet bi-weekly and may extend for up to two years. These services are outside of the Non-OMS and OMS bundles. They need to be requested using the “TCN” service class, the same way crisis and extended therapy codes are requested.

**Place of Service**

OMHCs, individual practitioners and those in private group practice may provide services in any location except a hospital medical unit, a nursing home, an adult medical daycare center, and emergency rooms (if included in the hospital rate). However, the fee remains the same as on-site service rates.
Mental health treatment services delivered by a mental health provider or OMHC under the PBHS are not reimbursed when provided in adult medical day care centers.

Services provided to a nursing home participant who has been transported to a provider’s office will not be reimbursable under the PBHS, unless the service is approved by the ASO as a diversion from inpatient services.

General mental health services within nursing homes are included as a part of the nursing home reimbursement rate. When authorized by the ASO, a psychiatrist may bill specialized mental health services to avoid an inpatient psychiatric admission (see Chapter 5, Section 22).

Service Eligibility

Services for participants with MA, certain dually eligible Medicare recipients and Uninsured Eligible participants are eligible for reimbursement from the PBHS.

Service Providers

Outpatient Mental Health Services are provided by OMHCs and individual practitioners rendering services through individual or group practices. Individual practitioners, licensed under Health Occupations in the state of Maryland, include physicians, psychologists, social workers, advanced practice nurses, and Licensed Clinical Professional Counselors. All providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with the DHMH.
Individual Practitioners, Group Practices

Outpatient Mental Health Services such as assessment and evaluation, and individual, group and family therapies are provided by individual mental health professionals authorized and licensed by the appropriate practice boards to practice independently.

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.

Authorization Process

Outcomes Measurement System (OMS)

Participants ages 6 to 64, who are treated in an OMHC, FQHC, or Hospital-based clinic, will receive authorizations for outpatient services through the Outcomes Measurement System. The participant will initially receive an authorization for two services. Prior to the 3rd service, and every six months thereafter, the provider must complete an OMS interview questionnaire with the participant in order to obtain authorizations. Authorizations will be granted in a service bundle that includes 75 units of service for six months. For services included in the OMS service bundle, refer to the Service Matrix. To obtain initial authorization, the
provider submits a request for authorization via ProviderConnect. The initial requested start date can be backdated up to 29-days. For continued stay authorization requests, the end date of the previous authorization will be changed to end one day before the start date of the new authorization. There is a 100-day grace period for the concurrent review to be submitted via ProviderConnect.

For services outside of the OMS service bundle, a separate authorization request must be submitted.

Only providers rendering services in an OMHC or HSCRC regulated outpatient service may be reimbursed for prolonged services. Prolonged services require a separate authorization request. Prolonged services are authorized for situations of imminent danger where additional time is needed to assess for and address safety concerns. If a participant has a psychiatric crisis which requires the provider to see the participant not at the regularly scheduled appointment, and the provider spends more than 60-minutes with the participant, providers may submit an authorization request for the prolonged service and submit a claim. For time between 60-74 minutes, CPT code 90839 should be requested. For an additional increment of 30-minutes (beyond the 74-minutes) required to manage the participant’s crisis, another unit of CPT code 90840 should be included in the authorization request for the prolonged services. Time spent beyond 104-minutes will be not be authorized or reimbursed. A provider may submit an authorization request for the prolonged services within two working days of the prolonged service. The authorization request can be submitted via ProviderConnect by selecting outpatient/extended therapy or called in to the Engagement Center. HSCRC Clinics should refer to the Service Matrix for appropriate corresponding revenue codes.
For complete information on OMS, refer to the OMS Chapter and OMS Appendix in this Provider Manual, as well as any updates that are posted on the ValueOptions® Maryland Web site.

Non-OMS authorizations (individual practitioners, group practices, and OMHCs)

All initial requests for authorization are auto-approved and can be backdated by the CareConnect system for up to 29-days after the initial date of service. After the initial 12-services are auto-authorized, continued outpatient services must also be authorized by submitting a concurrent review request. A new authorization is required when either the number of units is exhausted or the time span has expired. The start date for the new authorization will be the date the request is submitted or another, future date requested by the provider. Providers are required to submit updated clinical information to receive continued stay authorizations for up to 24-units of service, over the next 12-months.

Authorizations are given in service code blocks (see Service Matrix) for specific time frames. The services must be used within the given time frame and the number of sessions may not exceed the number of sessions authorized.

Authorizations can expire either when all authorized visits of a participant and provider have been used or when the authorized time frame for services has ended. To ensure reimbursement of services, if additional services are needed beyond the timeframe originally authorized by the ASO, the provider must submit an authorization request for continued services. This authorization request must be submitted prior to the expected date that all previously authorized services would
Outpatient services will only be authorized for registered PBHS participants who have a mental health diagnosis covered by the PBHS. If the participant does not have a mental health diagnosis covered under the PBHS, claims will be denied.

**Discharge**

The above-described process is continued for authorizations until the participant is no longer in treatment. Upon discharge, the provider must discharge the participant from their service by going to ProviderConnect and entering a discharge by searching for the participant authorization and choosing the discharge participant option.

**Claims Process**

A claim should NOT be submitted for services requiring registration or preauthorization unless there is an initial registration or a continuing authorization for the service. Claims should be submitted on a CMS 1500 form or a UB04 for hospital-based clinics (See Chapter 17). Date spans will not be accepted. Each date of service must be entered on a separate transaction line. Claims must specify an ICD 9 code, not a DSM 5 code.

**Claims for unauthorized services will be denied.**

Billing under a private practitioner’s or group practice’s license for services provided by individuals who do not have their own Medicaid provider number will not be reimbursed by the ASO.
Private practitioners of any discipline are not allowed to bill for services delivered by non-licensed/certified mental health professionals (e.g. students or interns). Only OMHCs, FQHCs and hospitals with formal training programs and supervision may receive reimbursement for other types of licensed/certified mental health professionals and professional students who are in a formal training program.

ECT services are authorized to the facility or physician performing the service. The anesthesiologist charges related to the ECT do not require a separate authorization, and may be billed using CPT code 00104.

The Mental Health Service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment (e.g., substance use treatment) providers when clinically appropriate.

If the services requested do not meet Medical Necessity Criteria and care is non-authorized, please refer to Chapter 10, Grievances and Appeals.

Amendments to COMAR 10.21.25 were adopted March 23, 2009. This includes rules for billing that apply to all PBHS providers. Regulations may be downloaded on www.dsd.state.md.us
6.17 Mental Health – Intensive Outpatient Services

Service Coverage

Intensive Outpatient Services (IOP), may only be provided and reimbursed by programs approved under Maryland Law (COMAR 10.21.20, COMAR 10.21.02). It is a short-term, intensive treatment intervention provided by a multidisciplinary team involving multiple treatment services across multiple days per week. An IOP program provides a minimum of three hours of psychiatric therapeutic activities per day, which includes at least two group therapies and needed psychiatric services (COMAR 10.21.25). The treatment constellation can include individual, group, family therapy and medication management.

Service Rules

IOP is an acute, short-term intervention for participants experiencing an exacerbation of psychiatric symptoms. The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment (i.e. substance use treatment) providers when clinically indicated and with appropriate releases of information.

When an OMHC provides IOP, physician services are included in the rate; when
delivered by a hospital-based program, physician services may be billed separately.

It is considered duplication to bill two IOP units for the same participant/same day (i.e. Substance Use IOP and Mental Health IOP).

Services for participants with co-occurring needs should be integrated and individualized to meet the needs of the participant. When the participant is receiving other IOP or Intensive Substance Use Services, this information is required to be provided to the ASO at the time of the authorization request.

The PBHS does not reimburse for non-mental health services such as 12 step programs.

**Service Eligibility**

Participants with Medicaid (MA) and participants who are dually eligible Medicare/Medicaid recipients are eligible for IOP. The PBHS does not reimburse IOP services rendered to Uninsured Eligible participants.

**Service Providers**

Partial Hospitalization Programs (PHP) approved under COMAR 10.21.02 and Outpatient Mental Health Centers (OMHC) approved under COMAR 10.21.20 may provide IOP services.

**Authorization Process**
To obtain initial authorization for IOP services, the provider must submit a preauthorization request through ProviderConnect. If the level of care is medically necessary, IOP services will be authorized. Providers obtain additional authorizations through the submission of a continuing review authorization request in ProviderConnect. See the ProviderConnect User Manual for directions on completing an authorization request. The request must be submitted prior to the expiration of the previous authorization time span.

If a ValueOptions® Maryland Care Manager is unable to authorize the service as medically necessary, the request for services will be referred to a ValueOptions® Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect downloads to the provider. If the services requested do not meet Medical Necessity Criteria and are non-authorized, refer to Chapter 10, Grievances and Appeals for further information.

Providers are expected to initiate discharge planning at the beginning of service delivery. Providers are also required to submit the discharge plan in the ProviderConnect authorization request.

**Claims Process**

Providers should not submit claims unless the service has been authorized by ValueOptions® Maryland.

- Claims should be submitted on a CMS 1500 form.
- Each date of service must be submitted on a separate transaction line.
- One day equals one unit; date spans will not be accepted.
• Claims must specify ICD 9 codes, not DSM 5 codes.

• Claims for unauthorized services will be denied.
6.18 Mental Health – Psychological Testing Services

Service Coverage

Psychological Testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a participant’s psychological or cognitive functioning for the purpose of answering specific questions about the participant’s diagnosis and future treatment. Testing is viewed as a potentially helpful second opinion for treatment failures and/or difficult to diagnose cases; it is not considered a routine procedure in a participant’s treatment plan. Specific testing procedures selected by the provider should clearly relate to the questions listed on the request for psychological testing found in ProviderConnect or on the Psychological/Neuropsychological Evaluation Form (Form# 3.704.1).

Service Rules

• There is a maximum limit of eight hours per calendar year, per participant for psychological testing.

• Psychological Testing is approved only for licensed psychologists and other clinicians for whom testing falls within the scope of their clinical license and who have specialized training in psychological and/or neuropsychological testing.

• Psychological Testing should only be requested when other interventions are not
successful in providing sufficient information with which to develop an appropriate plan of treatment.

- Psychological Testing requires a separate preauthorization request and is not included with other outpatient authorization requests. Psychological Testing may occur on an inpatient or outpatient basis; however, if the inpatient day rate includes psychological testing, the testing should not be billed to the PBHS.

- Psychological testing of participants in private psychiatric hospitals is usually part of the day rate. If it is not part of the facility bed rate, it must be preauthorized by ValueOptions® Maryland, and billed on a CMS 1500 form by the psychologist rendering the service.

- Testing regarding basic intellectual, cognitive, academic, developmental, psycho-motor and visual-motor functioning is usually considered educational. Testing that is partially or primarily for educational purposes is not a covered benefit. This disqualifier may be subject to account specific arrangements.

- In regards to ADHD testing, the expectation is that the diagnosis of ADHD can in most instances be made on the basis of DSM 5 criteria alone and such diagnosis does not necessarily require psychological testing. Extended testing for ADHD is not authorized prior to a thorough evaluation with rating scales. Providers should usually first seek approval for a 90791 and a 90834 for rating scale review and feedback before requesting further ADHD testing. A 96101 session for standardized attention measures may also be appropriate to provide clear explanation as to why initial evaluation was insufficient to answer the ADHD referral questions.

- Testing for a medical condition is the responsibility of the Managed Care Organization (MCO) and should be referred to the MCO for authorization.

The provider requesting Psychological Testing is expected to exchange information and coordinate care with the participant’s primary care physician and
other treatment (i.e. substance use treatment, school officials, etc.) providers when clinically indicated and when appropriate release of information has been obtained.

**Service Eligibility**

Participants with active Medicaid (MA) & participants dually covered under Medicare & Medicaid are eligible for Psychological Testing services. The PBHS reimburses Psychological Testing services rendered to Uninsured Eligible participants as state general funds are available.

**Service Providers**

Providers are licensed psychologists and psychological associates contracted with Maryland Medicaid to perform psychological testing. In limited situations, such as in an OMHC or in a hospital with a psychology training program, interns and externs may administer psychological testing under the supervision of a licensed psychologist. The use of psychological interns, externs or graduate students for psychological testing is not reimbursed by the PBHS to private practitioners.

**Authorization Process**

To obtain authorization for Psychological Testing, the provider must submit a preauthorization request through ProviderConnect (see ProviderConnect User Manual for directions on completing an authorization request). The need for Psychological Testing and the proposed tests plan will be reviewed by a Maryland licensed Clinical Care Manager at ValueOptions® Maryland and a determination will be made concerning medical necessity and the number of hours of testing authorized.

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In the preauthorization request, the provider can request time for a clinical interview prior to the administration of a psychological test. Units for initial interview and feedback session with the participant and family member(s), or care taker(s), to discuss the results of the psychological testing and its implications are processed at the same time the number of hours of testing is authorized.

The provider will be notified of ValueOptions® Maryland determination of medical necessity through a ProviderConnect download notification. If a ValueOptions® Maryland Care Manager is not able to authorize the service as medically necessary, and agreement regarding an alternative level of care cannot be reached, the request for services will be referred to a ValueOptions® Maryland Physician Advisor for review. The determination will be communicated via ProviderConnect downloads to the provider (see Chapter 10, Grievance and Appeals).

**Claims Process**

Claims should be submitted to ValueOptions® Maryland on a CMS 1500 form.

- The number of units billed must equal the number of hours of testing provided.
- In some cases, a Psychological Associate, under the supervision of a Clinical Psychologist, may assist in administering a psychological evaluation.
- In these cases, the number of hours of Clinical Psychologist time should be billed as CPT Code 96101 and hours spent by the associate should be billed as CPT Code 96102.

**Claims for unauthorized services will be denied.**
6.19 Mental Health – Nursing Home Psychiatric Consultation Services

Service Coverage

Nursing Home Psychiatric Consultations Services are provided on a short term basis to prevent psychiatric hospitalization. Maintenance mental health services for participants in nursing homes are expected to be covered by the nursing homes under the day rate paid by Medicaid (MA). Nursing Home Psychiatric Consultation services are not covered by the MA day rate. These services will be paid for by the Public Mental Health System if preauthorized by ValueOptions® Maryland and if medical necessity criteria are met. These psychiatric services are defined as mental health services, or psychiatric consultation services, which are necessary to avoid psychiatric hospitalization.

Service Rules

Nursing Home Psychiatric Consultations are provided on a short-term basis to prevent a psychiatric admission. An initial consultation in the nursing home will be authorized by ValueOptions® Maryland to evaluate the severity of a participant’s psychiatric problem. Additional services (up to four visits per episode) by the psychiatrist will be approved only for participants with a mental illness severity level which puts them at risk for hospitalization (i.e. the participant is exhibiting behavior that is threatening to self or
others or otherwise becoming increasingly at-risk for hospitalization). The participant must have a PBHS covered diagnosis.

The mental health service provider is expected to exchange information and coordinate care with the participant’s primary care physician and other treatment (i.e. substance use treatment and/or mental health) providers when clinically appropriate.

**Service Eligibility**

Only participants with Medical Assistance and/or dual eligibility (Medicare and Medicaid) are eligible for Nursing Home Psychiatric Consultation Services.

**Service Providers**

Psychiatrists with an active Maryland MA provider number may be providers of Nursing Home Psychiatric Consultation Services.

**Authorization Process**

The provider must submit a pre-authorization request by phone. The ValueOptions® Maryland Care Manager will review the clinical data to determine if medical necessity and severity of illness criteria are met in order to authorize Nursing Home Consultation Services.

**Pre-Admission Screening and Resident Review**

Pre-Admission Screening and Resident Review (PASRR) determinations will be reviewed to ensure that participants with Serious Mental Illness (SMI) are not unnecessarily
institutionalized, but can live in the least restrictive environment where their needs may be met. If a Nursing Facility is the least restrictive environment that can meet their needs, then services will be identified for their optimal functioning.

Those participants with a positive Level I screening will then have a Level II evaluation to confirm a Serious Mental Illness/Major Mental Disorder Diagnosis, Level of Impairment and Duration of Illness/Recent treatment related to the SMI.

Following the requirements of 42.CFR Part 483, COMAR 10.09.10.03 and Nursing Home Transmittals 159-239, a review of the Level II Evaluation will be completed by ValueOptions® Maryland within 3 business days of a completed request. The Level II Evaluation will include specific and clear recommendations by the AERS Reviewer for Nursing Facility Services.

ValueOptions®’ RN MCO Liaison and PASRR team licensed health care professionals will review all requests and communicate the determination to AERS and the requesting facility. If approved, the PASRR reviewer will sign and fax a copy of the determination PASRR Certificate to the AERS office. If a denial is rendered by a ValueOptions® Psychiatrist, then ValueOptions® shall notify in writing the applicant of his/her right to appeal the determination. For participants referred from hospitals, every effort will be made to expedite this process to assure timely discharge.

**Claims Process**

Psychiatrists must obtain authorization for consultations and follow-up services for Medicaid participants. Claims must be submitted on a CMS 1500 form.

Claims for unauthorized services will be denied. If the services requested by the
provider do not meet medical necessity criteria and are non-authorized, please refer to Chapter 10, Grievance and Appeals.
6.20 Mental Health – Home and Community-Based Services: Intensive Behavioral Health Services For Children, Youth and Families - 1915(i)

Service Coverage

The Home and Community-Based services benefit for children and youth with serious emotional disturbances (SED) and their families is authorized under a 1915(i) Medicaid State Plan Amendment. Intensive behavioral health services are provided by a program approved and operated under the provision of Maryland Law (COMAR 10.09.89) and are provided in the participant’s home or in an approved community-based setting. Services are designed to support the participant remaining in their homes by providing a wrap-around service delivery model.

Services covered include care coordination, child and family team participation, intensive in-home services, mobile crisis and stabilization, community-based respite care, out-of-home respite care, peer-to-peer support, expressive and experiential behavioral services, customized goods and services and behavioral health consultation services to health care professionals.

A Care Coordination Organization (CCO) is responsible for providing case management services to 1915(i) participants and families as described in COMAR
The Child and Family Team (CFT) means a team of participants selected by the participant and family to work with them to design and implement a plan of care (POC).

Intensive In-Home Services (IIHS) are a strength-based intervention with the youth and his or her family that include a series of components described in COMAR 10.09.89.14.

Mobile Crisis and Stabilization services are offered in response to urgent mental health needs and are available on a short-term basis, 24-hours per day, 7-days per week. These services are coordinated with the CCO and CFT. They are incorporated in the participants POC.

Respite services are offered to provide stabilization and relief to caregivers from the stress of care giving. These services may be provided in the home or community. In-home services offer additional temporary support, in the home and overnight. Out-of-Home Respite services provide a temporary overnight living arrangement outside the participant’s home.

Peer-to-Peer Support services are offered to ensure that family and participant opinions and perspectives are incorporated into the CFT process and POC. Services are provided by a family support organization (FSO) as described in COMAR 10.09.89.10.

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Expressive and Experiential Behavioral Services means the use of art, dance, music, equine, horticulture or drama to accomplish individualized goals as part of the plan of care. Services may be provided individually or in a group.

Customized goods and services are expenditures requested by the participant’s CCO and made by the CSA to support the POC as described in COMAR 10.09.89.09.

**Service Rules**

Children and youth are authorized on an annual basis as participants in the Home and Community-Based Services 1915(i) benefit. Enrollment begins when youth are identified by a CCO who provides:

- Intake
- Ongoing assessment
- Coordination and facilitation of the CFT
- Management of the POC
- Facilitation of access to services and supports in the POC
- Assistance with the development of the crisis plan
- Regular face-to-face meetings with the family and/or youth
- Follow-up monitoring and coordination of care services

Applicants shall have a face-to-face, psychiatric evaluation completed within 30-days of the submission of the enrollment application to the Administrative Service Organization (ASO). The participant must meet the eligibility criteria described below.

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Participant Eligibility

Participants with Medical Assistance (MA) must be under 18 years of age at the time of enrollment and who meet additional clinical and financial eligibility criteria according to Maryland Law (COMAR 10.09.89.03).

Termination of enrollment, for a variety of conditions, is also described in COMAR 10.09.89.04.

Some services are automatically authorized with the initial approval for any participant meeting the 1915(i) State Plan Amendment eligibility criteria. The Intensive, in-home services are automatically authorized for 60-days. Thereafter, the services will be authorized in six month increments. Both community-based and in-home Respite are also automatically authorized for 60-days. Thereafter, the services will be authorized in six month increments. Peer-to-Peer Support services are automatically authorized for one year. Thereafter, the services will be authorized in 6-months increments.

For the remaining services: Mobile Crisis and Stabilization, Expressive and Experiential Behavioral Services and Customized Goods and Services must receive prior authorization from the ASO before providing them to participants.

Service Eligibility

1. Age: Youth must be under 18 years of age at the time of enrollment although they may continue in HCBS Benefit up to age 22
2. Residence:
   a. Youth must reside in a home and community-based setting. Excluded community programs in which a youth may not reside while receiving the 1915(i) HCBS Benefit are: Group Home; Psychiatric Respite Care Facility located on the grounds on an IMD for the purpose of placement; residential program for adults with serious mental illness licensed under COMAR 10.21.22.
   b. Youth must reside in one of the geographic areas where the 1915(i) HCBS Benefit is available

3. Consent: Youth under 18 must have consent from the parent or legal guardian to participate; for young adults who are 18 or older and already enrolled, the young adult must consent to participate. Youth over 18 who are in the care and custody of the State, require consent from their legal guardian.

4. Behavioral Health Disorder:
   a. Youth must have a behavioral health disorder amenable to active clinical treatment. The evaluation and assignment of a Diagnostic and Statistical Manual (DSM) diagnosis must result from a face-to-face psychiatric evaluation that was completed or updated within 30-days of submission of the application to the ASO.
   b. There must be clinical evidence the child or adolescent has a serious emotional disturbance (SED) and continues to meet the service intensity needs and medical necessity criteria for the duration of their enrollment. Because of the clinical requirement that the young person have an SED, it will be required for the young person to be actively involved in ongoing mental health treatment on a regular basis in order to receive 1915(i) services.

5. Impaired Functioning & Service Intensity: A licensed mental health professional must complete a comprehensive psychosocial assessment within 30-days of the submission
of the application to the ASO. The psychosocial assessment must outline how the youth’s functioning presents potential danger to self or others, across settings, including the home, school, and/or community. The serious harm does not necessarily have to be of an imminent nature. The psychosocial assessment must support the completion of the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-21.

a. Youth must receive a score of:

i. 4 (High Service Intensity) or 5 (Maximal Service Intensity) on the ECSII
   1. Youth who are younger than 6 years old who have a score of 4 on the ECSII either must:
      a. Be referred directly from an inpatient hospital unit
         Or
      b. If living in the community, have two or more psychiatric inpatient hospitalizations in the past 12 months.
   Or

ii. 5 (Non-Secure, 24-Hour, Medically Monitored Services) or 6 (Secure, 24-Hours, Medically Managed Services) on the CASII

b. Youth with a score of 5 on the CASII also must meet one of the following criteria to be eligible based on their impaired functioning and service intensity level:

   i. Transitioning from a Residential Treatment Center
   ii. Living in the community and
      1. At least 13 years old and have
         a. 3 or more inpatient psychiatric hospitalizations in the past 12 months

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Or

b. Resided in an RTC within the past 90 days

2. Age 6 through 12 years old and have:
   
a. 2 or more inpatient psychiatric hospitalizations in the past 12 months
   Or
   
b. Resided in an RTC within the past 90 days

Youth will not be eligible for HCBS services if they meet one of the following criteria:

1. Youth is hospitalized for longer than 30-days.
2. Youth moves out of state for more than 30-days.
3. During the initial phase-in of the 1915(i) HCBS benefit, youth moves out of a geographic area within the State of Maryland where the youth cannot reasonably access services and supports.
4. Youth is admitted to and placed in an RTC for longer than 60-days.
5. Youth is admitted to and placed in a group home setting licensed under COMAR.
6. Youth is placed in a Psychiatric Respite Care program, a non-medical group residential facility located on the grounds of an IMD primarily for the purpose of placement.
7. Youth losses eligibility for Maryland MA for more than 30 days.
8. Youth turns 22-years old.
9. Youth is detained, committed to a facility, or incarcerated for longer than 60-days.
10. Youth’s annual Medical Review does not meet medical re-certification criteria.
11. There is no Child and Family Team (CFT) meeting held within 90-days.
12. The youth is no longer actively engaged in ongoing mental health treatment with a licensed mental health professional.
Service Providers

Services may only be provided by approved 1915(i) service providers whose eligibility has been verified by the Department of Mental Health and Hygiene according to the process outlined in Maryland Law (COMAR 10.09.89.08).

Authorization Process

An initial assessment session (Mobile Crisis Services) is pre-approved for all participants, and should be completed within the first week of CCO services to develop a crisis response plan. Subsequent to a “crisis” services are pre-approved for up to a 3-day stabilization period. Additional services require further documentation, review and pre-authorization through Value Options.

To obtain authorization for 1915(i) Services, the CCO in working with the participant and family must request authorization from ValueOptions® Maryland. The clinical information required consists of the list of applicable DSM 5 diagnoses and the current need for requested service. The description of the requested services should be identified as part of the participant’s individualized Plan of Care (POC). The POC should be developed through the CFT process. If medical necessity is demonstrated, authorizations will be given by ValueOptions® Maryland through its online, care management portal; ProviderConnect. If medical necessity cannot be determined and an agreed-upon alternative is not possible, ValueOptions® Maryland will refer the case to a ValueOptions® Physician Advisor for review (see Chapter 10, Grievances and Appeals).

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For authorizations beyond the initial authorization period, the provider must request a continued stay review via ProviderConnect. ValueOptions® Maryland requires continued demonstration that medical necessity criteria is met for additional authorizations to be granted.

**Claims Process**

1915(i) services must be billed on a HCFA 1500 form (See Chapter 17 for billing instructions)

Claims must specify an ICD 9 code (not DSM 5 code) for reimbursement.

**Claims for unauthorized services will be denied.**
6.21 through 6.29  Reserved for Future Use
6.30 through 6.40 Substance Use Service Descriptions

Additional guidance is being finalized will be forthcoming. Please refer to the Substance Use Disorder Matrix, FAQ documents, and the Department's transmittals for additional information on these services. These documents can be found on the ValueOptions® Maryland site (maryland.valueoptions.com) under “What’s New for 2015”.
Preamble

"Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."
National Consensus Statement on Mental Health Recovery U.S Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Introduction

The Public Behavioral Health System (PBHS) is committed to facilitating the participant’s recovery through treatment and rehabilitation services that are in the least restrictive and intensive level of care necessary to provide safe and effective treatment and meet the participant’s biopsychosocial needs. The continuum of care is a fluid treatment pathway, where participants may enter treatment at any level and receive services, in more or less intensive settings or levels of care, as their changing clinical needs dictate. The ASO will implement this philosophy while facilitating participant choice in the treatment process.

Principles of Medical Necessity

The Public Behavioral Health System is committed to the philosophy of providing treatment at the least intensive level of care necessary to provide safe and effective treatment and meet the participant’s biopsychosocial needs.
The Public Behavioral Health System is committed to the six goals of the New Freedom Commission on Mental Health:

1. Mental Health is essential to overall health.
2. Mental health care is participant and family driven.
3. Disparities in mental health services must be eliminated.
4. Early mental health screening, assessment and referral to service are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

The State of Maryland’s Administrative Services Organization (ASO) will make clinical decisions about each participant based on the clinical features of the participant case, the medical necessity criteria, and the real resources available. Since we recognize that a full array of services is not available everywhere, when a medically necessary level of care does not exist, (i.e. rural locations) the ASO will authorize alternative services.

Under the authority of the State of Maryland’s Public Behavioral Health System (PBHS), the ASO bases its decisions on “medical necessity”. Medical necessity is met when an participant has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that is able to safely meet the participant’s behavioral health and medical needs.
Acute Inpatient Mental Health (Adult)

Principles for Medical Necessity Criteria

When participants have a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Acute inpatient psychiatric treatment is defined as a 24-hour inpatient level of care that provides highly skilled psychiatric services to adults with severe mental disorders.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

<table>
<thead>
<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Admission Criteria</strong></td>
</tr>
<tr>
<td>A.</td>
</tr>
<tr>
<td>B.</td>
</tr>
<tr>
<td>C.</td>
</tr>
<tr>
<td>Severity of Need and Intensity of Service at the Acute Level of Care</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>A. PBHS Specialty Mental Health DSM 5 diagnosis.</td>
</tr>
<tr>
<td>B. The participant makes dire threats or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour basis are required.</td>
</tr>
<tr>
<td>C. The participant demonstrates violent, unpredictable, or uncontrolled behavior which represents potential serious harm to self or others or there is evidence for a clear and reasonable inference of self-harm to others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24-hour basis.</td>
</tr>
<tr>
<td>D. The participant demonstrates severe psychiatric symptoms which cannot be safely treated in an outpatient setting or which are not able to be successfully treated in a lower level of care due to their severity.</td>
</tr>
<tr>
<td>E. Where diagnostic assessment or treatment are not available or are unsafe on an outpatient basis (e.g., participant needs a somatic treatment, such as ECT or medication management that can only be safely accomplished in a hospital setting with 24-hour psychiatric and nursing care).</td>
</tr>
</tbody>
</table>

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Criteria for Continued Stay

The individual treatment plan should include documentation of diagnosis (DSM 5), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 2-hour basis. There should be daily progress notes documenting the provider’s treatment and the participant’s response to treatment. In addition to continuing to meet the criteria given above for admission, and continued evidence of active treatment, one of the criteria A-C, and D must be met for Continued Stay.

A. Clinical Evidence indicates that the persistence of the problems that caused the admission to the degree which would necessitate continued hospitalization, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree which would necessitate continued hospitalization.

B. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting.

C. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

D. There is clinical evidence of symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered.
## Level of Care 2: INPATIENT SERVICES

### Acute Inpatient Mental Health (Child/Adolescent)

#### Principles for Medical Necessity Criteria

When participants have a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Acute inpatient psychiatric treatment is defined as a 24-hour inpatient level of care that provides highly skilled psychiatric services to adults with severe mental disorders.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

<table>
<thead>
<tr>
<th>Criteria</th>
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</thead>
<tbody>
<tr>
<td><strong>Admission Criteria</strong></td>
</tr>
<tr>
<td>The following criterion is necessary for admission: (A-C below must be met)</td>
</tr>
<tr>
<td>A. The participant must have a diagnosed or suspected mental disorder that can be expected to improve significantly through medically necessary treatment.</td>
</tr>
<tr>
<td>B. The evaluation and assignment of the mental disorder diagnosis must take place in a face-to-face evaluation of the participant performed by an Attending Physician prior to, or within 24 hours following the admission.</td>
</tr>
<tr>
<td>C. Presence of the disorder(s) must be documented through the assignment of a DSM 5 code for the primary diagnosis, except for the diagnoses included in Appendix A (appended).</td>
</tr>
</tbody>
</table>

| Severity of Need and Intensity of Service at the Acute Level of Care |
| [Criterion A must be met. In addition, B, C, D, or E must be met]. |
| A. PBHS Specialty Mental Health DSM 5 diagnosis. |
| B. The participant makes direct threats or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour basis are required. |
| C. The participant demonstrates violent, unpredictable, or uncontrolled behavior which represents potential serious harm to self or others or there is evidence for a clear and reasonable inference of self-harm to others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24-hour basis. |
| D. The participant demonstrates severe psychiatric symptoms which cannot be safely treated in an outpatient setting or which are not able to be successfully treated in a lower level of care due to their severity. |
This care must require an individual plan of active psychiatric treatment which includes 24-hour need for, and access to, the full spectrum of psychiatric staffing and services.

E. Where diagnostic assessment or treatment are not available or are unsafe on an outpatient basis (e.g., participant needs a somatic treatment, such as ECT or medication management that can only be safely accomplished in a hospital setting with 24-hour psychiatric and nursing care).

<table>
<thead>
<tr>
<th>Criteria for Continued Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>The individual treatment plan should include documentation of diagnosis (DSM 5), discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 2-hour basis. There should be daily progress notes documenting the provider’s treatment and the participant’s response to treatment. In addition to continuing to meet the criteria given above for admission, and continued evidence of active treatment, one of the criteria A-C, and D must be met for Continued Stay.</td>
</tr>
</tbody>
</table>

A. Clinical Evidence indicates that the persistence of the problems that caused the admission to the degree which would necessitate continued hospitalization, despite therapeutic efforts, or the emergence of additional problems consistent with the admission criteria and to the degree which would necessitate continued hospitalization.

B. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting.

C. There is clinical evidence that disposition planning, progressive increases in hospital privileges and/or attempts at therapeutic re-entry into the community have resulted in, or would result in, exacerbation of the psychiatric illness to the degree that would necessitate continued hospitalization.

D. There is clinical evidence of symptom improvement. If there has been no improvement, the treatment plan should be reviewed and a second opinion considered.
The purpose of this section is to define and clarify criteria for when an RTC Level of Care is a medically necessary treatment for children and adolescents with a DSM 5 mental health disorder, except for excluded diagnoses which are appended.

**Principles for Medical Necessity Determination**

An RTC is defined in Health-General Article, Title 19, Annotated Code of Maryland as a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting.

When a participant has a mental health disorder that requires professional evaluation and treatment, he or she should be treated in the least intensive, least restrictive setting available that is most appropriate and able to meet the participant’s medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.
| Criteria for Admission | Medical necessity for admission to an RTC Level of Care must be documented by the presence of all the criteria given below in Section A (Severity of Need) and Section B (Intensity of Service).

The child or adolescent must have a mental health disorder amenable to active clinical treatment. The evaluation and assignment of a DSM 5 diagnosis must result from a face-to-face psychiatric evaluation. |
## Severity of Need

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>The child or adolescent has a PBHS Specialty Mental Health DSM 5 diagnosis.</td>
</tr>
<tr>
<td>B.</td>
<td>There must be clinical evidence the child or adolescent has:</td>
</tr>
<tr>
<td></td>
<td>i. For children under 18, a serious emotional disturbance (SED) or,</td>
</tr>
<tr>
<td></td>
<td>ii. For youth ages 18 and above, serious mental illness (SMI).</td>
</tr>
<tr>
<td>C.</td>
<td>Due to the SED or SMI, the child or adolescent exhibits a significant impairment in functioning, representing potential serious harm to self or others, across settings, including the home, school, and community. The serious harm does not necessarily have to be of an imminent nature. The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment.</td>
</tr>
<tr>
<td>D.</td>
<td>The child or adolescent requires services and supports to be available seven days per week/24 hours per day to develop skills necessary for daily living; to assist with planning and arranging access to a range of educational and therapeutic services; and, to develop the adaptive and functional behaviors that will allow him or her to remain successfully in his or her home and community and regularly attend and participate in work, school or training. In particular, the child or adolescent requires the availability of crisis and/or mental health services seven days per week/24 hours per day, with flexible scheduling and availability of other services and supports.</td>
</tr>
<tr>
<td>E.</td>
<td>Due to the SED or SMI, the child or adolescent also requires that there be a parent, guardian, individual or organization that is responsible for the 24-hour care and supervision of that child or adolescent.</td>
</tr>
</tbody>
</table>
**Intensity of Service**

A. RTC placement or Community-Based RTC Level of Care is considered medically necessary when all less intensive levels of treatment have been determined to be unsafe, unsuccessful, or unavailable.

B. The child or adolescent requires a 24 hours/day, 7 days/week structured and supportive living environment.

C. The child or adolescent requires the provision of individualized, strengths-based services and supports that:
   1. Are identified in partnership with the child or adolescent, if developmentally appropriate, and the family and support system, to the extent possible;
   2. Are based on both clinical and functional assessments;
   3. Are clinically monitored and coordinated, with 24-hour availability;
   4. Are implemented with oversight from a licensed mental health professional; and,
   5. Include:
      a. Assisting with the development of skills for daily living;
      b. Care coordination to plan and arrange access to a range of educational and therapeutic services;
      c. Services that support the development of adaptive and functional behaviors that will enable the child or adolescent to remain successfully in his or her home and community and regularly attend and participate in work, school or training;
      d. When appropriate and relevant, psychotropic medications to be used with specific target symptoms identification, with medical monitoring and 24-hour medical availability;
      e. Screening and assessment for current medical problems and concomitant substance use issues; and,
      f. Coordination with the child or adolescent’s community resources, with the goal of transitioning the youth out of the program as soon as possible and appropriate.
<table>
<thead>
<tr>
<th>Criteria for Continued Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to meeting all of the admission criteria on a continuing basis, and continued evidence of active treatment, criteria A, B, C, and D below must be met to satisfy the criteria for continued medical necessity for RTC.</td>
</tr>
</tbody>
</table>

Level of Care:

A. There must be evidence of the need for continued support twenty-four hours per day, seven days per week due to the degree of functional and/or behavioral health impairment.

B. There is clinical evidence that the child or adolescent can continue to make measurable progress in the program, as demonstrated by a further reduction in psychiatric symptoms, or acquire requisite strengths in order to be transitioned from the program or moved to a less restrictive level of care.

C. There must be a reasonable expectation by the family and treating clinicians that, if treatment services as currently provided in the plan of care were withdrawn, the child or adolescent’s condition would deteriorate, relapse further, or require a move to a more restrictive level of care.

D. For youth served in an RTC, short-term, therapeutic visits home with the purpose of testing treatment efficacy and supporting the goal of eventual family reunification are not, in and of themselves, to be considered grounds for a denial of continued stay. However, therapeutic passes to home are to be considered an indicator of upcoming discharge to home.
# Level of Care 4: Residential Crisis Services

<table>
<thead>
<tr>
<th>I. Principles for Medical Necessity Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Crisis services are provided on a short-term basis in a community-based residential setting to prevent a psychiatric inpatient admission or the need for a prolonged acute hospitalization.</td>
</tr>
<tr>
<td>When participants have a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.</td>
</tr>
<tr>
<td>Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II. Admission Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>All of the following criteria are necessary for admission:</td>
</tr>
<tr>
<td>A. The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention.</td>
</tr>
<tr>
<td>B. The participant is at risk for hospitalization or continued hospitalization.</td>
</tr>
<tr>
<td>C. There is a need for immediate intervention because the Participant:</td>
</tr>
<tr>
<td>1. Is at risk for harm of self or others; or</td>
</tr>
<tr>
<td>2. Is experiencing rapid deterioration of functioning as a result of psychiatric symptoms.</td>
</tr>
<tr>
<td>D. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Severity of Need and Intensity of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical necessity for admission to Residential Crisis services must be documented by the presence of all of the criteria. Length of service varies based on medical necessity but is designed to be short-term. Active involvement of the participant, family, caretaker or others involved in the Individual’s treatment should be sought.</td>
</tr>
</tbody>
</table>
### IV. Continued Stay Criteria:

*All of the following criteria are necessary for continuing treatment at this level of care:*

A. The participant continues to meet admission criteria.
B. Diversion from inpatient hospitalization continues to appear possible.
C. The participant’s current available living environment is not suitable for stabilizing the participant during the crisis.
D. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident.
## Level of Care 5: Residential Rehabilitation Program, General

### I. Principles for Medical Necessity Criteria:
Community-Based Residential Care for adults provides support in a residence outside of the participant’s own home and provides needed resources and support not sufficiently available within the participant’s own existing social support system. Community-Based Residential Care for adults includes community residential crisis intervention units, residential rehabilitation programs, licensed group homes in community-based home-like settings, and other residential settings which provide rehabilitation, assistance, support, and sometimes specialized services. These services are to promote the participant’s ability to engage and participate in appropriate community activities and to enable the participant to develop the daily living skills that are needed for independent functioning.

The decision to place a participant in a community residential crisis intervention unit, licensed group home (small 4-8 people, large 9-16 people), or other supervised residential setting is based upon a determination of which setting would best meet the needs of the participant, and availability.

Residential Rehabilitation Programs (RRPs) provide services based upon the participant’s needs in varying levels of support—general and intensive, and are subject to additional admission/continued stay criteria (Please refer to Level of Care 6: Residential Rehabilitation Program, Intensive).

- **General Support.** Staff is available on-call 24/7 and provides at a minimum, 3 face-to-face visits per week.

### II. Admission Criteria

*All of the following criteria are necessary for admission:*

- **A.** The participant has a PBHS specialty mental health DSM 5 diagnosis, included in the Priority Population, which is the cause of significant functional and psychological impairment, and the participant’s condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation, and support.

- **B.** The participant requires active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment, and manage the effects of his/her illness. As a result of the
current course of illness or by the past history of the illness;
• Harm to self or others as a result of the mental illness and as evidenced by the current behavior or past history; or
• Deterioration in functioning in the absence of a supported community-based residence that would lead to the other items.

C. The participant’s own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced for example, by one of the following:
• The participant has no residence and no social support;
• The participant has a current residential placement, but the existing placement does not provide sufficiently adequate supervision to ensure safety and ability to participate in treatment; or
• The participant has a current residential placement, but the participant is unable to use the existing residence to ensure safety and ability to participate in treatment, or

| III. Severity of Need and Intensity of Service | Medical necessity for admission to Community-Based Mental Health Residential Care must be documented by the presence of all of the criteria. Location and length of service varies based on the participant’s needs and medical necessity. Active involvement of the participant, family, or significant others involved in the |
IV. Continued Stay Criteria:

**All** of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria.
B. There is continued risk of deterioration in functioning that may lead to inpatient admission or harm to self and/or others.
C. There is evidence that the resources and social support system, which are available to the participant outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge planning.
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<tbody>
<tr>
<td><strong>E.</strong></td>
<td>There is documented active planning for transition to a less intensive level of care</td>
</tr>
</tbody>
</table>
I. Principles for Medical Necessity Criteria:
Residential Rehabilitation Programs (RRPs) for adults provide support in a residence outside of the participant’s own home and provides needed resources and support not sufficiently available within the participant’s own existing social support system.

Residential Rehabilitation Programs (RRPs) provide services based upon the participant’s needs in varying levels of support—general and intensive, and are subject to additional admission/continued stay criteria.

- **Intensive Support.** Staff provides services daily on-site in the residence, with a minimum of 40 hours per week, up to 24 hours a day, 7 days a week.

Participants must meet all Community-Based Mental Health Residential Care criteria and additional medically necessity criteria to qualify for RRP.

When a participant has a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet the participants’ medical needs.
## II. Admission Criteria

*All of the following criteria are necessary for admission:*

A. The participant has a PBHS specialty mental health DSM 5 diagnosis which is the cause of significant functional and psychological impairment, and the participant’s condition can be expected to be stabilized through the provision of medically necessary supervised residential services in conjunction with medically necessary treatment, rehabilitation, and support.

B. The participant meets diagnostic criteria as defined in BHA’s priority population.

C. The participant has a *history* of at least one of the following:
   - Criminal behavior
   - Treatment and/or medication non-compliance
   - Substance use
   - Aggressive behavior
   - Psychiatric hospitalizations
manage:
- Safety risk
- Active delusions
- Active psychosis
- Poor decision making skills
- Impulsivity
- Inability to perform ADL skills to maintain tasks necessary to live in the community environment
- Impaired judgment, including social boundaries
- Inability to self-protect in community situations
- Inability to safely self-medicate or otherwise self-manage the illness
- Aggression
- Inability to access community resources necessary for safety
- Impaired community living skills

D. The participant requires active support to ensure the adequate, effective coping skills necessary to live safely in the community, participate in self-care and treatment, and manage the effects of his/her illness. As a result of the participant’s clinical condition (impaired judgment, behavior control, or role functioning) there is significant current risk of one of the following:
- Hospitalization or other inpatient care as evidenced by the current course of illness or by the past history of the illness;
- Harm to self or others as a result of the mental illness and as evidenced by the current behavior or past history; or
- Deterioration in functioning in the absence of a supported community-based residence that would lead to the other items.

E. The participant’s own resources and social support system are not adequate to provide the level of residential support and supervision currently needed as evidenced for example, by one of the following:
- The participant has no residence and no social support;
- The participant has a current residential placement, but
the existing placement does not provide sufficiently adequate supervision to ensure safety and ability to participate in treatment; or
- The participant has a current residential placement, but the participant is unable to use the existing residence to ensure safety and ability to participate in treatment, or the relationships are dysfunctional and undermine the stability of treatment
F. The participant is judged to be able to reliably cooperate with the rules and supervision provided and to contract reliably for safety in the supervised residence.
G. The participant must also be receiving Psychiatric Rehabilitation Program (PRP) services.
H. Priority for this level of care is given to participants currently
hospitalized in state psychiatric hospitals that are ready for discharge and for participants at risk of hospitalization or due to the need for mental health support and treatment are at risk for incarceration or homelessness.

I. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.

| III. Severity of Need and Intensity of Service | Medical necessity for admission to a RRP must be documented by the presence of all of the criteria. Location and length of service varies based on the participant’s needs and medical necessity. Active involvement of the participant, family, or significant others |
| IV. Continued Stay Criteria: | All of the following criteria are necessary for continuing treatment at this level of care: |
| | A. The participant continues to meet admission criteria. |
| | B. There is continued risk of deterioration in functioning that may lead to inpatient admission or harm to self and/or others. |
| | C. There is evidence that the resources and social support system, which are available to the participant outside the supervised residence continue to be inadequate to provide the level of residential support and supervision currently needed for safety, self-care or effective treatment despite current treatment, rehabilitation and discharge planning. |
| | D. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and |
I. Principles for Medical Necessity Criteria:
Partial Hospitalization programs provide the nature and intensity of services that would be provided in a hospital (including medical and nursing supervision and interventions) for at least 4 hours/days, but the participant is not involved in a 24 hour/day program including a stay overnight.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

II. Admission Criteria
All of the following criteria are necessary for admission:

A. The participant has a PBHS mental health DSM 5 diagnosis, and the Participant’s condition can be expected to be stabilized at this level of care.
B. There is clinical evidence that the participant would be at risk to self or others if the participant was not in a partial hospitalization program.
C. There is clinical evidence that the participant will be safe in a structured environment under clinical supervision for part of the day, and has a suitable environment for the rest of the time, and that a partial hospitalization program can safely substitute for or shorten a hospital stay to prevent deterioration that would lead to a re-hospitalization.
D. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.

III. Severity of Need and Intensity of Service
Medical necessity for admission to a Partial Hospitalization Program must be documented by the presence of all of the criteria. The length of the program varies based on the participant’s condition and medical necessity. Evidence of a stable and safe living environment and participant safety during non-treatment hours is imperative to meet criteria and distinguish it from inpatient services. Active involvement of the participant, family, caretakers, or significant others involved in the participant’s treatment should be sought.

IV. Continued Stay Criteria:
All of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria.
B. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the
<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the participant's response to treatment.)</strong></td>
<td><strong>C.</strong> Clinical attempts at therapeutic re-entry into a less restrictive level of care have, or would, result in exacerbation of the mental disorder to the degree that would warrant the continued need for partial hospitalization services.</td>
</tr>
<tr>
<td><strong>D.</strong> There is evidence that the participant, family, caretaker or significant other is involved in treatment in the frequency and manner indicated by the treatment plan.</td>
<td><strong>E.</strong> There is documented active planning for transition to a less intensive level of care</td>
</tr>
</tbody>
</table>
## Level of Care: Enhanced Support Services

### I. Principles for Medical Necessity Criteria:
Enhanced Support Services are short-term, in-home, one-to-one services to provide supervision and assistance to a participant experiencing an increase or instability of psychiatric symptoms, or participants transitioning from an inpatient level of care. This service is only provided by a provider of psychiatric rehabilitation services (PRP), residential rehabilitation services (RRP) or mobile treatment services.

### II. Admission Criteria:
All of the following criteria are necessary for admission:

A. The participant either has MA, is PBHS-eligible Medicare, or is Uninsured Eligible. The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention.

B. The participant’s functioning is seriously disrupted and threatens the safety of the participant, family, community, or in-home placement.

C. The participant/family has the capacity and is willing to actively participate in this intervention.

D. There are multiple systemic problems that may require in-home intervention up to several hours per week.

### III. Severity of Need and Intensity of Service
Enhanced Support Services will be reimbursed for a maximum of ten days per episode/30 days per calendar year. Enhanced Support Services cannot be authorized in conjunction with Respite Services.

### IV. Continued Stay Criteria:
All of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria but has not reached the maximum episodic or annual limitations.

B. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident.

C. There is documented active planning for transition to a less intensive level of care.
I. Principles for Medical Necessity Criteria:
Intensive Outpatient (IOP) is a program of intense treatment involving multiple treatment services on multiple days provided by a multidisciplinary team. An IOP program provides a minimum of three hours of therapeutic services per day, which includes at least two group therapies. The treatment constellation can include participant, group or family therapy and medication management.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

<table>
<thead>
<tr>
<th>II. Admission Criteria</th>
<th>All of the following criteria are necessary for admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. The participant has a PBHS mental health DSM 5 diagnosis, and the Participant’s impairment(s) can be expected to be stabilized at this level of care.</td>
</tr>
<tr>
<td></td>
<td>B. The impairment(s) results in a clear, current threat to the Participant’s ability to live in his/her customary setting.</td>
</tr>
<tr>
<td></td>
<td>C. The Participant does not require a more intensive level of care.</td>
</tr>
<tr>
<td></td>
<td>D. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.</td>
</tr>
</tbody>
</table>

III. Severity of Need and Intensity of Service
Medical necessity for admission to an IOP must be documented by the presence of all of the criteria. The length of the program varies based on the Participant’s needs and medical necessity. IOP is less intensive than Partial Hospitalization services but is intended for Participants whose condition is not likely to respond to traditional outpatient services, and requires an integrated program of coordinated and structured multidisciplinary services at least 3 hrs/day. Active involvement of the Participant, family, caretakers, or significant others involved in the Participant’s treatment should be sought.

IV. Continued Stay Criteria:
All of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria.
B. Clinical evidence indicates that the therapeutic re-entry into a less intensive level of care would result in exacerbation of the symptoms of the Participant’s mental disorder.
C. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the
treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the Participant’s response to treatment.)

D. There is evidence that the Participant, family, caretaker or significant other is involved in treatment in the frequency and manner indicated by the treatment plan.

E. There is documented active planning for transition to a less intensive level of care
### Level of Care: Psychiatric Rehabilitation Programs (PRP) - Adult

#### I. Principles for Medical Necessity Criteria:
Psychiatric Rehabilitation services facilitate the Participant’s recovery and develop or restore an Participant’s independent living and social skills, including the Participant’s ability to make decision regarding: self-care management of illness, life, work and community participation; and promote the use of resources to integrate the Participant into the community. Services may be provided in an on-site facility, or in a setting most conducive to promoting the participation of the Participant in community life.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

#### II. Admission Criteria

**All of the following criteria are necessary for admission:**

- A. The participant has a PBHS specialty mental health DSM 5 diagnosis included in the Priority Population and the participant’s impairment(s) can be expected to be stabilized at this level of care.
- B. The impairment results in at least one of the following:
  - A clear, current threat to the participant’s ability to live in his/her customary setting
  - An inability to be employed or attend school without support
  - An inability to manage the effects of his/her mental illness
- C. The participant’s condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant’s recovery.
- D. The participant must be concurrently engaged in outpatient mental health treatment.
- E. All participants residing in a RRP must have PRP services available.
- F. The participant does not require a more intensive level of care.
- G. All less intensive levels of treatment have been determined to be unsafe or unsuccessful.

#### III. Severity of Need and Intensity of Service

Medical necessity for admission to Psychiatric Rehabilitation Program services must be documented by the presence of all of the criteria. The length and frequency of the services varies based on the participant’s needs and medical necessity. Profession and/or social supports must be identified and available to the participant outside of program hours, and the participant must be capable of seeking them as needed. Active involvement of the participant, family, caretakers, or significant others involved in the participant’s treatment should be sought.
| IV. Continued Stay | All of the following criteria are necessary for continuing treatment at |

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<table>
<thead>
<tr>
<th>Criteria:</th>
<th>this level of care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>The participant continues to meet admission criteria.</td>
</tr>
<tr>
<td>B.</td>
<td>Clinical evidence indicates that the therapeutic re-entry into a less intensive level of care would result in exacerbation of the symptoms of the participant’s mental disorder.</td>
</tr>
<tr>
<td>C.</td>
<td>Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the participant’s response to treatment.)</td>
</tr>
<tr>
<td>D.</td>
<td>There is evidence that the participant, family, caretaker or significant other is involved in treatment in the frequency and manner indicated by the treatment plan.</td>
</tr>
<tr>
<td>E.</td>
<td>There is documented active planning for transition to a less intensive level of care</td>
</tr>
</tbody>
</table>
**Level of Care: Psychiatric Rehabilitation Programs (PRP)- Children/Adolescents**

**I. Principles for Medical Necessity Criteria:**
Psychiatric Rehabilitation Program (PRP) services are for children and adolescents with serious mental illness of emotional disturbance who have been referred by a licensed professional of the healing arts based on a screening, assessment, or ongoing treatment of the participant. The services must be goal directed and outcome focused. The services are time-limited interventions provided only as long as they continue to be medically necessary to reduce symptoms of the participant’s mental illness and to restore the participant to an appropriate functional level.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

**II. Admission Criteria**

<table>
<thead>
<tr>
<th>All of the following criteria are necessary for admission:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The participant has a PBHS specialty mental health DSM 5 diagnosis, and the participant's impairment(s) and functional behavior can reasonably be expected to be improved or maintained by using these services.</td>
</tr>
<tr>
<td>B. The participant's mental illness is the cause of serious dysfunction in one or more life domains (home, school, community)</td>
</tr>
<tr>
<td>C. The impairment as a result of the participant's mental illness results in:</td>
</tr>
<tr>
<td>Y A clear, current threat to the participant's ability to be maintained in his/her customary setting, or</td>
</tr>
<tr>
<td>Y An emerging/pending risk to the safety of the participant and others, or</td>
</tr>
<tr>
<td>Y Other evidence of significant psychological or social impairments, such as inappropriate social behavior, causing serious problems with peer relationships and/or family members.</td>
</tr>
<tr>
<td>D. The participant, due to the dysfunction, is at risk for requiring a higher level of care, or is returning from a higher level of care.</td>
</tr>
<tr>
<td>E. The participant's condition requires an integrated program of rehabilitation services to develop and restore independent living skills to support the participant's recovery.</td>
</tr>
<tr>
<td>F. The participant does not require a more intensive level of care and is judged to be in enough behavioral control to be safe in the rehabilitation program and benefit from the rehabilitation provided.</td>
</tr>
<tr>
<td>G. A documented crisis response plan for the participant is in progress or completed.</td>
</tr>
<tr>
<td>H. An Individual Rehabilitation Plan (IRP) is in progress or completed.</td>
</tr>
</tbody>
</table>
I. PRP services will be rendered by staff that are supervised by a licensed mental health professional.

And either:

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

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

III. Severity of Need and Intensity of Service

Medical necessity for admission to Psychiatric Rehabilitation Program services must be documented by the presence of all of the criteria. The length and frequency of the services varies based on the participant’s needs and medical necessity. Professional and/or social supports must be identified and available to the participant outside of program hours and the participant or the participant’s parent/caretaker must be capable of seeking them as needed. Active involvement of the participant, family, caretakers, or significant others involved in the participant’s treatment should be sought.

IV. Continued Stay Criteria:

All of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria.

B. Clinical evidence indicates that the therapeutic re-entry into a less intensive level of care would result in exacerbation of the symptoms of the participant’s mental disorder.

C. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered. (There should be daily progress notes that document treatment and the participant’s response to treatment.)

D. The IRP and written crisis plan are complete and the IRP has been signed by at least two licensed mental health professionals who have collaborated regarding the IRP. The IRP is being carried out in accordance with the Child and Adolescent PRP regulations (COMAR 10.21.29).

E. There is evidence that the participant, family, caretaker or significant other is involved in treatment in the frequency and
indicated by the treatment plan.

E. There is documented active planning for transition to a less intensive level of care
### Level of Care: Mobile Treatment (Adults)

**I. Principles for Medical Criteria:** Mobile Treatment Services (MTS) are designed for adults with serious mental disorders which are exemplified by a lack of adherence to traditional services and vulnerability and to provide treatment in the least intensive setting that is able to meet the participant’s clinical needs. These services are provided by a multidisciplinary treatment team and are available to the participant on a 24/7 basis.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

**II. Admission Criteria:**

*All of the following criteria are necessary for admission:*

A. The participant has a PBHS specialty mental health DSM 5 diagnosis included in the Priority Population, which is the cause of significant psychological, personal care, and social impairment.

B. The impairments result in at least one of the following:
   - A clear, current threat to the participant’s ability to live in his/her customary setting, or the participant is homeless and would meet the criteria for a higher level of care if mobile treatment services were not provided; or is in a state institution or inpatient psychiatric facility and with the introduction of mobile treatment level of care would be able to return to living in his/her customary setting.
   - An emerging risk to self, property, or others, or the participant would experience heightened risk in these areas if mobile treatment services were not provided.
   - Inability to engage in, participate in, and benefit from traditional outpatient treatment.

C. Inability to form a therapeutic relationship on an ongoing basis as evidenced by one or more of the following:
   - Frequent use of emergency rooms/crisis services for psychiatric reasons.
   - A pattern of repeated psychiatric inpatient facility admissions or long-standing psychiatric hospitalizations or

**III. Severity of Need and Intensity of Service**

The participant’s condition requires intensive, comprehensive, integrated assertive mental health treatment, somatic treatment, and psychiatric rehabilitative services provided by a multidisciplinary team providing a minimum of weekly face to face contact to develop and restore independent living skills to support a participant’s recovery.

**IV. Continued Stay Criteria:**

*One of the following criteria are necessary for continuing treatment at the level of care:*

A. The participant continues to meet the admission criteria despite documented efforts to engage and support the participant in treatment and rehabilitation, or there is an emergence of additional problems consistent with admission criteria.
B. There is clinical evidence of symptom or functional improvement; however,
   ➢ the participant continues to be at risk for a higher level of care based on the participant’s response to attempts to reduce the frequency or intensity of services in a planned way or
   ➢ there is documented evidence that the participant is at risk due to the tenuous nature of clinical or functional gains.
C. There is documented evidence that the participant has either:
   ➢ Had limited or no progress toward goals and there are changes to the treatment plan and interventions or
   ➢ Had progress toward goals and there are changes to the treatment plan to support the participant’s transition to traditional outpatient services (i.e. scheduling and assisting participant with appointments, assisting participant with using public transportation independently, support participant’s efforts to actively participate in treatment, etc.)
# Level of Care: Mobile Treatment (Children and Adolescents)

## I. Principles for Medical Necessity Criteria: Mobile Treatment is designed for children and adolescents with serious mental disorders which are exemplified by non-compliance and vulnerability to provide treatment in the least intensive setting that is able to meet the participant’s clinical needs. These services are provided by a multidisciplinary treatment team and are available to the participant on a 24/7 basis.

## II. Admission Criteria:

**All of the following criteria are necessary for admission:**

A. The participant has a primary DSM 5 diagnosis that is the cause of significant psychological impairment.
B. The Participant is at risk for out-of-home placement and either:
   - Y The participant has not maintained, on a continuous basis, community mental health services that are prescribed, or
   - Y The participant is exhibiting behavior that is a risk of harm or self-harm
C. The primary caretaker:
   - Y Has the goal of maintaining the child or adolescent safely in the home, and
   - Y Agrees to participate in Mobile Treatment services.

## III. Severity of Need and Intensity of Service

The participant’s condition must require intensive, assertive mental health treatment and supportive services delivered by a multidisciplinary team, providing a minimum of weekly face-to-face contact.

## IV. Continued Stay Criteria:

**All of the following criteria are necessary for continuing treatment at this level of care:**

A. The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria.
B. Documentation exists of failed attempts to integrate the Participant into traditional outpatient treatment.
C. There is clinical evidence of symptom improvement using the service. If there is no improvement, there is documentation of treatment plan changes and/or a second opinion of the treatment plan.
D. The primary caretaker continues to support in-home placement and the Mobile Treatment services.
I. Principles for Medical Necessity Criteria:
The Therapeutic Behavioral Service (TBS) Program is a rehabilitative referred service for children and adolescents under 21 years of age. It is designed to provide rehabilitative treatment interventions to reduce or ameliorate the target maladaptive behavior(s) appropriately through restoration of a participant to his/her best possible functional level.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

II. Admission Criteria:  
All of the following criteria are necessary for admission:

| A. The participant has a PBHS specialty mental health DSM 5 diagnosis with maladaptive behaviors or symptoms relating to that diagnosis. |
| B. There is clinical evidence that the behaviors or symptoms place the participant’s current living arrangement at risk and create a risk for a more restrictive placement, or prevent transition to a less restrictive placement. |
| C. The services required are rehabilitative, not habilitative, custodial or activities of daily living. |
| D. The participant’s behaviors or symptoms can be safely and effectively treated in the community. |
| E. The participant requires on-site one-to-one behavioral assistance and intervention in order to accomplish outcomes specified in the behavioral plan. |

III. Severity of Need and Intensity of Service:
Medical necessity for admission to TBS Care must be documented by the presence of all of the criteria. Length and frequency of service varies based on the participant’s needs and medical necessity. TBS shall be decreased proportionally when indicated by the participant’s progress. A parent, guardian or the participant who customarily provides care must be present during the provision of services to participate in the behavioral plan unless there are clinical goals specifically addressed in the behavior plan that require that the parent, guardian or participant who customarily provides care not be present.
### IV. Continued Stay Criteria:

**All of the following criteria are necessary for continuing treatment at this level of care:**

A. The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria.

B. The target outcomes have not yet been reached.

C. The services have been decreased proportionally when indicated by the participant's progress.

D. There is clinical evidence of symptom improvement using the service. If there is no improvement:
   - the participant was reassessed for new target symptoms, and
   - the treatment plan has been reviewed and/or a second opinion of the treatment plan.

### V. Discharge Criteria

**Any of the following criteria are necessary and sufficient for planned discharge from TBS services:**

1. The consumer turns 21 years old.

2. The current behaviors no longer put the consumer at risk of out of home placement.

3. The consumer (consumer's family) has reached maximum benefit from TBS services as evidenced by the current care being more habilitative (rather than rehabilitative), custodial, or more focused on activities of daily living.

4. The parent, guardian or the individual who customarily provides care is no longer a pivotal part of the behavioral plan, or when the care giver fails to participate as outlined in the behavioral plan.

5. The parent, guardian or the individual who customarily provides care has learned to implement the behavioral plan and can continue to independently do so with consultation as needed from an outpatient therapist.

6. TBS has proven inadequate in addressing the consumer's needs. Therefore additional or more intensive services are clinically indicated.
# Level of Care: Outpatient Services

## I. Principles for Medical Necessity Criteria:
Outpatient Mental Health Services are less intensive than partial hospitalization and intensive outpatient treatment. Outpatient treatment is expected to be participant and family driven and recovery oriented.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

## II. Admission Criteria:
Both of the following criteria are necessary for admission:

A. The participant has a PBHS specialty mental health DSM 5 diagnosis with at least mild symptomatic distress and/or impairment in functioning due to the psychiatric symptoms and an appropriate description of the symptoms consistent with the diagnosis.

B. The participant’s behaviors or symptoms can be safely and effectively treated while living independently in the community.

## III. Severity of Need and Intensity of Service
Medical necessity for admission to Outpatient Mental Health Services must be documented by the presence of all of the criteria. Length and frequency of service varies based on the participant’s needs and medical necessity. Active involvement of the participant, family, caretakers, or significant others involved in the participant’s treatment should be sought.

## IV. Continued Stay Criteria:
All of the following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria despite treatment efforts, or there is emergence of additional problems consistent with the admission criteria.

B. The target outcomes have not yet been reached.

C. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident and/or a second opinion on the treatment plan has been considered.
Level of Care: Occupational Therapy Services

I. Principles for Medical Necessity Criteria:
Occupational Therapy involves a performance-based assessment and services relating to participant’s functioning in activities of daily living, cognitive skills, sensory-motor skills, and psycho-social skills. The goal of Occupational Therapy is to maximize the participant’s functional independence.

- Occupational Therapy performed in an inpatient unit by a hospital-based partial hospitalization program, or a hospital-based outpatient program, is provided as medically necessary, and does not require authorization by ValueOptions®.
- Occupational Therapy Services are not included in the daily rate for private psychiatric hospitals (Institutes of Mental Disease/IMDs). Consequently, Occupational Therapy Services provided in private psychiatric hospitals must be billed by a professional or professional group.
- Occupational Therapy performed in an outpatient setting requires authorization by ValueOptions® and is subject to medical necessity criteria.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

Claims Rules
- Claims for Occupational Therapy Services must be submitted on a CMS 1500 form in units of 15 minute increments. The exception is CPT Code 97150, Therapeutic Procedures Group, which is billed per.

II. Admission Criteria:

<table>
<thead>
<tr>
<th>All of the following criteria are necessary for admission:</th>
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</thead>
<tbody>
<tr>
<td>A. The participant either has MA, is PBHS-eligible Medicare, or Uninsured Eligible. The participant has a PBHS specialty mental health DSM 5 diagnosis.</td>
</tr>
<tr>
<td>B. The eligible participant has a co-morbid medical condition which requires, and is likely to respond to, outpatient occupational therapy services.</td>
</tr>
<tr>
<td>C. The service is provided by an Occupational Therapist actively licensed by the Maryland Board of Occupational Therapy Practice and demonstrates by training and experience the competency to provide Occupational Therapy to participants with mental illness, who also have a signed provider agreement with DHMH.</td>
</tr>
</tbody>
</table>

III. Severity of Need and Intensity of Service

Occupational therapy may be needed in any service setting in conjunction with other treatment modalities. The severity determination is made in an integrated fashion between the properly licensed and experienced occupational therapist and ValueOptions®. Length of treatment will vary depending on clinical status and is subject to medical necessity review.

IV. Continued Stay Criteria:

Both of the following criteria are necessary for continuing treatment at this level of care:
A. The participant continues to meet admission criteria and continues to be treated in an outpatient setting.

B. Progress in relation to specific symptoms/impairments/dysfunction is clearly evident and can be described in objective terms, but goals of treatment have not been achieved or adjustments in the treatment plan to address the lack of progress are evident.
### Level of Care: Respite Care- Child and Adolescent

**I. Principles for Medical Necessity Criteria:**
Respite Care should be considered a necessary level of care to provide support to family caregivers and maintain participants under age 18 in the current, least restrictive necessary level of care and to prevent escalation to more intensive levels. This service is intended to support caregivers for participants living in the home environment.

Participants already in out-of-home placements, such as group homes or other congregate facilities, are not appropriate for referral. Families whose ability to function is affected by the duties of childcare constitute the families to be referred for this service.

When a participant has a mental disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

**II. Admission Criteria:**
*All of the following criteria are necessary for admission:*

A. The participant has a PBHS specialty mental health DSM 5 diagnosis and has emotional and/or behavioral problems which stress the ability of the caregiver to provide for the Individual in the home.

B. The family caregiver’s ability to participate in normal activities of daily life in the community, including employment, training opportunities, other family obligations, and social connection is compromised as a result of caring for the Individual.

C. The additional stress on the caregiver of caring for the participant puts the participant at risk of out-of-home placement.

**III. Severity of Need and Intensity of Service**
Medical necessity for the use of Respite Care must be documented by the presence of all of the criteria. When an Individual has a mental disorder that requires professional evaluation and treatment, caring for this Individual can create a burden on caregivers. As a result, the level of burden on the family caregivers is as important a dimension in determining medical necessity as the clinical status of the Individual.

**IV. Continued Stay Criteria:**
The following criterion is necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria (A-C).
Level of Care: Respite Care - Adult

I. Principles for Medical Necessity Criteria:
Respite Care is provided when the caregiver, family member, or participant requires another environment on a short-term basis to support the participant in order to prevent escalation to more intensive levels of care.

In addition to the home environment, respite is an option when participants who live in congregate setting need a hiatus from the interactions with roommates in order to maintain their living environment.

When an Individual has a mental disorder that requires professional evaluation and treatment, he/she should be treated at the least intensive setting able to meet the individual’s medical needs. Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

II. Admission Criteria:  
All of the following criteria are necessary for admission:

A. The participant has a PBHS specialty mental health DSM 5 diagnosis and has emotional and/or behavioral problems which stress the ability of the caregiver to provide for the participant in the home.

B. The family or caregiver’s ability to participate in normal activities of daily life in the community, including employment, training opportunities, other family obligations, and social connection is compromised as a result of caring for the participant.

C. The additional stress on the caregiver of caring for the participant puts the participant at risk of out-of-home placement, homelessness, or a higher level of care.

III. Severity of Need and Intensity of Service
Medical necessity for the use of Respite Care must be documented by the presence of all of the criteria. Respite care can be used in a variety of settings to de-escalate situations that put the Individual at risk of losing his/her placement or needing higher levels of care.

IV. Continued Stay Criteria:
The following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria (A-C)
Level of Care: Case Management Services - Adult

I. Principles of Medical Necessity Criteria:
Case Management Services are provided to assist participants in gaining access to needed medical, mental health, social, educational, and other services. When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

II. Admission Criteria

**The following criteria are necessary for admission:**
A. The participant has a PBHS specialty mental health DSM 5 diagnosis which requires, and is likely to respond to, therapeutic intervention
   And Either
B. The participant is at risk of or needs continued community treatment to prevent inpatient psychiatric treatment
   Or
C. The participant is at risk of or needs community treatment to prevent being homeless
   Or
D. The participant is at risk of incarceration or will be released from a detention center or prison

** The specific diagnostic criteria may be waived for the following two conditions
1) An participant committed as not criminally responsible who is conditionally released from a BHA facility, according to the provisions of health General Article, Title 12, Annotated Code of Maryland
   Or
2) A participant in a BHA facility or a BHA-funded inpatient psychiatric hospital that requires community services. This excludes participants eligible for Developmental Disabilities Administration’s residential services

III. Severity of Need And Intensity of Service

Medical necessity for admission to Case Management Services must be documented by the presence of all of the criteria. Active involvement of the participant, family, caretaker, or others involved in the participant’s treatment should be sought.
Levels of Service:

**Level I – General:** Is based on the severity of the participant’s mental illness and if the participant meets at least one of the following conditions:

i. Not linked to mental health and medical services
ii. Lacks basic supports for shelter, food, and income
iii. Transitioning from one level of care to another; or
iv. Needs to maintain community-based treatment and services

**Level 2 – Intensive:** Is based on the severity of the participant’s mental illness, and if the participant urgently meets more than one of the following conditions:

i. Not linked to mental health and medical services
ii. Lacks basic supports for shelter, food, and income
iii. Transitioning from one level of care to another
iv. Needs to maintain community-based treatment and services

The following criteria are necessary for continuing treatment at this level of care:

A. The participant continues to meet admission criteria
   **And**
B. The participant is reassessed every six months after the initial assessment
   **And Either**
C. The participant's current/available living environment continues to present barriers to stabilizing them
   **Or**
D. Progress toward initial mental health, medical, social, and educational goals has not facilitated transition to another mental health service and the care plan reflects the necessary changes to address the lack of progress
   **Or**
E. There is evidence that case management services continue to plan for linkage to specific entitlements and/or services that will meet the ongoing needs of the participant
Psychological & Neuropsychological Testing

**Principles for Medical Necessity Criteria**

Psychological and neuropsychological testing involves the administration of reliable and valid psychological and neuropsychological tests for the purpose of answering specific questions about the participant's diagnosis and the development of clinically appropriate treatment recommendations. Psychological and neuropsychological testing should not be considered as a routine or normal procedure in a participant's treatment. Specific testing procedures selected by the psychologist should clearly relate to the questions listed on the request for psychological and neuropsychological testing.

When participants have a mental disorder that require professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below.

| Specific Medical Necessity Criteria for Psychological and Neuropsychological Testing | a. Testing request must not be solely for the purpose of vocational or educational assessments.  
| b. Testing request should be considered when other interventions are not successful in providing sufficient information with which to establish a diagnosis or to develop an appropriate plan of treatment or prior treatment has not been clinically effective.  
| • Participant’s should have already had a thorough diagnostic evaluation by a licensed mental health professional.  
| c. Testing for a medical condition (e.g., stroke, brain tumor, epilepsy, anoxia, head injury, etc.) is the responsibility of the Managed Care Organization (MCO) and should be referred to the MCO for authorization when the primary reason for the request is due to a medical diagnosis. |
III. Appendices

Appendix A

The following sole diagnoses are not in the domain of the public behavioral health system. Individuals with co-occurring covered PBHS psychiatric diagnosis are eligible for psychiatric services in the PBHS for treatment of that co-occurring psychiatric illness:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Pervasive Development Disorders
- Tic Disorders
- Delirium, Dementia, Amnestic and other Cognitive Disorders
- Mental Disorders due to a General Medical Condition (Personality Changes Due to a Medical Condition is an included PBHS diagnosis)
- Substance-Related Disorders
- Substance-Induced Disorders
- Sexual dysfunctions will not be covered except paraphilias and gender identity disorders
- Sleep Disorders (except Parasomnias)
- Antisocial Personality Disorder
- Psychological factors affecting medical condition
- Relational Problems
- Other V codes

Note: The Public Behavioral Health System will be available for consultation.
Appendix B - Therapeutic Leave of Absence Documentation

The criteria below for Therapeutic Leave of Absence (TLOA) are a more detailed elaboration of the above definition for the purposes of establishing medical necessity for these health care services.

**Definition**
Therapeutic Leave of Absence (TLOA) is any leave from a facility which is ordered by a physician, medically necessary, and not supervised by staff. A leave for medical reasons, e.g., consultations, evaluations, office visits, and treatments, is excluded from this definition.

**Documentation Guidelines**
To ensure that a TLOA is recognized as meeting the above definition, the medical record must contain the following information:
1. A physician must order each TLOA, identify it as a TLOA, and specify the number of leave hours approved.
2. Therapeutic rationale must be included in the ITP’s, and/or physician progress notes, and/or social worker notes.
3. The nurse, physician, or social worker must document the outcome of the TLOA in the medical record.

**Medical Necessity**
While these guidelines address the documentation of therapeutic leaves of absence, the medical necessity of each leave of absence continues to be determined by the application of the Psychiatric Hospitalization Criteria. Therapeutic leaves of absence are not reimbursed by the Public Mental Health System.
Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The participant receiving treatment is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. The ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement).

The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three (3) times per week. Continuation and maintenance ECT are most commonly administered at one- to four-week intervals.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific patient. This analysis considers the diagnosis of the patient and the severity of the presenting illness, the patient’s treatment history, the necessary speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

ECT can be safely administered at multiple levels of care including the outpatient setting. The least restrictive setting possible should be utilized. The medical necessity criteria for the requested setting should be utilized to determine level of care for delivery of the ECT.

The medical necessity determination for ECT should be independent of the determination for the level of care. A medical necessity review should be done for the appropriateness of ECT. A separate medical necessity review should be done for the appropriateness of level of care based on the applicable criteria (e.g. IPMH, OP, etc.). ECT should not be given at a higher level of care solely for convenience, due to dispositional factors, transportation issues, or due to provider protocols unless medical necessity is independently established for that level of care.

Criteria

Admission Criteria

The following criterion is necessary for admission:

1. The participant has been evaluated by a licensed psychiatrist and demonstrates severe symptomatology consistent with a DSM 5 primary diagnosis of major depression, bipolar disorder, mania, schizophrenia, or related psychotic disorder, which requires, and can reasonably be expected to, respond to ECT.

In addition, one of the following (2-4) must be present:

2. The participant has the immediate need for a rapid or high probability of response due to the existence of severe unstable medical illness or significant risk to self or other and other somatic treatments would potentially put the patient at significant risk due to the slower onset of action.

3. The participant has failed to respond to at least two adequate trials of pharmacotherapy. or

4. The participant is at significant risk of relapse or reoccurrence of a major mental illness that was successfully treated with ECT in the past.

Psychosocial, Occupational, and Cultural and Linguistic

These factors, as detailed in the introduction, may change the risk assessment and should be considered when making level-of-care decisions.
### Exclusion Criteria

**One of the following criteria (1-2) is sufficient for exclusion from this level of care:**

1. The participant can be safely maintained and effectively treated with a less intrusive therapy; or

2. Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific participant from this level of care. Such conditions include but are not limited to:
   a) unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease;
   b) aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure;
   c) increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions;
   d) recent cerebral infarction;
   e) pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and
   f) anesthetic risk rated as American Society of Anesthesiologists level 4 or 5.

### Continued Stay Criteria

**All of the following criteria (1-10) are necessary for continuing treatment:**

1. Treatment planning is individualized and appropriate to the participant’s changing condition with realistic and specific goals and objectives stated. This process should actively involve family, guardian, and/or other natural support systems unless contraindicated;

2. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice;

3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms but goals of treatment have not yet been achieved; or adjustments in the treatment plan to address lack of progress evident.

4. Care is rendered in a clinically appropriate manner and focused on the participant’s behavioral and functional outcomes as described in the discharge plan. The provider documents that there is careful monitoring of mood, psychosis, cognitive factors, and physical symptoms between treatments;

5. The total number of treatments administered should be a function of both the degree and rate of clinical improvement and the severity of adverse side effects. The typical course of treatment is between 6-12 sessions. In the absence of significant clinical improvement after 6-10 sessions, the indication for continued ECT should be reassessed. Partial response must be evident to extend authorization beyond 10 sessions;

6. The participant is actively participating in the plan of care and treatment to the extent possible consistent with his/her condition;

7. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as the treatment plan requires or there are active efforts being made and documented to involve them.
8. A thorough evaluation of the use of any psychopharmacological agents has been completed. This could include the concurrent use of medications or the requirement for discontinuation;

9. There is documented active discharge planning from the beginning of treatment; and

10. There is documented active coordination of care with other behavioral health providers, the PCC (primary care clinician), and other services and state agencies. If coordination is not successful, the reasons are documented and efforts to coordinate care continue.

**Discharge Criteria**

**Any of the following criteria (1-5) is sufficient for discharge from this level of care:**

1. Treatment plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed.

2. The participant, family, and/or legal guardian is competent but not engaged in treatment or in following program rules and regulations. The lack of engagement is of such a degree that treatment at this level of care becomes ineffective or unsafe, despite multiple, documented attempts to address engagement issues;

3. Consent for treatment is withdrawn and, either it has been determined that involuntary ECT treatment is not a valid legal option.

4. The participant is not making progress toward treatment goals, and there is no reasonable expectation of progress, nor is ECT required to maintain the current level of functioning; or

5. The participant’s physical or psychiatric condition necessitates discontinuation of ECT.
### Acute Neurobehavioral Unit

#### Principles for Medical Necessity Criteria

Acute inpatient psychiatric treatment is defined as 24-hour inpatient level of care that provides highly skilled psychiatric services to participants with severe mental disorders.

When participants have a mental health disorder that requires professional evaluation and treatment, they should be treated at the least intensive setting able to meet their medical needs.

Satisfaction of all admission and continued care criteria must be documented in the clinical record based upon the conditions and factors identified below before treatment will be authorized.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Admission Criteria</th>
</tr>
</thead>
</table>
| The following criteria are necessary for admission: (a-d must be met) | a. The participant must have a diagnosed or suspected mental disorder/serious emotional disturbance, with maladaptive behaviors or symptoms relating to that disorder.  
b. The participant’s symptoms and/or behaviors can be expected to improve significantly through medically necessary treatment. Symptoms and/or behaviors that are not improving or likely to improve are considered habilitative and do not meet admission criteria.  
c. The evaluation and assignment of the mental disorder/serious emotional disturbance must take place in a face to face evaluation of the participant performed by an attending physician prior to, or within 24 hours following an admission  
d. Presence of a mental disorder/serious emotional disturbance must be documented through the assignment of DSM 5 codes, excluded diagnoses can be found in Appendix A.  |

<table>
<thead>
<tr>
<th>Severity of Need and Intensity of Service at the Acute Level of Care</th>
<th>[Criterion a must be met. In addition, b, c, or d must be met].</th>
</tr>
</thead>
</table>
| a. PBHS Specialty Mental Health DSM 5 diagnosis                       | b. The participant’s behaviors make direct and significant harm to self, or there is a clear and reasonable inference of serious harm to self, requiring intervention and observation on a 24-hour basis. This behavior must require intensive psychiatric and nursing treatment interventions on a 24 hour basis.  
c. The participant demonstrates violent, unpredictable or uncontrolled behavior which represents potential serious harm to others. This behavior must require intensive psychiatric and nursing treatment interventions on a 24 hour basis.  |
<table>
<thead>
<tr>
<th>Criteria for Continued Stay</th>
<th>The individual treatment plan should include documentation of diagnosis (DSM-5), documentation of ongoing caregiver behavioral plan training, discharge planning, individualized goals of treatment and treatment modalities needed and provided on a 2 hour basis. There should be daily progress notes documenting the provider’s treatment and the participant’s response to treatment. In addition to continuing to meet the criteria given above for admission, all of criterion a, b, and c must continue to be met. Evidence must also exist for meeting at least one of criterion (d-f)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The participant continues to meet admission criteria despite treatment efforts.</td>
<td>a. The participant continues to meet admission criteria despite treatment efforts.</td>
</tr>
<tr>
<td>b. There is clinical evidence of symptom improvement or behavior reduction using the service. If there has been no improvement the treatment plan has been reviewed and/or a second opinion of the treatment plan has been obtained. Lack of evidence of improvement or behavior reduction is grounds for reconsideration of admission criterion II c: reassessment of habilitative nature of symptomatology.</td>
<td>b. There is clinical evidence of symptom improvement or behavior reduction using the service. If there has been no improvement the treatment plan has been reviewed and/or a second opinion of the treatment plan has been obtained. Lack of evidence of improvement or behavior reduction is grounds for reconsideration of admission criterion II c: reassessment of habilitative nature of symptomatology.</td>
</tr>
<tr>
<td>c. There is documented evidence that disposition planning, including plans to train after-care providers (home, school etc.) on behavioral strategies and interventions, is begun from the time of admission and continues throughout the hospitalization.</td>
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</tr>
<tr>
<td>d. The targeted outcome of 75% reduction in seriously unsafe behaviors has not yet been reached.</td>
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</tr>
<tr>
<td>e. The physician documents in daily progress notes that there is a severe reaction to medication or need for further monitoring and adjustment of dosage in an inpatient setting.</td>
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</tr>
<tr>
<td>f. The emergence of additional problems or behaviors which are consistent with the admission criteria and to the degree that would necessitate continued hospitalization.</td>
<td>f. The emergence of additional problems or behaviors which are consistent with the admission criteria and to the degree that would necessitate continued hospitalization.</td>
</tr>
<tr>
<td>Discharge Criteria</td>
<td>Any of the following criteria are sufficient for discharge from this level of care:</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1. Reduction of targeted behaviors (those which led to hospitalization) by 75%.</td>
<td>1. Reduction of targeted behaviors (those which led to hospitalization) by 75%.</td>
</tr>
<tr>
<td>2. Extended lack of evidence of improvement or behavior reduction despite multiple re-evaluations of treatment plan and second opinions. Admission criterion II c: needs to be reassessed to determine if symptomatology is habilitative in nature.</td>
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</tr>
<tr>
<td>3. Identification of a safe, continuing care program which can be arranged and deployed at a lower level of care. Follow-up aftercare should</td>
<td>3. Identification of a safe, continuing care program which can be arranged and deployed at a lower level of care. Follow-up aftercare should</td>
</tr>
<tr>
<td>continue to further develop and implement behavioral treatment plans developed on the neurobehavioral unit. Development of such a treatment plan and basic training of primary caretakers is sufficient for discharge. 4. The participant no longer meets admission criteria or meets criteria for a less intensive level of care. 5. The participant, family, legal guardian and/or custodian are competent but non-participatory in treatment or in following program rules and regulations; the non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 8

SERVICES FOR INDIVIDUALS WHO ARE DEAF AND HARD OF HEARING

Services under the Public Behavioral Health System (PBHS) are provided to individuals who are deaf and hard of hearing, who meet the eligibility for public mental health services. ValueOptions® strives to ensure there is an equal access to all services and resources for all Marylanders. To service individuals who are deaf and hard of hearing, ValueOptions® can be accessed through the TTY number (866) 835-2755.

In some instances there may be a need for an American Sign Language (ASL) or other visual language interpreter in order for services to be rendered. An interpreter may be needed in the following three instances: 1) a participant is deaf or hard of hearing, 2) a participant is a minor and has a parent(s) that is deaf or hard of hearing, or 3) a provider is deaf and hard of hearing.

1. If the behavioral health professional selected by the participant is not proficient in ASL/other visual language interpretation, an interpreter can be secured in order for the participant to access services. The treating professional shall be reimbursed for the service at normal rates and the interpreting services shall be reimbursed.
2. If the mental health professional selected for a minor is not proficient in ASL/other visual language interpretation, and the minor’s parent/s are deaf and hard of hearing, an interpreter may be secured in order for the minor’s parent(s) to participate in treatment with their child. The treating professional shall be reimbursed for the service at normal rates and the interpreting services shall be reimbursed.

3. If the service provider is deaf and hard of hearing and needs an interpreter in order to communicate with hearing participants, family members or group members participating in the services, interpreter reimbursement is also allowed.

**Reimbursement**

Providers MUST contact the CSA of the participant’s residence of record prior to service delivery. The CSA will pay for ASL interpreting or other visual language interpreting services Behavioral Health Administration (BHA) will adjust the CSAs contract accordingly, if funding is not available under their existing contract.

Providers should also access the Office of the Deaf and Hard of Hearing (ODHH). They work not only as an advocacy group, but are a resource for state and local agencies. The ODHH offers awareness training to increase knowledge about the accessibility of services, as well as technical assistance to government agencies who may have questions regarding communication access and constituent services.
CHAPTER 9

RESERVED FOR FUTURE USE

This chapter is being reserved for future use.
This chapter describes the reconsideration, grievance, and appeals process. Through ValueOptions® Maryland and the Behavioral Health Administration, the Department offers a reconsideration and grievance process as a benefit to participants. This process can be utilized when a participant receives a clinical service non-authorization decision from ValueOptions® Maryland with which he/she disagrees. The participant may provide written authorization for the provider to act on his/her behalf to initiate the reconsideration and grievance process. Maryland Medicaid participants are entitled to appeal rights as specified in COMAR 10.01.04 and Medicaid providers may file an appeal pursuant to COMAR 10.09.36, as detailed in this chapter.

Definitions

An administrative denial is a non-payment of a claim resulting from failure to meet administrative requirements set forth by the Department. More information and examples of reasons for administrative denials can be found on page 10 of this chapter.

An appeal is the formal process available to Medicaid participants, as described in COMAR 10.01.04, and to Medicaid providers, as described in COMAR 10.09.36, to request the Office of Administrative Hearings (OAH) to review a decision made by the Department or its designee.

Clinical service non-authorization is defined as a determination by a ValueOptions® Maryland Physician Advisor (PA) that based on information submitted the behavioral health services requested are not medically necessary.
A **grievance** is the process available to participants that have received a clinical service non-authorization and wish to request a review of the decision. The grievance process includes two levels of review, the first to ValueOptions® Maryland and the second to the Behavioral Health Administration (BHA).

A **Grievance and Appeal Coordinator** is a ValueOptions® Maryland administrative support staff member who coordinates the resolution of the grievance and appeal request with the appropriate staff.

The **Office of Administrative Hearings** is an independent state agency that resolves appeals through a formal and impartial hearing conducted by an Administrative Law Judge.

A **participant**, for the purposes of this document, is an individual with active Medicaid (MA) coverage. Uninsured individuals who receive substance use disorder services should contact their local health authority for information on grievance rights for grant-funded services.

A **Physician Advisor (PA)** is a board-certified, Maryland licensed psychiatrist who reviews authorization requests and performs medical necessity determinations for ValueOptions® Maryland. Only a PA can make clinical service non-authorization determinations.

A **reconsideration** is a request for a peer-to-peer review between the provider and a ValueOptions® Maryland Physician Advisor (PA) to review an initial non-authorization of service.
RECONSIDERATIONS and GRIEVANCES

The reconsideration and grievance processes provide participants an alternative to immediate appeal to OAH following a determination by ValueOptions® Maryland to deny authorization of a clinical service. The processes are available to participants who have executed a written authorization for their provider to act on their behalf. The participant may appeal a denial of authorization directly to OAH without participating in the reconsideration and grievance processes.

Reconsiderations

The reconsideration process is an option available to participants following a clinical service non-authorization. The participant may seek reconsideration by designating the provider to act on his/her behalf by providing written authorization. Upon receiving authorization from the participant, the provider may request a peer-to-peer review from a ValueOptions® Maryland Physician Advisor (PA), if a PA had not participated in such a review during the initial clinical service authorization determination. To request reconsideration, the provider must contact ValueOptions® Maryland within three (3) business days of receiving the initial clinical service non-authorization notice.

ValueOptions® Maryland Grievance Review I

If, after reconsideration, the participant continues to disagree with ValueOptions® Maryland’s decision, the provider, acting on behalf of the participant, may request a review by another ValueOptions® Maryland PA as part of the Grievance Review I process. To submit a Grievance Review I, the provider must call or mail ValueOptions® Maryland within ten (10) business days of receiving the initial clinical
service non-authorization to initiate a review. Providers can call, fax or mail their request to the following:

Call: 1-410-691-4049

Fax: 1-877-381-5571

Mail: ValueOptions® Maryland
      ATTN: Grievances & Appeals Dept.
      1099 Winterson Road, Suite 200
      Linthicum, MD 21090

ValueOptions® Maryland will directly contact the provider to offer a peer-to-peer review and make a timely decision. ValueOptions® Maryland will make its determination within 24 hours or close of next business day for an urgent request and five (5) calendar days for non-urgent requests. If the provider declines a peer-to-peer review or is not available within the timeframe for ValueOptions® Maryland to make a determination, the ValueOptions® Maryland PA will make a determination without a peer-to-peer review and will notify the provider in writing of its decision within two (2) business days. If the PA approves the service request, ValueOptions® Maryland will enter the authorization into ProviderConnect® and make it available for the provider to download. If the PA concludes that authorization is not granted, the participant may request a Grievance Review II to the Behavioral Health Administration (BHA).

**Behavioral Health Administration Grievance Review II**

If the participant does not agree with ValueOptions® Maryland’s decision to uphold the clinical service non-authorization, the provider, acting on behalf of the participant, may request a Grievance Review II to the BHA. The provider must file a request
postmarked within ten (10) business days of receiving ValueOptions® Maryland’s decision to uphold the clinical service non-authorization by mailing to BHA a letter stating the rationale for the grievance review, the original denial from ValueOptions® Maryland, and any supporting clinical documentation. Materials should be sent to the following address:

Mail: Behavioral Health Administration  
      ATTN: Grievances and Appeals  
      Spring Grove Hospital Center – Dix Building 55 Wade Avenue  
      Catonsville, MD  21228

The BHA’s review process may include input from a Core Service Agency (CSA) and/or Local Addictions Authority (LAA) as needed. The BHA generally completes reviews within thirty (30) calendar days and notifies the participant, provider, and ValueOptions® Maryland in writing once a decision has been reached.

If the BHA review results in the determination that the requested service is medically necessary, ValueOptions® Maryland will enter the authorization into ProviderConnect® and make it available for the provider to download. If the BHA review results in confirmation of non-authorization, the BHA’s response to a Grievance Review II is a final determination for uninsured individuals. In the case of Medicaid participants, an appeal can be submitted to the Office of Administrative Hearings (OAH).
APPEALS

Maryland Medicaid participants are entitled to appeal rights as specified in COMAR 10.01.04 and Maryland Medicaid providers may file an appeal pursuant to COMAR 10.09.36.

Participant Appeals

A participant may submit an appeal to the Office of Administrative Hearings (OAH) for the reasons listed in COMAR 10.01.04, including appealing the Department’s decision to not authorize a service based on a medical necessity determination. The participant can file the appeal him/herself, or designate an authorized representative to act on his behalf. A provider may act on behalf of the participant if the participant designates the provider as an authorized representative in writing with the participant’s signature or by providing proof of legal authority outlined in COMAR 10.01.04.12.

To submit an appeal, the participant must file a notice to OAH postmarked within ninety (90) days of the initial denial notice. The participant must make the request in writing, and include the specific reason(s) for the appeal with a copy of the original denial letter from ValueOptions® Maryland. Requests for appeal hearings must be submitted via mail to:

Mail: Department of Health and Mental Hygiene
Office of Health Services, Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, MD 21201

OAH expects the appellant to be present for the hearing. If, for any reason, the appellant or the appellant’s authorized representative cannot attend the hearing, OAH must be notified so that the hearing can be rescheduled. OAH does not require the
appellant to be represented by a lawyer, but the appellant may choose to be
represented by a lawyer. For more information on the OAH hearing process, please
refer to the OAH website:  http://www.oah.state.md.us/faq.asp.

Provider Appeals

A provider may submit an appeal to the Office of Administrative Hearings (OAH) for
the reasons listed in COMAR 10.09.36.09, including that the Department withheld
payment for a service that the provider delivered.

To submit an appeal, the provider must file a notice to the OAH within thirty (30)
days of the initial denial notice. The provider must make the request in writing, and
include the specific reason(s) for the appeal with a copy of the decision being appealed.
Requests for appeal hearings must be submitted via mail to:

Mail: Department of Health and Mental Hygiene
      Office of Health Services, Attention: Appeals
      201 W. Preston Street, 1st Floor
      Baltimore, MD 21201

ADMINISTRATIVE DENIALS

ValueOptions® Maryland may deny a request for authorization of services based on
administrative requirements, even in cases where the participant may meet the medical
necessity criteria. The majority of administrative denials occur for the following reasons:

1. The provider fails to obtain preauthorization.
2. The provider did not meet the timely filing requirements.
3. The participant is not a Medicaid participant.
4. The same service is provided on the same day by another provider, who has
   already received payment.
In accordance with COMAR 10.09.59.08, all services must be pre-authorized in order to receive payment. ValueOptions® Maryland will review requests for retrospective authorization only in cases where a participant has gained retroactive Medical Assistance benefits. ValueOptions® Maryland will process all other requests for retrospective authorization reviews as an administrative denial, including cases of retroactive provider enrollment. The Department encourages providers to utilize the courtesy review process to be compliant with COMAR 10.09.59.08 in cases when a provider is unsure whether a consumer is Medicaid eligible. Please call 1-800-888-1965 to initiate a courtesy review. The Department will honor preauthorizations issued through the courtesy review process and will reimburse for the authorized services covered under Maryland Medicaid.

If the provider believes the administrative denial has resulted from an error, technical or otherwise made by ValueOptions®, then documentation of the error must be submitted to ValueOptions® Maryland within 30 days from the date of the administrative denial notice by either fax or mail to the following:

Fax: 1-877-381-5571

Mail: ValueOptions® Maryland
ATTN: Grievances & Appeals Dept.
1099 Winterson Road, Suite 200
Linthicum, MD 21090
CHAPTER 11

PROVIDER AUDITS

Providers accepting Medicaid reimbursement are required to comply with regulations set forth in COMAR 10.09.36 and are required to structure and administer their programs and practices according to the regulations specific to the service(s) rendered. Participation in Public Behavioral Health System (PBHS) requires providers to maintain participant records which meet all federal and state documentation requirements. Providers are subject to announced and unannounced audits by ValueOptions® Maryland and are expected to make requested records available for review at the time of their audit.

ValueOptions® Maryland will perform audits on PBHS programs including:

- Individual Practitioners
- Group Practitioners
- Inpatient Hospitals
- Residential Treatment Centers,
- Substance Abuse Related Disorder Programs and Providers
- Community Mental Health Program Providers
- Other Licensed or Approved Programs as directed
ValueOptions® Maryland uses audit tools approved by the Behavioral Health Administration (BHA) and Medicaid. The audit tools can be found on the ValueOptions® Maryland website http://maryland.valueoptions.com/. All audits include a review of staffing; documentation— including consents, uninsured eligibility documentation, assessments, treatment plans, and contact/progress notes; evaluates service delivery, and; reviews billing records. Provider selection may be based on high utilizers, unusual service patterns, billing outliers, allegations of fraud and abuse, or recommendations from BHA and Medicaid.

Upon completion of an audit, ValueOptions® Maryland will issue a report to be shared with the provider, BHA, Medicaid, and, as required, DHMH Office of Inspector General and Office of the Attorney General/Medicaid Fraud Control Unit. Reports detail audit findings, billing retraction amounts and best practice recommendations. Providers are required to submit a Program Improvement Plan (PIP) for audit areas with less than 75 percent compliance rate.

If ValueOptions® Maryland suspects fraudulent or unethical behavior, providers will be referred to the appropriate state enforcement entity. Audits resulting in state disciplinary action or a PIP may require close monitoring by ValueOptions® Maryland and will be subject to frequent audits.
CHAPTER 12

COORDINATION OF CARE

The Maryland Public Behavioral Health System (PBHS) emphasizes communication between mental health providers, medical care providers, and substance related disorder providers. ValueOptions has embraced this integrated philosophy and provides key services that will enable better coordination of care for an individual’s treatment teams.

12.1 Coordination for Individuals with Medical Care Providers and HealthChoice MCOs

There can be many challenges in ensuring seamless care for an individual who utilizes a variety of treatment providers. However, ValueOptions offers a variety of services that assist in the bridging of any service gaps. With the consent of the individual, the treating behavioral health provider(s) communicate directly with the medical care provider on a regular basis in order to coordinate behavioral health and somatic health care. Interdisciplinary and interdepartmental conference calls, data sharing, treatment planning, and outreach to participants are all options for coordinating care on high-risk participants. To assist in this coordination of care, ValueOptions Maryland also communicates with the HealthChoice MCOs regarding high-risk participants with co-occurring behavioral health conditions and medical disorders. To better serve the
individual and the providers, ValueOptions is available to play a role in treatment and recovery plans developed to meet the needs of individuals.

ValueOptions will also coordinate with other agencies such as, DHR, DSS, DJS, DDA, Department of Education, BHA, Medicaid, Core Service Agencies, and Local Addictions Authorities on an as needed basis. Pharmacy data is integrated into ProviderConnect and is available to assist providers in the development and coordination of the optimal care plan.

To further ensure that individuals are receiving the appropriate coordination of services, ValueOptions will conduct both scheduled and unscheduled audits. On-site audits by ValueOptions® Maryland include a review of medical records for evidence of coordination of behavioral health services and somatic care.

12.2 Rare and Expensive Case Management (REM)

REM is a case management program for people who have rare and expensive diseases, the types of which are listed in Code of Maryland Regulations (COMAR). These individuals may have congenital anomalies, AIDS, metabolic disorders, or renal failure. REM is a carve-out of HealthChoice. Individuals who are in REM are disenrolled from their MCO, and become Medical Assistance, fee for service.

12.3 Coordination of Care for Individuals with Severe and Persistent Behavioral Health Disorders and Co-Occurring Medical Disorders
Individuals with severe and persistent behavioral health disorders leading to frequent medical and/or behavioral health hospitalizations may require more intensive coordination efforts. These participants are identified, flagged, and tracked by ValueOptions Maryland in order to facilitate coordination between hospitals and community-based behavioral health providers.

As described in the above sections, ValueOptions Maryland identifies and tracks high-risk participants within PBHS. Referrals are received on an ongoing basis from ValueOptions Maryland Clinical Care Managers, MCOs, CSAs, LAAs, and providers, as well as from regular reports of multiple inpatient admissions. Once participants are identified and their treatment history is analyzed, they are flagged in the ValueOptions Care Management system to track future utilization patterns. This allows ValueOptions to involve relevant stakeholders in the discharge, transition, treatment, and rehabilitation planning of their participants. When an individual is identified, ValueOptions Clinical Care Managers notify the treating and/or requesting behavioral health providers, by phone, regarding the high-risk status of the participant. ValueOptions also e-mails the participant’s CSA and/or LAA, daily, regarding any new admission to inpatient services for these high-risk participants.

For cases that involve the highest risk, ValueOptions has designated resources who provide Intensive Care Management and coordination of care activities. The goal of providing these services is to improve care and reduce inpatient recidivism by pulling together relevant stakeholders to collaborate on the participant’s aftercare plans. As part of this collaboration, ValueOptions often completes a Peer-to-Peer consultation with the treating behavioral health provider to review the treatment and aftercare plans. The ValueOptions’ MCO Liaison coordinates either telephonic or in-person meetings with relevant parties. These parties can include, but are not limited to, CSAs, LAAs, MCOs, behavioral health providers, and medical care providers, and are utilized to discuss a
comprehensive and individualized approach to address the participant’s behavioral health and medical care needs. Referrals for this program may be made by contacting the ValueOptions® Maryland MCO Liaison.
CHAPTER 13

LABORATORY SERVICES

Substance Used Disorder (SUD) Providers

For dates of service after 12/31/2014, laboratories must bill the Department’s Administrative Services Organization (ASO), ValueOptions® (VO), for drug screening services related to SUD treatment services. Maryland Medicaid will follow the guidance of the Centers for Medicare and Medicaid Services regarding drug screening services. Because Medicare has decided not to price the new drug testing codes, Maryland Medicaid will use the alphanumeric G codes developed to replace the 2014 CPT codes that are being deleted for 2015. Maryland Medicaid reimburses for lab tests at 80% of Medicare payment rates and therefore, we will not pay for new CPT codes for drug abuse tests.

Specifically, Maryland Medicaid will use G0434 to report simple testing methods, such as dipsticks, cups, cassettes, and cards that are interpreted visually, with the assistance of a scanner, or are read utilizing a moderately complex reader device outside the instrumented laboratory setting. This code is also used to report any other type of drug screen testing using test(s) that are classified as Clinical Laboratory Improvements (CLIA) moderate complexity test(s). G0434 includes qualitative drug screen tests that are waived under CLIA as well as dipsticks, cups,
cards and cassettes that are not CLIA waived. Please note that only one unit of service for code G0434 can be billed per patient encounter regardless of the number of drug classes tested. OMTs have this service included in their bundled weekly rates, therefore, if a physician working with an OMT orders G0434, the laboratory should bill the OMT for this service.

Maryland Medicaid will use G0431 for more complex testing methods, such as multi-channel chemistry analyzers, where a more complex instrumented device is required to perform some or all of the screening tests for the patient. This code may only be used if the drug screen is classified as a CLIA high complexity test(s). CLILA waived tests and comparable non-waived tests may not be reported under test code G0431 and must instead be billed under procedure code G0434. G0431 may only be reported once per patient encounter and laboratories billing G0431 must not append the QW modifier to the claim.

Other single use CPT codes which may be billed to ValueOptions® when medically appropriate are as follows:

- G6040 Alcohol; any specimen except breathe
- G6042 Amphetamine or methamphetamine
- G6043 Barbiturates, not otherwise specified
- G6031 Benzodiazepines
- G6044 Cocaine or metabolite
- G6053 Methadone
- G6056 Opiate(s), drug and metabolites, each procedure
Additionally, all claims must have the SUD diagnosis included on the claim.

*See COMAR 10.09.70, available at:
http://www.dsd.state.md.us/MDRegister/4120.pdf

Mental Health (MH) Providers

The PBHS will reimburse laboratories that are in compliance with Maryland law (COMAR 10.09.09) for medically necessary tests and procedures related to psychiatric treatment rendered to Medicaid recipients by psychiatrists in the PBHS network. The laboratory must have a valid Maryland MA provider number for laboratory services.
CHAPTER 14

PHARMACY

Medical Assistance Recipients

Medication Coverage

The Maryland Medicaid Pharmacy Program (MMPP) has a Preferred Drug List (PDL) Program. Substance Use Disorder (SUD) medications are a part of this program. The PDL is posted on the MMPP website at: https://mmcp.dhmh.maryland.gov/pap/SitePages/druglist.aspx. Alternatively, you may search the status of a drug using Epocrates Online. Some medications require Prior Authorization (PA) due to quantity limits and/or clinical criteria, which are measures to encourage the safe and appropriate use of a drug. SUD medications that have quantity limits and/or clinical criteria are available at: (quantity limits) https://mmcp.dhmh.maryland.gov/pap/docs/QL%20.pdf (clinical criteria) at: https://mmcp.dhmh.maryland.gov/pap/docs/Substance%20Use%20Disorder%20Medication%20Clinical%20Criteria%20Final%20Dec%205%2014%20(1).pdf

Pharmacy Network

Participants with medical assistance (MA) should use the pharmacy network and pharmacy card that they use for their medical prescription drug needs. However,
participants who are enrolled in a Managed Care Organization (MCO), use the pharmacy card they received from their enrollment MCO. Recipients do not need to carry a separate card or use a different pharmacy network for their Substance Use Disorder (SUD) medications. Participants without MA may contact their Core Service Agency (CSA) or Local Addictions Authority (LAA) to inquire about pharmacy assistance or other help that may be available.

Additional Information

Additional information regarding the Medicaid Pharmacy benefit may be accessed at: https://mmcp.dhmh.maryland.gov/pap/SitePages/paphome.aspx
CHAPTER 15
TRANSPORTATION

For Medicaid recipients, transportation to outpatient mental health clinic appointments is primarily the responsibility of the local health department. Transportation for Medicaid recipients will be based on closest, willing provider. Transportation to Psychiatric Rehabilitation Programs (PRP) is included in the PRP rate of reimbursement under the Public Behavioral Health System’s Fee-for-Services payment, whether or not the person is eligible for Medicaid. The time transporting the participant is not allowed. Transportation time and the act of transporting individuals to a rehab service is not reimbursed.

If an ambulance is called for a behavioral health emergency involving a Medicaid recipient, the ambulance provider must bill Medicaid directly. Ambulance services are not authorized through ValueOptions® Maryland, and the bill is not to be sent to ValueOptions® Maryland.

In accordance with Health General Article 10-628 for reimbursement for services provided under the Emergency Petition process, the Behavioral Health Administration (BHA) will pay for transportation of an individual by a public safety officer, to an emergency facility for an emergency evaluation, if the individual is uninsured or their insurance does not cover this. If, after evaluation by a physician, the individual is
verified for an involuntary admission, BHA will reimburse for transportation from the community hospital’s emergency department, to the receiving hospital that has been identified to accept that person as an involuntary admission. In these two instances, ValueOptions® Maryland may be billed for transportation. However, if an individual is subsequently found to have private insurance, the ambulance service bill should be paid by the private insurance. For costs requested for transportation reimbursement under Emergency Petition process, ValueOptions® Maryland should be provided a bill and documentation of services.
CHAPTER 16 Medicaid Waivers

16.1 Waiver for Adults with Traumatic Brain Injury Services

Maryland’s Home and Community Based Services Waiver for Adults with Traumatic Brain Injury (referred to as TBI Waiver) was implemented July 1, 2003 and renewed for an additional five years July 1, 2006. The administering state agency is the Mental Hygiene Administration (MHA) with oversight from the Office of Health Services, Division of Waiver Programs (OHS/ DWP).

The program was initially designed as a resource for Maryland residents with traumatic brain injury who could not be served in traditional long-term care settings within the state primarily due to the severity of their neurobehavioral deficits. Technical eligibility is based on type of injury, age at injury and the location where the applicant is residing. Technical eligibility is limited to individuals with a traumatic brain injury that has occurred after the age of 21 who are in a state psychiatric hospital, an out of state placement funded through Maryland Medicaid, a state owned and operated nursing facility, or a chronic hospitals that is CARF accredited for inpatient brain injury rehabilitation.

The following four services are available through the Waiver for Adults with Traumatic Brain Injury: residential habilitation, day habilitation, supported
employment, and individual support services.

Technical, medical and financial eligibility for the program is established in COMAR 10.9.46. TBI waiver services are authorized by MHA’s office of Adult Services. Providers of TBI waiver Services must be approved by MHA’s Office of Adult Services in accordance with COMAR 10.09.46.

Residential Habilitation

Residential habilitation services provide participants with assistance with acquisition, retention, or improvement in skills related to activities of daily living and the social and adaptive skills necessary to enable the individual to live in a non-institutional setting. The services provided in a residential program are provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of care approved by the MHA:

- Level 1 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.
- Level 2 requires a minimum of 1:3 staff to participant ratio during day and evening shifts and awake, on-site supervision during overnight shift.
- Level 3 requires a 1:1 staff to participant ratio during day and evening shifts and awake on-site supervision during overnight shift.

Day Habilitation
Day habilitation services provide participants with assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which takes place in a nonresidential setting, separate from the home or facility in which the individual resides, normally furnished 4 or more hours per day.

The services provided in a day habilitation program are provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of care approved by the MHA:

- Level 1 requires a minimum of 1:6 staff to participant ratio.
- Level 2 requires a minimum of 1:4 staff to participant ratio.
- Level 3 requires a minimum of 1:1 staff to participant ratio.

**Supported Employment**

Supported employment services include activities needed to support paid work by individuals receiving waiver services, including supervision and training.

The services are provided and reimbursed at one of three levels of service, as preauthorized in the participant's waiver plan of care approved by the MHA:

- Level 1 requires that staff members provide daily contacts to the waiver participant. Level 2 requires that staff members provide a minimum of one hour of direct support per day.
- Level 3 requires that staff members provide continuous support for minimum of
4 hours of service per day.

**Individual Support Services**

Individual support services means assistance provided to an individual to enable participation in the community, which may include, but are not limited to, supports involving: budgeting; medication administration; counseling; helping an individual to access and complete the individual's education; participating in recreational and social activities; accessing community services; grocery shopping; behavioral and other services and supports needed by the family of the individual; and developing relationships.

**Rates**

Rates for TBI waiver services can be found in COMAR 10.21.25.

- Residenti Hab. Level 1  W003
- Residential Hab. Level 2  W003
- Residential Hab. Level 3  W0039
- Day Habilitation Level 1  W0054
- W0055 Day Habilitation Level 3
- W0056
- Supporte Emp Level 1  W005
Limitations:

The Program shall reimburse for a participant not more than:

- One unit of residential habilitation services for a date of service;
- One unit of day habilitation per day;
- One unit of supported employment per day;
- A combined maximum of five units of supported employment and day habilitation per week; or
- Eight units of individual support services for a date of service. The Program does not cover the following:
  - Payment for day habilitation on the same date of services as on-site psychiatric rehabilitation as defined in COMAR 10.21.21 and COMAR 10.21.25;
  - Payment for residential habilitation on the same date of service as residential rehabilitation services as defined in COMAR 10.21.22;
  - Payment for supported employment on the same date of service as mental health vocational supported employment as defined in COMAR 10.21.28;
- Payment for individual support services on the same day as residential habilitation services.

MHA, Office of Adult Services (410) 402-8476
NOTE: Information contained in this manual may be periodically updated or further explained through Provider Alerts

http://maryland.valueoptions.com/provider/prv_alerts.htm

General Claims Submission Guidelines

NOTE: Claims submitted electronically are generally processed more quickly than paper claims.

For electronic claims:

- To learn how to create 837 batch files using free ValueOptions® software, please refer to the website:
  

- For the ValueOptions® companion guide to 837 submissions please refer to the website:
  

- For information on submitting claims directly through the web please refer to
the website:
http://www.valueoptions.com/providers/ProviderConnect/ProviderConnect_SCS_How_To_Less_Screen_Prints_Final.pdf

Or call the EDI Help Desk at 888-247-9311

For paper claims:

ValueOptions® Maryland will accept paper CMS-1500 forms or Uniform Billing (UB)-04 forms. Do not use discontinued HCFA-1500 or UB-94 forms. Claims billed on discontinued forms may be denied. Please use original forms with red ink.

- CMS-1500 forms are for professional/practitioner services
- UB-04 forms are for inpatient and outpatient facility claims

Claim Mailing Address

Mail completed claim forms to:

ValueOptions Maryland
PO Box 1950
Latham, NY 12110

Timely Filing Guidelines Initial Submission
Claims must be submitted within 12 months of the first date of service on the claim. ValueOptions® Maryland will deny claims received more than 12 months after the date of service.

**Denials**

If the original claim was filed with ValueOptions® Maryland within 12 months of the date of service, the provider may resubmit the claim with additional information for consideration to ValueOptions® Maryland within that same 12 month period, or if after the 12 month period, within 60 days of the date of the ValueOptions® Maryland provider voucher which denied the claim. (COMAR 10.09.36.06 B (3)

**When Commercial Insurance is Primary**

The timely filing limit for claims is 60 days from the date of the other carrier’s EOB, or 12 months from the first DOS, whichever is later. The provider must submit the claims to the primary carrier within the primary carrier’s timely filing limit. ValueOptions® Maryland requires the other carrier’s remittance advice as proof of timely filing.

**When Medicare is Primary**

If Medicare benefits are exhausted or if Medicare will deny benefits for another reason the provider must submit claims to Medicare within Medicare’s timely filing limits and submit the paper claim and Explanation of Medicare benefits (EOMB) to ValueOptions® Maryland within 12 months of DOS or 120 days from EOMB, whichever is later) of Medicare’s EOMB date. Authorizations are required for services
not covered or exhausted by Medicare. COMAR 10.09.36.06 B (2) a-b

If the service is known not to be covered by Medicare, e.g. PRP, the provider does not need to submit to Medicare. Refer to the “EOP Required” grid on the ValueOptions® Maryland website to identify services for which a Medicare EOMB is not required. The direct link is

http://maryland.valueoptions.com/provider/cliams_finance/EOP_Approved.pdf

For services and providers covered by Medicare, submit claims directly to Medicare following Medicare’s timely filing guidelines. Claims covered by Medicare should not be sent to ValueOptions® Maryland.

When Medicaid Eligibility is Assigned Retroactively

Claims must be submitted to ValueOptions® Maryland within 12 months from the date of eligibility determination. The Department of Social Services Medical Assistance eligibility Determination Award Letter 1 (MA-81 letter of retro-eligibility) or a retro-eligibility timely filing waiver forms must be submitted with every claim. The Form can be downloaded at: http://maryland.valueoptions.com/, “For Providers”, “Provider Forms”, and Administrative Forms”. Please include the Medical Assistance Eligibility Determination Letter, if available. COMAR 10.09.36.06 B (6-8)

• If a claim is submitted for which you do not receive a payment or a rejection within 90 days, please resubmit the claim.

Consumer/Recipient Eligibility
It is the provider’s responsibility to confirm consumer eligibility. Before rendering services, providers should request the recipient’s Medicaid identification card. See DHMH’s instructions for verifying eligibility using the Eligibility Verification System (EVS) at https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.asp

NPI – General Information

The National Provider Identifier (NPI) is a unique 10-digit numeric identifier for covered healthcare providers. The NPI must be used on all claims.

For all claims, whether submitted electronically or on paper, the provider’s billing and rendering NPI must be submitted. There are some exceptions to the rendering NPI requirement, based on provider type. Outpatient Mental Health Clinics (OMHC), Federally Qualified Health Centers (FQHC) and Psychiatric Rehabilitation Providers (PRP) are not required to include the rendering provider’s NPI.

On all outpatient laboratory claims whether submitted electronically or on paper, the referring provider’s NPI must be included.

On all institutional claims whether submitted electronically or on paper, the attending provider’s NPI must be included.

Paper CMS-1500 Forms:

- When submitting on paper, providers must use current CMS-1500 form (version 02/12)
  
  [Link to CMS-1500 Form PDF]

- The CMS-1500 forms are available from the Government Printing Office can be reached at:
  - [Link to GPO Form Directory]
  - or call 866-512-1800

NPI Information

ValueOptions® Maryland will accept NPI numbers that are registered with MMIS II. To update or clarify provider information (including, but not limited to, Tax Identification number, NPI, service location, and payment address), contact DHMH Provider Enrollment at 410-767-5340 or email to dhmh.bhenrollment@maryland.gov

Show the provider’s Billing NPI in box 33a and Rendering NPI in box 32a on all CMS-1500 claims.

ValueOptions® will deny any claims that do not include valid billing and rendering NPI numbers.

- Exception: OMHC, FQHC, PRP providers may leave Box 32a blank (rendering NPI)
• Claims from outpatient laboratories must include the referring provider’s NPI in box 17b.

Multiple Services on a Single Claim

• The Dates of Service on a claim cannot span a calendar month. If billing for more than one calendar month, split onto separate claims
• Submit each date of service on a separate line
• Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line.

Completing the Paper Form

The following information shows field by field description of required data elements in addition to the NPI requirements listed above. Please note that the terms “patient,” “recipient,” and “consumer” are used interchangeably.

Block 1
Show all type(s) of health insurance applicable to this claim by checking the appropriate box(es).

Block 1a
INSURED’S ID NUMBER – Claims must be submitted with either the consumer’s Medicaid Identification Number or the ValueOptions® Maryland assigned Member Identification Number. Claims submitted with a Social Security Number, including claims for Uninsured Eligible participants, will be rejected.
Block 2
PATIENT’S NAME (Last Name, First Name, and Middle Initial) – Enter the patient’s (recipient’s) name as it appears on the Medical Assistance card.

Block 3
PATIENT’S BIRTH DATE/SEX – Enter the patient's (recipient’s) birth date and gender. Use the eight digit format (MM|DD|CCYY) format for date of birth. Enter an X in the correct box to indicate the patient’s gender. Only one box can be marked. If the gender is unknown, leave blank.

Block 4
INSURED’S NAME (Last Name, First Name, Middle Initial) – Enter the name of the person in whose name the third party coverage is listed, only when applicable. Enter the insured's full last name, first name and middle initial. If the insured has a last name suffix (e.g., Jr., Sr.) enter it after the last name, but before the first name.

Block 5
PATIENT’S ADDRESS – Enter the patient’s (or participant’s) complete mailing address with zip code and telephone number. On the first line, enter the street address (apartment number or Post Office Box number); the second line, the city and state; the third line, the ZIP code and phone number.

NOTE: Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). When entering a nine-digit ZIP code, include the hyphen. Do not use a hyphen or space as a separator within the telephone number. If the patient is homeless, please indicate HOMELESS on the first line.
Block 6
PATIENT'S RELATIONSHIP TO INSURED – Enter the appropriate relationship only when there is third party health insurance

Block 7
INSURED’S ADDRESS – When there is third party health insurance coverage enter the insured’s address and telephone number.

Block 8
PATIENT STATUS - Check the appropriate box for the patient’s marital status and whether employed or a student

Block 9
OTHER INSURED’S NAME - Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.

Block 9a
OTHER INSURED’S POLICY OR GROUP NUMBER – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.

Block 9b
OTHER INSURED’S DATE OF BIRTH— Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the
sex of the other insured. Only one box can be marked. If gender is unknown, leave blank.

**Block 9c**
EMPLOYER’S NAME OR SCHOOL NAME – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.

**Block 9d**
INSURANCE PLAN OR PROGRAM NAME – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program name.

**Block 10a thru 10c**
IS PATIENT'S CONDITION RELATED TO - Check “Yes” or “No” Place an "X" in the box dictating whether or not the condition for which the patient is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question.
NOTE: The state postal code must be shown if “yes” is marked in 10b for “auto accident”. Any item marked yes indicates there may be other applicable insurance coverage that would be primary such as automobile liability insurance. Primary insurance information must then be shown in item 11.

**Block 10d**
RESERVED FOR LOCAL USE – Leave blank.

**Block 11**
INSURED’S POLICY GROUP OR FECA NUMBER – Enter the Insured's policy or
group number as it appears on the insured’s health care identification card.

**Block 11a**

**INSURED’S DATE OF BIRTH** – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the eight-digit date of birth in MM/DD/CCYY format and enter an "X" to indicate the sex of the other insured. **Only one box can be marked. If gender is unknown, leave blank.**

**Block 11b**

**EMPLOYER’S NAME OR SCHOOL NAME** – Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name or school.

**Block 11c**

**INSURANCE PLAN OR PROGRAM NAME** – Required if Field 11d is yes. Enter the other insured's insurance company or program name.

**Block 11d**

**IS THERE ANOTHER BENEFIT PLAN?** – Place an "X" in the box indicating whether there maybe other insurance involved in the reimbursement of this claim.

**Block 12**

**PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE** – The patient must sign and date the claim if authorizing the release of medical information. If "signature on file" is indicated, the provider must maintain a signed release form or CMS-1500 (formally HCFA 1500). The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or
supplier, when the provider of service or supplier accepts assignment on the claim.

**Block 13**
INSURED’S OR AUTHORIZED PERSON’S SIGNATURE – The signature in this item authorizes payment of benefits to the physician or supplier. Signature on file, SOF, or the legal signature is acceptable. If there is no signature on file leave this item blank or enter “no signature on file”.

**Block 14**
DATE OF CURRENT ILLNESS, INJURY, PREGNANCY – Optional.

**Block 15**
IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS – Optional.

**Block 16**
DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION – Optional.

**Block 17**
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE – required for outpatient laboratory claims.

**Block 17a**
ID NUMBER OF REFERRING PHYSICIAN – Enter the ID Qualifier.

**Block 17b**
Enter the NPI of the referring, ordering, or supervising provider listed in Block 17. This field is required for outpatient laboratory claims.
Block 18
HOSPITALIZATION DATES RELATED TO CURRENT SERVICES – Required if this claim includes charges for services rendered during an inpatient admission. Enter dates in MMDDYY format.

Block 19
RESERVED FOR LOCAL USE – No entry required.

Block 20
OUTSIDE LAB – Optional.

Block 21
DIAGNOSIS OR NATURE OF THE ILLNESS OR INJURY – Enter a valid ICD-9 diagnosis code, coding to the highest level of specificity (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Enter up to four codes in priority order (primary, secondary, etc.) The primary diagnosis must be a PMHS Specialty Mental Health Diagnosis. See link for the list of covered diagnosis:

Block 22
MEDICAID RESUBMISSION – List the original reference (claim) number for resubmitted claims.

Block 23
PRIOR AUTHORIZATION NUMBER – Optional. Not required for claims processing.
Block 24a
DATE(S) OF SERVICE – Enter each separate date of service as a 6-digit numeric date (e.g. June 1, 2010 would be 06/01/10) under the FROM heading. Leave the space under the TO heading blank. Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates are not accepted.

Block 24B
PLACE OF SERVICE – For each date of service, enter the appropriate 2 digit place of service code.

Block 24C
EMG – Leave blank.

Block 24D
PROCEDURES, SERVICES OR SUPPLIES – Enter a valid CPT or HCPCS code for each service rendered. Enter a valid CPT or HCPCS code modifier, as applicable, for each service entered.

Block 24E
DIAGNOSIS POINTER – Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line. When multiple services are performed, the primary reference number for each service, 1, 2, 3 or 4, is shown. Do not enter the ICD-9 diagnosis code.

Block 24F
CHARGES – Enter the provider’s usual and customary charges. Do not enter the Maryland Medicaid maximum fee unless that is the provider’s usual and customary charge. (PRP claims should bill the cascade rate schedule, see link for reference

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If there is more than one unit of service on a line, the charge for that line should be the total of all units.

**Block 24G**

DAYS OR UNITS – Enter the total number of units of service for each procedure. The number of units must be for a single visit or day. Multiple, identical services rendered on different days should be billed on separate lines.

**Block 24H**

EPSDT FAMILY PLAN – Leave blank.

**Block 24I**

ID QUAL. – Enter the ID Qualifier 1D (Medicaid Provider Number) – used if the provider does not have a NPI, enter the appropriate qualifier and identifying number in the shaded area. Providers who do not have an NPI will need to report non-NPI identifiers on their claim forms. The qualifiers will indicate the non-NPI number being reported. – Optional

**Block 24J**

RENDERING PROVIDER ID # – Enter the NPI number in the un-shaded area of the field. All claims must include rendering provider NPI except those from OMHC, FQHC, and PRP providers.

**Block 25**

FEDERAL TAX I.D. NUMBER – Enter the nine-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered. Claims with an incorrect or missing Tax ID number will be denied.
Block 26
PATIENT'S ACCOUNT NUMBER – Enter the unique number assigned by the provider for the patient. If entered, the patient account number will be returned to the provider on the Provider Summary Voucher. – Optional

Block 27
ACCEPT ASSIGNMENT? – Enter an "X" in the appropriate box. **NOTE:** Providers must accept payment by the Program as payment in full for covered service (in addition to applicable copay). No additional charge to any recipient may be made for covered services.

Block 28
TOTAL CHARGE – Enter the sum of the charges shown on all lines of Block #24F of the invoice.

Block 29
AMOUNT PAID – Enter the amount of any collections received from any third party payer or the patient. If the recipient has third party insurance and the claim has been rejected, the appropriate rejection code shall be placed in Block #11. Entering an amount in this field does not eliminate the need to attach the paper EOB from the primary carrier. If there is other insurance, an EOB from the primary carrier must be submitted with the claim. If an EOP is not required for the service, it is not necessary to bill the primary carrier. See the list of service codes that don’t require a primary carrier EOB at the following site:
http://maryland.valueoptions.com/provider/claims_finance/EOP_Approved.pdf

Block 30
BALANCE DUE – (Box 28 minus Box 29 equals Box 30 “balance due”).
Block 31
SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS
– this is the *rendering* provider’s signature and degree/license level.

Block 32
SERVICE FACILITY LOCATION INFORMATION – Facility where services were rendered.

Block 32a
NPI – Enter the NPI of the service facility.

Block 32b
May be left blank.

Block 33
BILLING PROVIDER INFO & PH# – Enter the name, complete street address, city, state, and zip code of the provider. This is the address to which payment should be made.

Block 33a
NPI – Enter the NPI number of the billing provider in Block # 33. Error or omission of this number will result in non-payment of claims.

Block 33b
May be left blank.
Facility Billing: UB-04 Claims

See the DHMH UB04 Hospital Billing Instructions at:

See type of bill instructions at the end of this section

NOTE: Only one date of service may be billed per claim for outpatient facility services. If submitting on paper, providers must use UB-04 claim forms. UB-92 forms may be rejected. A copy of a UB-04 form is shown at the end of the field instructions.

Paper UB-04 forms:

• Providers must use current UB-04 forms. UB-92 forms will not be accepted.

• Show the billing NPI in box 56 and the attending NPI in box 76.

• The attending physician’s NPI must be included on all UB-04 claims.

Completing the UB04 (CMS1450) Claim Form:

<table>
<thead>
<tr>
<th>Field</th>
<th>Field Description</th>
<th>Field</th>
<th>Instructions</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Field</th>
<th>Field Description</th>
<th>Field Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name, Address, Telephone Number, and Required</td>
<td>This field contains the complete Service address (the address where the services are being performed /rendered) and the telephone and/or fax number.</td>
</tr>
<tr>
<td>2</td>
<td>Pay-to Name and Address Required</td>
<td>This field contains the address to which payment should be sent if different from the information in Field 1.</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number Optional</td>
<td>Complete this field with the patient account number that allows for the retrieval of individual patient financial records. If completed, this number will be included on the Provider's Summary Voucher.</td>
</tr>
<tr>
<td>3b</td>
<td>Medical/Health Record Number</td>
<td>In this field, report the patient's medical record number as assigned by the provider.</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill Required</td>
<td>The type of bill code indicates the facility type, whether the claim is inpatient or outpatient, and the bill frequency. See the references at the end of this section for acceptable Bill Field.</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number Required</td>
<td>Enter the number assigned by the Federal Government for tax reporting purposes. This may be either the Tax Identification Number (TIN) or the Employer Identification Number (EIN). Affiliated subsidiaries are identified.</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers Period &quot;From&quot; and Required</td>
<td>Use this field to report the beginning and end dates of service for the period reflected on the claim in MMDDYY format.</td>
</tr>
<tr>
<td>7</td>
<td>Reserved for Assignment Not Required</td>
<td>N/A</td>
</tr>
<tr>
<td>8a</td>
<td>Patient Identifier Required</td>
<td>This field is for the patient's identification.</td>
</tr>
<tr>
<td>8b</td>
<td>Patient Name Required</td>
<td>This field is for the patient's last name, first name and middle initial.</td>
</tr>
<tr>
<td>9a</td>
<td>Patient Address Required</td>
<td>This field is for entering the patient's street address.</td>
</tr>
<tr>
<td>9b</td>
<td>(unlabeled field) Required</td>
<td>This field is for entering the patient's city.</td>
</tr>
<tr>
<td>9c</td>
<td>(unlabeled field) Required</td>
<td>This field is for entering the patient's state code.</td>
</tr>
<tr>
<td>9d</td>
<td>(unlabeled field) Required</td>
<td>This field is for entering the patient's ZIP code.</td>
</tr>
<tr>
<td>9e</td>
<td>(unlabeled field) Required</td>
<td>This field is for entering the patient's Country.</td>
</tr>
<tr>
<td>10</td>
<td>Patient Date of Birth Required</td>
<td>This field includes the patient's complete date of birth using the eight-digit format MMDDYY.</td>
</tr>
<tr>
<td>11</td>
<td>Sex Required</td>
<td>Use this field to identify the sex of the patient.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Admission Date/State of Care Date</td>
<td>Required</td>
<td>Enter the date care begins. For inpatient care, it is the date of admission. For all other services, it is</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>Required</td>
<td>Enter the hour in which the patient is admitted for inpatient or outpatient care. NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only. See</td>
</tr>
<tr>
<td>14</td>
<td>Priority (Type) of Visit</td>
<td>Required</td>
<td>Enter the appropriate code for the priority of the admission or visit. See valid codes at the end of this section</td>
</tr>
<tr>
<td>15</td>
<td>Source of Referral for Admission or Visit</td>
<td>Required</td>
<td>This field indicates the source of the referral for the visit or admission (e.g., physician, clinic, facility, transfer, etc.). See valid codes at the end of this section</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>Conditional</td>
<td>This field is used for reporting the hour the patient is discharged from inpatient care. NOTE: Enter using Military Standard Time (00-23) in top-of-the-hour times only. See</td>
</tr>
</tbody>
</table>

**Field | Field Description | Field | Instructions**
---|-------------------|-------|-------------|
<p>| 17    | Patient Discharge Status | Required | Use this field to report the status of the patient upon discharge-- required for institutional claims. See valid codes at the end of this section |
| 18-28 | Condition Codes | Conditional | Use these fields to report conditions or events related to the bill that may affect the processing of it. See valid codes at the end of this section |
| 29    | Accident State | Conditional | When appropriate, assign the two-digit abbreviation of the state in which an event occurred. |
| 30    | Reserved for Assignment by NUBC | Not Required | N/A |
| 31-34 | Occurrence Codes and Dates | Conditional | The occurrence code and the date fields associated with define a significant event associated with the bill that affects |
| 35-36 | Occurrence Span Codes and Dates | Conditional | This field is for reporting the beginning and the end dates of the specific event that affects |
| 37    | Reserved for Assignment by NUBC | Not Required | N/A |
| 38    | Responsible Party Name | Required | This field is for reporting the name and address of the person responsible for |
| 39-41 | Value Codes and Amounts | Required | These fields contain the codes and related dollar amounts to identify the monetary data for processing claims. This field is |</p>
<table>
<thead>
<tr>
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<th>Field</th>
<th>Field Description</th>
<th>Field Type</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>Required</td>
<td>Enter the applicable revenue code for the services rendered. There are 22 lines available and should include the total line.</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description</td>
<td>Optional</td>
<td>This field is used to report the abbreviated revenue code categories included in the bill.</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/ Tate/ HIPPS</td>
<td>Conditional</td>
<td>This field is used to report the appropriate HCPCS codes.</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Service Date</td>
<td>Conditional</td>
<td>Indicates the date the outpatient service was provided and the date the bill was created using the six-digit format (MMDDYY).</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Service Units</td>
<td>Required</td>
<td>In this field, units such as pints of blood used, miles traveled and the number of inpatient days are reported.</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Required</td>
<td>This field reports the total charges—covered and non-covered—related to the revenue code.</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Non-Covered Charges</td>
<td>Conditional</td>
<td>This field indicates charges that are non-covered charges by the payer as related to the revenue code.</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Reserved for Assignment by NUBC</td>
<td>Not Required</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>51a, b, c</td>
<td>Health Plan Identification Number</td>
<td>Not Required</td>
<td>This field includes the identification number of the health insurance plan that covers the patient and from which.</td>
</tr>
<tr>
<td>52a, b, c</td>
<td>Release of Information Certification Indicator</td>
<td>Required</td>
<td>Enter the appropriate code denoting whether the provider has on file a signed statement form the member to release information. Refer to Attachment B for.</td>
</tr>
<tr>
<td>53a, b, c</td>
<td>Assignment of Benefits Certification Indicator</td>
<td>Required</td>
<td>Enter the appropriate code to indicate whether the provider has a signed form authorizing the third party insurer to pay the provider directly for the service.</td>
</tr>
<tr>
<td>54a, b, c</td>
<td>Prior Payments</td>
<td>Conditional</td>
<td>Enter any prior payment amounts the facility has received toward payment of this bill for the payer indicated in Field 50 lines a–b.</td>
</tr>
<tr>
<td>55a, b, c</td>
<td>Estimated Amount Due</td>
<td>Not Required</td>
<td>Enter the estimated amount due from the payer indicated in Field 50 lines a–b.</td>
</tr>
<tr>
<td>56</td>
<td>National Provider Identifier</td>
<td>Required</td>
<td>Enter the Facility's billing NPI.</td>
</tr>
<tr>
<td>Field</td>
<td>Field Description</td>
<td>Instructions</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Other Provider Identifier</td>
<td>Not Required</td>
<td>The unique provider identifier assigned by the health plan is reported in this field.</td>
</tr>
<tr>
<td>58a</td>
<td>Insured's Name (last, first name, middle initial)</td>
<td>Required</td>
<td>The name of the individual who carries the insurance benefit is reported in this field. Enter the last name, first name.</td>
</tr>
<tr>
<td>59a</td>
<td>Patient's Relationship to Insured</td>
<td>Required</td>
<td>Enter the applicable code that indicates the relationship of the patient to the insured.</td>
</tr>
<tr>
<td>60a</td>
<td>Insured's Unique Identification</td>
<td>Required</td>
<td>This is the unique number the health plan assigns to the insured individual. The ID number is assigned by the health plan and is required to be used with diagnosis codes.</td>
</tr>
<tr>
<td>61a</td>
<td>Group Name</td>
<td>Required</td>
<td>Enter the group or plan name of the primary, secondary and tertiary payer through which the coverage is.</td>
</tr>
<tr>
<td>62a</td>
<td>Insurance Group Number</td>
<td>Conditional</td>
<td>Enter the plan or group number for the primary, secondary, and tertiary payer through which the coverage is.</td>
</tr>
<tr>
<td>63a</td>
<td>Treatment Authorization Codes</td>
<td>Optional</td>
<td>Enter the authorization number assigned by the payer indicated in Field 50, if known. This indicates.</td>
</tr>
<tr>
<td>64a</td>
<td>Document Control Number</td>
<td>Not Required from</td>
<td>This number is assigned by the health plan to the bill for their internal control.</td>
</tr>
</tbody>
</table>

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### Field Description

<table>
<thead>
<tr>
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<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>67 a-q</td>
<td>Other Diagnosis Codes/Present on Admission Indicator (POA)</td>
<td>This field is for reporting all diagnosis codes in addition to the principal diagnosis that coexist, develop after admission, or impact the treatment of the patient or the length of stay. The present on admission (POA) indicator applies to diagnosis codes (i.e., principal, secondary and E codes) for inpatient claims to general acute-care hospitals or other facilities. This field is required.</td>
</tr>
<tr>
<td>68</td>
<td>Reserved for Assignment</td>
<td>Not Required</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis</td>
<td>Required</td>
</tr>
<tr>
<td>70 a-c</td>
<td>Patient's Reason for Visit</td>
<td>Conditional</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment Diagnosis</td>
<td>Not Required</td>
</tr>
<tr>
<td>72</td>
<td>External Cause of Injury (ECI) Code</td>
<td>Not Required</td>
</tr>
<tr>
<td>73</td>
<td>Reserved for Assignment by NUBC</td>
<td>Not Required</td>
</tr>
<tr>
<td>74 a-e</td>
<td>Other Procedure Codes and Dates</td>
<td>Conditional</td>
</tr>
<tr>
<td>75</td>
<td>Reserved for Assignment by NUBC</td>
<td>Not Required</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Names and Identifiers</td>
<td>Required</td>
</tr>
<tr>
<td>77</td>
<td>Operating Physician Name and Identifiers</td>
<td>Conditional</td>
</tr>
<tr>
<td>78-79</td>
<td>Other Provider Names and Identifiers</td>
<td>Conditional</td>
</tr>
<tr>
<td>80</td>
<td>Remarks Field</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Description</th>
<th>Inpatient/Outpatient General Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>011x</td>
<td>Hospital Inpatient (including Medicare Part A)</td>
<td>IP</td>
</tr>
<tr>
<td>012x</td>
<td>Hospital Inpatient (Medicare Part B ONLY)</td>
<td>OP</td>
</tr>
<tr>
<td>013x</td>
<td>Hospital Outpatient</td>
<td>OP</td>
</tr>
<tr>
<td>015x</td>
<td>Chronic Hospitals, Chronic Rehabilitation</td>
<td>IP</td>
</tr>
<tr>
<td>021x</td>
<td>Intermediate Care Facility -Mental Retardation</td>
<td>IP</td>
</tr>
<tr>
<td>021x</td>
<td>Skilled Nursing-Inpatient (including Nursing Home Claims)</td>
<td>IP</td>
</tr>
<tr>
<td>022x</td>
<td>Skilled Nursing-Inpatient (including Nursing Home Therapy)</td>
<td>IP</td>
</tr>
<tr>
<td>033x</td>
<td>Home Health-Outpatient (plan of treatment under Part A, including DME under Home Health Agency)</td>
<td>OP</td>
</tr>
<tr>
<td>065x</td>
<td>Intermediate Care Facility -Addictions</td>
<td>IP</td>
</tr>
<tr>
<td>072x</td>
<td>Clinic-Hospital Based or Independent Renal</td>
<td>OP Free-Standing Dialysis</td>
</tr>
<tr>
<td>081x</td>
<td>Specialty Facility- Hospice</td>
<td>IP</td>
</tr>
<tr>
<td>082x</td>
<td>Specialty Facility-Hospice Nursing Home-Room and</td>
<td>IP</td>
</tr>
<tr>
<td>086x</td>
<td>Specialty Facility-Residential Treatment</td>
<td>IP</td>
</tr>
</tbody>
</table>
### Type of Bill Frequency Codes

<table>
<thead>
<tr>
<th></th>
<th>Type of Bill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Admit Through Discharge Claims</td>
<td>The provider uses this code for a bill encompassing an entire inpatient confinement for which it expects payment from the payer.</td>
</tr>
<tr>
<td>2</td>
<td>Interim Billing-First Claim</td>
<td>This code is to be used for first (admit) of an expected series of bills for the same confinement or course of treatment for which the provider expects payment from the payer. FL 17 should equal &quot;30.&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Interim Billing-Continuing Claim</td>
<td>This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal &quot;30.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Interim Billing-Last Claim</td>
<td>This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.</td>
</tr>
<tr>
<td>5</td>
<td>Late Charge(s) Only Claim</td>
<td>This code is to be used for submitting additional charges to the payer which were identified by the provider after the admit through discharge claim or the last interim claim has been submitted. This code is not intended for use in lieu of an adjustment claim or a replacement claim. <strong>See note on late charges below.</strong></td>
</tr>
</tbody>
</table>

**OX**

- Replacement of Prior Claim

| OX | Replacement of Prior Claim |

**5) Late Charge(s) Only Claim:**

- FL 6 “Statement Covers Period” on the late charge claim must be the same as the dates of the original claim to which the last charge refers. In addition, all “general information” must be the same on the late charge claim and the original claim.

- Late charges are subject to the 12 month statute of limitations.
- Late charges will be allowed one time only for each patient bill or outpatient bill with which the late charges are associated. COMAR 10.09.36.06 (7) a-b (8)
Other Insurance Coverage

The Medical Assistance Program is the payer of last resort. If a recipient is covered by other insurance or third party benefits such as Worker’s Compensation, CHAMPUS or Blue Cross/Blue Shield, the provider must first bill the other insurance company before Medical Assistance will pay the claim. If the primary denies the claim, the provider must exhaust all available levels of appeal and provide corresponding documentation.

When Medicare is Primary

If both Medicare Part A and Part B are active for the consumer

ValueOptions® Maryland does not coordinate benefits with Medicare. When Medicare is primary, providers must send their claims directly to DHMH in compliance with their timely filing guidelines.

Certain Services that are not covered by Medicare may be billed to Medicaid. See Provider INFORMATION for current list of covered service codes.

http://maryland.valueoptions.com/provider/claims_finance/EOP_Approved.pdf

If Medicare Part A is exhausted but Medicare Part B is active:

• ValueOptions is the primary payer for Room & Board, admission, and laboratory charges. Providers should submit their paper claim to ValueOptions. The UB-04 must list occurrence code A3 with the date Medicare benefits were exhausted. Providers must attach a copy of the Medicare EOMB stating that coverage is exhausted.
• Providers should submit all other ancillary charges to Medicare Part B for payment and to Maryland Medical Assistance for payment of any co-pay and/or deductibles. ValueOptions® Maryland will not process these claims.

If Medicare Part A is exhausted and Consumer does not have Medicare Part B:

• ValueOptions® Maryland is the primary payer for both outpatient and inpatient charges.

• Pre-authorizations are required for all services, as indicated by the plan

• The UB-04 must be submitted on paper and list occurrence code A3 with the date Medicare benefits were exhausted. Providers must attach a copy of the Medicare EOMB stating that coverage is exhausted.

If Medicare Part A is active but Medicare Part B is terminated or there is no Part B coverage:

• ValueOptions® Maryland is primary for outpatient charges.

• Inpatient charges should be submitted directly to Medicare in compliance with their timely filing guidelines.

• Pre-authorizations are required for all services, as indicated by the plan.
Commercial Insurance is Primary

• When commercial insurance is a consumer’s primary coverage, submit claims to the commercial carrier first. Submit the commercial insurance’s explanation of benefits to ValueOptions® Maryland with the claim. These claims can be submitted electronically or on paper. If the primary denies the claim, the provider must exhaust all available levels of appeal and provide corresponding documentation.

• Medicaid is always the payor of last resort. However, in some cases the PMHS will pay as primary for services rendered to Medicaid recipients who also have commercial coverage when the provider has received a rejection from the commercial carrier:
  • Preauthorization by ValueOptions® Maryland is required.
  • The coverage is not in effect on the service date
  • The service does not meet the primary payor’s Medical Necessity Criteria, but meets the PMHS Medical Necessity Criteria. The provider shall submit supporting documentation of denial of the claim by the primary carrier.
  • The provider has demonstrated due diligence in assuring the consumer was Medicaid eligible by checking EVS and after date of service learned the individual had third party insurance.

• Medicaid will not pay as primary for the following:
  • The claim was denied by the primary carrier for failure to meet timely filing requirement.
  • The claim was denied because the provider is not participating with the primary carrier unless there is justification of a low health care shortage area.
  • The claim was denied for no authorization by the primary carrier.
• To submit primary carrier payment information electronically, see the Companion Guide at:
  http://valueoptions.com/providers/Compliance/ediclaimslinkmanual.pdf

• When benefits have been exhausted by the primary carrier, the claim must be submitted on paper with a copy of the primary carrier’s EOB for the same date of service as the claim.

Claim Adjustments/Corrections

A claim adjustment is performed when a paid claim is determined to have been incorrectly processed, either due to an error or when updated information is provided. An adjustment means the paid claim is reversed (and dollars paid are backed-out) and a new claim is processed with the correct information. If the new claim results in a lesser payment than the original paid claim, or is denied, then the provider’s account is in a negative balance. Future payments to the provider will be used to offset a negative balance.

Providers can request a claim adjustment using one of the following methods:

• Submit a corrected claim:
  To electronically submit corrected claims, please refer to the 837 Companion Guide at

• To submit corrected claims on paper, indicate CORRECTED CLAIM at the top of the CMS-1500 or UB-04 form. Please indicate the original
ValueOptions® Maryland claim number on the corrected claim.

- Inquiry through ProviderConnect:
  See [http://www.valueoptions.com/providers/Provider_Connect.htm](http://www.valueoptions.com/providers/Provider_Connect.htm) for directions on how to submit an inquiry through ProviderConnect.

**Refunds**

To refund ValueOptions® Maryland for an overpayment, please send a copy of the associated provider summary voucher, and explanation of the overpayment with the check to:

ValueOptions Maryland
P.O. Box 1950
Latham, NY 12110
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ATTACHMENT B – CURRENT DESIGNATED EMERGENCY
  FACILITIES ........................................................................15
Introduction

MHA has requested that ValueOptions® Maryland develop and operate a system to process claims and invoices for services rendered to individuals who come into an emergency room on an emergency petition and who have no insurance and cannot afford to pay these charges.

Submissions of claims/invoices may be made for the following:

- Emergency room services
- Emergency room evaluations by licensed consultant physicians
- Transportation to a designated emergency facility/or State Hospital by Ambulance, Sheriff Departments, and Fire Departments

The following rules apply:

1. Claims for services rendered under emergency petitions are processed in accordance with COMAR 10.21.15.
2. MHA is the payer of the last resort for claims for services rendered under an emergency petition. The provider of services is responsible for attempting to collect from all other sources including the evaluatee. ValueOptions® Maryland is not to pay for services when the evaluatee had active health insurance coverage on the date of service. If the claims form indicates the evaluatee has other insurance, an Explanation of Benefits (EOB) from the primary carrier must be attached that indicates the evaluatee’s benefits were not active on the date of service.
3. ValueOptions® Maryland will deny the claim if there is any indication of insurance, Medicare and/or Medicaid coverage for the services provided.
4. Services must be performed within 5 days of the approval date on the emergency petition.
5. Providers have twelve (12) months from the date of service to submit the claim for payment to the ValueOptions® Maryland.
6. If claims was submitted within the initial twelve months and denied, the provider has an additional sixty (60) days from the date of the denial to submit a corrected claim for payment.
7. ValueOptions® Maryland will issue a Payment Summary Voucher (PSV), specific to each provider, for each check run, in which claims were processed.
8. ValueOptions® Maryland will issue a standard 1099 Form, in compliance with tax laws, to all providers issued payment during that tax year.

Claims from a Facility for Emergency Room Services

1. In accordance with COMAR 10.21.15.02, only designated emergency psychiatric facilities are eligible for reimbursement.
2. “Designated emergency facility”, means a health care organization currently identified by DHMH to perform the functions.
3. Attachment B contains the list of current designated emergency facilities. This list is

January 2010
updated each fiscal year by MHA. The current list remains in effect until January 1, 2011.

**Claim Forms**

1. Emergency facilities must submit claims for services on an UB-04 claim form.
2. Only one UB-04 claim per evaluee, per day, is payable to an emergency facility.
3. Medicaid rules covering the submission of hospital claims apply.

**Procedure Codes**

1. Only the **basic** emergency room fee is payable. All other services are non-covered services.
2. Payable revenue codes include 450, or 451 and 452. Revenue code 450 is not payable with revenue codes 451 or 452, however both 451 and 452 are payable for the same episode of service:
   - 450 - General Classification (EMERG ROOM)
   - 451 - EMTALA Emergency Medical Screening Services (ER/EMTALA)
   - 452 - ER Beyond EMTALA Screening (ER/BEYOND EMTALA)

**Rates**

1. The procedure codes listed above are to be billed at the rate approved by the Health Services Cost Review Commission (HSCRC) for the specific facility.
2. Payment will be made at 94% at billed charges.

**Required Documentation**

Several documents must be submitted and completed in order for payment to occur. The forms include:

1. **Request for Reimbursement Form**
   - Standard form generated/designated by MHA *(Attachment A)*
   - Provider must complete all fields on the form.

2. **Emergency Petition (Form DC-13)**
   - Petitions must include the identity of the petitioner, identity of evaluee, reason for petition, signature of petitioner.
   - For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the judge.
   - For petition requests by professionals (e.g. physician, psychologist, social worker, Health Officer, peace officer), form DC-14 must be endorsed by petitioner. If the petitioners is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer.

3. **UB-04 claim form**
The provider must submit a completed UB-04 form.

The form must be legible and completed in ink. Any changes made to the form must be crossed out and initialed. “White out” is not acceptable.

Incomplete claim forms may delay or prevent payment of the claim.

The required fields include:

- Field 1 must reflect the complete facility name and address.
- Field 5 must reflect the facility 9-digit Federal tax identification number (TIN).
- Field 6 must reflect the ‘from’ and ‘through’ dates of the date(s) of service. In most cases, these will reflect the same date. In cases where the evaluatee was in the facility overnight, the dates may be different.
- Field 12 must reflect the evaluatee’s name. The name must match the name listed on the Emergency Petition form (DC-13).
- Field 13 must reflect the evaluatee’s address. If the address is unknown, the field should state “UNKNOWN”, if the evaluatee is homeless; the field should state “HOMELESS”.
- Field 14 must reflect the evaluatee’s date of birth. If the date of birth is unknown, the filed should state “UNKNOWN”.
- Field 15 must reflect the evaluatee’s gender.
- Field 22 must reflect the patient status.
- Field 42 must reflect the revenue codes for the services provided.
- Field 43 must reflect the description of the revenue code.
- Field 44 must reflect the HCPCS code corresponding to the revenue code in field 42.
- Field 45 must reflect the date of service.
- Field 46 must reflect the number of units of service provided for the revenue code in field 42.
- Field 47 must reflect the total charges for the revenue code in field 42. Rates submitted should be the HSCRC approved rate for the procedure rendered.
- Field 50 must reflect DHMH.
- Field 54 must reflect $0.00 to show no other payments.
- Field 55 must reflect the estimated amount due (must be the total of charges in field 47 minus the amount in field 54).
- Field 60 must list the evaluatee’s Social Security Number (SSN), if the SSN is unknown, the field should state “UNKNOWN”.
- Field 82 must reflect the attending physician ID.
- Field 85 must reflect the signature of the appropriate provider representative, or state “SIGNATURE OF FILE”.
- Field 86 must reflect the date the document was signed by appropriate provider representative.

4. Other documents that may be attached include:

- A copy of the complete medical record listing the services performed. It should include the name of the evaluatee, date of service, and facility’s name. The

January 2010
ValueOptions® Medical Director will only review emergency room notes when verifying the intensity of the care provided.

- An Explanation of Benefits (EOB) from the evaluee’s primary carrier indicating that the evaluee did not have active coverage on the date of service.

**Claims from a Physician for Emergency Room Evaluation Services**

1. In accordance with COMAR 10.21.15.02, only consultant physicians are eligible for reimbursement.
2. “Consultant” means a physician, licensed by the State, who is not a salaried staff member of the emergency facility and who is authorized by the facility to perform an examination of an emergency evaluee.

**Claim Forms**

1. Physicians must submit claims for services on a CMS-1500 claim form.
2. Only one CMS-1500 claim per evaluee per day is payable to a physician.

**Procedure Codes**

1. Only the initial examination performed in the emergency room of a designated psychiatric emergency facility by a consultant physician is payable. All other services are non-covered services.
2. Payable CPT-IV codes include 90801, 99282, 99283, 99284, and 99285. Only one of these codes is payable per evaluee per day.
   - 90801 - Psychiatric diagnostic interview examination.
   - 99282 - Emergency department visit for the evaluation and management of a patient, which requires these three components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity.
   - 99283 - Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity.
   - 99284 - Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or
family’s needs. Usually, the presenting problem(s) are of high severity and require urgent evaluation.

- 99285 - Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient’s clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

**Rates**

1. The procedure codes listed above are payable at the lesser of the amount billed or the statewide average prevailing charges for an examination by a physician consultant based on Medicare’s 75th percentile as determined according to 42 CFR §405.504.
2. The hospital’s county, not the evaluatee’s county of residence, determines locality.

**Required Documentation**

1. Request for Reimbursement Form
   - Standard form generated/designated by MHA *(Attachment A).*
   - Providers must complete all fields on the form.
2. Emergency Petition (Form DC-13)
   - Petition must include the identity of the petitioner, identity of evaluatee, reason for petition, and signature of petitioner.
   - For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the Judge.
   - For petition requests by professionals (e.g. physician, psychologist, social worker, Health Officer, peace officer), form DC-14 must be endorsed by the petitioner. If the petitioner is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer.
3. CMS-1500 Form
   - The provider must submit a completed CMS-1500 form.
   - The form must be legible and completed in ink. Any changes made to the form must be crossed out and initialed. “White Out” is not acceptable.
   - Incomplete claim forms may delay or prevent payment of the claim.
   - The required fields include:
     - Field 2 must reflect the evaluatee’s name.
     - Field 3 must reflect the evaluatee’s date of birth (if known) and gender.
     - Field 5 must reflect the evaluatee’s address. If the address is unknown, the field should state “UNKNOWN”, if the evaluatee is homeless; the field should state “HOMELESS”.
     - Field 9a through 9d must be complete if the evaluatee has coverage through a health insurance policy.
     - Field 11 must state “Emergency Petition”.
     - Field 12 must reflect the evaluatee’s signature and date of the signature or state
Field 21 must reflect the primary diagnosis.
Field 24a must reflect the date of service.
Field 24b must reflect the place of service.
Field 24d must reflect the appropriate CPT-IV code.
Field 24f must reflect the charges associated with the CPT-IV code in field 24d.
Field 24g must reflect the number of units of service associated with the CPT-IV code in field 24d.
Field 25 must reflect the provider’s Federal tax identification number (TIN).
Field 28 must reflect the total charges (must be the sum of charges in field 24f).
Field 29 must reflect any amounts paid by other parties.
Field 30 must reflect the balance due (field 28 minus field 29).
Field 31 must reflect the signature and date of the physician or state “signature on file”.
Field 32 must reflect the name and address of the facility where services were rendered.
Field 33 must reflect the complete physician’s or physician group’s name and address.

4. Psychiatric Evaluation
   The psychiatric evaluation must contain the name of the evaluatee, the date of service and must be signed and dated by the physician.

5. Other documents that may be attached include:
   - An Explanation of Benefits (EOB) from the evaluatee’s primary carrier indicating that the evaluatee did not have active coverage on the date of service.

**Claims for Transportation Services**

1. In accordance with COMAR 10.21.15.02, only transportation provided by an emergency vehicle is eligible for reimbursement.
2. “Emergency vehicle” means:
   - A vehicle operated by a law enforcement officer; or
   - An ambulance regulated according to COMAR 14.22.01-14.22.12.

**Claim Forms**

1. Transportation providers must submit claims for services on a CMS-1500 claim form.
2. Two transportation bills can be paid for the same date of service.
   - Transport to the designated emergency facility (ambulance or Peace Officer).
   - For an evaluatee involuntarily certified, from the designated emergency facility to the admitting facility (ambulance only).

**Procedure Codes**

January 2010
1. For ambulance transportation, basic life support (BLS) charges plus the basic mileage rate are payable.

2. For Peace Officers, the basic mileage rate plus the officer’s regular hourly wage (maximum of four hours total) are payable. All other services are non-covered services.

3. Payable HCPCS codes for ambulance transportation include A0362 and A0380.
   - A0362 - Ambulance service, BLS, emergency transport, mileage and disposable supplies separately billed.
   - A0380 – BLS mileage (per mile).

4. Payable HCPCS codes for transportation by a peace officer include A0080 and A0170. Are there CPT-IV codes that are more appropriate?
   - A0080 - Non-emergency transportation: Per mile-volunteer, with no vested or personal interest.
   - A0170 - Non-emergency transportation: ancillary, parking fees, tolls other.

**Rates**

The procedure codes for mileage listed above are payable at the rate established for the county in which the transportation provider is located. Each county should supply their current rate.

**Required Documentation**

1. Request for Reimbursement Form
   - Standard form generated/designed by MHA (Attachment A).
   - Providers must complete all fields on the form.

2. Emergency Petition (Form DC-13)
   - Petition must include the identity of the petitioner, identity of evaluee, reason for petition, and signature of petitioner.
   - For petition requests by a lay petitioner (a family member or friend), the petition must be endorsed by the judge.
   - For petition requests by professionals (e.g. physician, psychologist, social worker, Health Officer, peace officer), form DC-14 must be endorsed by the petitioner. If the petitioner is a health officer designee, the form must include a signature and date indicating the individual as the designated health officer.

3. CMS – 1500 Claim Form
   - The provider must submit a complete CMS-1500 form. One form for each evaluee.
   - The form must be legible and completed in ink. Any changes made to the form must be crossed out and initialed. “White out” is not acceptable.
   - Incomplete claim forms may delay or prevent payment of the claim.
   - The required fields include:
     - Field 2 must reflect the evaluee’s name
     - Field 3 must reflect the evaluee’s date of birth (if known) and gender.

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January 2010
Field 5 must reflect the evaluee’s address. If the address is unknown, the field should state “UNKNOWN”, if the evaluee is homeless; the field should state “HOMELESS”.

Field 9a through 9d must be complete if the evaluee has coverage through a health insurance policy.

Field 11 must state “Emergency Petition”.

Field 12 must reflect the evaluee’s signature and date of the signature or state “signature on file”.

Field 24a must reflect the date of service.

Field 24b must reflect the place of service. What is place of service from CPT-IV?

Field 24d must reflect the appropriate HCPCS code.

Field 24f must reflect the charges associated with the HCPCS code in field 24d.

Field 24g must reflect the number of units of service associated with the HCPCS code in field 24d.

Field 25 must reflect the provider’s Federal tax identification number (TIN).

Field 28 must reflect the total charges (must be the sum of charges in field 24f).

Field 29 must reflect any amounts paid by other parties.

Field 30 must reflect the balance due (field 28 minus field 29).

Field 32 must reflect the name and address of the facility to which the evaluee was transported.

Field 33 must reflect the complete transportation provider’s name and address.

4. Other

- Two certificates of involuntary admission and the application for involuntary admission (DHMH 34) are required for ambulance transportation from a designated emergency facility to the admitting facility.

- An Explanation of Benefits (EOB) from the evaluee’s primary carrier indicating that the evaluee did not have active coverage on the date of service if the consumer is believed to have insurance.

- An Emergency Vehicle Certificate (DHMH 210C) is required for transportation by a Peace Officer to certify that the vehicle used to transport the evaluee contains health equipment.
Attachment A – Request for Reimbursement Forms

MHA has created three (3) Request for Reimbursement forms, one for each type of service reimbursed (Emergency Room Services, Emergency Room Psychiatric Evaluation, and Transportation). The completed form is required for every payment request for services rendered for an emergency petition.

In signing the form, the provider certifies that every effort has been made to collect the fee from the patient, responsible persons, private insurers, Medicare and Medical Assistance, and payment has not been received.
Memorandum

TO: ValueOptions® Maryland MHA Claims
P.O. Box 1950
Latham, NY 12110
Attn: Emergency Petitions

FROM: ________________________________
Name of Facility
Address ________________________________

This is a request for reimbursement for basic emergency room fee for:

________________________ on ____________
(Patient’s Name) (Date of Service)

This is to certify that the above named patient was admitted to the emergency room at this hospital on the above date under a petition for emergency psychiatric evaluation. Every effort has been made to collect the fee from the patient, responsible persons, private insurers, Medicare and Medical Assistance, and the Facility has not been paid for the basic emergency room fee.

Authorized Signature: ________________________________

Title: ________________________________

Date: ________________________________

Attachments:

______ Petition for Emergency Psychiatric Evaluation

______ Invoice

______ Other ________________________________
Memorandum

TO: ValueOptions® Maryland MHA Claims
    P.O. Box 1950
    Latham, NY 12110
    Attn: Emergency Petitions

FROM: ____________________________________________

Physician or Firm

Address ____________________________________________

This is a request for reimbursement for the emergency psychiatric evaluation of:

__________________________________________ on __________

(Patient’s Name)           (Date of Service)

by ______________________  at ______________________

(Examining Physician)       (Facility)

I certify that the psychiatric evaluation referenced above was made by a consultant physician who is not a salaried staff member of the hospital. I further certify that every effort has been made to collect the fee from the patient, responsible persons, private insurers, Medicare and Medical Assistance, and the physician has not been paid for this service. The examination performed complies with COMAR 10.21.15.02 (7) which entails a face-to-face diagnostic interview and examination by a consultant physician that includes a medical history, an assessment of mental status, a neurological examination, an assessment of dangerousness, and a written report outlining the consultant physician’s findings and conclusions.

Authorized Signature: ________________________________

Title: ____________________________________________

Date: ____________________________________________

Attachments:

______ Petition for Emergency Psychiatric Evaluation

______ Psychiatric Evaluation

______ Invoice

______ Other ______________________________________

January 2010
Memorandum

TO: ValueOptions® Maryland MHA Claims
    P.O. Box 1950
    Latham, NY 12110
    Attn: Emergency Petitions

FROM: ________________________________
      Name of Business or Agency

Address ________________________________

Request for Reimbursement for Transportation of ________________________________
on ________________________________.

This is to certify that the above named patient was transported from ________________________________
to ________________________________ as a consequence of a Petition for Emergency Psychiatric
Evaluation. The patient was transported by ambulance or other vehicle containing health
equipment. Every effort has been made to collect the cost of this service from the patient,
responsible persons, private insurers, Medicare and Medical Assistance, and payment has not been
received.

Authorized Signature: ________________________________

Title: ________________________________

Date: ________________________________

Attachments:

    _______ Emergency Petition (DC 13/14)
    _______ Certification of Involuntary Admission
             (Required if transporting from an emergency room to hospital. 2 signatures
             required)
    _______ Invoice
    _______ Other ________________________________

January 2010
### Allegany County

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Braddock Hospital (formerly Sacred Heart)</td>
<td>900 Seton Drive, Cumberland, MD 21502</td>
<td>(301) 723–4200</td>
</tr>
<tr>
<td>Memorial Hospital Medical Center of Cumberland</td>
<td>600 Memorial Avenue, Cumberland, MD 21502</td>
<td>(301) 723–4000</td>
</tr>
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### Anne Arundel County

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<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel Medical Center</td>
<td>2001 Medical Parkway, Annapolis, MD 21401</td>
<td>(443) 481–1000</td>
</tr>
<tr>
<td>Baltimore Washington Medical Center</td>
<td>301 Hospital Drive, Glen Burnie, MD 21061</td>
<td>(410) 787–4565</td>
</tr>
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### Baltimore City

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td>Bon Secours Baltimore Health System</td>
<td>2000 W. Baltimore Street, Baltimore, MD 21223</td>
<td>(410) 362–3075</td>
</tr>
<tr>
<td>Johns Hopkins Hospital &amp; Health System</td>
<td>600 N. Wolfe Street, Baltimore, MD 21287</td>
<td>(410) 955–5964</td>
</tr>
<tr>
<td>Johns Hopkins Bayview Medical Center</td>
<td>4940 Eastern Avenue, Baltimore, MD 21224</td>
<td>(410) 550–0350</td>
</tr>
<tr>
<td>Maryland General Hospital</td>
<td>827 Linden Avenue, Baltimore, MD 21201</td>
<td>(410) 225–8100</td>
</tr>
<tr>
<td>Sinai Hospital <em>(Lifebridge Health)</em></td>
<td>2401 W. Belvedere Avenue, Baltimore, MD 21215</td>
<td>(410) 601–5000</td>
</tr>
<tr>
<td>Union Memorial Hospital <em>(MedStar Health System)</em></td>
<td>201 E. University Parkway, Baltimore, MD 21218</td>
<td>(410) 554–2000</td>
</tr>
<tr>
<td>University of Maryland Hospital</td>
<td>22 S. Greene Street, Baltimore, MD 21201</td>
<td>(410) 328–6722</td>
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## Baltimore County

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin Square Hospital <em>(MedStar Health)</em></td>
<td>9000 Franklin Square Drive, Baltimore, MD 21237</td>
<td>(443) 777–7046</td>
</tr>
<tr>
<td>St. Joseph Medical Center</td>
<td>7601 Olser Drive, Towson, MD 21204</td>
<td>(410) 337–1226</td>
</tr>
<tr>
<td>Northwest Hospital</td>
<td>5401 Old Court Road, Randallstown, MD 21133</td>
<td>(410) 521–5945</td>
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## Calvert County

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone</th>
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</thead>
<tbody>
<tr>
<td>Calvert Memorial Hospital</td>
<td>100 Hospital Rd., Prince Frederick, MD 20678</td>
<td>(410) 535–8344</td>
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## Caroline County

<table>
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<tr>
<th>Hospital Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Memorial Hospital at Easton <em>(Shore Health System)</em></td>
<td>219 S. Washington Street, Easton, MD 21601</td>
<td>(410) 822–1000</td>
</tr>
<tr>
<td>Chester River Hospital Inc.</td>
<td>100 Brown Street, Chestertown, MD 21620</td>
<td>(410) 778–3300</td>
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## Carroll County

<table>
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<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Carroll Hospital Center</td>
<td>200 Memorial Avenue, Westminster, MD 21157</td>
<td>(410) 848–3000</td>
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## Cecil County

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Union Hospital</td>
<td>106 Bow Street, Elkton, MD 21921</td>
<td>(410) 392–7061</td>
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*January 2010*
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<thead>
<tr>
<th>County</th>
<th>Hospital Name</th>
<th>Address</th>
<th>City, State Zip</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles County</td>
<td>Civista Medical Center</td>
<td>701 E. Charles Street</td>
<td>La Plata, MD 20646</td>
<td>(301) 609-4000</td>
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<tr>
<td>Dorchester County</td>
<td>Dorchester General Hospital (Shore Health System)</td>
<td>300 Byrn Street</td>
<td>Cambridge, MD 21613</td>
<td>(301) 228-5511</td>
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<tr>
<td>Frederick County</td>
<td>Frederick Memorial Healthcare System</td>
<td>400 W. Seventh Street</td>
<td>Frederick, MD 21701</td>
<td>(240) 566-3300</td>
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<tr>
<td>Garrett County</td>
<td>Garrett County Memorial Hospital</td>
<td>251 N. Fourth Street</td>
<td>Oakland, MD 21550</td>
<td>(301) 533-4000</td>
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<tr>
<td>Harford County</td>
<td>Upper Chesapeake Medical Center (Upper Chesapeake Health System)</td>
<td>500 Upper Chesapeake Drive</td>
<td>BelAir, MD 21014</td>
<td>(443) 643-2000</td>
</tr>
<tr>
<td></td>
<td>Harford Memorial Hospital (Upper Chesapeake Health System)</td>
<td>501 S. Union Avenue</td>
<td>Havre DeGrace, MD 21078</td>
<td>(443) 843-5500</td>
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<tr>
<td>Howard County</td>
<td>Howard County General Hospital (Johns Hopkins Health System)</td>
<td>5755 Cedar Lane</td>
<td>Columbia, MD 21044</td>
<td>(410) 740-7777</td>
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January 2010
### Kent County

Chester River Hospital Center, Inc.  
100 Brown Street  
Chestertown, MD 21620  
(410) 778-3300

### Montgomery County

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holy Cross Hospital</td>
<td>1500 Forest Glen Road</td>
<td>(301) 754-7500</td>
</tr>
<tr>
<td>Silver Spring, MD 20910</td>
<td></td>
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</tr>
<tr>
<td>Shady Grove Adventist Hospital</td>
<td>9901 Medical Center Drive</td>
<td>(301) 279-6053</td>
</tr>
<tr>
<td>(Adventist Health Care)</td>
<td>Rockville, MD 20850</td>
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</tr>
<tr>
<td>Washington Adventist Hospital</td>
<td>7600 Carroll Ave.</td>
<td>(301) 891-7600</td>
</tr>
<tr>
<td>Takoma Park, MD 21912</td>
<td></td>
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</tr>
<tr>
<td>Montgomery General Hospital</td>
<td>18101 Prince Philip Drive</td>
<td>(301) 774-8900</td>
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<td>Olney, MD 20832</td>
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<tr>
<td>Suburban Hospital Health Care System</td>
<td>8600 Old Georgetown Road</td>
<td>(301) 896-3880</td>
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<td>Bethesda, MD 20814</td>
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### Prince George’s County

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<tr>
<td>Laurel Regional Hospital</td>
<td>7300 Van Dusen Road</td>
<td>(301) 497-7954</td>
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<tr>
<td>Laurel, MD 20707</td>
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<tr>
<td>Prince George’s Hospital Center</td>
<td>3001 Hospital Drive</td>
<td>(301) 618-3162</td>
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<tr>
<td>Cheverly, MD 20785</td>
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<tr>
<td>Southern Maryland Hospital Center</td>
<td>7503 Surratts Road</td>
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<td>Memorial Hospital at Easton (Shore Health System)</td>
<td>219 S. Washington Street</td>
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<tr>
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<tr>
<td>Chester River Hospital Center, Inc.</td>
<td>100 Brown Street</td>
<td>(410) 778-3300</td>
</tr>
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<tr>
<td>St. Mary’s</td>
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<tr>
<td></td>
<td>25500 Point Lookout Road</td>
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<tr>
<td></td>
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<td>Somerset</td>
<td>Peninsula Regional Medical Center</td>
<td>(410) 543-7101</td>
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<td>100 E. Carroll Street</td>
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<tr>
<td>Talbot</td>
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<tr>
<td>Washington</td>
<td>Washington County Health System</td>
<td>(301) 790-8300</td>
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<td>251 E. Antietam St.</td>
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CHAPTER 19

OUTCOMES MEASUREMENT SYSTEM (OMS)

Background Information:

Participant outcomes regarding the management of their illnesses and the quality of their lives are important measures of the benefit provided by services in the PBHS. In addition, information about outcomes of mental health services is a key element to supporting the recovery and resiliency of participants (along with access to appropriate services, active participant participation in treatment decisions, and a recovery culture), because knowledge about treatment effectiveness is empowering and instills hope.

Maryland’s Outcomes Measurement System (OMS), in operation since September 2006, is the result of a collaborative relationship among the Behavioral Health Administration (BHA), the University of Maryland Systems Evaluation Center (SEC), and BHA’s Administrative Services Organization (ASO). The OMS questions cover several life domains, including living situation, employment, school attendance, substance use, legal system involvement, symptoms, functioning, etc. The information is collected in order to understand more about the individuals who are receiving services from the PBHS and to begin to understand the outcomes of those services.
General Information:

- The Outcomes Measurement System (OMS) is only for outpatient services.
- The OMS collects data through mental health professional (clinician)/participant or child/adolescent/caregiver interviews, utilizing OMS questionnaires.
- OMS responses are captured in the ASO’s Authorization System.
- OMS is required only of the following provider types:
  - Outpatient Mental Health Center – OMHC (MMIS Provider Type – MC)
  - Federally Qualified Health Center – FQHC (MMIS Provider Type – 34)
  - Acute Hospital Based Clinics - HSCRC Clinics (MMIS Provider Type – 01)
  - Local Health Department (MMIS Provider Type – 35)
  - Chronic Hospital Clinic (MMIS Provider Type – 05)
  - Special Chronic Hospital Clinic (MMIS Provider Type – 07)
- OMS is for participants who are between 6 and 64 years old.
- Authorization for bundles of services is tied to the submission of the OMS questionnaire.
- There are 2 questionnaires – one for Youth (6-17) and the other for Adults (18-64). The participant’s age at the time of the current OMS interview date triggers the administration of the appropriate questionnaire.
- Participants dually eligible for Medicare/Medical Assistance (MA) and participants being treated by out-of-state providers are excluded from OMS.
- Dually eligible commercial insurance/Medicaid participants are included in OMS for OMS bundle services that are not covered by the commercial insurance.
- Administration of the OMS questionnaire itself is not a separately billable service.
  It may be administered during the course of another billable service (e.g.,
diagnostic interview, individual therapy, etc.).

- The OMS Interview Guide (see “Links to OMS Documents”) contains explicit detailed instructions for administering the OMS questionnaires.
- Clinical contact/progress notes should include that the OMS questionnaire was completed during the session.
- The program/agency is required to accept the End User Licensing Agreement (EULA) in order to access the BASIS-24® items in the Adult Questionnaire. Providers that decline to accept the EULA will request and receive authorizations for services in the same manner as non-OMS outpatient service providers (i.e., the 75-unit OMS service bundle will not be authorized).

**Service Bundle:**

- Services included in the OMS 75-units service bundle are 2 outpatient evaluations (90791/90792), 2 family therapy sessions without the participant present (90846), individual and group psychotherapy, family psychotherapy with participant present, and medication management. Services excluded are all extended psychotherapy codes, additional sessions of 90791/90792 or 90846, evaluation and follow up services associated with crisis bed stay, Intensive Outpatient and Partial Hospitalization services, and initial and subsequent inpatient care. The procedure codes included in the OMS bundle are 90791, 90792, 90832, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 90833, 90836, 90837, 90846, 90847, 90849, 9014, 9015, 9016, 9017, 9018, 9019, 0510, 0513, T1015, ; however, only 2 units of 90791/90792 and 90846 are allowed in the 75-unit service bundle. Additional 90791s and 90846s may only be requested after the 2 allowed visits are used and must be submitted in a separate pre-authorization request.
- Providers that are required to complete OMS questionnaires can also request a
pre-authorization for non-OMS services for OMS participants, with medical necessity criteria reviewed by the ASO’s care managers.

- The combination of services billing rules apply to OMS.
- For pre-authorization requests for additional sessions of 90846, the provider should enter the number of visits deemed medically necessary. Providers must include the rationale for the request.
- Medication management visits by non-OMHC physician groups, who are billing independently of the OMHC in which they are providing services, are not included in OMS. The medication management provider should request pre-authorization for medication management services.

Registration/Authorization:

- When an OMS initial registration is done by a provider, an authorization with 2 service units for a span of 3 months is generated, having an authorization start date of the date of the registration.
- The initial request for 2 units can be backdated in the system for up to 29 days.
- If there is already an open outpatient OMS authorization, the system will not accept a new request for authorization via initial registration. The open authorizations with other providers need to be discharged by the participant calling in to the Engagement Center.
- At or before the second service unit, the OMS questionnaire is completed through an interview with the participant or child/adolescent/caregiver. The request is submitted before the third service unit. The 75-unit bundle will start the day after the interview/requested start date.
- If a provider needs additional service units for a participant before the first OMS questionnaire can be completed, the provider will need to call the ASO’s care manager, who will be able, under special circumstances, to authorize additional
service units. This typically should not happen. The provider must call prior to the submission via ProviderConnect for the 75-unit bundle. If the provider calls after the submission via ProviderConnect for the 75-unit bundle, the ASO’s care manager will not be able to add units.

- The system will allow a provider to complete the OMS Initial Registration and the OMS continuing registration/authorization with the OMS questionnaire submission on the same day. The initial registration should be submitted first. Once the continuing registration/authorization request with the OMS questionnaire is submitted, the end date of the initial registration will change to the date of the OMS interview (same date). The start date of the continuing registration/authorization will be the day after the OMS interview date. For example, if provider A completes the OMS initial registration for participant X on 10/1/2009, the system will trigger an authorization with 2 service units, having a begin date of 10/1/2009 and end date of 12/31/2009 (3 months). When the provider then submits the continuing registration with the OMS questionnaire on the same day, the initial OMS registration end date is changed to 10/1/2009 and the continuing registration authorization will have a start date of 10/2/2009 and end date of 4/1/2010 (6 months).

- Whenever an OMS questionnaire is completed and submitted, a new continuing registration authorization will automatically be created with 75 service units for a 6 month span and the next OMS will be due at the end of the authorization, making OMS due every 6 months while a participant is in active treatment.

- The current OMS interview date is required; this date should not be a future date, neither should it be earlier than the previous OMS interview date.

- The provider can submit a continuing authorization request as early as 30 days prior to the end date of the previous authorization or up to 100 days after the previous authorization end date.

- The start date for the concurrent review may not precede the start date for the
initial authorization. This creates significant problems in the ProviderConnect system and may result in retraction of claims.

- The start date for a continuing authorization submitted on either the exact end date of the previous authorization or early (up to 30 days prior to the end date of the previous authorization) will be the day after the current OMS interview date. The previous authorization will end on the day of the current OMS interview.

- The provider is also able to submit a continuing registration of the previous authorization as late as 100 days after the previous authorization end date. Start dates of the authorizations submitted late will be made retroactive to start the day after the previous authorization end date and end six months from that start date. The previous authorization will end on the date of the current OMS interview date. The submit date must be within 21 days of the current OMS interview date (but still may not exceed the 100 days).

- There must be a funding stream on file at the start date of each concurrent review in order for ProviderConnect to process the request. If there is a gap in funding for that time, you may call ValueOptions® and request that a courtesy review span be added for the start date of the new request. This courtesy review span will not pay, but will allow submission of the concurrent review until such time that a participant receives funding that will pay.

- Any remaining units on an OMS authorization will go away when a new Continuing Registration is created.

- At any given time, only one OMS authorization can be open for a participant. When a participant is receiving services from multiple OMS providers, the first OMS provider to request an authorization will be the one responsible for completing OMS. The second provider may then submit for a non-OMS or medication management authorization. ProviderConnect will allow this as long as there is another OMS authorization on file; however, there must be good clinical
justification for this scenario. In a situation where a participant is seeing two OMS providers, BHA expects the providers to coordinate care. The therapy provider should request an OMS continuing registration on or before the expiration date of the previous OMS authorization. Consider the following example:

- Provider A has an OMS authorization that expired 10/1/09 for a participant.
- Provider B requests a medication management authorization for the same participant on 10/15/09.
- Provider B is directed by the authorization system to create an OMS initial registration for the participant.
- However, Provider A is still within the 100 days after the OMS authorization expires and may be planning to come back to request the OMS Continuing Registration, whose start date will backdate to 10/2/09. Provider A will not be able to complete this request due to the open OMS authorization for Provider B.

If the situation in the example occurs, the two providers will need to discuss the situation and may arrange for the Medication Management provider to discharge the participant from the OMS authorization so that the therapy provider may obtain an OMS authorization. The Medication Management provider could then request a pre-authorization for Medication Management services.

- Providers whose service utilization is outside parameters defined by BHA may be required to obtain authorizations for services via a more stringent authorization process. They will continue to be required to submit the OMS questionnaire as part of the more stringent process; however, they will not receive the automatic bundle of 75 service units.
End of Authorization/Discharge:

- When a participant transfers from one OMS provider to another, the first authorization is administratively closed with the participant’s approval. The first provider is allowed to perform a participant discharge up to 10 days after the participant’s authorization is closed. When an authorization is administratively closed, the current provider has 10 days to discharge the participant and submit the discharge information sheet. Claims for discharge information will not be paid if the discharge information sheet is not submitted within 10 days.
- After 100 days, neither a continuing OMS nor a discharge OMS will be accepted. If a provider does not complete the OMS questionnaire within 100 days of the expiration of the prior OMS authorization, the prior OMS authorization will be closed. If the participant has to continue treatment, a new episode of care must be started.
- The discharge OMS interview can be submitted no later than 100 days after the end date of the previous continuing authorization.
- There will be two ways in which OMS discharge information is collected:
  - Discharge with participant or child/adolescent/caregiver participating in OMS interview. When the participant or child/adolescent/caregiver is participating, the following are completed and submitted:
    - Discharge Information Sheet: this consists of 6 mandatory items that can be completed without interviewing the participant. It collects information about the discharge (date, planned/unplanned, reasons, etc.).
    - OMS Questionnaire: in addition to the Discharge Information Sheet, the clinician should conduct an OMS interview as usual and submit the appropriate OMS questionnaire.
  - Discharge with participant or child/adolescent/caregiver not participating
in OMS interview. When the participant or child/adolescent/caregiver is not participating, the following are completed and submitted:

- **Discharge Information Sheet**: this consists of 6 mandatory items that can be completed without interviewing the participant. It collects information about the discharge (date, planned/unplanned, reasons, etc.).

- **Discharge OMS Forms (Participant or Child/Adolescent/Caregiver Not Participating)**: These forms collect basic OMS information; they do not include any of the participant or child/adolescent/caregiver opinion only questions. There is one form for adults and one form for children/adolescents/caregivers.

- Submission of the Discharge Information Sheet triggers a one unit authorization for the discharge date listed on the Discharge Information Sheet.

- Authorization for discharge payment of $20 is triggered by the submission of the OMS Discharge Information Sheet.

- An outpatient treatment service and completion of the Discharge Information Sheet are allowed to occur on the same day and providers can bill for these two different services on the same day.

- Providers will be paid for completing the OMS Discharge Information Sheet only if the OMS questionnaire has been completed at least once in the past.

**Other OMS Procedures and Processes:**

- The OMS interview may be conducted either by using the online version of the questionnaire or by using a hard copy of the questionnaire and then entering responses on-line at a later time.
• A partially-completed OMS questionnaire can be saved online without submitting it; this allows a provider to re-access the OMS questionnaire in order to complete it prior to submission.

• There are a few “skip patterns” within each questionnaire. These are situations in which one or more questions are “skipped” based on the response provided in the previous question. The ASO’s system is designed to move to the next appropriate question automatically. If using a hardcopy version of the questionnaires, follow the “skip patterns” carefully.

• Some questions are mandatory (designated by an asterisk) – the system will not accept submission of the OMS questionnaire when any of the mandatory questions are not answered. If a participant or child/adolescent/caregiver, in a face-to-face interview, refuses to answer a mandatory question, the provider is allowed to respond to the question to the best of his/her ability and can note the “refusal to respond” in the optional text box provided at the end of the questionnaire.

• The symbol $\Psi$ is used to identify a participant opinion-only question and the symbol * is used to identify mandatory questions.

• In the online version, an underlined item question indicates that a definition for a term within the question is available. Click on the hyperlink that appears in order to access the definition (e.g., living situation, homelessness). In the hard copy version, a notation is made that a definition is available in the OMS Interview Guide.

• An optional free text box, labeled Clinician’s Notes, is available at the end of the questionnaire so that providers have the option to type in their own notes, if desired.

• When the OMS questionnaire is submitted, the questionnaire completion rate is displayed in a pop-up box, which is calculated factoring in the skip patterns.

• Providers are able to view previous OMS questionnaires on-line.
• Providers have the option to print a condensed version of the OMS interview/questionnaire to keep in the individual’s medical record, if desired. The print version includes:
  
  - Name of Participant
  - Current OMS Interview Date
  - Place for signature of clinician
  - Entire Questionnaire, condensed with chosen responses only
  - The C&A OMS has 2 print options: the full OMS questionnaire (condensed) and just the Substance Abuse Domain questions.

**Links to OMS Documents:**

OMS Website and Datamart


OMS User Guide


OMS Interview Guide

*Note Chapter 6 includes the following documents:*

- *Child and Adolescent Questionnaire*
- *OMS Child and Adolescent Questionnaire – Response Cards*
- *Adult Questionnaire*
- *Adult Questionnaire – Response Cards*
- *Discharge Information Sheet*
- *Child and Adolescent Discharge Form – Child/Adolescent/Caregiver Not Participating*
- *Adult Discharge Form – Client Not Participating*
OMS Adult Questionnaire (18-64 years)

OMS Child and Adolescent Questionnaire (6-17 years)