

6.16. Mental Health – Outpatient Mental Health Services (OMHCs, FQHCs, Hospital-Based Clinics, Individual Practitioners, and Private Group Practices)

DESCRIPTION OF SERVICES

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 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, seven days per a week, as regulated under COMAR 10.21.20. The OMHC must prominently display the hours of operation of the facility or office.

SERVICE RULES

Initial Evaluation/Diagnostic Interview

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 fifth 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 Maryland Public Behavioral Health System (PBHS) will not reimburse, as the primary payer, for services covered by Medicare for Medicare recipients served by OMHCs 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.

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:

- Asignificant change in the participant’s condition; reasonable clinical judgment will be applied by Beacon 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 the appropriate evaluation and management code and the “add on” therapy code.

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 Beacon 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 PBHS only if the agency/provider is an approved OMHC and approved by BHA as an approved evidence-based practice 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 Beacon 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 Beacon, 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 Medicaid, 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 and 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 Medicaid provider number or a physician group practice Medicaid number. If you have a physician currently in your group practice under one Medicaid group practice provider number, a new Medicaid provider application is to be submitted to Medicaid Provider Enrollment Unit for a separate Medicaid 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 OMS. The participant will initially receive an authorization for two services. Prior to the third 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 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 into Beacon. HSCRC clinics should refer to the service matrix for appropriate corresponding revenue codes.

For complete information on OMS, refer to the Chapter 19 and the OMS Appendix of this Provider Manual, as well as any updates that are posted on the Beacon website.

Non-OMS Authorizations (Individual Practitioners, Group Practices, and OMHCs)

All initial requests for authorization are auto-approved and can be backdated in Beacon's 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 Beacon, 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 be used.

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 UB-04 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-10 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 Beacon.

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, federally qualified health centers, 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.

Electroconvulsive therapy (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 disorder 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.