PSYCHIATRIC REHABILITATION PROGRAMS (PRP)

FREQUENTLY ASKED QUESTIONS

This document is provided as an ongoing resource for PRP providers. It is organized into three major sections:

A. Issues pertaining to all PRP
   - Questions concerning Referrals
   - Questions concerning Authorizations

B. PRP-Adult (PRP-A)

C. PRP-Minors (PRP-M) to include services rendered by BHA designated Transition Aged Youth (TAY) programs as well as to children and adolescents

Abbreviations used in this document

APRN-PMH	Advanced Practice Psychiatric Nurse
CRNP-PMH	Psychiatric Nurse Practitioner
COMAR	Code of Maryland Regulations
IPP	Incedo Provider Portal
IRP	Individual Rehabilitation Plan
MNC	Medical Necessity Criteria
PRP-A	Psychiatric Rehabilitation Program for Adults
PRP-M	Psychiatric Rehabilitation Program for Minors
LCSW-C	Licensed Clinical Social Worker-Certified
LCPC	Licensed Clinical Professional Counselor
LCMFT	Licensed Clinical Marriage and Family Counselor
LCADC	Licensed Clinical Alcohol and Drug Counselor
LGPAT	Licensed Graduate Professional Art Therapist
LGMFT	Licensed Graduate Marriage and Family Therapist
LGMT	Licensed Graduate Marriage Therapist
LMSW	Licensed Masters Social Worker
LGADC	Licensed Graduate Alcohol and Drug Counselor
CAC-AD	Certified Associate Counselor- Alcohol and Drug
CSC-AD	Certified Supervised Counselor- Alcohol and Drug
RN-C	Registered Nurse-Certified
DLA-20	Daily Living Activities-20 (used to support the functional assessment data needs of assessment providers.

A. **Issues pertaining to all PRP**

Questions concerning referrals

Q1. What are the rules concerning who may make referrals to PRP?

PRPs are almost exclusively funded by Medical Assistance. The rules for referral contained in COMAR 10.09.59.05 B (1) apply.

"(1) A participant who has been referred for psychiatric rehabilitation program services by a Maryland licensed mental health professional who:

(a) Is actively enrolled as a provider in the [Medicaid] Program on the date of service;
(b) Facilitates an informed choice of psychiatric rehabilitation program providers; and
(c) Provides inpatient, residential treatment center, or outpatient mental health services to the individual;"

The licensed mental health professional is required to be independent of the PRP.

Q2. Who is defined as a "mental health professional" eligible to make referrals to a PRP?

- Licensed Mental Health Professionals, including Psychiatrists, CRNP-PMH, Licensed Psychologists, LCSW-C, LCPC, APRN-PMH, LCMFT, LCADC, LCPAT, LGMFT, LGADC, and LGPAT may make referrals *subject to payer referral requirements* (See Q1 for Medicaid requirements).
- LGPC, LGMFT, LGADC, LGPAT and LMSW staff may only make referrals if they are currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Counselors and Therapists or the Maryland Board of Social Work Examiners, as applicable.
- Referrals from non-mental health professionals who do not have a mental health specialty are not permitted.
- RN-C, CAC-AD and CSC-AD are not eligible to make referrals.

Q3. How far in advance can the referral be dated for an initial or concurrent authorization request? What information should the referrals include?

All referrals must be based on a face to face or telehealth clinical assessment within 60 days of the date that the proposed authorization starts. The referral must contain clinical information demonstrating the medical necessity criteria met for PRP services. For concurrent reviews, the BHA ASO will also accept evidence of clinical collaboration.

For the first concurrent review in PRP-A only, which occurs after only two months, the initial referral from the licensed mental health professional may be used again.

Q4. With COVID-19, it can be challenging to get a written referral from the outpatient provider. What format is required?

A written referral is required that clearly states that the Mental Health Professional is referring the participant to begin or continue PRP and the medical necessity criteria met for PRP services. This can be in the form of a copy of an email or a faxed referral.

Q5. Why the requirement for a new referral every six months? Is this new?

There has been no change in BHA's policy concerning the requirement for new (AKA referrals for continuation of services) referrals to be submitted every six months, which was outlined in a policy memo on April 25, 2012. As an alternative to referral, documented evidence of clinical collaboration between the treating therapist and rehabilitation staff is permitted for concurrent authorizations, as discussed in the provider alert titled "Psychiatric Rehabilitation Program Referrals (PRP-A/PRP-M) Authorization Administrative Denials" on August 3, 2020. The specific duration of an approved authorization is driven by the participant's recovery status and if MNC continues to be met.

Questions concerning authorizations

Q6. What documents must be attached to complete my request?

The following documents must be attached to your request in addition to the information provided within the form.

- Initial request: Written referral from the treating mental health professional not affiliated with the PRP dated within 60 days of the start of the proposed initial authorization timeframe.;

- For Concurrent request: Either:
    A. A written referral based on an in-person or telehealth meeting with the individual conducted in the previous 60 days, or
    B. Documentation that Clinical Collaboration standards are met. (See Q5, above)

- A copy of the IRP which must indicate participant agreement to the plan. (Generally achieved through signature, but in limited cases may be an attestation that the consumer is unable to sign and is in agreement with the plan.)
- Evidence of SSI/SSDI eligibility, if applicable.
- Though not submitted as an attachment:
    A. The DLA-20 form must be completed in the portal for all Adult requests.
    B. The MNC form in Incedo must be completed.

Q7. The IRP contains the clinical information you are requesting. Can I just say; "see attached." What form my responses in the form?

No, "see attached" is not sufficient. The information in the form is more detailed than one would generally find in an IRP because it speaks to overall current functional status. If information on the IRP

answers questions on the form fully, then the data may be copied into the form as appropriate. The IRP needs to be uploaded because it contains additional information necessary in Medical Necessity determination such as individualized goals, objectives, and interventions.

Q8. Does a person have to be in and continue to be in therapy if in PRP?

Yes, to remain eligible, an individual must be in mental health treatment for the conditions that the PRP is addressing in psychiatric rehabilitation, and the PRP service must be coordinated with treatment. This is not a change in policy.

Q9. I am now required to fill out a form to determine eligibility for PRP based on Medical Necessity Criteria (MNC). Why was this requirement suddenly added?

Participants in PRP services have always been required to meet MNC. However, upon audit, documentation to substantiate medical necessity was not always evident in the provider's client record, resulting in retractions of paid provider claims. This documentation is now being requested proactively to confirm medical necessity for PRP services, reduce unanticipated payment retractions and ensure the prioritization of this intensive service is available to those who need it most.

Q10. What are the documentation requirements to justify SSDI/SSI eligibility, and when are they needed? Can this be self-reported by the participant? Or are supporting documents needed?

This documentation will be needed once a planned upgrade of Incedo is implemented that allows for MNC determinations in some cases to skip some functional assessment elements. This will require evidence of SSI/SSDI enrollment along with a Category A diagnosis.

Written evidence of SSI/SSDI eligibility must be provided by the time of the first concurrent authorization. (This requirement has been waived for any first concurrent authorization obtained in July or August,2020, but will need to be met on all subsequent requests).

Acceptable Documentation of SSDI/SSI eligibility:

1) Social Security Administration (SSA) Award or Benefits Verification Letter (Award letter can be obtained online using beneficiary's mySSA Account)

2) Social Security Administration (SSA) Benefits Planning Query (BPQY)

3) Social Security Administration (SSA) Notice of Change in Payment

4) Social Security Administration (SSA) Ticket to Work Letter - States that individual receives SSA disability benefits, but does not include the type or amount

5) Social Security Administration (SSA) Overpayment letter

6) SSA-1099 tax documents issued to Title II beneficiaries

7) SSA-1042S tax documents issued to nonresident aliens who receive Title II benefits

8) Print out from the Social Security Administration Ticket to Work (TTW) Portal demonstrating TTW eligibility (for agencies who are also Employment Networks)

9) Bank statement or online printout showing direct deposit of SSA benefits

Q11. If we receive an Administrative denial because required documents were not submitted and we submit the missing documents after receiving the denial, will we be able to obtain authorization and if so, does authorization go back to the original requested start date?

If the denial is based on missing documents, submit the missing documents and request for authorization. However, a *new* authorization request must be submitted and can only be backdated as far as the system allows for new submission. Providers will have until December 31, 2020 to enter authorizations for the period from July 1, 2020 forward and should note that claims will not be payable until authorizations are approved. Beginning January 1, 2021, the maximum period for retro-submission of authorizations will be fourteen (14) days.

If, *prior to receiving an administrative denial,* one recognizes that required documentation was omitted from the original submission initially and is available for submission, please immediately attach the documentation to the authorization request in the portal.

When possible, the BHA ASO will reach out either by secure email or phone to request the missing documentation. In those cases, if the documentation is provided within two (2) business days, an administrative denial will be issued.

Q12. If we receive an Administrative denial for a reason other than missing documentation, what is the appeal process?

Rights of grievance and appeal depend on the type of denial.

Denials for services in the "reconciliation tranches" during the January-June 2020 timeframe should be handled using the process spelled out in an upcoming provider alert on the topic.

Denials made in the normal course of system operations are handled in accordance with the grievance and appeals processes contained in the Maryland PBHS Provider Manual.
https://maryland.optum.com/content/dam/ops-maryland/documents/provider/Maryland%20Provider%20Manual_Product%20Implementations_BH2535_FINAL_REVISED-02.05.20.pdf

Q13. What documentation is needed for an IRP consent.

It is expected that the development of the IRP is a collaborative process with the consumer, or the consumer's guardian (in the case of a minor or somebody who has been assigned a guardian of person).

The IRP must be signed and dated by the participant or guardian indicating participant and/or guardian agreement with the plan. If the participant/guardian is unable to sign, the provider preparing the plan documents their oral agreement with the plan, as applicable. The person preparing the plan must always sign and date the plan. E-signatures are acceptable.

Q14. On the forms, if a provider says a crisis plan has not been done, or psychopharmacology has not been considered, are these considered exclusionary criteria, and a care advocate would administratively deny the request?

Currently, failure to meet these criteria will not in themselves constitute grounds to deny on the basis of MNC. However, it is expected that providers ensure that these measures are in place, and in future this may well be added as independent exclusionary criteria in MNC because they are important to treatment.

Q15. Is there specific information that is mandated in a transition plan?

Accreditation standards generally contain more specifics than are listed here and should be followed. However, the basics of a transition plan involves a detailed description and process for the transition of the participant to an alternate level of service, what assistance is needed, and the providers of the referring and receiving services.

B. PRP-Adult

Q-A-1. It appears that some items have been added to the Medical Necessity Criteria for Psychiatric Rehabilitation programs for adults (PRP-A) which were previously not there

In developing a screening tool for MNC, BHA and Maryland BHA ASO have attempted to operationalize criteria in more objective terms to establish a decision workflow for the Maryland BHA ASO reviewers to use. In some instances, this has resulted in items being listed specifically rather than making general references. For example, the requirement that an individual not require a higher level of care has been explained more clearly by listing some of the potentially conflicting types of care, as shown in the answer to the question below.

Q-A-2. The new Adult PRP Medical Necessity Criteria prohibits combinations of service with several other service types, such as IOP. This is an unannounced change! Why?

As of July 1, 2020, PRP may not be provided in conjunction with
a. Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT) -Adult
b. Adult Targeted Case Management (TCM)
c. Inpatient
d. MH-Residential Treatment Center (RTC)
e. Residential SUD Treatment Level 3.3 and higher
f. SUD IOP/2.1, PHP 2.5
g. MH IOP/PHP
h. Residential Crisis

The rationale for the change shown above is that rarely is there clinical justification for these services to be offered in combination with PRP. Providers are likely to already offer the services being requested

from the PRP. Specific exceptions may be made in limited individual circumstances to allow for co-existence of these services, but these will have to be clinically justified, and will likely only be granted on appeal. To request exceptions, the PRP must follow the appeals process.

Q-A-3. Am I supposed to discharge all my clients and lay off my staff because of the combination of service change?

You definitely should not simply discharge active clients in treatment because of the MNC provision mentioned above, and you remain liable for ensuring that service termination is handled ethically. Individuals should continue in treatment, as appropriate from the perspective of medical necessity, and, if necessary, referred to the appropriate level of treatment at the conclusion of this treatment episode.

If you have an existing authorization span with any of the above combination of services, these will be honored, although you are always responsible for ensuring that the treatment meets MNC criteria.

If you request a new authorization for services that includes prohibited combinations of services, the request will likely be denied. However, in limited circumstances a clinical exception may be granted for a brief period to allow for appropriate transition.

If you request a concurrent authorization for services that may not be combined, services may be authorized through September 30, 2020, to allow for a smooth transition from care.

Q-A-4. What information (clinical and not clinical) must be included on a transition plan? Does it need to be signed by both the PRP and the other LOC?

There is not a specific template for this. A plan should clearly demonstrate how the individual will transition from the current level of service to another level of service during the authorization period. Authorization may, or may not, be granted based on detailed information in the plan, if the plan is assessed as an acceptable path forward and if the implementation plan is feasible.

Q-A-5. What do I do if I have a client in my PRP-A who needs higher level treatment for a substance use disorder?

If a participant i served under an existing PRP authorization is found to need substance use treatment at an intensive level, the PRP authorization timeframe will remain but the PRP provider only bills for the Substance Use Treatment program. If the individual requires medication monitoring, etc. at night, then the PRP may use existing authorizations to continue off-site only services for the duration of the SUD treatment, but the rationale for this must be clearly documented.

Q-A-6. Do participants with a Category B diagnosis, who were receiving SSI, and were either not competent to stand trial, or who had been discharged from a State hospital, need to detail functional impairments? This is not clear in the MNC, as the MNC states category B must meet criteria D.

Additionally, the waivers are only listed under Category A, so did not seem relevant to Category B. Can this be clarified?

Individuals who meet either of the two cited conditions under which the specified diagnosis may be waived are essentially deemed to have met category A criteria and are therefore subject to the designated Category A workflow. Under such circumstances, the PRP provider is not required to provide further evidence of functional limitations in Section D. Since Category A and Category B diagnoses are mutually exclusive, any individual with a primary category B diagnosis would, by definition, be eligible for the Category A diagnostic waiver, if either of the two cited conditions were to apply. Since the intent is for these individuals to follow the designated Category A workflow, it is not necessary to include these cited conditions under the Category B criteria.

C. **PRP-Minors**

Q-M-1 The MNC criteria in PRP-M have been changed, and I am going to have to discharge most of my clients because of it. What should I do?

As noted in the Provider Council call on 7/10/2020, the provider community's concerns about problems caused by an attempted clarification made in the MNC for PRP-M were heard. The MNC have returned to the original wording until the issue can be resolved in collaboration with stakeholders.

The revised wording in the Maryland BHA ASO MNC alert published on June 26, 2020 states "The youth, due to the dysfunction, is at risk for requiring an out of home or residential placement or is returning from out of home or residential placement."

Due to provider concerns, the proposed wording has been replaced with the original wording; "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."