Frequently Asked Questions: Psychiatric Rehabilitation Programs (PRP)

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.

The requirement "provides treatment" means that the provider has assessed the individual over a period of time and is providing ongoing treatment to the individual.

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 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. A LMSW may only make referrals if currently in a formal clinical supervision arrangement with a supervisor approved by the Maryland Board of Social Work Examiners.
- Referrals from non-mental health professionals who do not have a mental health specialty are <u>not</u> permitted.
- PA, RN-C, CAC-AD and CSC-AD are <u>not</u> eligible to make referrals.

Q2A. Supervision of LMSW or LGPC by an outside contractor. (This is an existing statutory requirement which has been added to clarify the FAQ)

If an LMSW or LGPC, LGMFT, LGADC or LGPAT is supervised by an independent contractor, the organization must have a HIPAA Business Associates Agreement (BAA) with the supervisor that allows the supervisor access to PHI.

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. See Provider Alerts Psychiatric Rehabilitation Program Referrals (PRP-A/PRP-M) Authorization Administrative Denials August 3, 2020 and Updated Guidance 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? (Updated 10/21/2021)

For an initial referral, a written referral is required that clearly states that the Mental Health Professional is referring the participant to begin 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. For concurrent referrals, providers can submit a re-referral or documentation of clinical collaboration between the PRP and the therapist, as described in Q5.

Q5. What should a referral include?

Referrals must be dated within sixty days prior to the requested start date of services. The referral should include the participant's mental health diagnosis, clinical rationale for why the participant is being referred for PRP services and be signed by the referring behavioral health clinician (e-signature acceptable).

Q6. 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

Q7. 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

    1. Referral for continuation of services
        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)

    2. 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.)

    3. Evidence of SSI/SSDI eligibility, if applicable.

    4. Though not submitted as an attachment:
        A. The DLA-20 form must be completed in the portal within 30 days prior to the requested start date for all Adult and TAY concurrent requests. B. The MNC form in Incedo must be completed.

Q8. The individualized rehabilitation plan (IRP) contains the clinical information you are requesting. Can I just say, "see attached"? What forms my responses?

No, simply stating "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 the overall current functional status. If information on the IRP fully answers questions on the form, then the data may be copied into the form as appropriate. The IRP needs to be uploaded because it contains specific individualized goals, objectives, and interventions for the upcoming period. All of this information is important in determining whether the request meets Medical Necessity criteria.

Q9. Does a person have to be in therapy currently and continue to be in therapy if in PRP?

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.

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

The requirement “provides treatment” means that the provider has assessed the individual over a period of time (**generally expected to be four (4) visits or more)** and is providing ongoing treatment to the individual.

Q10. 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.

Q11. 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? (Updated 10/21/2021)

Written evidence of SSDI/SSI eligibility, dated no earlier than one year prior to the date of the initial authorization request, must be provided at the first concurrent review for PRP services for adult participants with a Category A diagnosis when it is indicated the participant receives SSDI/SSI. If the individual continues to meet Medical Necessity Criteria, no further SSDI/SSI eligibility documentation is required on subsequent concurrent requests. If there is a break in the episode of care of more than three (3) months, and the individual returns for a PRP precertification request, updated documentation of SSDI/SSI eligibility, dated within one year of the new precertification request, must be submitted coincident with the initial authorization request.

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 my SSA 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

If it is not possible to obtain this acceptable documentation, you may obtain authorization by providing clinical evidence of functional impairments (Criteria D) as indicated in the Provider Alert published on March 9, 2021.

Q12. 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? If so, does authorization go back to the original requested start date?

All required documentation must be submitted with each authorization request (see Q5). If any information is missing at the time Optum reviews the request, an administrative denial will be issued.

If the denial is based on missing documents, submit a *new* authorization request that includes the missing documents. Please note: when submitting a new authorization request, the requested start date can only be backdated as far as the system allows (20 days) as outlined in the Provider Alert released on April 26, 2021.

If, *prior to receiving an administrative denial,* the submitter 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.

Q13. If we receive an Administrative denial for a reason other than missing documentation, what is the appeal process? (Updated 10/21/21)

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

Administrative denials may be addressed by submitting a *new* authorization request with all necessary documentation.

Medical necessity denials are handled in accordance with the grievance and appeals processes contained in the Maryland PBHS Provider Manual.

Claims denials for services in the “reconciliation tranches” during the January-August 3, 2020 timeframe should be handled using the ongoing estimated payment reconciliation process

Q14. 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 must document their oral agreement with the plan, as applicable. The person preparing the plan must always sign and date the plan. E-signatures are acceptable.

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 involve 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.

Q16. Is backdating no longer allowed for concurrent authorization requests? (Updated 10/21/2021)

As noted above, authorizations can be backdated by a maximum of 20 days and may be entered 30 days prior to requested start date. This applies to all initial or concurrent PRP requests as indicated in the April 26, 2021, Provider Alert.

Q17. What happens if the participant has not attended or participated in PRP services for a period of time?

If a participant is out of PRP treatment for three months or longer, a new initial authorization request is required. If the participant was in treatment all along, but for some reason that treatment was not authorized, a concurrent review may be submitted as long as proof of participant's attendance throughout treatment can be provided.

• 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 routinely 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

If you are aware the participant is receiving services that should not routinely be provided in conjunction with PRP, please indicate this within the service request form and attach a transition plan or provide clinical rationale to justify the need for multiple services.

Q-A-3. Am I supposed to discharge all my clients and lay off my staff because of the combination of service change? (Updated 10/21/21)

No. 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 combinations of services, the request will likely be denied. In limited circumstances, the authorization may be approved for a shortened authorization span to allow for appropriate transition.

Q-A-4. What information (clinical and non-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 should I do if I have a client in my PRP-A who needs higher-level treatment for a substance use disorder?

If a participant served under an existing PRP authorization is found to need substance use treatment at an intensive level (residential treatment), the PRP authorization timeframe will remain but the PRP provider **cannot bill** for services while the participant is engaged in an intensive residential (3.3, 3.5, 3.7, 3.7WM, 4.0) Substance Use Treatment program.

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 in PRP-M has 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 meeting on July 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."

Q-M-2. 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. BHA is considering whether, in future, this may be added as independent exclusionary criteria in MNC because they are important to treatment.

Q-M-3. If a youth participant is turning 18 during an authorization period, when will the authorization end? (Updated 1021/2021)

If the participant meets MNC for the service request, the PRP authorization will be approved for six months / six units. If the participant transitions to an adult PRP program, an adult initial service request should be submitted with supporting documentation of a priority population diagnosis and other clinical details to make determination of medical necessity.

Q-M-4. The Provider Alert sent on March 1, 2021, addresses updates to medical necessity criteria for PRP-M. Can you elaborate on the combination of services that were historically allowed? (Updated 10/21/2021)

As noted in Updates to Medical Necessity Criteria for PRP-M Provider alert, as of April 1, 2021, Optum Maryland will make a more concerted effort to ensure authorization requests submitted for PRP meet a combination of services rules.

PRP-M should not be routinely provided in conjunction with:

- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)
- Targeted Case Management (TCM)
- Inpatient Psychiatric Services
- Crisis Residential Services
- Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)
- Mental Health- Intensive Outpatient Program (IOP)
- Mental Health- Partial Hospitalization Program (PHP)
- Therapeutic Behavioral Services (TBS)
- Residential Substance Use Disorder Treatment Level 3.3 or higher
- Substance Use Disorder-Intensive Outpatient Program (IOP)
- Substance Use Disorder- Partial Hospitalization Program (PHP)

Optum Maryland has modified their workflows within the Incedo Provider Portal to allow providers the opportunity to submit a narrative text within the form detailing the clinical justification. The intent behind these changes is not to present any unnecessary barriers to needed services but rather ensure medical necessity is met and the small subset of youth who need the combination of services will receive the services needed to include coordination of care between the two rendering providers.

C&A TCM & PRP:

The provider alert did not provide details about the different intensities of C&A TCM services. This combination will be allowed if MNC is met if the participant is engaged in:

- TCM level II (moderate)
- TCM Level III (intensive)

Additional information should be included in the service request to justify the participant's need for multiple services and medical necessity for PRP.

Be advised, TCM Level 1 will not be allowed in combination with PRP as this is the general level of case management services and PRP has a basic level of case management component embedded in the programming.

C&A Respite & PRP:

Respite and PRP will be allowed if the clinical justification submitted by the providers meets medical necessity for the two services.

TBS & PRP:

TBS and PRP may be allowed only if the clinical justification submitted by the providers meets medical necessity for the two services.

Need help with submitting an authorization request and demonstrating MNC is met?

Kris Wright, M.S. LCPC from the University of Maryland Evidence-Based Practice Center, offers Technical Assistance Sessions which can include reviewing narrative summaries that demonstrate medical necessity.

For more information, please click here.