Personalized Recovery Oriented Services (PROS) Finance

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This handbook is designed to clarify PROS financing issues. The goals of this handbook are:

- To summarize all of the regulatory provisions related to billing Medicaid for PROS services;
- To explain the PROS Client Registration process;
- To help PROS providers understand the Medicaid Management Information System (MMIS) so that they will be able to bill accurately, to be reimbursed appropriately, and to comply with electronic and field audits associated with the PROS program;
- To explain the components of the PROS rates;
- To provide guidance on billing Medicare and other third party payers when appropriate

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Section 1 - Medicaid Requirements for PROS Programs

This section of the PROS financing chapter provides a summary of the requirements included in the NYS Office of Mental Health's Personalized Recovery Oriented Services regulations, as they pertain to receipt of Medicaid payments. These requirements have been extracted from 14 New York Codes, Rules and Regulations (NYCRR) Part 512. In some instances, additional guidance or clarification is provided. The section is organized into the following six components:

- Eligibility for Admission;
- Allowability of Service;
- Client Registration;
- Billing Requirements, Limitations and Combinations;
- Supporting Documentation; and
- Medicaid Disallowances

The Eligibility component outlines the minimum requirements that must be met in order for an individual to be admitted to a PROS program. The Provision of Service component specifies the requirements that must be met in order for a provider to be able to bill Medicaid on behalf of a specific individual, for a given service. The Client Registration component describes the process of admitting individuals to a PROS program. The Billing component summarizes the basic billing rules and limitations. The Documentation component summarizes the requirements which, when met, provides supporting documentation that the

eligibility and billing requirements have been met. Even when there is not a specific documentation requirement included in the regulations, providers are advised to ensure that they have sufficient documentation to verify compliance with other standards. There is no practice of approach that substitutes for thorough, accurate and timely record keeping. The Medicaid Disallowances component identifies reasons commonly associated with Medicaid disallowances in other programs that are also relevant to PROS programs.

Providers are advised that the information included in this section is not a substitute for a careful review of the applicable regulations. In the event of any conflict between this document and 14 NYCRR Part 512, the regulations are controlling.

Providers are encouraged to maintain up-to-date copies of the regulations, and to ensure that they are accessible to relevant staff. Regulations can be found on the Office of Mental Health's (OMH) website. Any revisions to the regulations will also be posted on this website.

Eligibility for Admission

Persons eligible for admission to a PROS program must:

- Be 18 years of age or older;
- Have a designated mental illness diagnosis;
- Have a functional disability due to the severity and duration of mental illness; and
- Be recommended for admission by a licensed practitioner of the healing arts. (It is not required that the practitioner be a member of the PROS staff.)

Designated mental illness diagnosis is a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis (or International Classification of Diseases (ICD) equivalent other than: 1) alcohol or drug disorders; 2) developmental disabilities; 3) organic brain syndromes; 4) social conditions (V-Codes))

> **Note**: The mental illness diagnosis is not required to be the primary diagnosis. For pre-admission screening services, "diagnosis deferred" (799.9) may be used.

Functional disability is a deficit that rises to the level of impairment in one or more of the following areas: self-care; activities of family living; interpersonal relations; or adaptation to change or task performance in work or work-like settings.

Licensed practitioner of the healing arts is a nurse practitioner, physician, physician assistant, psychiatric nurse practitioner; psychiatrist, psychologist, registered professional nurse, Licensed Clinical Social Worker (LCSW); and Licensed Master Social Worker (LMSW) if supervised by an LCSW, licensed psychologist, or psychiatrist employed by the agency.

Allowability of Service

Services provided must be:

- Consistent with the terms of the provider's operating certificate (i.e., included in the list of required PROS services, or identified on the operating certificate as an "additional" service).
- Consistent with the regulatory definition [see Part 512.4(b)].

> **Note**: While program activities can be described in multiple ways and many providers prefer to use local terminology, providers are advised to use the service labels included in the regulations to ensure that the meaning and intent of the service is understood by external

reviewers. As an alternative, providers are advised to develop a "crosswalk", comparing provider terminology with regulatory language.

Services provided must be:

- Identified in the participant's Individualized Recovery Plan (IRP); or
- A pre-admission screening service; or
- A crisis intervention service; and
- Be provided by a member of the program's staff

Note: While the person rendering the service may include a member of the professional staff, a non-professional member of the clinical staff, or an identified volunteer, such person, including any recipient employee, should be reflected on the provider's staffing plan.

Recipient employee is an individual who is financially compensated by a provider for providing clinical or non-clinical PROS services in the same program where the individual also receives PROS services.

Services provided must be provided, face-to-face, to an individual who:

- Has been admitted to the PROS program or is in pre-admission status; or
- Is a collateral of an individual who has been admitted to the PROS program or is in pre-admission status.

If services are provided to a collateral, the person receiving services must meet the regulatory definition of "collateral" and the services must be provided for the benefit of the PROS participant.

Collateral is a significant other or member of the PROS participant's family or household, academic, workplace or residential setting, who: regularly interacts with the individual and is directly affected by, or has the capability of affecting, his or her condition; is identified in the individualized recovery plan, and approved by the individual as having a role in services and/or is identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the individual prior to admission; and is not a staff member of the PROS program or any other mental health service provider functioning in his/her professional role.

Client Registration

Medicaid rules prohibit paying more than once for the same service. Client Registration was developed in response to concerns from providers about the potential liability for retroactive recoveries. The state was also concerned about the technical difficulty of building a billing system that could handle the complexities of post-audit recoveries. The Client Registration process will prevent co-enrollment before it occurs. Client Registration will restrict the individual's Medicaid card to a specific provider and specific services. Only the PROS provider who is registered to that individual will be able to bill. At the time providers verify Medicaid eligibility they will know if they will be paid.

Verifying Eligibility

All PROS providers will need the capability for verifying Medicaid eligibility and checking the registration status of their individuals. Information regarding this can be found on www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx#MEVSPM

Admission & Registration Process - Overview

- When an individual begins attending a PROS program, the provider will be required to submit a registration to OMH through the Children & Adult Information Reporting System (CAIRS).
- A registration is requested by completing the CAIRS PROS Admission screen.
- Until that registration is processed, the PROS provider will not be paid for any services other than pre-admission for that individual. Providers will be required to submit registrations for all individuals, including those who are not Medicaid eligible.
- Registration will ensure that providers know whether they will be paid before delivering services.
- For each registration submitted, providers will need to retain in the individual's record a copy of an attestation signed by the individual agreeing to the registration. (See Appendix A for copy of Attestation)
- Registration with a new PROS program will automatically disenroll the individual from a prior PROS program without the need to return to the former program to request disenrollment.

Registration & CAIRS

- Using CAIRS, OMH has provided an automated process for submitting PROS registrations.
- PROS providers request registration by admitting the individual through CAIRS.
- For each individual, PROS providers must register each service component separately.
- The admission date for each component is the system date of the CAIRS registration screen. CAIRS auto fills the admission date field at the time the registration is entered into CAIRS. It cannot be back dated or edited by the provider.
- Providers will be advised of the status of their registration requests through CAIRS. CAIRS will inform the provider whether the individual has been successfully registered, with or without Medicaid, into their program. A discharge will be generated for individuals who have registered to another provider.
- When a subsequent PROS admission triggers a discharge for the first PROS provider, the first PROS provider will receive notification of discharge the next day before they provide any uncovered services. The fields with this type of discharge are auto-filled with “Unknown” and should be updated with the correct data by the provider. A link “Clients Receiving Services Elsewhere” was added on the Program Notes page for these individuals. Please complete the discharge data on this link. The effective discharge date is the first day of the following month and allows them to bill for the previous month.
- CDTs, clinics and ACT providers that cannot access CAIRS will be provided with a hard copy of the Cancellation Form from PROS (See Appendix B and Appendix C for copy) that they can fax to OMH.

Registration and Medicaid Eligibility Verification

- A provider is expected to verify an individual's Medicaid eligibility at every visit.
- The verification of a registered individual's Medicaid eligibility will indicate the type of registration and will provide advance warning to other providers that their bills may be denied if they serve the individual.
- All PROS services are "carved out" from Medicaid managed care. If it is determined that an individual is in a Medicaid managed care program Medicaid should be billed directly.
- In most cases, a successful verification will guarantee clinics and CDTs payment for services rendered. However, retroactive recoveries may still be made in the following limited circumstances for which registration edits cannot be programmed:
    - When an individual is billed for both a PROS program and a fee-for-service program operated by the same corporate entity when co-enrollment would have been allowed if the two programs were operated by different providers;

- Since the verification will not show which PROS provider an individual is registered with, PROS providers must rely on the information they receive from CAIRS.
- When Medicaid eligibility is verified, registration restriction codes are displayed. However, a detailed description is not shown. Therefore, all providers must learn the billing implications of the various restriction codes.
- If a registered individual is not Medicaid eligible at first and later becomes Medicaid eligible, a provider may be able to retroactively bill to the day that eligibility began. The provider will be required to request an override by contacting a member of the OMH Financial Planning staff person who can approve or reject the request based on the circumstances involved.
- It is possible that two PROS providers can be registered at one time. One provider could be registered with an exception code 84 or 85 while another provider could be registered with an exception code 86. (The following paragraphs describe the various restriction codes and their allowances.)

Registration Exception Codes

- Exception Code 84 – PROS Base/Community Rehabilitation and Support (CRS) with clinic
- Exception Code 85 – PROS Base/CRS without clinic
- Exception Code 86 – Intensive Rehabilitation (IR)/Ongoing Rehabilitation Support (ORS)

Exception Codes and their Allowances	84 Base/CRS with clinic	85 Base/CRS without clinic	86 IR/ORS
84	No	No	Yes
85	No	No	Yes
86	Yes	Yes	No

Pre-Admission

- If pre-admission program participation occurs in the month preceding the month of admission or the month of admission, but the individual has not been registered in the PROS program during that month, reimbursement cannot exceed the Pre-Admission Monthly Base Rate.
- If pre-admission program participation occurs during the month of admission, and the individual has been registered in the PROS program during that month, the base rate is calculated using the entire month. The three add-on components cannot be billed.
- Pre-admission rate code is 4510.
- Cannot be billed for more than two consecutive months.

Registration for individuals enrolled in a PROS program:

- Registrations will be processed daily with almost immediate notification.
- Recipients will be allowed two admissions per client per month and one change per client, per provider, per calendar month. There are no restrictions on discharges. You will receive an error message if more than the allowed occur.
- The provider will be authorized to bill for the admitted individual until the individual elects to either disenroll from that PROS program, submit a subsequent registration form for another PROS program, or a fee-for-service clinic, CDT or ACT provider submits a cancellation form for the individual. (See Appendix B and Appendix C for copy of form.)

PROS Registration & Fee-for-Service Providers (FFS)

- FFS providers are expected to swipe an individual's Medicaid card before providing services.
- PROS registrations will be effective the last day of the month. This date will allow FFS providers who check eligibility before each service to bill until the registration is in Electronic Medicaid Eligibility Verification System (EMEVS).
- FFS providers will need to know which registration codes disable their FFS rate codes.

PROS Disenrollment and FFS Providers

- For individuals who want to re-qualify for FFS services, FFS clinics, CDTs and ACT providers can submit cancellation forms to OMH by faxing them to OMH Financial Management staff at (518) 473-8255. These forms can be found in Appendix B for FFS Clinics and CDTs or Appendix C for ACT providers of this Handbook.
- FFS providers will be notified through EMEVS of an individual's registration status.
- FFS providers will be required to have the individual's attestation form in the individual's service plan.

PROS with Clinic and FFS Outpatient Clinic

- For individuals discharged from the PROS that received Clinic services (code 84) the billing date will be the end date of the restriction code (this should be the discharge date). This will allow the FFS Outpatient Clinic to be able to submit claims for the services that were provided.

Billing Requirements, Limitations and Combinations

General Reimbursement requirements for PROS programs

- Reimbursement shall be made only for individuals who:
  - Are in pre-admission status; or
  - Are registered in a PROS program; or
  - Are collaterals, on behalf of individuals who are registered in a PROS program or are in pre-admission status
- Unless an individual is registered with a PROS program reimbursement is limited to the Pre-Admission Monthly Base Rate.
- A PROS program is considered to be a carved out program eligible to bill fee-for-service for individuals enrolled in Medicaid managed care.
- When available and appropriate, PROS providers should maximize the use of funding from Vocational & Educational Services for Individuals with Disabilities (VESID). Time spent in such funded activities should not be included in the duration of program participation (described below).
- Any PROS service provided to an individual in the individual's employment setting must be on a one-to-one basis.

Reimbursement for Comprehensive PROS programs

- Reimbursed on a monthly case payment basis
- Structure consists of the following four elements:
  - Monthly Base Rate;
  - IR component add-on;
  - ORS component add-on; and
  - Clinical Treatment component add-on

- The basic measure for the PROS monthly base rate is the PROS unit of service. PROS units are accumulated during the course of each day that the individual participates in the PROS program and are aggregated up to a monthly total to determine the amount of the PROS monthly base rate that can be billed for the individual during a particular month.
- The PROS unit is determined by the duration of program participation, which includes a combination of on-site and off-site program participation and service frequency, as defined below:
    - Program Participation - the time between sign-in and sign-out minus scheduled meal periods and/or planned recreational activities.
    - Service Frequency - the number of medically necessary PROS services delivered to an individual or collateral during the course of a program day. Services to collaterals may be included in the calculation of service frequency as long as the participant is not being credited with service for the same time.
- Medically necessary PROS services include:
    - Crisis intervention services;
    - Pre-Admission screening services provided to an individual or his collateral who is in pre-admission status;
    - Services delineated in the screening and admission note, which are provided subsequent to the individual's admission date, but prior to the completion of the initial IRP; and
    - Services identified in and provided in accordance with the individual's IRP.
- If a recipient employee provided a medically necessary service to other participants in the PROS program, such service may be included in the calculation of PROS units for such other participants. The service may not be included in the calculation of PROS units for the recipient employee.
- PROS services must be of at least 30 minutes in duration for a group service or 15 minutes in duration for an individual service.
- PROS units are accumulated in intervals of 0.25. 15 minutes of program participation equals 0.25 PROS units. Intervals of less than 15 minutes of program participation must be rounded down to the nearest quarter hour before equating program participation time to PROS units.
- The formula for accumulating PROS units during a program day is listed below:
    - If one medically necessary PROS service is delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or two units, whichever is less.
    - If two medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or four units, whichever is less.
    - If three or more medically necessary PROS services are delivered, the number of PROS units is equal to the duration of program participation, rounded down to the nearest quarter hour, or five units, whichever is less.

      Note: See Appendix D for the PROS Unit Conversion Chart which illustrates the number of PROS units earned by combining program participation with service frequency.

- When a medically necessary CRS service is provided in a group format the service can only be used to satisfy the service frequency requirements for 12 members per staff person. If the group exceeds 15 members per each participating staff member, the service can only be used to satisfy the service frequency requirements for 12 participants of the group.
- The number of PROS units per individual per day cannot exceed five.
- The daily PROS units accumulated during the calendar month are aggregated and translated into one of the five payment levels to determine the monthly base rate.
- At least two PROS units must be accrued for an individual during a calendar month in order to bill the monthly base rate or the clinical treatment rate.

- Practitioners can split times within the allowable timeframes (15 minutes for individual/30 minutes for a group) as long as it is congruent services.

Reimbursement for component add-ons for a Comprehensive PROS program

- The three component add-ons: IR, ORS and Clinical Treatment are each listed below in more detail.
- The Clinical Treatment component and the IR or ORS component may be billed per individual per month.
- An ORS component add-on and IR component add-on may not be billed in the same month for the same individual.
- Component add-ons cannot be billed for individuals in pre-admission status.
- Time spent in any component counts toward determining PROS visits for the monthly base rate.

Intensive Rehabilitation (IR)

- The individual must be registered in Welfare Management System (WMS) as an individual with the IR component of PROS.
- The individual must have received at least six PROS units during the month, including at least one IR service in order to bill for IR.
- When an IR service is provided in a group format the service can only be used to satisfy the service frequency requirements for 8 members per staff person. If the group exceeds 10 members per each participating staff member, the service can only be used to satisfy the service frequency requirements for 8 participants of the group.
- Medicaid will reimburse the IR component add-on for up to 50% of the provider's total number of monthly base rate bills submitted annually.
- When a Comprehensive PROs program provides IR services to an individual but CRS services are provided by another provider or no CRS services are provided in the month, the Comprehensive PROS provider may submit an IR only bill. When this happens, the minimum 6 PROS units required shall be limited to the provision of IR services.

Ongoing Rehabilitation and Support (ORS)

- The individual must be registered in WMS as an individual with the ORS component of PROS.
- PROS programs may only bill the ORS component add-on for individuals who work in an integrated competitive job for a minimum of 10 hours per week. To allow for periodic absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement.
- At least two face-to-face contacts with the individual, which includes ORS services, must be provided per month and must occur on different days. A minimum contact is 30 continuous minutes in duration. A contact may be split between the individual and the collateral. At least one visit per month shall be with the individual only.
- When a Comprehensive PROS program provides ORS services to an individual, but CRS services are provided by another provider or no CRS services are provided in the month, the Comprehensive PROS provider may submit an ORS only bill.

Clinical Treatment

- The individual must be registered in WMS as an individual with the clinical treatment component of PROS.

- At least one clinical treatment service must be provided during the month in order to receive reimbursement.
- May be reimbursed in conjunction with the monthly base rate and/or IR or ORS.
- At least one face-to-face contact with a psychiatrist or psychiatric nurse practitioner must occur during each three month period.*

Note: For example, if an individual is seen by the physician in February, he must be seen again by the end of May in order to bill for May. That physician contact authorizes billing for June and July as long as he receives a clinic service in those months. The individual would then need to be seen again by the end of August to bill for August, September and October.

*For a provider's first three months of operation of a PROS program, the requirement that would have necessitated a psychiatrist visit within the first month for newly admitted clients is waived. However, the client must be seen by a psychiatrist within the first three months of enrollment.

Reimbursement for Limited License PROS programs:

- Will be reimbursed on a monthly case payment basis.
- Will be reimbursed in a given month for either one monthly IR component or one monthly ORS component per individual.
- To bill the IR component for an individual, the individual must participate in at least 6 hours of IR services per month.
- To bill the ORS component for an individual, a minimum of two face-to-face contacts per month must be provided and they must occur on separate days. A minimum contact is 30 continuous minutes in duration.
- Providers may only bill the ORS component for individuals who work in an integrated competitive job for a minimum of 10 hours per week. To allow for occasional absences due to illness, vacations, or temporary work stoppages, individuals who are scheduled to work at least 10 hours per week and have worked at least one week within the month for 10 hours qualify for reimbursement.

Billing Combinations

- A PROS program may bill for either PROS Base/CRS with clinic or PROS Base/CRS without clinic for each individual served per month.
- A PROS program may bill for either the IR component of PROS or the ORS component of PROS for each individual served per month, subject to the 50% IR cap explained earlier.
- Depending on the licensure category of the PROS program, the services provided, and any services provided by another PROS program, monthly billing may include several combinations.
- The minimum service time and service type associated with each possible billing combination is summarized below:

1. To submit a monthly Base Rate bill, you must have at least 2 PROS units which include any PROS service.
2. To submit a Base Rate + IR bill, you must have at least 6 PROS units which includes at least 1 IR service.
3. To submit a Base Rate + ORS bill, you must have at least 2 PROS units which includes at least 2 ORS services.
4. To submit a Base Rate + Clinical treatment bill, you must have at least 2 PROS units which include at least 1 Clinic service and at least 2 ORS or one CRS or IR service.
5. To Submit a Base Rate + IR + Clinical treatment bill you must have at least 6 PROS units which includes at least 1 CRS, 1 IR, and 1 Clinic service.

6. To submit a Base Rate + ORS + Clinical treatment bill you must have at least 2 PROS units which include at least 1 CRS, 2 ORS, and 1 Clinic service.
7. To submit an IR only bill you must have at least 6 PROS units which must include an IR service. If however an individual is enrolled in CRS then the agency could bill for the base rate + IR.
8. To submit an ORS only bill you must have at least 1 PROS unit which must include 2 ORS services.

The Monthly Base Rate is associated with the combined total of all CRS, IR, ORS and Clinical Treatment service hours included in an individual's IRP provided by a single PROS program to a single PROS participant and his or her collateral(s) in a given month.

Reimbursement is limited to participation within a single Medicaid-funded program, except as follows:

	Comprehensive PROS	**Limited License PROS**
PROS	Co-enrollment is permitted for unduplicated service components. IR and ORS may not be provided together in the same month.	Co-enrollment is permitted for unduplicated service components. IR and ORS may not be provided together in the same month.
Clinic	Co-enrollment is not permitted with PROS with clinic. Co-enrollment is permitted when registered with a PROS program without clinic but only when the clinic is not operated by the same entity as the PROS.	Co-enrollment is permitted.
CDT	Co-enrollment is not permitted	Co-enrollment is permitted for providers which are not operated by the same sponsor.
Partial Hospitalization (PH)	Co-enrollment is permitted.	Co-enrollment is permitted.
Intensive Psychiatric Rehabilitation Treatment Program (IPRT)	Co-enrollment is not permitted.	Co-enrollment is not permitted.
ACT	Co-enrollment is permitted for up to 3 months in a 12-month period. A PROS provider may bill at Level 1, 2 or 3 of the PROS Monthly Base Rate. An ACT provider may bill for the partial step-down payment level of services.	Co-enrollment is not permitted.
Targeted Case Management (TCM)	Co-enrollment is permitted.	Co-enrollment is permitted.

Prepaid Mental Health Plan (PMHP)	PMHP programs will not be reimbursed by Medicaid for PROS individuals who are receiving Base/CRS with clinic. However, the PMHP may receive reimbursement for PROS individuals not receiving their clinic services from the PROS. The full value of the PROS services will be deducted from the PMHP payments, up to the amount paid to the PMHP provider.	Co-enrollment is permitted. The full value of the PROS services will be deducted from the PMHP payments, up to the amount paid to the PMHP provider.
Office for People With Developmental Disabilities (OPWDD)	Co-enrollment is permitted between an OPWDD-sponsored day program and a Comprehensive PROS program. However, the PROS program is limited to Levels 1 & 2 of the Monthly Base Rate. Unauthorized co-enrollment with an OPWDD-sponsored pre-vocational or supported employment program is not permitted. The PROS provider is not entitled to retain the full value of the IR/ORS services.	Unauthorized co-enrollment with an OPWDD-sponsored pre-vocational or supported employment program is not permitted. The PROS provider is not entitled to retain the full value of the IR/ORS services.
Department of Health (DOH) Waivers-Traumatic Brain Injury (TBI), Long Term Home Health Care Program (LTHHCP), and Nursing Home Transition and Diversion (NHTD) (effective 1/27/11)	Co-enrollment is permitted between the waivers listed to the left and a Comprehensive PROS program. However the PROS program is limited to Levels 1 and 2 of the Monthly Base Rate. The clinic add-on is permitted. Unauthorized co-enrollment with the waiver programs listed is not permitted. The PROS provider is not entitled to retain the full value of the IR/ORS services.	Unauthorized co-enrollment with the waiver programs listed is not permitted. The PROS provider is not entitled to retain the full value of the IR/ORS services.

Note: When co-enrollment is permitted, visits to such programs may occur on the same day.

Supporting Documentation

- Services provided must be described in the Individualized Recovery Plan (IRP).
- Services described in the IRP must be consistent with the individual's identified goals, objectives and diagnosis.
- Services provided must be identified in the progress notes.
- Case records must include:
    - Pre-admission screening notes, which include:
        - Reason for admission;
        - Primary service-related needs and services; and
        - Admission diagnosis;

    - The IRP and IRP reviews;
    - A record of service that identified all on-site and off-site face-to-face contacts with the individual and/or collaterals, the service(s) provided, and the duration of each daily contact;
    - Dated progress notes
- For Comprehensive PROS programs, the case records must also include:
    - A substance abuse screening;
    - An assessment of the individual's social needs; and an assessment of the individual's psychiatric rehabilitation needs
- For individuals receiving Clinical Treatment, the case records must also include:
    - An assessment of the individual's psychiatric needs;
    - An assessment of the individual's physical needs; and
    - Dated and signed records of all medications prescribed
- Initial IRPs must be developed within 60 days of the individual's admission to the program and include the following:
    - A statement of the individual's recovery goals and program participation objectives;
    - The individualized course of action to be taken, including the identification of services to be provided, which are for the purpose of promoting the achievement of the individual's recovery goals;
    - Results of any assessments and screenings including identification of the individual's strengths and challenges related to program participation;
    - Descriptions and goals of any linkage and coordination activities with other service providers
    - Criteria to determine when goals and objectives have been met so that the individual can move forward in his or her recovery process;
    - The identification of any collaterals who will assist the individual in his or her recovery;
    - Any advance directives expressed by the individual, including a description of his or her wishes to be served in the event of a crisis;
    - The individual's signature attesting that the individual participated in and agree with the plan; and
    - The signature of the professional staff member who prepared the IRP
- For individuals receiving IR, ORS or Clinical Treatment, the IRP must identify by program component the specific services to be provided, as well as the associated needs, goals, expected duration and anticipated outcome for each service.
- If a PROS individual is receiving PROS services from multiple PROS providers:
    - Upon the receipt of a release signed by the individual, the provider of CRS services is responsible for forwarding copies of the IRP and related updated to the provider of the IR or ORS services;
    - The provider of IR or ORS services is responsible for developing an IR or ORS plan which is a component of the IRP, and which is consistent with the IRP developed by the provider of CRS services; and
    - All PROS providers involved with the individual must share bi-weekly progress notes, subsequent to obtaining a signed release from the individual.
- For PROS participants receiving treatment services from a Part 599 clinic, the IRP must include a description of how such clinic services are integrated with the individual's IRP. Treatment plans and progress notes must be shared both ways, subsequent to obtaining a signed release from the individual
- IRPs must be reviewed and updated at least every six months
- For individuals receiving IR or ORS services, the IRP must be reviewed at least every three months
- Progress notes must be maintained for each individual and include at least the following:
    - Identification of services and interventions provided;
    - A description of the individual's response toward goals identified in the IRP; and

    - Identification of any necessary changes to the IRP and services related to such changes
- Progress notes must be completed, dated and signed at a minimum, one time each month.

Medicaid Disallowances

PROS providers are advised to be aware of circumstances under which disallowances have previously occurred and to take steps to avoid vulnerability of future audit adjustments. Listed below are common reasons for Medicaid disallowances:

- Missing case records;
- Missing service plans;
- Missing progress notes;
- Missing clinician signatures on services plans;
- No indication of services provided;
- Untimely completion or review of service plans; and
- Improper rate codes used.

Section 2 - PROS Rates

Rate Overview

PROS rates have up to four components. This section will describe these components and the rules that determine how each component will be calculated for each provider.

- **Base Rate component**: There are nine PROS rate codes for Comprehensive PROS programs. There are three rate codes for Limited License PROS programs. The base rate components consist of Pre-Admission, five levels for accumulated units, plus add-ons for IR, ORS and Clinical Treatment.
- **Regional Adjustment component**: New York City, Nassau, Suffolk, Westchester, Rockland and Putnam counties will have regionally adjusted (i.e., higher) rates.
- **Article 28 Capital Adjustment component**: Article 28 providers will have a rate adjustment to recognize capital costs which are allocated to outpatient mental health programs by mandated hospital costing methodologies.

Base Rate and Regional Adjustment Components

The PROS rate structure and rate codes are displayed in the chart below. A Regional Adjustment of 10% above the Upstate amount has been applied to the monthly Base Rate and to the component rates for providers in New York City, and the counties of Nassau, Suffolk, Westchester, Rockland and Putnam (Downstate Rate). These rates are effective 7/1/12.

Rate Category	Rate Code	Upstate Rate	Downstate Rate
Pre-Admission	4510	$140.00	$153.00
Base Rate Level 1 (2-12 Units)	4520	$214.00	$235.00
Base Rate Level 2 (13-27 Units)	4521	$503.00	$553.00
Base Rate Level 3 (28-43 Units)	4522	$718.00	$789.00
Base Rate Level 4 (44-60 Units)	4523	$786.00	$866.00

Base Rate Level 5 (61+ Units)	4524	$908.00	$998.00
Clinical Treatment	4525	$254.00	$279.00
IR	4526	$377.00	$414.00
ORS	4527	$324.00	$355.00
Limited License IR	4528	$431.00	$474.00
Limited License ORS	4529	$355.00	$391.00

The correct Revenue Code for all of the PROS services is 0240.

Article 28 Capital Add-On

- Hospital-based providers may receive an add-on to their monthly case payment that reflects their capital costs.
- PROS eligible programs operated by providers pursuant to Article 28 of the Public Health Law, shall be added an allowance for the cost of capital, this will be determined by the application of the principles of cost-finding for the Medicare program.
- Allowable capital expenditures shall not include costs specifically excluded pursuant to Section 2807-c of the Public Health Law.
- The capital payment per service month for a provider's PROS licensed outpatient mental health programs shall be determined by dividing all allowable capital costs of the provider's PROS programs, after deducting any exclusions, by the annual number of service months for all enrollees of the PROS program.

Section 3 - Medicaid Billing Application Process

Providers must be enrolled in the correct Category of Service (COS) in order to be reimbursed by Medicaid. Providers will also need to know the following before submitting for reimbursement:

- National Provider Identification (NPI) Number (this will be needed to be enrolled in the correct COS);
- Rate codes to use when submitting bills; and
- Billing rates

If a provider decides to use an NPI for PROS that has already been reported to Medicaid, then an e-mail with the correct NPI will need to be sent to Financial Planning so that the correct COS (0268) can be added to the existing Medicaid ID. If a provider decides to use an NPI not yet recognized by Medicaid, a new Provider Enrollment Application will need to be filled out. Please contact Financial Planning at (518) 474-6911 to receive this Application via e-mail.

Please refer to the following for information regarding the 5010 claims processing changes including the discontinued use of “0FILL”, the enforcing of the Comprehensive Billing System (COB) Balancing and the Submitter Dashboard:
https://www.emedny.org/hipaa/5010/webinar/5010_presentation.pdf

Section 4 - Medicare Billing (including Medicare/Medicaid crossovers)
Federal mandates make Medicaid a payer of last resort, which means that Medicaid will make payments only after all other sources of reimbursement have been exhausted. Therefore, potential third party reimbursement sources, including Medicare, must be pursued if Medicaid is to be billed.

Medicare reimbursement will not be available for the majority of services provided in a PROS program since Medicare pays for only certain licensed practitioners (e.g., Medicare enrolled physicians, PhD clinical psychologists, Licensed Clinical Social Worker (LCSW) social workers, RN nurse practitioners, RN clinical nurse specialists or physicians' assistants) to provide certain specialized services (e.g., medication management, counseling, individual psychotherapy, or evaluation and monitoring).

The CRS, IR and ORS components of PROS programs have no Medicare eligibility. However, the clinical treatment add-on may be Medicare reimbursable and Medicare reimbursement must be pursued.

Note: Eligible professionals must enroll in Medicare. Therefore, if a professional is eligible to enroll in Medicare, he/she must be enrolled and Medicare claims submitted as appropriate. For dual Medicare/Medicaid clients, if the service and the professional performing the service are acceptable for Medicaid, but Medicare will not pay because the professional is not eligible to enroll as a Medicare service provider, the Provider Agency may submit a claim directly to Medicaid. Provider Agencies may not submit claims to Medicaid if denied by, rejected by, or not submitted to Medicare solely due to the eligible professional not being enrolled.

Medicaid Reimbursement for Medicare Crossover Claims

PROS is processed, priced and paid at the document level. Line level information is not required for PROS claims. Claims are paid at a monthly reimbursement methodology. For claims involving Medicare, the easiest method is to report the total Medicare paid amount and patient responsibility amounts (deductible, co-pay and coinsurance) for the entire month at the header level. The system will add the deductible, co-pay and coinsurance amounts entered and pay the total.

The procedure code entry for a rate based claim has nothing to do with payment amount. It serves no purpose to have multiple procedures, but if a provider wants to enter multiple procedures then they must use multiple lines and enter one 5 digit procedure code on each line with a date of service that matches the date in the header. The part that says: "The Medicare paid amount and patient responsibility amounts (deductible and coinsurance) are reported in Loop 2320 on the 837I claim format", means that the total Medicare amounts (paid, deductible, coinsurance) are entered on the header level and the claim is paid at the header level, so multiple lines do not affect that either. The lines can have the procedures performed during that month but the date of service on each line must be the same as the date of service on the header level. PROS claims have the last day of the month as the date of service and that date represents all the days of that month. Therefore all the line dates must be the last day of the month. You can report as many procedures on the line level as desired, with one procedure code on each line. Therefore if there were 10 procedures performed in a month, you can have 10 lines, with each line having a single procedure code with a date of service that is the last day of the month that matches the date in the header.

PROS programs that are licensed to offer Clinical Treatment must apply to become a Medicare provider. The Medicare application process generally takes between three and six months to complete. Approval is retroactive to the date of application. Programs will be given a full year (not just the expected three to six months) to get Medicare approval, begin billing and credit Medicaid for any Medicare payments received. Medicaid can be credited simply by filing an adjustment claim which contains the Medicare approved and paid information. For the Medicare application please check the following web site: www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage. For assistance with the Medicare application process, please check the following web site: www.cms.gov/RegionalOffices/Downloads/NewYorkRegionalOffice.pdf.

Should a PROS program not begin billing Medicare within the 12-month window, the following two actions will be taken:

- The Medicaid system will disallow any further billing on the Clinical Treatment rate codes; and
- On the assumption that at least one bill per quarter would have been paid by Medicare, one-third of the Medicaid payments for the Clinical Treatment add-on for Medicare-eligible individuals will be recovered.

Section 5 - Other Fiscal Issues

COPS

Upon conversion of a CDT to PROS, the PROS fees will supplant the CDT base fees plus the COPS add-on. PROS fees were calculated to cover the costs of an efficiently and economically run program. Therefore, while is recognized that PROS providers will not be able to bill for every individual serviced each month, the program will be able to generate sufficient Medicaid revenue to cover the provider's costs.

Recipient Financial Issues (Sliding-Fee Schedules and Medicaid Spend Down)
The PROS program is approved as a Medicaid program under the Rehabilitation option. Both federal and state Medicaid rules require that all individuals receiving services from a Medicaid program be liable for the cost of those services, regardless of whether the individuals are eligible for Medicaid. In actual practice this requirement means that all participants in a PROS program are liable for the full cost of the services received.

- **Sliding-Fee Schedules**
  Medicare, Medicaid and state statutes recognize that many individuals receiving public health services do not have the ability to pay the full cost of the services they receive. The "ability to pay" concept has developed over the years as a rational approach to the patient liability problem.

  Note: Third party coverage is considered as part of an individual's ability to pay. Therefore the individual must make his/her third party coverage available for covered services. Third party payers include, but are not limited to: Medicare, V.A. Health Insurance, and non-Medicaid Managed Care. The PROS program is carved out of Medicaid Managed Care.)

  Ability to pay, simply stated, means an individual's income and assets are matched against a reasonable and rational fee schedule and charts are assessed accordingly. Typically, a sliding fee schedule is developed which sets a base level for income and assets. A percentage of poverty level is often used to determine the base level. Individuals whose income and assets are under this base level are not charged for services based on their ability to pay. The sliding fee schedule will set incrementally larger fees to be charged to the individual based on where his or her income falls on a predetermined chart of income and asset levels in excess of the base level. Usually the fee derived is charged per service received. However, as most individuals receiving mental health services have set monthly incomes, sliding fee schedules commonly set monthly maximum charges. Monthly maximums insure that no matter how many services an individual requires in a month, he will not be charged in excess of the amount he can afford.

  A sliding fee schedule that is documented and enforced will meet the requirements of the Medicaid program. For PROS programs that are part of agencies that already participate in the Medicaid program, it is suggested that the sliding fee schedule already used by the agency also be used for PROS. Those PROS programs that are new to Medicaid and have

no experience with sliding fee schedules should contact their County Mental Hygiene Department for guidance.

- **Medicaid Spend Down**
  Medicaid Spend Down is a complicated, and sometimes confusing, process. For the purposes of this discussion, only income Spend Down will be reviewed, since resource Spend Down is extremely difficult to accomplish in a community setting. If an individual has excess resources over the Medicaid resource limit, the individual should be encouraged to reduce those resources to the Medicaid limit.

  In order to be eligible for income Spend Down, the individual must qualify for a federally-related Medicaid category. This means the individual must be either disabled, aged (age 65 or over), blind, Aid to Dependent Children (ADC) eligible, of Low Income Families (LIF) eligible. Therefore, if a PROS program is serving a single individual under age 65 for whom disability under Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) disability rules cannot be established, Spend Down is not an option. If an individual does appear to qualify for a federally-related Medicaid category but has income in excess of the Medicaid income limit for the individual's living situation, then Spend Down can be considered.

  Income Spend Down involves determining how much an individual's monthly income exceeds the Medicaid limit and applying medical expenses to that income overage. Income Spend Down can be accomplished in two ways:

The Pay-In Program – The simplest and most straightforward method, the local Department of Social Services (LDSS) determines the amount of the individual's monthly income that is over the Medicaid limit. The individual agrees to pay this amount to the LDSS each month. In exchange for this payment, the individual receives full Medicaid coverage in the community. Additionally, if the individual does not incur medical expenses in a month sufficient to cover the pay-in amount, the excess pay-in amount is refunded to the individual. The pay-in option is usually best suited for individuals with small income overages.

The Traditional Spend Down Program – Although this program is much more complex than the Pay-In Program, the basic concept is the same in that the individual applies for Medicaid and the LDSS determines the amount of income over the Medicaid income limit. Under Spend Down this income overage must be covered with medical bills. If the individual has medical bills sufficient to cover the excess income, Medicaid will be authorized for any covered medical expense **not included** in the Spend Down amount. Providers and recipients must understand that medical costs used to meet the Spend Down amount **cannot** be billed to Medicaid. These costs are the recipient's responsibility. The LDSS office will give notice to both the provider and the recipient that those charges cannot be billed to Medicaid, but it is the provider that must insure they are not charged to Medicaid.

Medical charges that can be used to meet Spend Down can include paid bills, unpaid but viable bills and medical bills for some non-Medicaid service. However, the rules for when these bills can be used and for what period of time are complicated and cannot be simply explained in this narrative. Guidance can be supplied by the LDSS office.

It is anticipated that some participants in the PROS program may qualify for Spend Down. The typical example would be an individual receiving a Social Security disability monthly benefit that is in excess of the Medicaid income limit for the individual's living arrangement. This individual meets the disability requirement to qualify for federally-related Medicaid. In this situation, the PROS provider should take the following steps:

- Work with the individual to determine if Pay-In or Spend Down is feasible.

- If the Spend Down option is chosen, determine what medical expenses could be used to meet the Spend Down amount. These expenses can be the PROS charges or other expenses, such as medications.
- If it is determined that PROS charges should be used, produce bills to give to the recipient. It is recommended that a full cost bill be used for this purpose.
- Assist the recipient in applying for Medicaid.

When the monthly Spend Down amount overage is determined, the recipient must be billed for that amount. This bill must be viable which means that the provider cannot simply write it off. The PROS must also net this recipient responsibility amount off the Medicaid bill that is eventually submitted for the individual.

Note: When Spend Down is being pursued, charges to the recipient will be based on the Spend Down amount rather than the sliding fee discussed previously.