MEDICAID REQUIREMENTS

FOR

OMH-LICENSED OUTPATIENT PROGRAMS

NYS Office of Mental Health
January 2004

INTRODUCTION

This document provides a summary of the requirements included in the NYS Office of Mental Health's outpatient regulations, as they pertain to receipt of Medicaid payments. These requirements have been extracted from **14 NYCRR Parts 587 and 588**, which are applicable to clinic treatment programs, continuing day treatment programs, day treatment programs for children, intensive psychiatric rehabilitation treatment programs, and partial hospitalization programs. In some instances, additional guidance or clarification is provided. The document is organized into the following three sections:

- Eligibility for Reimbursement;
- Billing Requirements and Limitations; and
- Supporting Documentation.

The Eligibility section outlines the minimum requirements which must be met in order for a specific provider to be able to bill Medicaid on behalf of a specific individual, for a given service. The Billing section summarizes the basic billing rules and limitations. The Documentation section summarizes the requirements which, when met, provide 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 or approach that substitutes for thorough, accurate and timely record keeping.

Providers are advised that this document is not a substitute for a careful review of the applicable regulations. In the event of any conflict between this document and 14 NYCRR Parts 587 and 588, 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. The regulations are available on OMH's website at www.omh.state.ny.us/omhweb/policy_and_regulations/index.html#fulltext.

ELIGIBILITY FOR REIMBURSEMENT

❑ The recipient meets the eligibility criteria for admission to the program (or is in pre-admission status).

PROGRAM	ADMISSION CRITERIA
Clinic Treatment Program	designated mental illness diagnosis
Continuing Day Treatment Program	designated mental illness diagnosis and dysfunction due to mental illness
Day Treatment Program for Children	designated mental illness diagnosis, plus either an extended impairment in functioning due to emotional disturbance or a current impairment in functioning with severe symptoms
Intensive Psychiatric Rehabilitation Treatment Program	designated mental illness diagnosis, dysfunction due to mental illness which is likely to continue for a prolonged time, readiness to participate in the program, and referral by a licensed practitioner
Partial Hospitalization Program	designated mental illness diagnosis which has resulted in dysfunction due to acute symptomatology which requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to, or continued stay in, an inpatient hospital

Designated mental illness diagnosis is a DSM diagnosis (or ICD equivalent) other than: 1) alcohol or drug disorders; 2) developmental disabilities; 3) organic brain syndromes; 4) social conditions (V-Codes). V-Code 61-20 Parent-Child problem is included for eligibility for services in clinic treatment programs serving children with a diagnosis of emotional disturbance.

❑ Admission to the program occurs within the first three visits. (The third visit must occur no later than the end of the calendar month following the month of the first pre-admission visit.)

❑ The service provided is reflected on the provider's operating certificate (if other than a "required" service).

❑ The service provided is consistent with the regulatory definition.

NOTE: While program activities can be described in multiple ways and many providers prefer to use local terminology, providers are advised, whenever practicable, 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.

- ❑ The service provided is consistent with the recipient's goals, objectives and diagnosis

- ❑ The service is 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 should be reflected on the provider's staffing plan.

- ❑ If the service is provided to a collateral, the service is a "clinical support service", and the person receiving the service meets the regulatory definition of "collateral."

Clinical support services are services provided to collaterals, by at least one therapist, with or without recipients for the purpose of providing resources and consultation for goal oriented problem solving, assessment of treatment strategies and provision of skill development to assist the recipient in management of his or her illness.

Collateral persons are members of the recipient's family or household, or significant others who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition and are identified in the treatment or psychiatric rehabilitation service plan as having a role in treatment and/or identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the recipient prior to admission. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.

NOTE: An individual cannot be considered a "collateral person" based on his or her role as a staff member of the outpatient program, or any other mental health service provider.

❑ The duration of the service is consistent with the minimum and maximum threshold requirements associated with the visit category.

PROGRAM	VISIT CATEGORY & DURATION
Clinic Treatment Program	Pre-admission: 30+ minutes Brief: 15 - 29 minutes Regular: 30+ minutes Crisis: 30+ minutes Group: 60+ minutes Collateral: 30+ minutes Group collateral: 1 - 2 hours
Continuing Day Treatment Program	Pre-admission: 1 hour+ 1 - 5 hours (recipient visit) Collateral: 30 minutes - 2 hours Group collateral: 1 - 2 hours
Day Treatment Program for Children	Pre-admission: 3 hours+ Full: 5+ hours Half: 3 - 5 hours Brief: 1 - 3 hours Collateral: 30+ minutes Home: 30+ minutes Crisis: 30+ minutes
Intensive Psychiatric Rehabilitation Treatment Program	Pre-admission: 1 hour+ 1 - 5 hours
Partial Hospitalization Program	Pre-admission: 1 hour+ 4 - 7 hours (recipient visit) Collateral: 30 minutes - 2 hours Group collateral: 1 - 2 hours

MOST COMMON REASONS FOR MEDICAID DISALLOWANCES ASSOCIATED WITH ELIGIBILITY

✓ pre-admission visits exceed the limit
✓ minimum duration of visit is not met

BILLING REQUIREMENTS AND LIMITATIONS

- ❑ Pre-admission services are limited to three visits per recipient.

- ❑ The Medicaid claim includes an ICD-9CM code which equates to a designated mental illness diagnosis.

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

- ❑ Within a single program, limits on multiple visits per recipient per day are as follows:

  - ❑ one recipient visit*; and
  - ❑ one collateral visit*; and
  - ❑ one or more crisis visits.

> * **NOTE:** A single visit can include multiple services, provided by multiple members of the clinical staff. Multiple, non-contiguous contacts during a single day may be aggregated for a single bill.

- ❑ Group sessions (when billed as a "group" visit or "group collateral" visit) are subject to the following limitations:

  - ❑ services are provided to at least 2 but not more than 12 individuals; and
  - ❑ "group collateral" visits are limited to one collateral bill per recipient.

- ❑ Within certain program categories, reimbursement is limited as follows:

  - ❑ Visits associated with a partial hospitalization program, per recipient, are limited to:

    - ❑ 180 hours per course of treatment; and
    - ❑ 360 hours per calendar year.

- ❑ Visits associated with an intensive psychiatric rehabilitation treatment program, per recipient, are limited to:

  - ❑ 72 hours per month; and
  - ❑ 720 hours per year.

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

  - ❑ up to three concurrent visits are permitted during periods of transition from one outpatient program to another;
  - ❑ up to five clinic visits per month are permitted for a recipient concurrently admitted to an intensive psychiatric rehabilitation treatment program;
  - ❑ up to five clinic visits per month are permitted for a recipient concurrently admitted to a continuing day treatment program or a day treatment program for children (clinic visits are limited to clozapine medication therapy); and
  - ❑ up to five continuing day treatment visits per month are permitted for a recipient concurrently admitted to an intensive psychiatric rehabilitation treatment program.

> **NOTE:** Although co-enrollment is permitted in the above circumstances, visits to multiple programs cannot occur on the same day.

- ❑ Correct rate codes are used, in accordance with the program type, service provided, and duration of visit.

PROGRAM	RATE CODES
Clinic Treatment Program	4301 - 4306
COPs-Only*	4093 - 4098
Interim Specialty Clinics*	4601 - 4606
Continuing Day Treatment Program	4307 - 4348
Day Treatment Program for Children	4060 - 4067
Intensive Psychiatric Rehabilitation Treatment Program	4364 - 4368
Partial Hospitalization Program	4349 - 4363

* For use on behalf of persons enrolled in Medicaid Managed Care. (Interim Specialty Clinics are also commonly referred to as “SED Clinics.”)

- ❑ In clinic treatment programs, the need for continued service beyond 40 visits per benefit year is determined, no later than at the 40th visit. For adults, no more than 20 of such visits can be collateral and group collateral visits. Visits in excess of 40 must be approved pursuant to the Medicaid Utilization Threshold System (MUTS).

- ❑ All applicable insurance sources are billed before submitting claims to Medicaid.

  - ❑ for "crossover" claims (i.e., for persons who are dually eligible for Medicaid and Medicare), the correct Medicaid co-payment is billed.

MOST COMMON REASONS FOR MEDICAID DISALLOWANCES ASSOCIATED WITH BILLING
✓ improper rate codes used ✓ duplicate bills in the same day

SUPPORTING DOCUMENTATION

- ❑ The service provided is described in the treatment/service plan. (Treatment plans are required in clinic treatment programs, continuing day treatment programs, day treatment programs for children, and partial hospitalization programs. Psychiatric rehabilitation service plans are required in intensive psychiatric rehabilitation treatment programs.)

- ❑ The service described in the treatment/service plan is consistent with the recipient's identified goals, objectives and diagnosis.

- ❑ The service provided is identified in the progress notes.

- ❑ The case record includes a screening and admission note.
- ❑ The case record includes a record with the date of all contacts with recipients and collaterals, type of services provided, and duration of the contacts.

> **NOTE:** The dates of service in this record must match the dates of service reflected in the Medicaid claim.

> **NOTE:** Although some providers include this information in the progress notes, a separate service record may be maintained. Regardless of the approach used, providers should consider adopting a consistent approach by all clinicians throughout the program. Such consistency would aid the process of any external review.

- ❑ Treatment plans are developed by professional staff; service plans are developed by clinical staff.

- ❑ Treatment/service plans are completed within the required time frame.

PROGRAM	COMPLETION OF TREATMENT/SERVICE PLAN
Clinic Treatment Program	prior to the fourth visit after admission, or within 30 days of admission, whichever comes first
Continuing Day Treatment Program	prior to the twelfth visit after admission, or within 30 days of admission, whichever comes first
Day Treatment Program for Children	within 30 days of admission

PROGRAM	COMPLETION OF TREATMENT/SERVICE PLAN
Intensive Psychiatric Rehabilitation Treatment Program	within five visits after admission
Partial Hospitalization Program	prior to the fourth visit after admission

❑ Treatment plans include the following:

- ❑ recipient's designated mental illness diagnosis;
- ❑ recipient's goals, which are consistent with the purpose and intent of the program;
- ❑ specific objectives and services necessary to accomplish identified goals;
- ❑ plan for the provision of any additional services to support the recipient outside of the program;
- ❑ recipient's signature (unless the reason for its absence is identified in the case record);
- ❑ criteria for discharge planning; and
- ❑ physician's signature.

❑ Psychiatric rehabilitation service plans include the following:

- ❑ statement of rehabilitation aspirations;
- ❑ statement of service goals and objectives;
- ❑ identification of planned interventions; and
- ❑ proposed time periods.

❑ Treatment/service plan reviews are conducted within the required time frames.

PROGRAM	TREATMENT/SERVICE PLAN REVIEWS
Clinic Treatment Program	every three months
Continuing Day Treatment Program	every three months
Day Treatment Program for Children	every three months
Intensive Psychiatric Rehabilitation Treatment Program	every month
Partial Hospitalization Program	every two weeks

❑ Treatment/service plan reviews include the following:

- ❑ input of all staff involved;
- ❑ input of the recipient, and collaterals as appropriate;
- ❑ assessment of the recipient's progress in relation to the identified goals;
- ❑ adjustment of goals, time periods for achievement, intervention strategies; and
- ❑ physician's signature.

❑ Progress notes are recorded, by the clinical staff member who provided the service. Such notes identify the services provided, and any changes in goals, objectives and services, as appropriate.

❑ Progress notes are completed in accordance with the following time frames:

PROGRAM	COMPLETION OF PROGRESS NOTES
Clinic Treatment Program	every visit
Continuing Day Treatment Program	every two weeks
Day Treatment Program for Children	every week
Intensive Psychiatric Rehabilitation Treatment Program	N/A (part of monthly service plan review)
Partial Hospitalization Program	every visit

NOTE: Treatment/service plans and related reviews, and progress notes, when signed, should be dated so that compliance with completion schedules can be tracked.

☐ A utilization review process is applied to a random 25 percent sample of recipients' records, and is conducted in accordance with the required time frames.

PROGRAM	UTILIZATION REVIEW SCHEDULE
Clinic Treatment Program	within 30 days of admission, and every 6 months thereafter
Continuing Day Treatment Program	by the 12th visit, or within 30 days of admission, and every 6 months thereafter
Day Treatment Program for Children	within 30 days of admission, and every 6 months thereafter

PROGRAM	UTILIZATION REVIEW SCHEDULE
Intensive Psychiatric Rehabilitation Treatment Program	within 30 days of admission, and every 3 months thereafter
Partial Hospitalization Program	by 4th visit after admission, and every 2 weeks thereafter

MOST COMMON REASONS FOR MEDICAID DISALLOWANCES ASSOCIATED WITH DOCUMENTATION

- ✓ missing progress notes
- ✓ missing physician signature on treatment plan
- ✓ missing treatment plans
- ✓ no indication of services provided
- ✓ untimely completion/review of treatment plans
- ✓ duration of visit not documented
- ✓ missing case records