

**OMH Outpatient
Service Recording Guidelines**

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1.1 Background / History

The initial recording of services was completed via the mainframe system **DMHIS** (Department of Mental Health Information System) which was implemented in the early 1980s. Three digit service codes were used to denote where the service took place, who received the service and what type of service was provided. The Comprehensive Outpatient Billing system (**COBS**) extracted these services from DMHIS on a monthly basis, aggregated them into visits and created bills.

In 1996, **PMHP** (Prepaid Mental Health Plan) was introduced as a voluntary Medicaid managed care plan. Medicaid eligible recipients can be enrolled in the PMHP plan and once accepted and enrolled, they are billed a monthly capitated rate regardless of the number or type of service they receive. Service recording is still required because it is the only means to record and tabulate contacts with enrollees which are subject to review by the Department of Health per the MOU between OMH and DOH.

In 2001, a new electronic medical record system called **MHARS** (Mental Health Automated Record System) was developed to replace DMHIS. Eventually the data entry portion of DMHIS was turned off and MHARS became the only means for entering service and recipient information. This data is downloaded every evening from MHARS to DMHIS because the billing system still needs to receive its billing data (admissions, discharges, diagnosis, legal status, attending physicians and services) from DMHIS.

Service recording in MHARS has changed from 3 digit service codes to a selection of forced-choice narrative service types that includes the information as to where services are provided, who provided the service and the type of service that is provided. Nightly, an interface crosswalks the MHARS narrative service information into the older three-digit service code and stores them as codes in DMHIS.

In 2003, a new licensed program called **ACT** (Assertive Community Treatment) was introduced which added not only a number of new services that were only allowed in ACT programs, but added new billing logic to COBS. The ACT services are also crosswalked into existing 3 digit services codes which are stored in DMHIS.

In 2006, OMH started billing for the drug Risperdal Consta. This is accomplished by recording Risperdal Consta as a service in MHARS. These services do not feed into DMHIS but instead, a monthly extract is done that pulls Risperdal Consta services directly from MHARS and stores the data into the existing COBS data base. New billing programs were written to bill the administration and the cost of the drug.

In 2009, in response to an increase in Medicare denials, OMH identified the need to change how and what we bill to Medicare. Medicare billing does not allow a visit to consist of an aggregation of several services in one day as with Medicaid, but instead requires discrete services or procedures to be billed. For this new billing methodology, a monthly service extract is drawn from MHARS, similar to how Risperdal Consta services are extracted. The services are stored in COBS, and then Medicare, third party health insurance and private party are billed for

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the individual services rather than for aggregated services. Note that MHARS continues to feed the services to DMHIS which are then extracted to bill aggregated services to Medicaid.

In October of 2010, “clinic restructuring” (based on the new Part 599 regulations) changed the type of services that can be provided in a clinic and changed the way we bill Medicaid. The new services align with procedures that we started billing Medicare as described in the above paragraph. These new clinic services are extracted from MHARS, stored in COBS and billed to Medicare, TPHI, private party and Medicaid as procedures.

As of January 1, 2011 Medicaid provided reimbursement for two additional long-acting, extended-release injectable antipsychotics: Invega Sustenna and Zyprexa Relprevv. These drugs are recorded and billed the same as Risperdal Consta. The billing programs were modified to include these drugs on the claims to Medicare.

1.2 OMH Outpatient Programs

There are two categories of outpatient programs operated by OMH: licensed programs and Community Support Programs (**CSP**).

Licensed Outpatient (OP) Treatment Programs – These programs are defined and regulated by outpatient regulations Parts 587/588, and now Part 599 for Clinic Treatment. Included in this category are Clinic Treatment, Continuing Day Treatment (CDT), Children’s Day Treatment, Partial Hospitalization (PH) and Intensive Psychiatric Rehabilitative Treatment (IPRT). These programs are eligible for Medicaid reimbursement on a fee-for-service basis, unless the recipient is enrolled in the Prepaid Mental Health Plan (PMHP) through which Medicaid is billed using a partially capitated rate. Recipients admitted to one of these licensed programs may also be eligible for reimbursement from other Third Party or Private Party payers. Only clinic programs are eligible for Medicare reimbursement.

ACT – Also a licensed program, was developed by OMH to deliver comprehensive and effective services to individuals who are diagnosed with severe mental illness and whose needs are not well met by more traditional service delivered approaches. ACT services are eligible for Medicaid reimbursement only.

Community Support Programs (CSP) – These programs include a variety of support programs which are not billable to Medicaid, Medicare or other Third Party payers. These programs include such types as psychosocial clubs, vocational assistance and free-standing case management units.

Each program type has a distinct three-digit program code for reporting purposes and is assigned a specific URC cost center code. [Appendix 1.1](#) lists the program types, codes, and cost centers of outpatient programs operated by OMH.

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1.3 Program Assignment

The program assignment of any recipient receiving services in OMH operated programs is dependent on the recipient's needs, their available payers and their enrollment or non-enrollment in PMHP. The following are some guidelines which should be considered when determining the program to which a recipient will be assigned in MHARS.

If a recipient is to receive any services from one of the following licensed programs: Clinic, CDT, PH, IPRT, Children's Day or ACT, the recipient must be admitted or pre-admitted to that program in MHARS. If they are not, the services provided by the licensed program cannot be recorded in MHARS and therefore these services will not be billed.

If a recipient has Medicare, Medicaid Fee-For-Service, Third Party insurance or Private Party payment ability, bills will not be produced unless the recipient is admitted to a licensed outpatient program. Additionally, in those cases with Medicare coverage, Medicare bills are only produced for visits provided *onsite in clinic programs*.

Family Care recipients are the exception and should be admitted to the family care unit. These recipients can then receive services at any licensed or CSP program. The services should be entered into MHARS and will bill when appropriate.

Any recipient, whether a PMHP enrollee or not, can receive services at any CSP unit even if they are not admitted to that unit.

Recipients who are admitted to ACT should not be admitted to any other licensed OMH program or enrolled in PMHP.

Any recipient enrolled in PMHP who receives treatment services must be admitted to a clinic.

Risperdal Consta, Invega Sustenna and Zyprexa Relprevv can only be billed if the recipient is admitted to a Clinic, CDT, partial hospitalization or ACT program.

Services provided by OMH staff to recipients who are inpatients in general hospitals, private psychiatric hospitals, or skilled nursing facilities are not billable to Medicaid by OMH. To prevent the services provided to these recipients from passing to the billing system, the services should be recorded in a CSP unit even if the recipient is admitted to a licensed outpatient program.

**Appendix 1.1
Program / Cost Center Codes**

Program Name	Program Code	Adult URC	Children & Youth URC
Licensed Programs			
Assertive Community Treatment (ACT) Intensive Supportive	250	XX73 XX74	
Clinic	210	XX70	XX78
Continuing Day Treatment (CDT)	131	XX67	
Childrens Day Treatment	200		XX83
Intensive Psychiatric Rehabilitation Treatment (IPRT)	232	XX69	
Partial Hospitalization (PH)	220	XX68	
Community Support Programs (CSP)			
Assisted Competitive Employment	335	XX43	
Case Management	810	XX57	XX80
Crisis Residence	910	XX52	XX88
Crisis Services	700	XX59	XX88
Day Training	330	XX48	
Family Care	140	XX53	XX86
Intensive Case Management	181	XX65	XX79
Community Residence Licensed SOCR	050	XX61	XX85
Licensed SOCR (Medicaid Eligible)	050	XX63	XX85
Licensed RCCA	051	XX60	
Unlicensed Residential	052	XX66	
Transitional Placement Licensed	050	XX62	
Unlicensed	052	XX66	
Mobile Treatment	680		XX87
Nursing Home Support	602	XX72	
Onsite Rehabilitation	320	XX55	
Psychosocial Club	770	XX58	
Recovery Services* (deleted 10/1/2009)	600	XX46	
Screening	520	XX50	XX84
Sheltered Workshop	340	XX56	
Other	990	XX42 XX44	

* Recovery (formerly aka "PMHP") services are now reported in the clinic unit

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2.1 Background

A service is a procedure, intervention or activity that a staff person provides at an outpatient program (i.e., Clinic, CDT, PH, IPRT, ACT, Childrens Day Treatment or CSP) in regard to a recipient. Services may be provided onsite, offsite or home and may be direct or indirect. The services may be provided to the recipient and/or a collateral, or a group of recipients and/or a group of collaterals. Only certain services are allowed at each program type. See [appendix 2.1](#) for a list of allowable services within each program type.

- **Onsite** – the service is provided by staff at the program or satellite site.
- **Offsite** – the service is provided by staff at any location other than a program/satellite such as the recipient's place of employment, an adult recipient's home, or in association with childrens clinic programs, the child's home.
- **Home** – provided at the recipient's home.
- **Direct** – any face-to-face contact between a recipient or collateral and a provider. A service delivered through telepsychiatry (i.e. videoconferencing) is considered direct.
- **Indirect** – any activity or intervention in regard to a specific recipient accomplished without the recipient's or collateral's presence. This includes consultation and service coordination through multi-agency and facility multi-unit meetings and information exchange and recipient related phone calls.
- **Recipient** – the client
- **Collateral** – member of the recipient's family or household, or personal significant other (e.g. Landlord, employer, teacher) who regularly interact with the recipient. A collateral is **not** a fellow clinician or staff, outside agency or service provider.

With the introduction of ACT, the services that existed at the time did not accurately reflect the defined services that were to be provided in the ACT programs. Additional services were added, and can only be selected for recipients admitted to the ACT unit.

As of 2006, the drug Risperdal Consta can be recorded and billed. As of January 1, 2011, Invega Sustenna and Zyprexa Relprevv can also be recorded and billed. They are recorded the same way a regular service is recorded in MHARS, but they are not migrated to DMHIS and do not convert to a valid DMHIS service code. See [section 2.5](#) for instructions on how to record Risperdal Consta, Invega Sustenna and Zyprexa Relprevv services.

In 2010, clinic restructuring introduced new services that can only be provided in clinics. These new services do not migrate to DMHIS.

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2.2 Service Code Structure in DMHIS

Services entered into MHARS were migrated to DMHIS because the services from DMHIS were used for billing. As of 10/1/2010, the only services that are migrated to DMHIS are those that are recorded for the following licensed programs: CDT, IPRT, ACT, PH and childrens day treatment programs.

When the MHARS service is loaded into DMHIS the 3 digit service code is derived from the data entered into MHARS. The following is a description of the three-digit service code structure used in DMHIS. Exceptions are noted below.

- **First Character: Where The Service Was Provided**
 - 4 = On-Site
 - 5 = Off-Site
 - 6 = Home (for use only in children and adolescent day treatment programs)

- **Second Character: Who The Service Was Provided To**

1 = Recipient Direct	6 = Recipient Indirect
2 = Collateral Direct	7 = Collateral Indirect
3 = Group Recipient Direct	8 = Recipient Crisis Indirect
4 = Group Collateral Direct	9 = Group Recipient Indirect
5 = Recipient Crisis Direct	0 = Group Collateral Indirect

- **Third Character: What Service Was Provided**
 - 0 = Treatment & Crisis
 - 1 = Rehabilitation Service
 - 2 = Support Service
 - 3 = Self-help and Empowerment Service
 - 4 = Education
 - 5 = Recovery

Exceptions:

112 = Risperdal Consta, 12.5 mg.
125 = Risperdal Consta, 25 mg.
137 = Risperdal Consta, 37.5 mg.
150 = Risperdal Consta, 50 mg.
419 = injection
499 = no show
700 = administration
800 = inpatient services

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2.3 Recording Services in MHARS

Business Rules for All Programs

It is imperative that services are recorded accurately and timely in MHARS. The ability to continue the operation of the programs relies on generating revenue and reaching projected revenue targets each year. The recording of services also directly affects the rate setting and identifies staff productivity. The following business rules should be followed when recording services:

- Any face to face interaction with a recipient should be recorded
- Any phone calls or indirect service related to a recipient should be recorded
- Reporting of time spent in activities of an administrative nature, or in creating documentation or meeting other clinical “paperwork” requirements may be required at each individual Facility’s discretion
- The services recorded by staff should not exceed the number of hours worked
- The services recorded for a recipient on a day should not exceed the number of hours worked in a day (usually 8) and should not exceed the duration of the direct and indirect services that were provided to that recipient
- Progress notes should be recorded immediately after each visit
- Services should be recorded within 31 days of the delivery of that service (“best clinical practice” suggest much more timely service recording for purpose of accuracy and availability of information)
- All services provided must be accounted for in order to accurately allocate costs and determine staff productivity
- The complete time you spend with the recipient, on the phone, or in contact with other providers in regard to a recipient should be recorded regardless of whether it is a billable or non-billable service
- The following services are collateral only services:
 - Treatment – clinical support (for CDT, PH, Childrens day and CSP only)
 - Treatment - Psyc Rehab Support Services (IPRT and CSP only)
- More than one staff can be recorded on a service or group service. This will allow each staff to be given service credit
- If three or more recipients are being seen, the service must be recorded as a group

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- Indirect services for a patient can be provided by more than one staff at the same time
- Outreach and support is only allowed offsite
- A recipient enrolled in PMHP should have all services recorded in order to accurately determine the cost of the program. Also, the PMHP MOU (memorandum of understanding) stipulates that PMHP “encounter” data must be available for review by the Department of Health (DOH). The services are also credited toward staff productivity

Recording Crisis Services in Clinics

Everyone involved in a crisis should record their own participation. A crisis procedure will be created and billed as follows:

- Crisis Intervention Complex: minimum 1 hour and at least 2 staff intervening, one being licensed
- Crisis Intervention Per Diem: minimum 3 hours and at least 2 staff intervening, one being licensed
- Crisis Brief: all the crisis durations for the day will be added and divided by 15 to get the number of crisis units that can be billed, maximum of 6.

To Properly Record Testing Services in Clinics

There are 4 different testing services that can be recorded in clinics:

- Developmental testing
- Psychological testing
- Neuropsychological testing
- Neurobehavioral Status Exam

The patient must be admitted to the clinic in order to receive and bill for any tests.

Each test administered should be recorded as a “**direct**” service, regardless of whether it was face to face or self administering. The duration should be the cumulative amount of time spent on the test or interpreting the test on that day, not including writing the report.

Any additional time spent on the **same test** on a **different day** should be recorded as “**indirect**” regardless of whether the patient was present or not. Recording must take place in this manner to bill correctly.

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Recording Services to Maximize Billing

- Childrens Day Treatment programs can bill a recipient for:
Brief Day, >= 1 hour and < 3 hours
Half Day, >= 3 hours and < 5 hours
Full Day, >= 5 hours
- in a Childrens Day Treatment program, education services will only be included in the daily bill if an additional service was provided on the same day.
- for clinics before 10/1/2010 and for all other licensed programs, only 3 preadmission visits are billable and these visits must occur within the month the first visit is provided and the next full calendar month
- If a recipient is dually enrolled in two or more licensed outpatient programs and services are reported in each on the same day, the highest cost visit will get billed
- Medicare will only pay for onsite direct clinic treatment services
- If a Risperdal Consta, Invega Sustenna or Zyprexa Relprevv service is recorded, another service must be entered for the day to reflect the encounter with the recipient.
- Services cannot be billed if the minimum duration is not met. See [Appendix 6.6](#) to view the specific billing requirements by program.
- Administrative services are never billed
- Indirect services are never billed
- Outreach and Support is not billed

Recording Services to Maximize Billing in a Clinic after 10/1/2010

- only 3 preadmission procedures per clinic episode are billable, for adults, no more than one of which may be a collateral procedure
- for adults, no more than 3 preadmission **assessment procedures** (services) for the same recipient in the same clinic can be billed within a 12 month period.
- for children, no more than 3 preadmission **assessment visits** (days) for the same recipient in the same clinic can be billed within a 12 month period.
- only one health physical a year can be billed
- only one psychological test can be billed a day (there are 3 different types of psychological tests). See section above on how to accurately record tests.
- only one developmental test can be billed a day

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- a psychotropic medication treatment cannot be billed the same day as a psychiatric assessment or psychiatric consultation
- complex care can only be billed within 5 working days of either a psychotherapy or crisis visit
- no more than 5 clozapine therapy or psychotropic injections a month can be billed for a patient that is concurrently admitted to a CDT
- only treatment, crisis and injectable drugs are billed even though you can also record recovery services
- The only treatment services allowed in a group setting are:
 1. psychotherapy
 2. health monitoring
 3. smoking cessation counseling
- The only offsite service billable to adults is crisis.
- Outreach and Support did not receive federal approval for reimbursement so it can be recorded but is not billed
- Smoking cessation counseling cannot be billed the same day as a psychotherapy
- The following services, if provided offsite will be billable for children:
 1. initial MH assessments
 2. psychiatric assessments
 3. crisis
 4. psychotropic injection with monitoring and education
 5. psychotropic medication treatment
 6. psychotherapy
- The following services are only billable if the patient is admitted:
 1. developmental testing
 2. psychological testing
 3. health physicals
 4. health monitoring
- Medicaid will pay more for treatment services if:
 1. the services are provided after hours: between 6:00 PM and 8:00 AM, and on weekends
 2. the service was provided in a language other than English, including sign language
 3. a psychiatrist or psychiatric nurse practitioner participated at least 15 minutes in the provision of a service with another practitioner or alone

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Service Recording Data Entry Screens

There are many different ways to record a service in MHARS. The data required is the same in all cases, but different situations would make you choose one way over the other.

The following screens are available to record services:

Services by Patient

Can be used to record a service when **One Recipient** is being seen by **One or More Staff**

Services by Staff

This screen can be used when **One Staff** is providing a service to **One Recipient**, or providing the **Same Service** to **Multiple Recipients** at **Different Times** on the same day.

Services by Group *

Always used when **at Least Three Recipients** are being seen, with **One or More Staff**

Progress Note

One Service given to **One Recipient** by **One Staff** can be created with a progress note. Additional services that were created by one of the above 3 screens can be linked to the progress note

Multi Detail Progress Note

When **One or More Services** are given to **One Recipient** by **One Staff** a "Multi Detail Progress Note" can be used. Additional services that were created thru the first 3 screens can be linked to this progress note

Group Progress Note

A service record for **More Than One Recipient and/or Collateral** given by **One or More Staff** can be created with a group progress note.

The data required when entering a service on each of these screens is:

- the unit **
- a valid service (see [appendix 2.1](#) for a list of valid services for each program)
- date and time of the service
- duration
- on-site, off-site or home
- direct or indirect
- staff who performed the service

* It is very important that if three or more recipients are being seen at one time, that the services by group screen is used. Individual services should never be created using the services by patient screen in this situation because not only does it incorrectly represent the number of staff hours that was spent giving services, but the higher cost individual rate will be used rather than the group rate.

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** If the recipient is in a licensed program and the service is billable (treatment services) always use the licensed unit

2.4 Allowable Clinic Services By Provider

In 2002, New York state adopted a “scope of practice law” that required anyone proposing to provide psychotherapy to obtain a license to do so. This law contains a temporary exemption for programs operated or funded by the Office of Mental Health. However, unless extended, the exemption provision expires on July 1, 2013.

In addition, non-licensed individuals with a psychology title in the employ of State and local governments are permitted to perform all duties within the scope of practice of licensed psychologists, including testing and provision of treatment.

With the exception of outreach, **on or after July 1, 2013, the provision of all billable treatment services is limited to licensed staff, and unlicensed staff in Psychology civil service titles**, unless the exemption is extended and the Commissioner approves other qualified staff.

During the exemption period, OMH is allowing for treatment services a transition to licensed staff.

Staff authorized to work in OMH licensed clinics AFTER July 1, 2013 include the following:

- Physician
- Licensed Marriage and Family Therapists
- Licensed Master Social Worker
- Licensed Clinical Social Worker
- Licensed Psychoanalyst
- Licensed Mental Health Counselors
- Licensed Psychologists
- Non-licensed staff in Psychology titles
- Physician Assistant
- Registered Nurse / Licensed Practical Nurse
- Limited Permit staff
- Students within approved SED programs
- Nurse Practitioner in Psychiatry
- Licensed Creative Arts Therapists
- Non-licensed staff including qualifier peer advocates and family advisors

Unless the Legislature acts to extend the exemption, after July 1, 2013 licensed or certified staff not mentioned in the above list (e.g. Certified Rehabilitation Counselors, Certified Alcoholism and Substance Abuse Counselors, Occupational Therapists) are not authorized to work as professional clinic staff under Part 599.

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For a crosswalk of services and allowable staffing, see [appendix 2.2A](#) for a listing by procedure, and [appendix 2.2B](#) for a listing by provider.

NOTE: Until July 1, 2013, only the following procedures are validated to insure that the correct licensed staff provided the service:

- Psychiatric assessment
- Psychiatric consultation
- Psychotropic injection
- Psychotropic medication treatment
- Health physicals
- Health monitoring
- Psychological testing
- Neuropsychological testing
- Neurobehavioral status exam

2.5 Recording Injectable Drugs: Risperdal Consta, Invega Sustenna and Zyprexa Relprevv Services

As of 2006, we can bill for the drug Risperdal Consta. Starting in 2011 we can also bill Invega Sustenna and Zyprexa Relprevv. The service recording screens are used to record the drug. The recipient must be admitted to a Clinic, CDT, partial hospitalization or ACT program in order to record Risperdal Consta, Invega Sustenna or Zyprexa Relprevv.

You need to record from one to three services for injectable drugs:

1. One for the cost of the drug (entered by the administering nurse)
2. One for the administration of the drug (entered by the administering nurse)
3. One for the doctor's visit with the recipient (entered by the physician)

Service 1 – The recording for the drug is **not a service** but a means for us to bill Risperdal, Invega or Zyprexa (recovering the cost of the drug). It should only be recorded if the drug came from the hospital pharmacy (we cannot bill for the drug if it is dispensed from an outside pharmacy) and should be recorded at each injection (not for each prescription)

Service 2 should **always** be recorded when a Risperdal, Invega or Zyprexa injection is given (this is the RN injection note for administering the drug).

Service 3 should be recorded only when the doctor sees the recipient to prescribe the drug, review the dosage, etc. (i.e. the physician's usual note for medication therapy)

Service 1 – Cost Of the Drug (Completed By RN)

This service recording for the drug should only be entered into MHARS when dispensed by the facility pharmacy. ***Do not enter this service into MHARS when the drug is dispensed by an outside pharmacy. We cannot bill for the cost of the drug if we did not dispense it.***

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This service should be entered on the services by patient screen. It is not necessary to write a progress note for this service.

To enter the service on the service by patient screen

- Enter the date and time of the injection
- Enter the ID of the physician/NP that ordered/prescribed the drug
Note: Only a Physician or NP can order/prescribe one of the injectable drugs, therefore a staff member in one of these titles must be the responsible staff for the service. An agent for the Physician or NP can do this step but they must put the Physician or NPs name on the service recording.
- The duration is irrelevant since it does not affect billing. However since it is a required field, 10 minutes is acceptable
- Select the unit in which the service was provided. This must be a Clinic, CDT, PH or ACT unit
- Select the appropriate Risperdal, Invega or Zyprexa, dosage from the service drop down menu:
 - Risperdal Consta 12.5 mg
 - Risperdal Consta 25 mg
 - Risperdal Consta 37.5 mg
 - Risperdal Consta 50 mg
 - Invega Sustenna 39 mg
 - Invega Sustenna 78 mg
 - Invega Sustenna 117 mg
 - Invega Sustenna 156 mg
 - Invega Sustenna 234 mg
 - Zyprexa Relprevv 210 mg
 - Zyprexa Relprevv 300 mg
 - Zyprexa Relprevv 405 mg
- The rest of the recording will be the same as other services.
- For Risperdal, prior to 1/1/2011 a Prior Authorization Number (PA) was required. As of 1/1/2011, a PA is not required for Risperdal
- Save

Service 2 – Administration of The Drug (RN Injection Note)

This service is reported for the actual administration of the drug so that the nurse can get credit for her/his time as well as billing for the service. This service can and should **always** be reported regardless of whether the drug came from a facility or an outside pharmacy. It is appropriate to write a progress note for this service. A nurse can administer the drug and write the note to record the service, including confirming and saving it.

To enter the service:

- Select the recipient and episode of care for correct progress note documentation
- Select "Progress Note: Single Detail"
- Enter date and time of the visit

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- Enter the RN or clinician that administered the medication
- Select a medication note code
- Enter the duration of the recipient's visit
- The Service should be **Psychotropic Injection (clinic only) or Treatment – Medication Management or Treatment Medication Education (for licensed programs other than clinic)**
- Select on site or off site
- Select Direct
- In the "Notes" section on the bottom, include the name of the physician who ordered the medication as the individual service associated to the note does not include the physician's name.
- Confirm and save the note

Service 3 – Doctor's Progress Note

- This is the service the doctor records when prescribing Risperdal, Invega or Zyprexa for the recipient, reviewing the medication with the recipient, etc. This service should be recorded within a progress note. The service would be **Psychotropic Injection with Monitoring and Education (clinic only) or Treatment – Medication Management or Treatment Medication Education (for licensed programs other than clinic)**

Appendix 2.1

Allowable Services Within Program - Effective Date of 6/3/2011	Licensed/Programs (B = billable, X = unbillable)					
	Clinic	CDT	PH	IPRT	Children's Day Treatment	ACT
Treatment						
- assessment	-	B	B	-	B	B
- case management	-	B	B	-	B	B
- clinical support (collateral service)	-	B	B	-	B	-
- clozapine therapy	B	B	-	-	B	-
- discharge planning	-	B	B	B	B	B
- health screening and referral	-	B	B	-	B	B
- ISP development	-	B	B	-	B	-
- medication education and support	-	B	B	-	-	B
- medication management (excluding clozapine)	-	B	B	-	B	-
- psych rehab readiness determination and referral	-	B	B	B	-	-
- psych rehab support services (collateral service)	-	-	-	B	-	-
- symptom management	-	B	B	-	-	B
- treatment planning	-	B	B	-	B	-
- verbal therapy	-	B	B	-	B	-
ACT only treatment services						
- collateral	-	-	-	-	-	B
- engagement	-	-	-	-	-	B
- family education	-	-	-	-	-	B
- family life and social relationships	-	-	-	-	-	B
- health	-	-	-	-	-	B
- integrated treatment for MICA	-	-	-	-	-	B
- problem solving	-	-	-	-	-	B
- PTSD treatment	-	-	-	-	-	B
- service planning and coordination	-	-	-	-	-	B
- wellness self management	-	-	-	-	-	B
Clinic only treatment services						
- complex care management	B	-	-	-	-	-
- health monitoring	B	-	-	-	-	-
- health physicals	B	-	-	-	-	-
- Initial MH assessment	B	-	-	-	-	-
- outreach and engagement	X	-	-	-	-	-
- psychiatric assessment	B	-	-	-	-	-
- psychiatric consultation	B	-	-	-	-	-
- psychotherapy	B	-	-	-	-	-
- psychotropic injection	B	-	-	-	-	-
- psychotropic injection with Monitoring & Education	B	-	-	-	-	-
- psychotropic medication treatment	B	-	-	-	-	-
- smoking cessation counseling	B	-	-	-	-	-
- Status exam - Neurobehavioral	B	-	-	-	-	-
- test - Developmental	B	-	-	-	-	-
- test - Neuropsychological	B	-	-	-	-	-
- test - Psychological	B	-	-	-	-	-
Crisis						
- crisis brief or by phone	B	-	-	-	-	-
- crisis intervention	B	B	B	-	B	B
Rehabilitation						
- psych rehab functional and resource assessment	-	-	-	B	-	-
- psych rehab goal setting	-	-	-	B	-	-
- psych rehab service planning	-	-	-	B	-	-
- psych rehab skills and resource development	-	-	-	B	-	-
- rehab readiness development	-	B	-	-	-	-
- rehabilitation	-	-	-	-	-	B
- school and training opportunities	-	-	-	-	-	B
- work opportunities	-	-	-	-	-	B
Support						
- activity therapy	-	B	-	-	-	-
- advocacy	-	-	B	-	-	-
- case management	-	-	-	-	-	-
- Daily activities	-	-	-	-	-	B
- housing	-	-	-	-	-	B
- money management and entitlements	-	-	-	-	-	B
- outreach	-	-	-	-	-	-
- personal support services	-	-	-	-	-	-
- self-help support	-	-	-	-	-	-
- sheltered workshop	-	-	-	-	-	-
- social training	-	-	-	-	B	-
- socialization	-	-	-	-	B	B
- supportive skills training	-	B	-	-	-	-
- task and skills training	-	-	-	-	B	-
- transitional employment placement	-	-	-	-	-	-
Recovery						
- benefits and personal financial management	X	-	-	-	-	-
- Creative arts (non-"treatment")	X	-	-	-	-	-
- Family activity	X	-	-	-	-	-
- housing support	X	-	-	-	-	-
- life skills acquisition or restoration	X	-	-	-	-	-
- medication support	X	-	-	-	-	-
- parenting education and support	X	-	-	-	-	-
- peer support, empowerment and self help	X	-	-	-	-	-

- physical health	X	-	-	-	-	-
- rehabilitation planning and goal acquisition	X	-	-	-	-	-
- situational problem solving	X	-	-	-	-	-
- standard linkage and coordination services	X	-	-	-	-	-
- vocational support	X	-	-	-	-	-
- wellness self management (non-“treatment”)	X	-	-	-	-	-
Self Help and Empowerment						
- self help and empowerment	X	-	-	-	-	B
- self help and peer support education	-	-	-	-	-	B
Billable Medications						
- Invega Sustenna	B	B	B	-	-	B
- Risperdal Consta	B	B	B	-	-	B
- Zyprexa Relprev	B	B	B	-	-	B
Administration						
- any other activity	X	X	X	X	X	-
Education						
- classroom educational services	-	-	-	-	B	-

Appendix 2.2A: Who can Provide What Services

1/9/2012

SERVICES by profession	LCAT	LCSW	Lic. Psychoanalyst	Psychology Title	LMFT	LMHC	LMSW	LPN	Physician	Psychiatrist	NPP	PA	NP	RN	Parent advisor	Skilled peer advocate
PROFESSION CODE	5	73	19	68	6	18	72	10	60-61	60-61	40	23	30-39, 41-43	22		
Smoking Cessation									X			X	X	X		
Initial MH Assessment	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Psychiatric Assessment										X	X					
Psychiatric Consultation										X	X					
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Psychotropic Injection								X	X	X	X	X	X	X		
Psychotropic Injection with Monitoring & Education									X	X	X	X	X	X		
Psychotropic Medication Treatment										X	X					
Psychotherapy	X	X	X	X	X	X	X		X	X	X		X	X		
Health Physicals									X	X	X	X	X			
Health Monitoring								X	X	X	X	X	X	X		
Complex Care Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Developmental Testing	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Psychological Testing				X					X	X						
Neuropsychological Testing				X					X	X						
Neurobehavioral status exam				X					X	X						

CPS Clinical Professional Staff
LCAT Licensed Creative Arts Therapist
LCSW Licensed Clinical Social Worker
LMFT Licensed Marriage & Family Therapist
LMHC Licensed MH Counselor
LMSW Licensed Master Social Worker
LPN Licensed Practical Nurse
MD Medical Doctor, Physician

NP Nurse Practitioner
NPP Nurse Practitioner in Psychiatry
PA Physician's Assistant
RN Registered Professional Nurse

Appendix 2.2A continued

SERVICES by title	Resident Physician	Medical Student	Psychology Intern	Associate Psychologist	RN Nursing Student	LPN Nursing Student	Psychiatric Intern	Psychiatric Resident	Social Work Student	MH Counseling Student	Creative Arts Therapy Student
title code	5201220	208	6161010	see below	210	211	207	203	209	214	213
SAME AS	Physician	Physician	Psychology Title	Psychology Title	RN	LPN	Psychiatrist	Psychiatrist	LCSW	LMHC	LCAT
Smoking Cessation	X	X			X						
Initial MH Assessment	X	X	X	X	X	X	X	X	X	X	X
Psychiatric Assessment							X	X			
Psychiatric Consultation							X	X			
Crisis Intervention	X	X	X	X	X	X	X	X	X	X	X
Psychotropic Injection	X	X			X	X	X	X			
Psychotropic Injection with Monitoring & Education	X	X			X		X	X			
Psychotropic Medication Treatment							X	X			
Psychotherapy	X	X	X	X	X	X	X	X	X	X	X
Health Physicals	X	X					X	X			
Health Monitoring	X	X			X	X	X	X			
Complex Care Management	X	X	X	X	X	X	X	X	X	X	X
Developmental Testing	X	X	X	X	X	X	X	X	X	X	X
Psychological Testing	X	X	X	X			X	X			
Neuropsychological Testing	X	X	X	X			X	X			
Neurobehavioral status exam	X	X	X	X			X	X			

The following titles and title codes would be Associate Psychologist:

- 6160110 Psychologist 1
- 6160400 Assoc Psychologist
- 6160410 Assoc Psychologist Spanish Language
- 6160430 Assoc Psychologist Chinese Language

**Appendix 2.2B
What Services Can and Cannot be Provided By Each Licensed Professional**

LPN	Licensed Practical Nurse	What services they CAN perform	What services they can NOT perform
	LPN Nursing Student	Initial MH Assessment - till 7/20/13	Psychiatric Assessment
		Crisis Intervention - till 7/20/13	Psychiatric Consultation
		Psychotropic Injection	Psychotropic Medication Treatment
		Health Monitoring	Psychotropic Injection w/monitoring & edu
		Complex Care Management - till 7/20/13	Health Physicals
		Developmental Testing - till 7/20/13	Psychological Testing
			Neuropsychological testing
			Neurobehavioral status exam
			Psychotherapy
			Smoking Cessation Counseling
RN	Registered Professional Nurse	What services they CAN perform	What services they can NOT perform
	RN Nursing Student	Initial MH Assessment	Psychiatric Assessment
		Crisis Intervention	Psychiatric Consultation
		Psychotropic Injection	Psychotropic Medication Treatment
		Psychotropic Injection w/monitoring & edu	Health Physicals
		Psychotherapy	Psychological Testing
		Health Monitoring	Neuropsychological testing
		Complex Care Management	Neurobehavioral status exam
		Developmental Testing	
		Smoking Cessation Counseling	
NP	Nurse Practitioner	What services they CAN perform	What services they can NOT perform
		Initial MH Assessment	Psychiatric Assessment
		Crisis Intervention - till 7/20/13	Psychiatric Consultation
		Psychotropic Injection - till 7/20/13	Psychotropic Medication Treatment
		Psychotropic Injection w/monitor & ed - till 7/20/13	Psychological Testing
		Psychotherapy - till 7/20/13	Neuropsychological testing
		Health Physicals - if within scope of competency	Neurobehavioral status exam
		Health Monitoring	
		Complex Care Management - till 7/20/13	
		Developmental Testing - till 7/20/13	
		Smoking Cessation Counseling	
NPP	Nurse Practitioner in Psychiatry	What services they CAN perform	What services they can NOT perform
		Outreach and Engagement	Psychological Testing
		Initial MH Assessment	Neuropsychological testing
		Psychiatric Assessment	Neurobehavioral status exam
		Psychiatric Consultation	Smoking Cessation Counseling
		Crisis Intervention	
		Psychotropic Injection	
		Psychotropic Injection w/monitoring & edu	
		Psychotropic Medication Treatment	
		Psychotherapy	
		Health Physicals	

		Health Monitoring - if within scope of competency	
		Complex Care Management	
		Developmental Testing	
PA	Physician's Assistant	What services they CAN perform	What services they can NOT perform
		Initial MH Assessment - till 7/20/13, then waiver	Psychiatric Assessment
		Crisis Intervention - till 7/20/13, then waiver	Psychiatric Consultation
		Psychotropic Injection - under supervision of doctor	Psychotropic Medication Treatment
		Psychotropic Injection w/monitoring and edu - under supervision of doctor	Psychological Testing
		Health Physicals - under supervision of doctor	Neuropsychological testing
		Health Monitoring - under supervision of doctor	Neurobehavioral status exam
		Complex Care - till 7/20/13, then waiver	
		Developmental Testing - till 7/20/13, then waiver	Psychotherapy
		Smoking Cessation Counseling	
	Medical Doctor, Physician	What services they CAN perform	What services they can NOT perform
	Resident Physician	Initial MH Assessment	Psychiatric Assessment
	Medical Student	Crisis Intervention	Psychiatric Consultation
		Psychotropic Injection	Psychotropic Medication Treatment
		Psychotropic Injection w/monitoring & edu	
		Psychotherapy	
		Health Physicals	
		Health Monitoring	Note: If the clinic has received a waiver to allow an M.D. in lieu of a psychiatrist then all three services above would be allowed.
		Complex Care Management	
		Developmental Testing	
		Psychological Testing	
		Neuropsychological testing	
		Neurobehavioral status exam	
		Smoking Cessation Counseling	
	Psychiatrist	What services they CAN perform	What services they can NOT perform
	Psychiatric Intern	Initial MH Assessment	Smoking Cessation Counseling
	Psychiatric Resident	Psychiatric Assessment	
		Psychiatric Consultation	
		Crisis Intervention	
		Psychotropic Injection	
		Psychotropic Injection w/monitoring & edu	
		Psychotropic Medication Treatment	
		Psychotherapy	
		Health Physicals	
		Health Monitoring	
		Complex Care Management	
		Developmental Testing	
		Psychological Testing	
		Neuropsychological testing	
		Neurobehavioral status exam	

LCAT	Licensed Creative Arts Therapist	What services they CAN perform	What services they can NOT perform
LCSW	Licensed Clinical Social Worker	Initial MH Assessment	Psychiatric Assessment
	Licensed Psychoanalyst	Crisis Intervention	Psychiatric Consultation
LMFT	Licensed Marriage & Family Therapist	Psychotherapy	Psychotropic Injection
LMHC	Licensed MH Counselor	Complex Care Management	Psychotropic Injection w/monitoring & edu
LMSW	Licensed Master Social Worker	Developmental Testing	Psychotropic Medication Treatment
	Social Work Student		Health Physicals
	MH Counseling Student		Health Monitoring
	Creative Arts Therapy Student		Psychological Testing
			Neuropsychological testing
			Neurobehavioral status exam
			Smoking Cessation Counseling

	Psychology Title	What services they CAN perform	What services they can NOT perform
	Psychology Intern	Initial MH Assessment	Psychiatric Assessment
		Crisis Intervention	Psychiatric Consultation
		Psychotherapy	Psychotropic Injection
		Complex Care Management	Psychotropic Injection w/monitoring & edu
		Developmental Testing	Psychotropic Medication Treatment
		Psychological Testing	Health Physicals
		Neuropsychological testing	Health Monitoring
		Neurobehavioral status exam	Smoking Cessation Counseling

Appendix 2.3
Common “Primary Psychiatrist / Nurse and Nurse Practitioner” Tasks
 What you do most and how to record it in MHARS

Direct Treatment Services- Face To Face With Recipient
 Recipient Present

What You Do	How to Log it (New Services after Oct 1, 2010)
Perform a medical history and physical	Direct, Health Physical
Meet with recipient, write medication prescription (not Clozapine)	Direct, Psychotropic Medication Treatment
Meet with recipient, write Clozapine medication prescription	Clozapine Medication Management
Meet with recipient, provide medication education- benefits/side-effects -no prescription written	Direct, Psychotherapy - Patient
Meet with recipient, unscheduled session to avoid psychiatric decompensation, ER visit or hospitalization.	Direct, Crisis Intervention - Patient
Complete psychiatric evaluation/mental status with recipient present	Direct, Psychiatric Assessment - Patient
Interview/ Assess recipient (AIMS, BPRS, for Psych Eval, Mental Status) with recipient present	Direct, Psychiatric Assessment - Patient
Meet with nonprofessional significant other for session with or without the recipient	Direct, Psychotherapy – Patient and Collateral <u>or</u> Direct, Psychotherapy – Collateral Only
Call to another agency re: services with recipient present	Direct, Complex Care Management see below for requirements
Review a health screening document , formulate medical recommendations with recipient present	Direct, Health Physicals
Give the recipient an injection	Direct, Psychotropic Injection

INDIRECT= Recipient Not Present

Indirect and Administrative Services- Recipient Service Related Phone Calls, Faxes, Paperwork, Etc

What You Do	How to Log it (New Services after Oct 1, 2010)
Phone call within 5 days of individual session and call is about Coordination required to treat co-occurring disorders, complex health status, risk to self or others, coordination necessary to break cycle of multiple hospitalizations, loss of housing, employment, or children/adults with multiple service providers in need of coordination, children at risk of school failure, expulsion or lack of school placement, children at risk of out of home placement, changes in custody status (from the parents' or child's perspective); and/or calls re: AOT, or CPL status and process.	Indirect, Complex Care Management see below for requirements
Phone call not within 5 days of individual session and call is about coordination of care	Indirect, Standard Linkage and Coordination of Services
Write/type progress note about med therapy session not written collaboratively with the patient	Administration Service Review/Documentation
Write/type progress note about med therapy session, written collaboratively with the patient	Include as part of the session
Write/type progress note documenting medication education not written collaboratively with the patient	Administration Service Review/Documentation
Write/type progress note documenting medication education written collaboratively with the patient	Include as part of the session
Call a pharmacy to facilitate services	Indirect, Complex Care Management see below for requirements
Complete a form without the recipient's participation	Administration Service Review/Documentation
Call or meet with other professionals- agencies- advocate for recipient, create, maintain, monitor linkage to service systems. (recipient not present)	Indirect, Complex Care Management see below for requirements or Indirect Standard Linkage and Coordination
Review a recipient chart without the recipient present	Administration Service Review/Documentation
Review a Health Screening Document and formulate medical recommendations without recipient present	Administration Service Review/Documentation

Complex Care - This service must be provided within 5 working days **following** a face to face therapy or crisis visit. It can be provided by phone or in person. Medicaid will only reimburse for one complex care within 5 working days following the provision of these services.

Appendix 2.4
Common “Primary Clinician” Tasks
 What you do most and how to record services in MHARS

Direct Treatment Services- Face To Face With Recipient

What You Do	How to Log it (New Service after Oct 1, 2010)
Verbal therapy session with recipient - goal oriented psychotherapy, behavior therapy, family/group and other face-to-face contacts. Include time spent summarizing and documenting the session if conducted collaboratively with the recipient	Direct, Psychotherapy - Patient
Therapy with an emphasis on provision of skills and techniques specific to recipient’s condition. Include time spent summarizing and documenting the session if conducted collaboratively with the recipient	Direct, Psychotherapy - Patient
Meet with recipient for therapy in an unscheduled visit to avoid decompensation, possible ER visit or hospitalization	Direct, Crisis Intervention - Patient
Formulate/Complete ISP with recipient present	Direct, Psychotherapy - Patient
Meet with nonprofessional (personal) significant other with or without the recipient present	Direct, Psychotherapy – Patient and Collateral <u>or</u> Direct, Psychotherapy – Collateral Only
Complete any assessment form /evaluation with the recipient present	Direct, Initial MH Assessment for initial assessment Direct, Psychotherapy – Patient for ongoing assessment
Meet with recipient to ask about vocational/educational desires , do a vocational assessment, review and assist with application process	Direct, Rehab Planning and Goal Acquisition
Complete Health Screening form and evaluate health issues with recipient present	Direct, Psychotherapy – Patient if PSC Direct, Health Physical if RN
Meet with a group of recipients, provide medication or general health education and awareness	Wellness (reportable but not billable)
Conduct ISP review- with recipient present- review progress on ISP goals	Direct, Psychotherapy - Patient
Phone call within 5 days of individual session and call is about coordination required to treat co-occurring disorders, complex health status, risk to self or others, coordination necessary to break cycle of multiple hospitalizations, loss of housing, employment, or children/adults with multiple service providers in need of coordination, children at risk of school failure, expulsion or lack of school placement, children at risk of out of home placement, changes in custody status (from the parents’ or child’s perspective); and/or calls re: AOT, or CPL status and process.	Direct, Complex Care Management see below for requirements

INDIRECT = Recipient Not Present	
Indirect and Administrative Services- Recipient Related Phone Calls, Faxes, paperwork, Etc.	
What You Do	How To Log It
Phone call not within 5 days of individual session and call is about coordination	Indirect, Standard Linkage and Coordination
Write progress notes documenting a verbal therapy session without client's active participation	Administration Service Review/Documentation
Write progress notes documenting a verbal therapy session with client's active participation	Include with session
Talk with recipient on the phone, provide phone support/therapy.	Indirect, Psychotherapy – Patient
Complete any chart form/evaluation without the recipient present- type and finish up the form alone in your office.	Administration Service Review/Documentation
Complete any chart form/evaluation with the recipient's active participation	Include with session
Make phone calls/send faxes, write letters to other professionals and agencies- to advocate for recipient, to create, maintain, monitor linkage to other service systems. (Recipient Not Present)	Indirect, Complex Care Management see below for requirements
Complete parts of an ISP or ISP review without recipient present –incorporate info from recipient interview	Administration Service Review/Documentation
Complete discharge paperwork without recipient present	Administration Service Review/Documentation
Complete paperwork on recipient- document treatment response and progress without client's direct participation.	Administration Service Review/Documentation
Complete paperwork on recipient – document treatment response and progress with client's direct participation	Include with session

Complex Care: This service must be provided within 5 working days **following** a face to face therapy or crisis visit. It can be provided by phone or in person. If a therapy and crisis visit occurs on the same day, Medicaid will only reimburse for one complex care within 5 working days following the provision of these services.

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3.1 Background

The array of services provided in OMH outpatient programs is defined by regulations Parts 587/588 and regulations Part 599 for licensed programs, by OMH policy for ACT and PMHP and from Medicare general coding guidelines. This section provides service definitions by type as they appear in either regulation, policy or guidelines.

The specific array of services that are available in a selection menu will depend on the type of program in which services are being reported. See [appendix 2.1](#) for a list of which services are allowed at each program.

3.2 Treatment Services for Clinic Programs

The goals of a clinic treatment program that serves **adults** are to diagnose and treat an individual's mental illness, to work with the individual in developing a plan of care designed to minimize symptoms and adverse effects of illness, maximize wellness, and promote recovery toward the achievement of life goals such as, but not limited to, education and employment. [Part 599 language]

The goals of a clinic treatment program that serves **children** are early assessment and identification of childhood emotional disturbances, and engagement of the child and family in the development of a plan of care designed to minimize the symptoms and adverse effects of illness, maximize wellness, assist the child in developing a resilient and hopeful approach to school, family, and community, and maintain the child in his or her natural environment. [Part 599 language]

Complex Care Management means an ancillary service to psychotherapy or crisis intervention services. It is provided by a clinician in person or by telephone, with or without the client. It is a clinical level service which is required as a follow up to psychotherapy or crisis service for the purpose of preventing a change in community status or as a response to complex conditions. [Part 599 language]

Health Monitoring means the continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, blood pressure, body mass index (BMI), and smoking status. For children and adolescents, these indicators include, but are not limited to, BMI percentile, activity/exercise level, and smoking status. [Part 599 language]

Health Physical means the physical evaluation of an individual, including an age and gender appropriate history, examination, and the ordering of laboratory/diagnostic procedures. [Part 599 language]

Initial MH Assessment means a face-to-face interaction between a clinician and recipient and/or collaterals to determine the appropriateness of the recipient for admission to a clinic, the appropriate mental health diagnosis, and the development of a treatment plan for such recipient. [Part 599 language]

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Outreach and Engagement means face-to-face services with an individual, or, in the case of a child, the child and/or family member(s) for the purpose of beginning or enhancing the engagement process, or reengaging with individuals who are reluctant to participate in services, or to promote early intervention to prevent a psychiatric crisis. [Part 599 language]

Psychiatric Assessment means an interview with a consumer, child, family, or other collateral performed by a psychiatrist or nurse practitioner in psychiatry, or physician assistant with specialized training approved by the Office, which may occur at any time during the course of treatment, for the purposes of diagnosis, treatment planning, medication therapy, and/or consideration of general health issues. A psychiatric assessment may also include on-site psychiatric consultation which includes an evaluation, report or interaction between a psychiatrist or nurse practitioner in psychiatry or physician assistant with specialized training approved by the Office and a referring physician for the purposes of diagnosis, integration of treatment and continuity of care. [Part 599 language]

Psychiatric Consultation means a face-to-face evaluation, including video tele-psychiatry, of a consumer by a psychiatrist or nurse practitioner in psychiatry, including the preparation, evaluation, report or interaction between the psychiatrist or nurse practitioner in psychiatry and another referring physician for the purposes of diagnosis, integration of treatment and continuity of care. [Part 599 language]

Psychotherapy means therapeutic communication and interaction for the purpose of alleviating symptoms or dysfunction associated with an individual's diagnosed mental illness or emotional disturbance, reversing or changing maladaptive patterns of behavior, encouraging personal growth and development, and supporting the individual's capacity to achieve age-appropriate developmental milestones. [Part 599 language]

Psychotropic Injection means the process of preparing, administering, and managing the injection of intramuscular psychotropic medications.

Psychotropic Injection with Monitoring and Education means the process of preparing, administering, managing and monitoring the injection of intramuscular psychotropic medications. It includes consumer education related to the use of the medication, as necessary.

Psychotropic Medication Treatment means monitoring and evaluating target symptom response, ordering and reviewing diagnostic studies, writing prescriptions and consumer education as appropriate. [Part 599 language]

Smoking Cessation Counseling is allowed for both adults and children as a health monitoring service. Can be provided in a group with up to eight patients.

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Test - Developmental means the administration, interpretation, and reporting of screening instruments for children or adolescents to assist in the determination of the individual's developmental level for the purpose of facilitating the mental health diagnosis and treatment planning processes. [Part 599 language]

Test - Psychological means a psychological evaluation using standard assessment methods and instruments to assist in mental health assessment and the treatment planning processes. [Part 599 language]. There are 3 psychological tests to choose from:

- **Status Exam – Neurobehavioral**
Clinical assessment of thinking, reasoning and judgment, eg. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities (CPT Coding manual)
- **Test – Neuropsychological**
eg. Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales, Wisconsin Card Sorting Test (CPT Coding manual)
- **Test - Psychological**
Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg. Minnesota Multiphasic Personality Inventory (MMPI), Rorschach, Wechsler Adult Intelligence Scale (WAIS) (CPT Coding manual)

3.3 Recovery Services for Clinic programs

Benefits and personal financial management services are designed to increase an individual's understanding and skill in handling his or her financial resources. The services may include information and counseling on budgeting, income and benefits, including incentives for returning to work as well as basic information and counseling on income maintenance, eligibility for benefits from relevant sources, and determination of the need for plans for additional support and assistance in managing personal finances. This service also includes directly assisting the individual in money matters such as: completing entitlement applications, accompanying consumers to entitlement offices for establishment and re-determination of benefits.

Creative Arts (non-“treatment”) services provide opportunities for clients to learn and practice skills in working with specific art media as well as other forms of creative expression (dance, music, or drama) Creative arts help to build skills in communication, problem solving and collaboration. These skills can then be used to pursue additional art interests independently as well as to increase self esteem, utilize free time and to enhance one's space and living environment.

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Family Activity includes:

- **Family psycho-education** is a service designed to provide information and support to collaterals for the purpose of assisting and enhancing the capacity of a collateral to facilitate an individual's recovery. Such service includes, but is not limited to: education about mental illness and its treatment, information on community resources, general guidance on how to manage or cope with difficult behaviors and problem-solving skills training.
- **Family Support** services are services provided to collaterals, with or without the patient present, for the purpose of providing resources and consultation for goal oriented problem solving, assessment of treatment strategies and provision of skill development for purpose of supporting the patient in management of his or her illness.

Housing Support assists an individual with finding safe, affordable housing, negotiating leases and paying rent, purchasing and repairing household items and developing relationships with landlords.

Life Skills Acquisition or Restoration includes:

- **Community living exploration** is a service designed to help an individual understand the demands of specific community life roles, in order to make decisions regarding participation in those roles. Community living exploration services can also be used to help inspire individuals who do not feel ready or prepared for more integrated community life roles, by increasing their knowledge of opportunities available in the community. Topics may include, but are not limited to: options for satisfactory experiences with living environments, work or career opportunities, educational opportunities, opportunities to connect to culturally-based community services, and resources for use of leisure time.
- **Living skills coaching** is a service designed to improve an individual's ability to achieve maximum independence and comfortably fit into the community. This service focuses on specific skills, as well as strategies. Teaching interventions may be used, such as motivational, educational and cognitive-behavioral techniques. The service may include opportunities to practice, observe, reinforce and improve the individual's skill performance. The topics which may be covered include, but are not limited to: personal hygiene and presentation, nutrition, homemaking, building relationships, childcare, transportation, use of community resources, and interacting socially.
- **Socialization** is activity meant to improve or maintain a recipient's capacity for social involvement by providing opportunities for application of social skills.
- **Personal Interests Exploration and Development** includes introduction to hobbies and interests which may lead to absorbing leisure time activities. The purpose is that such activities, tailored to the individual, could become part of a regime of "personal medicine" that can distract and provide comfort in times of stress and mental discomfort, and effectively augment other forms of treatment.

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Medication Support services include:

- Providing recipients and collaterals with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication
- Monitoring the effects of medication on the recipient's mental and physical health
- Activities that focus on educating recipients about the role and effects of medication in treating symptoms of mental illness
- Training in the skill of self-medication;
- Ordering medications from pharmacies; and
- Delivering medications, if needed.

Parenting Education and Support includes activities that are designed to increase parenting skills as well as staff interventions that encourage skill practice and acquisition. It also includes coordinating with child welfare and family agencies, and the legal system, and other forms of support to effective parenting.

Peer Support, Empowerment and Self Help includes:

- **Information and education** regarding self-help is a service designed to encourage individuals to participate in self-help and mutual assistance groups. The service is designed to help an individual understand what self-help resources are available in the community and the potential benefits from participating in them.
- **Self Help and Empowerment** is peer-led training on topics which will increase recipient's sense of empowerment and their ability to live as independently as possible. May include topics such as rights education, self-directed rehabilitation, meditation, developing a personal repertoire of coping skills, etc.

Physical Health includes:

- **Health screening** service is the gathering of data concerning the recipient's medical history and any current signs and symptoms, which will contribute to an assessment of the data by a qualified health professional to determine his or her physical health status and need for referral for noted problems. The data may be provided by the recipient or obtained with his or her participation. The assessment of the data shall be done by a nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse.
- **Physical Exercise and Fitness** is monitored physical exercise that is intended to help improve or maintain the recipient's optimal physical and mental health status.

Rehabilitation Planning and Goal Acquisition includes:

- **Rehabilitation Readiness Development** is the process of building a recipient's skills to proceed with the rehabilitation goal setting process. This service might include confidence building activities, self-awareness activities, or trial visits to various environments.

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- **Psychiatric Rehabilitation Skills and Resource Development** is the process of improving a recipient's use of skill and arranging for or adapting social and environmental resources necessary to achieve a psychiatric rehabilitation goal.

Situational Problem Solving means providing personal contact, listening, and consultation for problem-solving in a non-crisis context, and thereby assist the recipient in developing coping skills and strategies for community living. As a support service outside of formal psychotherapy treatment, this is often facilitated in a group format.

Standard Linkage and Coordination services (when not meeting the criteria for Complex Care Coordination) link the individual to the service system and monitor the provision of services with the objective of continuity of care and services. Case management includes the following components:

- **Linking.** The process of referring the individual to all required services and supports as specified in the individual service plan.
- **Case-specific advocacy.** The process of interceding on behalf of the individual to gain access to needed services and supports.
- **Monitoring.** The process of observing the individual to assure that needed services and supports are received.

Vocational Support includes:

- **Job, Career, and School Exploration**
- **Ongoing Vocational Support**
- **School and Training Opportunities** – helping the individual identify interests and skills, finding and enrolling in school/training programs and supporting participation in school/training programs.
- **Work Opportunities** – helping the individual identify interests and skills, prepare for finding employment, job coaching and social skills training, develop and strengthen relationships with employers and other vocational support agencies and educating employers about serious mental illness.

Wellness Self Management (non-“treatment”) also known as illness management and recovery are **psychoeducational** services designed to teach or improve coping strategies, prevent relapse, and promote recovery. Such services may be provided to recipients and/or collaterals, and may include, but are not limited to:

- coping skills coaching which means working with individuals on strategies to address symptoms, manage stress and reduce exposure and vulnerability to stress [might include individualized “personal medicine”];
- disability education which means instruction on the facts concerning mental illness and the potential for recovery.
- dual disorder education which means providing individuals with basic information on the nature of substance abuse disorders and how they relate to the symptoms and experiences of mental illness;
- medication education and self-management which means providing individuals with information on the individual's medications, including related efficacy, side effects and adherence issues.

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- relapse prevention planning which means a process to engage individuals in understanding factors which may trigger a recurrence of severe symptoms of mental illness and ways to cope with the potential for recurrence. Planning activities may include the development of an advance directives document and specific instructions on what steps need to be taken in the event of a relapse.
- health education to maximize independence in personal health care by increasing the recipient's awareness of his or her physical health status and the resources required to maintain physical health, including regular medical and dental appointments, basic first aid skill and basic knowledge of proper nutritional habits and family planning. Also included is training on topics such as AIDS awareness.

3.4 Treatment Services for licensed and unlicensed programs other than clinic

Assessment is the continuous clinical process of identifying a recipient's behavioral strengths and weaknesses, problems and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral condition and history. The assessment shall be the basis for establishing a diagnosis, treatment plan or psychiatric rehabilitation service plan. [Part 587 language]

Case Management services link the recipient to the service system and monitor the provision of services with the objective of continuity of care and service. Case management includes the following components:

- Linking. The process of referring the recipient to all required services and supports as specified in the individual service plan.
- Case-specific advocacy. The process of interceding on behalf of the individual to gain access to needed services and supports.
- Monitoring. The process of observing the recipient to assure that needed services and supports are received. [Part 587 language]

Clinical Support services are services provided to collaterals, by at least one therapist, with or without the patient present for the purpose of providing resources and consultation for goal oriented problem solving, assessment of treatment strategies and provision of skill development to assisting the patient in management of his or her illness. [Part 587 language]

This service is for the treatment of the family unit when maladaptive behaviors of family members are exacerbating the beneficiary's mental illness or interfering with the treatment, or to assist the family in addressing the maladaptive behaviors of the patient and to improve treatment compliance. [Medicare coding guidelines].

Clozapine Medication Management means prescribing and/or administering clozapine, reviewing the appropriateness of the recipient's existing medication regimen through review of records and consultation with the recipient and/or family or care giver,

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and monitoring the effects of medication on the recipient's mental and physical health [Part 587 language]

This service includes 1) prescribing medication, 2) monitoring the effect of the medication and its side effects, 3) adjusting the dosage (the medical record must include this information in addition to the diagnosis/diagnoses treated), and 4) psychotherapy. Any psychotherapy provided is minimal and is usually supportive in nature. [Medicare coding guidelines]

Discharge Planning is the process of planning for termination from a program or identifying the resources and supports needed for transition of an individual to another program and making the necessary referrals, including linkages for treatment, rehabilitation and supportive services based on assessment of the recipient's current mental status, strengths, weaknesses, problems, service needs, the demands of the recipient's living, working and social environment, and the client's own goals, needs and desires. [Part 587 language]

Health Screening and Referral is the gathering of data concerning the recipient's medical history and any current signs and symptoms, and the assessment of the data to determine his or her physical health status and need for referral for noted problems. The data may be provided by the recipient or obtained with his or her participation. The assessment of the data shall be done by a nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse. The assessment of physical health status shall be integrated into the recipient's treatment plan. [Part 587 language] Referral is a post-assessment planning activity with the objective of referring or directing recipient to a program providing the appropriate services. [Part 587 language]

ISP Development is the process of working with the recipient to complete an appropriate individual service plan.

Medication Education and Support means providing recipients with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication. [Part 587 language]

Medication Management (Excluding Clozapine) means prescribing and/or administering medication, reviewing the appropriateness of the recipient's existing medication regimen through review of records and consultation with the recipient and/or family or care giver, and monitoring the effects of medication on the recipient's mental and physical health. [Part 587 language]

This services include 1) prescribing medication, 2) monitoring the effect of medication and its side effects, 3) adjusting the dosage (the medical record must include this information in addition to the diagnosis/diagnoses treated), and 4) psychotherapy. Any psychotherapy provided is minimal and is usually supportive in nature. [Medicare coding guidelines]

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Psychiatric Rehabilitation Readiness Determination and Referral means an interview and observation process which evaluates rehabilitation readiness based on a recipient's perceived need, motivation, and awareness of the process involved in making a change in his or her life. [Part 587 language]. Referral is a post-assessment planning activity with the objective of referring or directing recipient to a program providing the appropriate services. [Part 587 language]

Psychiatric Rehabilitation Support Services are consultation and technical assistance services provided to collaterals, by at least one therapist, with or without recipients. The purpose of this service is to enhance the capacity of the collateral to serve as a resource in assisting the recipient to achieve or maintain his or her psychiatric rehabilitation goal. [Part 587 language]

Symptom Management as a service for adults, means the development and provision of appropriate skills and techniques specific to the individual recipient's condition to enable him or her to recognize the onset of psychiatric symptoms and engage in activities designed to prevent, manage, or reduce such symptoms. [Part 587 language]

Transitional Employment Placement - The objective is to provide vocational assessment, training, and paid work in a protective and non-integrated work environment for individuals disabled by mental illness. Services are provided according to wage and hour requirements specified in the Fair Labor Standards Act administered by the Department of Labor.

Treatment Planning is the process of developing, evaluating and revising an individualized course of treatment based on an assessment of the recipient's diagnosis, behavioral strengths and weaknesses, problems, and service needs. [Part 587 language]

Verbal Therapy means providing goal oriented therapy including psychotherapy, behavior therapy, family and group therapy and other face-to-face contacts between staff and recipients designed to address the specific dysfunction of the recipient as identified in his or her treatment plan. As a service in a program serving children with a diagnosis of emotional disturbance, play therapy and expressive art therapy may also be included. [Part 587 language]

3.5 Crisis Services – Unscheduled Visit

Crisis Brief or by Phone (clinic only) means activities including medication and verbal therapy designed to address acute distress and associated behaviors when the individual's condition requires immediate attention, [Part 599 language], including crisis hotline activities.

Crisis Intervention means activities including medication and verbal therapy designed to address acute distress and associated behaviors when the individual's condition requires immediate attention. [Part 599 language]

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Crisis Respite services (CSP only) are seven day, 24 hour access to support and counseling by trained peers and/or other staff provided in a safe, home-like environment outside of the recipient's home. The goal is to reduce distress in a comfortable setting when the recipient cannot or does not wish to remain in their own home. These services may be provided in a crisis hostel, in apartments rented for such purposes, or other settings.

In-Home Crisis Support (CSP only) is seven day, 24 hour access to support and counseling by trained peers and/or other staff, provided in the recipient's home with the goal of reducing distress while allowing the recipient to stay in familiar surroundings.

Psychiatric Consultation (CSP only) provides availability of psychiatric consultation coverage 24 hours each day to do triage and provide consultations on medication reactions, etc.

3.6 Rehabilitation Services

Rehabilitation Services are interventions and technologies designed to assist recipients in developing skills and gaining access to the supports required to live, learn, work and recreate as independently as possible in their chosen living environments. These services may be provided in a variety of settings.

Psychiatric Rehabilitation Functional and Resource Assessment is the process by which the recipient and practitioner develop and understanding of the skills the recipient can and cannot perform and the social and environmental resources that are available related to achieving the recipient's psychiatric rehabilitation goals. [Part 587 language]

Psychiatric Rehabilitation Goal Setting is the process by which a recipient selects a specific environment in which he or she intends to live, work, learn, and/or socialize. The psychiatric rehabilitation goal identifies a specific environment, specific time frames, and is mutually agreed upon by the recipient and the staff. [Part 587 language]

Psychiatric Rehabilitation Service Planning is the process of designing and continuously revising an individualized program to assist the recipient in obtaining and maintaining a psychiatric rehabilitation goal. [Part 587 language]

Psychiatric Rehabilitation Skills and Resource Development is the process of improving a recipient's use of skill and arranging for or adapting social and environmental resources necessary to achieve a psychiatric rehabilitation goal. [Part 587 language]

Rehabilitation Readiness Development is the process of building a recipient's skills to proceed with the rehabilitation goal setting process. This service might include confidence building activities, self-awareness activities, or trial visits to various environments. [Part 587 language]

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3.7 Support Services

Support Services in a Recovery context are a flexible array of interventions and resources designed to assist recipients in maximizing their recovery. The objective is to promote settings of their choice, to strengthen their natural support systems, and to increase their involvement in the mainstream of their communities.

Such support services are accessed based upon the needs and preferences of individual recipients. For example, support services might include skills training that contribute to the goal of independent living (i.e., cooking classes), or may provide particular services which recipients cannot perform on their own, but which would allow them to live most independently (i.e. access to Meals on Wheels or homemaker/housekeeping services). Support services may be offered in a variety of settings including traditional program settings, drop-in centers, peer support programs, and clubhouses. This category is not to be confused with clinical support service defined in 587/588 NYCRR, which is only provided to recipients' collaterals and is considered a treatment service.

Activity Therapy means therapy designed to assist a recipient in developing the functional skills and social and environmental supports needed to function more successfully in current or intended life environments (i.e. living, learning, working and social). Such therapy should provide an opportunity for a recipient to practice the skills and build or sustain the supports needed to improve functioning. [Part 587 language]

Advocacy is the process of interceding on behalf of the recipient to assist them in gaining access to services, resources and supports of their choice. [PMHP memo 96-03]

Case Management services is the process of linking the recipient to the service system and monitoring the provision of the services with the objective of continuity of care and service. Case management includes the following components:

- **Linking.** The process of referring the individual to all required services and supports as specified in the individual service plan.
- **Case-Specific Advocacy.** The process of interceding on behalf of the individual to gain access to needed services and supports.
- **Monitoring.** The process of observing the individual to assure that needed services and supports are received. [Part 587 language]

Outreach is services or basic living supports offered in a person's home or other community setting to enable recipient to continue to live as independently as possible, assure personal survival and general well-being. [PMHP memo 96-02]

Personal Support Services means providing personal contact, listening, counseling and consultation for problem-solving, and to assist the enrollee in developing coping skills and strategies for community living. [PMHP memo 96-03]

Self Help Support is providing counseling and consultation to recipients regarding the development of peer-run activities. [OMH language]

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Social Training is an activity whose purpose is to assist a child in the acquisition or development of age-appropriate social and interpersonal skills. [Part 587 language]

Socialization is an activity whose purpose is to develop, improve or maintain a child's capacity for social or recreational involvement by providing age-appropriate opportunities for development, application and practice of social or recreational skills. [Part 587 language]

Supportive Skills Training is the development of physical, emotional and intellectual skills needed to cope with mental illness and the performance demands of personal and community living activities. Such training is provided through direct instruction techniques including explanation, modeling, role playing and social reinforcement interventions. [Part 587 language]

Task and Skills Training is a nonvocational activity whose purpose is to enhance a child's age-appropriate skills necessary for functioning in home, school and community settings. Task and skill training activities shall include but not be limited to: personal care, budgeting, shopping, transportation, use of community resources, time management and study skills. [Part 587 language]

3.8 Self Help and Empowerment Services

Self-Help and Empowerment are peer-run activities which promote rehabilitation and recovery by providing a social and support network based on the sharing of common experiences. These services provide opportunities for recipients to share coping skills and strategies, to move into "helper" roles and away from a passive "helpee" roles, and/or to build competencies by working together on specific projects with defined outcomes. Activities such as support groups led by a professional, group therapy, and other treatment services do not meet the definition of self-help and empowerment services.

3.9 Administrative Services

Administration services are those activities which are not services to recipients, but whose performance is necessary to the functioning of a program such as clinical and program documentation, staff meetings and community relations presentations. [OMH language]

3.10 Education Services

Classroom Educational Services refer to services provided in conjunction with treatment and rehabilitation services provided to recipients involved in children's day treatment program.

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3.11 Services allowed in ACT programs

The services provided by ACT include a full range of clinical treatment, psychosocial rehabilitation, and community support services designed to promote recovery by improving psychiatric symptoms, preventing relapse, teaching skills, providing direct assistance and securing community resources necessary for successful functioning in work, school, home and social relationships. Services should be culturally relevant and recovery based. Engaging and retaining recipients in treatment is a high priority in the ACT model. [ACT Program Guidelines, Sept 2007]

Developing and working with the recipient's support system can be an important part of treatment that furthers the recipient's integration into the community and provides skills and supports for that network. The ACT team should persistently attempt to engage with the recipient's family and support network and include them in the treatment and rehabilitation process, with the recipient's consent.

Assessment is the continuous clinical process of identifying a recipient's behavioral strengths and weaknesses, problems and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral condition and history. The assessment shall be the basis for establishing a diagnosis and service plan. [ACT Program Guidelines, Sept 2007]

Case Management is an active process that connects persons to resources and supports to help them live in the community, manage their mental illness and meet their personal goals. [ACT Program Guidelines, Sept 2007]

Collateral services provided to a member of the recipient's family or household, or significant other (landlord, criminal justice staff, employer) 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 service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team (e.g. meeting with a shelter staff that is assisting an ACT recipient in local housing). 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. [ACT Program Guidelines, Sept 2007]

Crisis Intervention services are activities and interventions, including medication and verbal therapy, designed to address acute distress and associated behaviors when the individual's condition requires immediate attention. [ACT Program Guidelines, Sept 2007]

Daily Activities – helping the patient with basic activities such as personal care and safety skills, grocery shopping, cooking, purchasing and caring for clothing, household chores, using transportation and using other community resources. [ACT Program Guidelines, Sept 2007]

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Discharge Planning is the process of planning for termination of ACT services, and/or identifying the resources and supports needed for transition of an individual to another program. This process includes making the necessary referrals/linkages for treatment, rehabilitation and supportive services based on an assessment of the recipient's current mental status, strengths, weaknesses, problems, service needs, the demands of the recipient's living, working and social environments, and the recipient's own goals, needs and desires. [ACT Program Guidelines, Sept 2007]

Engagement is the process of obtaining a person's trust, interest and commitment to participate in service planning and services to promote recovery [ACT Program Guidelines, Sept 2007]

Family Education is a service that is provided by professionals that is long-term (over 6 months), that focuses on education, stress reduction, coping skills and other supports. The service is provided to relatives and families who are in regular contact with the recipient of services. The primary rationale for the service is that many recipients live at home and/or have contact with relatives; thus education and support for these families will reduce stress and increase the chance for recovery. [ACT Program Guidelines, Sept 2007]

Family Life and Social Relationships – restoring and strengthening the individual's unique social and family relationships, psycho-educational services (providing accurate information on mental illness and treatment to families and facilitation communication skills and problem solving), coordinating with child welfare and family agencies, support in carrying out parent role, teaching coping skills to families and enlisting family support in recovery of recipient. [ACT Program Guidelines, Sept 2007]

Health is training to maximize independence in personal health care by increasing the individual's awareness of his or her physical health status and the resources required to maintain physical health, including regular medical and dental appointments, basic first aid skill and basic knowledge of proper nutritional habits and family planning. Also included is training on topics such as AIDS awareness. [ACT Program Guidelines, Sept 2007]

Health Screening is the gathering of data concerning the recipient's medical history and any current signs and symptoms, and the assessment of the data to determine his or her physical health status and need for referral for noted problems. The data may be provided by the recipient or obtained with his or her participation. The assessment of the data shall be done by a nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse. [ACT Program Guidelines, Sept 2007]

Housing – Assisting the individual with finding safe, affordable housing, negotiating leases and paying rent, purchasing and repairing household items and developing relationships with landlords. [ACT Program guidelines, Sept 2007]

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Integrated Treatment for MICA (Mentally Ill Chemical Abuser) is a service characterized by assertive outreach and stage wise treatment models that emphasize a harm reduction approach. The service is provided to recipients with co-occurring substance abuse disorders. The primary rationale for the service is that substance abuse worsens outcomes and up to 50% of recipients have co-occurring substance abuse disorders [ACT Program Guidelines, Sept 2007]

Medication Education and Support means a full range of medication related services including:

- Providing recipients and collaterals with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication
 - Prescribing and/or administering medication
 - Reminding individuals to take medications
 - Reviewing the appropriateness of the recipient's existing medication regimen through review of records and consultation with the recipient and/or facility or care-giver
 - Monitoring the effects of medication on the recipient's mental and physical health
 - Storing, monitoring, record keeping and supervision associated with the self-administration of medication
 - Activities that focus on educating recipients about the role and effects of medication in treatment symptoms of mental illness
 - Training in the skill of self-medication
 - Ordering medications from pharmacies
 - Delivering medications, if needed
- [ACT Program Guidelines, Sept 2007]

Money Management and Entitlements – assisting the individual in money matters such as: completing entitlement applications, accompanying consumers to entitlement offices, re-determination of benefits, budgeting skills, financial crisis management and managing food stamps. [ACT Program Guidelines, Sept 2007]

Problem Solving – individual, group, family and behavior therapy that is problem specific and goal oriented; uses a therapeutic approach which is consistent with evidence-based practices for a particular problem, emphasizes social/interpersonal competence; addresses self-defeating beliefs, expectation, and behaviors that disrupt the recovery process, and considers a recipient's strengths, needs and cultural values. [ACT Program Guidelines, Sept 2007]

Post Traumatic Stress Disorder (PTSD) Treatment is a service provided to recipients who have been exposed to catastrophic events, have had past exposure to trauma, or a trauma victims. Treatment of co-morbid disorders target symptoms of each disorder simultaneously by providing combination therapy (e.g. individual, medication, global, family, group and social rehabilitation therapies). The primary rationale for the service is that people exposed to similar catastrophic events react differently; some will develop severe psychological distress (e.g. PTSD) while others will not. People treated for PTSD can make a full recovery. [ACT Program Guidelines, Sept 2007]

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Rehabilitation - therapeutic interventions designed to increase the functioning of a person with psychiatric disabilities so he or she can succeed in a community environment of living, working, learning or social relationships.

School and Training Opportunities – helping the individual identify interests and skills, finding and enrolling in school/training programs and supporting participation in school/training programs. [ACT Program Guidelines, Sept 2007]

Self-Help and Empowerment - encouraging and assisting recipients to participate in self-help, advocacy, social clubs and culturally preferred and supportive community organizations. Educating in self-help and recovery oriented literature organizations, and related resources. Educating in rights of recipients. [ACT Program Guidelines, Sept 2007]

Self Help and Peer Support Education are peer-led, voluntary associations of recipients who meet regularly to provide support to each other. This service is based on the principle that people who share a common condition or experience can be of substantial assistance to each other. Recipients share coping strategies and skills, improve their self-esteem, and serve as role models for others within a meaningful, self-generated structure. [ACT Program Guidelines, Sept 2007]

Service Planning and Coordination – developing, in partnership with the recipient, a comprehensive, individualized and culturally sensitive, goal oriented service plan, including coordination with other format and informal providers, identifying primary psychiatric and co-occurring psychiatric disorders, symptoms, and related functional problems, identifying individual strengths, preferences, needs and goals, identifying risk factors regarding harm to self or others and monitoring response to treatment, rehabilitation and support services. [ACT Program Guidelines, Sept 2007]

Socialization means activities that are intended to diminish tendencies toward isolation and withdrawal by assisting recipients in the acquisition or development of social and interpersonal skills. “Socialization” is an activity meant to improve or maintain a recipient’s capacity for social involvement by providing opportunities for application of social skills. This occurs through the interaction of the recipient and the ACT team staff in the program and through exposure to opportunities in the community. Modalities used on socialization include individual and group counseling and behavior intervention. [ACT Program Guidelines, Sept 2007]

Symptom Management means activities which are intended to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of a recipient’s mental illness symptoms and response to treatment, interventions designed to help recipients manage their symptoms, and assisting recipients to develop coping strategies to deal with internal and external stressors. Services range from providing guidance in everyday life situations to addressing acute emotional distress through crisis management and behavior interventions technique. [ACT Program Guidelines, Sept 2007]

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Wellness Self Management is a set of services designed to improve community functioning and prevent relapse including:

- Psycho education (counseling and coaching on early warnings signs and avoidance of stressors) to minimize the incidence of relapse by enhancing medication adherence through behavioral tailoring, motivational interviewing, and skills training for recipient-doctor interactions.
- Skills training through multiple education and skills training sessions over time (between 3 month and 1 year), individual and group formats, and “in vivo” training to facilitate generalization of skills.
- Cognitive behavioral therapy for psychosis including education about stress-vulnerability.

[ACT Program Guidelines, Sept 2007]

Work Opportunities – helping the individual identify interests and skills, prepare for finding employment, job coaching and social skills training, develop and strengthen relationships with employers and other vocational support agencies and educating employers about serious mental illness. [ACT Program Guidelines, Sept 2007]

3.12 Injectable Drugs: Risperdal Consta, Invega Sustenna, or Zyprexa Relprevv

Risperdal Consta, Invega Sustenna or Zyprexa Relprevv is not a service but a drug. It is recorded on the service recording screen when the drug is dispensed from an OMH pharmacy. The selection should denote the dosage and will be used to bill the cost of the drug.

3.13 Medicare Description of Psychiatric Services

- Outpatient psychiatric services represent a continuum of care, which can complement the services rendered by a physician
- Active treatment provided to individuals with mental disorders
- All services, with the exception of certain diagnostic services covered under this benefit, must be rendered incident to a physician’s services and be reasonable and necessary for the diagnosis or treatment of the patient’s condition
- “Physician” is defined as a psychiatrist or other physician (MD/DO), trained in the treatment of psychiatric disorders
- Must be reasonable and necessary for the diagnosis or active treatment of the psychiatric condition
- Reasonable expectation of improvement

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- Treatment is designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization
- Improve/maintain the patient's level of functioning
- Decrease the patient's symptoms and impairments over a reasonable period of time
- Services must benefit the patient as measured by documentation of improvement
- Include a spectrum of intensity which varies from very infrequent visits up to several visits per week. Attempts at reducing the level of service should be made; the frequency of which will depend on the level of service rendered
- Medically Necessary Diagnostic Services must be ordered by Medicare authorized physicians.

4.1 Overview

MHARS is the official electronic medical record and the system used to record all recipient data. The billing systems still rely on DMHIS for much of its billing data. Each evening, data that was entered into MHARS during the day is extracted and sent to DMHIS. Data relevant to outpatient billing is: outpatient movements (admissions, discharges, ward transfers and screenings); diagnosis; attending physicians; and services. See [appendix 4.1](#) for a data flowchart.

NOTE: Clinic services entered after 10/1/2010 are no longer interfaced from MHARS to DMHIS

4.2 Interface Errors

The data that interfaces with DMHIS from MHARS is processed through the original DMHIS edits before being stored. All data that is successfully stored in DMHIS is listed on a daily update report in RMDS. Each facility has access to these reports and can print them out to see what data was loaded to DMHIS.

Reports located in RMDS

DC MHARS_DMHIS VALID RPT	movements
DC MHARS_VALSVCLIST – BTCH EDIT	services

Data that fails a DMHIS edit (does not interface) is rejected and listed on an error report in RMDS. It is the expectation that information related to the data is corrected and resent. The data must be fixed in MHARS and resubmitted in order for it to be stored in DMHIS. If the error is not fixed, there will be a discrepancy between the two systems. See [appendix 4.2](#) for admission/release interface errors and [appendix 4.3](#) for service recording interface errors.

Reports located in RMDS

DC MHARS_DMHIS ERROR RPT	movement errors
DC SVCERRLIST – BTCH EDIT	service errors

4.3 Admission Issues

The structure of MHARS and DMHIS are not completely compatible. The one main difference is that DMHIS cannot handle open episodes in multiple programs as easily as MHARS. Many times the interface program interprets the end result incorrectly. In these cases, services may get rejected because a movement was not stored correctly in DMHIS. In these instances the movements in DMHIS need to be manually fixed. A request to the CIT Help desk is necessary for programming staff to fix the problem.

There are admission requirements for recording services, plus minor differences between MHARS and DMHIS which are summarized below:

- A recipient must be admitted or pre-admitted (in screening status) to a licensed outpatient program to report services in that program.
- In MHARS, a recipient may be admitted to multiple outpatient programs at the same time whereas in DMHIS, a recipient may only be admitted to one outpatient program at a time. The exceptions to this are:
 - an IPRT recipient may be co enrolled in a clinic or a CDT
 - a CDT recipient may be co enrolled in a clinic for the purpose of receiving clozapine
- In both MHARS and DMHIS a recipient may be pre-admitted to multiple outpatient programs at the same
- A recipient admitted to a licensed outpatient program does not have to be admitted to a community support (CSP) to receive and report services from that unit.
- A recipient admitted to an ACT program should not be enrolled in any other program or receive services from any program except for unscheduled crisis visits.
- Preadmission status is not recognized in an ACT program
- A recipient must be admitted to a Clinic, CDT, partial hospitalization or ACT program in order to record and bill Risperdal Consta, Invega Sustenna or Zyprexa Relprevv.
- All recipients enrolled in PMHP should always be admitted to a clinic if receiving treatment services

4.4 Other Interface/Billing Data Requirements

Diagnosis

Diagnosis is also downloaded to DMHIS to be used by billing. The following are diagnosis requirements for billing:

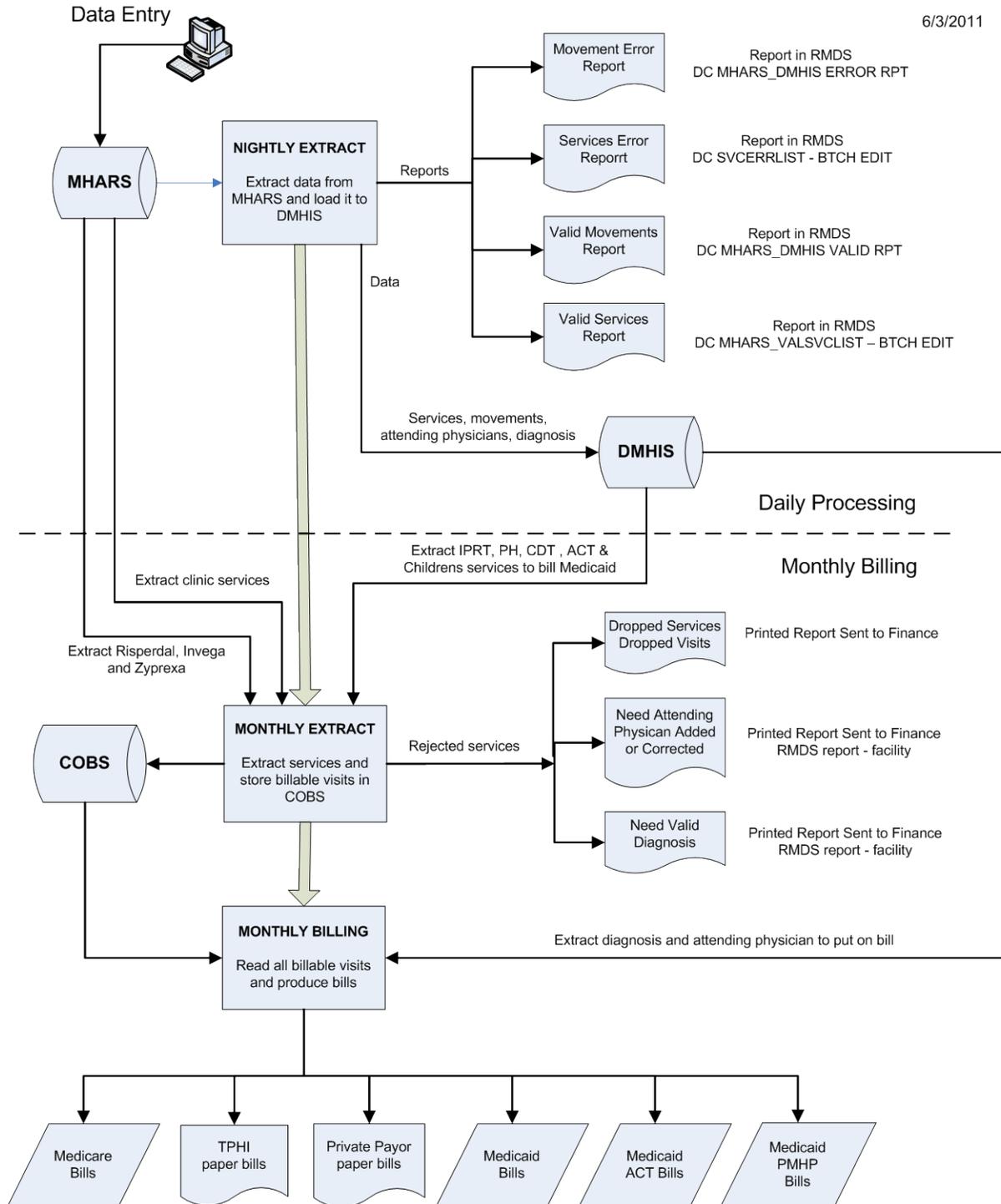
- A recipient must have a valid designated mental illness diagnosis to be admitted to an outpatient treatment program.
- A designated mental illness, as defined by outpatient regulations Parts 587/588 and 599, is a DSM-IV-R diagnosis other than alcohol or drug disorders, developmental disabilities, organic brain syndrome, diagnoses without predominant psychiatric features or social disorders (V codes). See [appendix 4.4](#) for valid diagnosis codes.
- V Code 61.20 is considered a designated mental illness diagnosis only in clinic treatment programs serving children.

Attending Physician

Admitted recipients must have a licensed attending physician in DMHIS active on the date of service. A designated attending physician is not needed for recipients in screening status..

Appendix 4.1

Migration of Data From Service Recording to Billing



Appendix 4.2
Admission / Release Interface Errors

AKA name contains an invalid character
Address of recipient contains an invalid character
Admit or screening at an outpatient program must have a diagnosis
Admit to certified outpatient program must have a designated mental illness diagnosis
Cannot change SSN to all zeroes or all 9s
Recipient not admitted to this unit on this date.
Effective date cannot be a future date
IP admission 725 detail has already been added
Inpatient release 116 already added to DMHIS
Invalid Case Number
Invalid Facility Number
Invalid admit/nonadmit flag
Invalid code for admit to family care or convalescent care
Invalid phone number
Invalid phone number of responsible party
Invalid provider 4 type
Invalid release/termination date
Invalid release/termination disposition
Invalid release/termination inpatient ward
Invalid release/termination outpatient unit
Invalid release/termination unit
Invalid soURCe of referral
MHARS name does not match DMHIS name
MHARS name is an AKA in DMHIS
New last name or first name all spaces
New name is already an AKA in DMHIS
New SSN not numeric
No open screenings exist at this unit on this date
Not a valid type of AKA in DMHIS
Notice of Dismissal of Indictment can only follow Jackson or observation
Old SSN not numeric
Outpatient admission is not allowed during a closed screening
Outpatient release already added
Too many diagnosis records to be stored on this date. Must be resequenced in DMHIS
Unit not open on this date
accepted date before interview date
admission rejected, diagnosis stored
admit date prior to recipients date of birth
admit or screening to outpatient program must have a diagnosis
both last name and first name are missing
both old NPI and new NPI do not match current NPI in dmhis
case connected to different state id. Contact Central Files
case number assigned to someone else
case number cannot be assessed because of last name, first name or both are blank
case number not in DMHIS

case number not in DMHIS, check number entered
case number not valid
recipient has expired, no movement accepted
recipient is dead, check all-names history
recipient less than 4 years old
recipient over 110 years old on transaction date
recipient under 3 years old, too young to admit
county of residence missing
date of birth missing
deletion of outpatient admission or screening must be referred to help desk
deletion of release must be referred to help desk
disposition type not allowed for inpatients
disposition type not allowed for outpatients
disposition unit error
DMHIS SSN does not match new or old number
fifth other psychiatric diagnosis not accepted as psychiatric by OMH
first name does not start with A to Z
first other psychiatric diagnosis not accepted as psychiatric by OMH
first physical/medical diagnosis in physical range
flow break with previous movement
fourth other psychiatric diagnosis not accepted as psychiatric by OMH
fourth physical/medical diagnosis in physical range
inpatient ward for this movement on this date does not match
inpatient ward for this movement on this date does not match
invalid MHARS record type, contact Help desk
invalid admit date
invalid admit unit
invalid current GAF code
invalid date of birth
invalid diagnosis date
invalid facility in disposition
invalid facility number
invalid fifth other psychiatric diagnosis
invalid first name
invalid first other psychiatric diagnosis
invalid first physical/medical diagnosis
invalid fourth other psychiatric diagnosis
invalid fourth physical/medical diagnosis
invalid gender
invalid inpatient, outpatient or residential indicator, contact Help desk
invalid last name
invalid middle initial
invalid principal diagnosis
invalid release/termination transfer facility number
invalid screening date
invalid screening unit
invalid second other psychiatric diagnosis
invalid second physical/medical diagnosis

invalid social security number
invalid third other psychiatric diagnosis
invalid third physical/medical diagnosis
invalid ward
ITT internal transfer error
last name does not start with A to Z
license not found for employee
MHARS old state id does not match DMHIS state id. Contact Central Files
middle initial not A to Z
more recent movement exists
movement before recipient's date of birth
movement not allowed while an inpatient in DMHIS
must mark no further service type, refer or accept
name for employee does not match name on license
no census movement for date entered or movement not appropriate for purpose
no corresponding IP movement entered into DMHIS
no corresponding inpatient movement entered in DMHIS
old name not in DMHIS
op admission already added
open screening exists at this unit
recipient already admitted, just stored diagnosis, verify census in DMHIS
physician does not have a valid time period for the license
physician license is not active for period selected
physician license number not on file
physician name does not match what is on file for that license
principal diagnosis not accepted as psychiatric by OMH
purpose code not appropriate for date in DMHIS
release not allowed for date and unit
screening not allowed during inpatient in DMHIS
second other psychiatric diagnosis not accepted as psychiatric by OMH
second physical/medical diagnosis in physical range
social security number assigned to someone else, check spelling and number
spelling of the DMHIS name is different
state id added to case record
state id already assigned
third other psychiatric diagnosis not accepted as psychiatric by OMH
third physical/medical diagnosis in physical range
this recipient has another case number which is active
too many errors have been found for this report
unit not open on this date
ward flow error

Appendix 4.3
Service / Recording Interface Errors

Case Number Not Registered
Recipient Released Prior to Service Date
Closed Unit
Duplicate Service
Incorrect Unit Code
Invalid Program / Service Combination
Invalid Program/Unit Combination
Invalid Service/Program For Part 587 Outpatient
Invalid Service/Unit Combination
Name Difference
No Staff Identified
Not Valid Group Service
Not Valid Program
Not Valid Service
Not a Recipient at This Program on Service Date
Not a Valid Date
Not at Any Part 585 Program on Service Date
Outpatient Service Rendered On Inpatient Ward
PMHP Enrollee at Children's Unit
Processed as Dup, But Orig. Record Not Found
Service Time Error
Staff Item No 1 Not Registered
Staff Item No 10 Not Registered
Staff Item No 2 Not Registered
Staff Item No 3 Not Registered
Staff Item No 4 Not Registered
Staff Item No 5 Not Registered
Staff Item No 6 Not Registered
Staff Item No 7 Not Registered
Staff Item No 8 Not Registered
Staff Item No 9 Not Registered
Staff Time 1 Error
Staff Time 10 Error
Staff Time 2 Error
Staff Time 3 Error
Staff Time 4 Error
Staff Time 5 Error
Staff Time 6 Error
Staff Time 7 Error
Staff Time 8 Error
Staff Time 9 Error
Staff Time GT Service Time
Staff time error
Time error
Total Staff Time LT Service Time
not valid program

Appendix 4.4 Valid Designated Mental Illness Diagnosis

ICD-9-CM Code	DSM-IV Code	DSM-IV Diagnostic Literal
290.12	290.12	Dementia of the Alzheimer's type, early onset, with delusions
290.13	290.13	Dementia of the Alzheimer's type, early onset, with depressed mood
290.20	290.20	Dementia of the Alzheimer's type, late onset, with delusions
290.21	290.21	Dementia of the Alzheimer's type, late onset, with depressed mood
290.42	290.42	Vascular dementia, with delusions
290.43	290.43	Vascular dementia, with depressed mood
293.81	293.81	Psychotic disorder with delusions, due to <i>general medical condition</i>
293.82	293.82	Psychotic disorder with hallucinations, due to <i>general medical condition</i>
293.83	293.83	Mood disorder due to <i>general medical condition</i>
293.89	293.89	Anxiety/Catatonic Disorder due to <i>general medical condition</i>
295.10	295.10	Schizophrenia, disorganized type
295.20	295.20	Schizophrenia, catatonic type
295.30	295.30	Schizophrenia, paranoid type
295.40	295.40	Schizophreniform disorder
295.50	295.50	Schizophrenia, residual type
295.70	295.70	Schizoaffective disorder
295.90	295.90	Schizophrenia, undifferentiated type
296.00	296.00	Bipolar I disorder, single manic episode, unspecified
296.01	296.01	Bipolar I disorder, single manic episode, mild
296.02	296.02	Bipolar I disorder, single manic episode, moderate
296.03	296.03	Bipolar I disorder, single manic episode, severe, without psychotic features
296.04	296.04	Bipolar I disorder, single manic episode, severe, with psychotic features
296.05	296.05	Bipolar I disorder, single manic episode, in partial remission
296.06	296.06	Bipolar I disorder, single manic episode, in full remission
296.20	296.20	Major depressive disorder, single episode, unspecified
296.21	296.21	Major depressive disorder, single episode, mild
296.22	296.22	Major depressive disorder, single episode, moderate
296.23	296.23	Major depressive disorder, single episode, severe, without psychotic features
296.24	296.24	Major depressive disorder, single episode, severe, with psychotic features
296.25	296.25	Major depressive disorder, single episode, in partial remission
296.26	296.25	Major depressive disorder, single episode, in full remission
296.30	296.30	Major depressive disorder, recurrent, unspecified
296.31	296.31	Major depressive disorder, recurrent, mild
296.32	296.32	Major depressive disorder, recurrent, moderate
296.33	296.33	Major depressive disorder, recurrent, severe, without psychotic features
296.34	296.34	Major depressive disorder, recurrent, severe, with psychotic features
296.35	296.35	Major depressive disorder, recurrent, in partial remission
296.36	296.36	Major depressive disorder, recurrent, in full remission
296.40	296.40	Bipolar I disorder, most recent episode manic, unspecified
296.41	296.41	Bipolar I disorder, most recent episode manic, mild
296.42	296.42	Bipolar I disorder, most recent episode manic, moderate
296.43	296.43	Bipolar I disorder, most recent episode manic, severe, without psychotic features
296.44	296.44	Bipolar I disorder, most recent episode manic, severe, with psychotic features
296.45	296.45	Bipolar I disorder, most recent episode manic, in partial remission
296.46	296.46	Bipolar I disorder, most recent episode manic, in full remission
296.50	296.50	Bipolar I disorder, most recent episode depressed, unspecified
296.51	296.51	Bipolar I disorder, most recent episode depressed, mild
296.52	296.52	Bipolar I disorder, most recent episode depressed, moderate
296.53	296.53	Bipolar I disorder, most recent episode depressed, severe, without psychotic features
296.54	296.54	Bipolar I disorder, most recent episode depressed, severe, with psychotic features
296.55	296.55	Bipolar I disorder, most recent episode depressed, in partial remission
296.56	296.56	Bipolar I disorder, most recent episode depressed, in full remission
296.50	296.50	Bipolar I disorder, most recent episode mixed, unspecified
296.61	296.61	Bipolar I disorder, most recent episode mixed, mild
296.62	296.62	Bipolar I disorder, most recent episode mixed, moderate
296.63	296.63	Bipolar I disorder, most recent episode mixed, severe, without psychotic features
296.64	296.64	Bipolar I disorder, most recent episode mixed, severe, with psychotic features
296.65	296.65	Bipolar I disorder, most recent episode mixed, in partial remission
296.66	296.66	Bipolar I disorder, most recent episode mixed, in full remission
296.7	296.7	Bipolar I disorder, most recent episode unspecified
296.80	296.80	Bipolar disorder NOS
296.89	296.89	Bipolar II disorder
296.90	296.90	Mood disorder NOS
297.1	297.1	Delusional disorder
297.3	297.3	Shared psychotic disorder
298.8	298.8	Brief psychotic disorder
298.9	298.9	Psychotic disorder NOS

ICD 9CM Code	DSM-IV Code	DSM-IV Diagnostic Literal
300.00	300.00	Anxiety disorder NOS
300.01	300.01	Panic disorder without agoraphobia
300.02	300.02	Generalized anxiety disorder
300.11	300.11	Conversion disorder
300.12	300.12	Dissociative amnesia
300.13	300.13	Dissociative fugue
300.14	300.14	Dissociative identity disorder
300.15	300.15	Dissociative disorder NOS
300.16	300.16	Factitious disorder with predominantly psychological signs/symptoms
300.19	300.19	Factitious disorder NOS
300.19	300.19	Factitious disorder with predominantly physical signs/symptoms
300.19	300.19	Factitious disorder with combined psychological signs/symptoms
300.21	300.21	Panic disorder with agoraphobia
300.22	300.22	Agoraphobia without history of panic disorder
300.23	300.23	Social phobia
300.29	300.29	Specific phobia
300.3	300.3	Obsessive compulsive disorder
300.4	300.4	Dysthymic disorder
300.6	300.6	Depersonalization disorder
300.7	300.7	Body dysmorphic disorder or Hypochondriasis
300.81	300.81	Somatization disorder
300.9	300.9	Unspecified mental disorder (nonpsychotic)
301.0	301.0	Paranoid personality disorder
301.13	301.13	Cyclothymic disorder
301.20	301.20	Schizoid personality disorder
301.22	301.22	Schizotypal personality disorder
301.4	301.4	Obsessive-compulsive personality disorder
301.50	301.50	Histrionic personality disorder
301.6	301.6	Dependent personality disorder
301.7	301.7	Antisocial personality disorder
301.81	301.81	Narcissistic personality disorder
301.82	301.82	Avoidant personality disorder
301.83	301.83	Borderline personality disorder
301.9	301.9	Personality disorder NOS
302.2	302.2	Pedophilia
302.3	302.3	Transvestic fetishism
302.4	302.4	Exhibitionism
302.6	302.6	Gender identity disorder in children or NOS
302.70	302.70	Sexual dysfunction NOS
302.71	302.71	Hypoactive sexual desire disorder
302.72	302.72	Female sexual arousal or male erectile disorder
302.73	302.73	Female orgasmic disorder
302.74	302.74	Male orgasmic disorder
302.75	302.75	Premature ejaculation
302.76	302.76	Dyspareunia
302.79	302.79	Sexual aversion disorder
302.81	302.81	Fetishism
302.82	302.82	Voyeurism
302.83	302.83	Sexual masochism
302.84	302.84	Sexual sadism
302.85	302.85	Gender identity disorder of adolescents or adults
302.89	302.89	Frotteurism
302.9	302.9	Sexual disorder NOS/Paraphilia NOS
306.51	306.51	Vaginismus
307.0	307.0	Stuttering
307.1	307.1	Anorexia nervosa
307.20	307.20	Tic disorder NOS
307.21	307.21	Transient tic disorder
307.22	307.22	Chronic motor or vocal tic disorder
307.23	307.23	Tourette's disorder
307.3	307.3	Stereotypic movement disorder
307.42	307.42	Insomnia related to another mental disorder (nonorganic) or primary insomnia
307.44	307.44	Hypersomnia related to another mental disorder (nonorganic) or primary hypersomnia
307.45	307.45	Circadian rhythm sleep disorder
307.46	307.46	Sleep terror disorder/Sleepwalking disorder
307.47	307.47	Nightmare disorder/Dyssomnia NOS/Parasomnia NOS
307.50	307.50	Eating disorder NOS
307.51	307.51	Bulimia nervosa
307.52	307.52	Pica
307.53	307.53	Rumination disorder
307.59	307.59	Feeding disorder of infancy/childhood
307.6	307.6	Enuresis not due to <i>general medical condition</i>
307.7	307.7	Encopresis, no constipation, no overflow incontinence
307.80	307.80	Pain disorder with psychological factors
307.89	307.89	Pain disorder with psychological factors and <i>general medical condition</i>
307.9	307.9	Communication disorder NOS

ICD 9CM Code	DSM-IV Code	DSM-IV Diagnostic Literal
308.3	308.3	Acute stress disorder
309.0	309.0	Adjustment disorder with depressed mood
309.21	309.21	Separation anxiety disorder
309.24	309.24	Adjustment disorder with anxiety
309.28	309.28	Adjustment disorder with mixed anxiety and depressed mood
309.3	309.3	Adjustment disorder with disturbance of conduct
309.4	309.4	Adjustment disorder with mixed disturbance of emotions and conduct
309.81	309.81	Posttraumatic stress disorder
309.9	309.9	Adjustment disorder NOS
310.1	310.1	Personality change due to <i>general medical condition</i>
311	311	Depressive disorder NOS
312.30	312.30	Impulse control disorder NOS
312.31	312.31	Pathological gambling
312.32	312.32	Kleptomania
312.33	312.33	Pyromania
312.34	312.34	Intermittent explosive disorder
312.39	312.39	Trichotillomania
312.81	312.81	Conduct disorder, childhood onset
312.82	312.82	Conduct disorder, adolescent onset
312.89	312.89	Other, specified disturbance of conduct
312.9	312.9	Disruptive behavior disorder NOS
313.23	313.23	Selective mutism
313.81	313.81	Oppositional defiant disorder
313.82	313.82	Identity problem
313.89	313.89	Reactive attachment disorder of infancy or early childhood
313.9	313.9	Disorder of infancy, childhood or adolescence NOS
314.00	314.00	Attention-deficit disorder/hyperactivity disorder, predominantly inattentive type
314.01	314.01	Attention-deficit/hyperactivity disorder, combined type
314.9	314.9	Attention-deficit/hyperactivity disorder, NOS
316	316	Psychological factors affecting <i>general medical condition</i>
780.54	780.54	Sleep disorder due to <i>general medical condition</i>
V61.20	V61.20	Parent-child relational problem

DSM-IV Alphabetical Listing
of

OFFICE OF MENTAL HEALTH

Designated Mental Illness Diagnostic Codes NYCRR, Title 14, Part 587/588

DSM-IV Code	Diagnosis	ICD-9-CM Code	DSM-IV Code	Diagnosis	ICD-9-CM Code
	Adjustment disorder		D		
309.24	with anxiety.....	309.24	297.1	Delusional disorder.....	297.1
309.3	with conduct disturbance.....	309.3		Dementia, Alzheimers type	
309.0	with depressed mood.....	309.0	290.13	early onset, depressed.....	290.13
309.28	with mixed anxiety and depressed mood.....	309.28	290.12	early onset, delusions.....	290.12
309.4	with mixed disturbance of emotions and conduct.....	309.4	290.20	late onset, delusions.....	290.20
309.9	NOS.....	309.9	290.21	late onset, depressed.....	290.21
300.22	Agoraphobia without history of panic disorder.....	300.22		Dementia, vascular	
300.12	Amnesia, dissociative.....	300.12	290.42	Delusions.....	290.42
307.1	Anorexia nervosa.....	307.1	290.43	Depressed.....	290.43
	Anxiety disorder		300.6	Depersonalization disorder.....	300.6
293.89	due to <i>general medical condition</i>	293.89	311	Depressive disorder, NOS.....	311
300.00	NOS.....	300.00	312.9	Disruptive behavior disorder NOS.....	312.9
300.02	generalized.....	300.02	300.15	Dissociative disorder NOS.....	300.15
309.21	separation.....	309.21	302.76	Dyspareunia.....	302.76
313.89	Attachment disorder, reactive, infancy/childhood.....	313.89	307.47	Dyssomnia, NOS.....	307.47
	Attention-deficit/hyperactivity disorder		300.4	Dysthymic disorder.....	300.4
314.00	inattentive type.....	314.00			
314.01	impulse or combined type.....	314.01	E		
314.9	NOS.....	314.9	307.50	Eating Disorder NOS.....	307.50
296.80	Bipolar disorder NOS.....	296.80	302.75	Ejaculation, premature.....	302.75
296.7	Bipolar disorder, most recent episode unspecified.....	296.7	307.7	Encopresis, no constipation, no overflow incontinence.....	307.7
	Bipolar I disorder, most recent episode depressed,		307.6	Enuresis, <i>not due to general medical condition</i>	307.6
296.56	in full remission.....	296.56	302.72	Erectile disorder, male.....	302.72
296.55	in partial remission.....	296.55	302.4	Exhibitionism.....	302.4
296.51	mild.....	296.51			
296.52	moderate.....	296.52	F		
296.53	severe without psychotic features.....	296.53		Factitious disorder	
296.54	severe with psychotic features.....	296.54	300.16	predominantly psychological signs and symptoms.....	300.16
296.50	unspecified.....	296.50	300.19	predominantly physical signs and symptoms.....	300.19
	Bipolar I disorder, most recent episode manic,		300.19	both physical and psychological symptoms.....	300.19
296.46	in full remission.....	296.46	307.59	Feeding disorder, infancy/childhood.....	307.59
296.45	in partial remission.....	296.45	302.81	Fetishism.....	302.81
296.41	mild.....	296.41	302.3	Fetishism, transvestic.....	302.3
296.42	moderate.....	296.42	302.89	Frotteurism.....	302.89
296.43	severe without psychotic features.....	296.43	300.13	Fugue, dissociative.....	300.13
296.44	severe with psychotic features.....	296.44			
296.40	unspecified.....	296.40	H		
	Bipolar I disorder, most recent episode mixed,		307.44	Hypersomnia.....	307.44
296.66	in full remission.....	296.66	780.54	Hypersomnia due to <i>general medical condition</i>	780.54
296.65	in partial remission.....	296.65	300.7	Hypochondriasis.....	300.7
296.61	mild.....	296.61			
296.62	moderate.....	296.62	I		
296.63	severe without psychotic features.....	296.63		Identity disorder	
296.64	severe with psychotic features.....	296.64	313.82	or problem.....	313.82
296.60	unspecified.....	296.60	300.14	dissociative.....	300.14
	Bipolar I disorder, single manic episode		302.5	gender, childhood, NOS.....	302.5
296.06	in full remission.....	296.06	302.85	gender, adolescent/adult.....	302.85
296.05	in partial remission.....	296.05	313.9	Infancy/childhood disorder.....	313.9
296.01	mild.....	296.01	312.30	Impulse control disorder NOS.....	312.30
296.02	moderate.....	296.02	307.42	Insomnia.....	307.42
296.03	severe without psychotic features.....	296.03	312.34	Intermittent explosive disorder.....	312.34
296.04	severe with psychotic features.....	296.04			
296.00	unspecified.....	296.00	K		
296.89	Bipolar II disorder.....	296.89	312.32	Kleptomania.....	312.32
300.7	Body dysmorphic disorder.....	300.7			
307.51	Bulimia nervosa.....	307.51	M		
293.89	Catatonic disorder due to <i>general medical condition</i>	293.89		Major depressive disorder, recurrent	
307.9	Communication disorder NOS.....	307.9	296.36	in full remission.....	296.36
	Conduct disorder		296.35	in partial remission.....	296.35
312.81	childhood onset.....	312.81	296.31	mild.....	296.31
312.82	adolescent onset.....	312.82	296.32	moderate.....	296.32
312.89	other/specified.....	312.89	296.33	severe without psychotic features.....	296.33
300.11	Conversion disorder.....	300.11	296.34	severe with psychotic features.....	296.34
301.13	Cyclothymic disorder.....	301.13	296.30	unspecified.....	296.30

DSM-IV Alphabetical Listing of Designated Mental Illness Diagnostic Codes NYCRR, Title 14, Part 587/588

DSM-IV Code	Diagnosis	ICD-9-CM Code	DSM-IV Code	Diagnosis	ICD-9-CM Code
	Major depressive disorder, single episode		P contd.		
296.26	in full remission.....	296.26	307.52	Pica.....	307.52
296.25	in partial remission.....	296.25	316	Psychological factor, affecting medical condition.....	316
296.21	mild.....	296.21		Psychotic disorder	
296.22	moderate.....	296.22	298.8	brief.....	298.8
296.23	severe without psychotic features.....	296.23	298.9	NOS.....	298.9
296.24	severe with psychotic features.....	296.24	297.3	shared.....	297.3
296.20	unspecified.....	296.20	293.81	with delusions, due to <i>general medical condition</i>	293.81
			293.82	with hallucinations, due to <i>general medical condition</i>	293.82
300.9	Mertal disorder, nonpsychotic, unspecified.....	300.9	312.33	Pyromania.....	312.33
293.83	Mood disorder due to <i>general medical condition</i>	293.83			
296.90	Mood disorder, NOS.....	296.90	R		
307.3	Movement disorder, stereotypic.....	307.3	V61.20	Relational problem, parent-child.....	V61.20
313.23	Mutism, selective.....	313.23	307.53	Rumination disorder.....	307.53
N			S		
307.47	Nightmare disorder.....	307.47	295.70	Schizoaffective disorder.....	295.70
				Schizophrenia	
O			295.20	catatonic.....	295.20
300.3	Obsessive compulsive disorder.....	300.3	295.10	disorganized type.....	295.10
313.81	Oppositional defiant disorder.....	313.81	295.30	paranoid.....	295.30
302.73	Orgasmic disorder, female.....	302.73	295.60	residual.....	295.60
302.74	Orgasmic disorder, male.....	302.74	295.90	undifferentiated type.....	295.90
P			295.40	Schizophreniform disorder.....	295.40
307.80	Pain disorder with psychological factors.....	307.80	302.72	Sexual arousal disorder, female/male.....	302.72
307.89	Pain disorder with psychological factors and a <i>general medical condition</i>	307.89	302.79	Sexual aversion disorder.....	302.79
300.01	Panic disorder without agoraphobia.....	300.01	302.71	Sexual desire, hypoactive.....	302.71
300.21	Panic disorder with agoraphobia.....	300.21	302.9	Sexual disorder, NOS.....	302.9
302.9	Paraphilia, NOS.....	302.9	302.70	Sexual dysfunction, NOS.....	302.70
307.47	Parasomnia, NOS.....	307.47	302.84	Sexual sadism.....	302.84
312.31	Pathological gambling.....	312.31	302.83	Sexual masochism.....	302.83
302.2	Pedophilia.....	302.2	307.46	Sleepwalk/sleepterror disorder.....	307.46
310.1	Personality change due to <i>general medical condition</i>	310.1	307.45	Sleep disorder, circadian rhythm/sleep-wake schedule.....	307.45
	Personality disorder		300.81	Somatization/somatoform disorder.....	300.81
301.7	antisocial.....	301.7	308.3	Stress disorder, acute.....	308.3
301.82	avoidant.....	301.82	309.81	Stress disorder, posttraumatic.....	309.81
301.83	borderline.....	301.83	3070	Stuttering.....	3070
301.6	dependent.....	301.6			
301.50	histrionic.....	301.50	T		
301.81	narcissistic.....	301.81	307.20	Tic disorder, NOS.....	307.20
301.9	NOS.....	301.9	307.22	Tic disorder, chronic motor/vocal.....	307.22
301.4	obsessive compulsive.....	301.4	307.21	Tic disorder, transient.....	307.21
301.0	paranoid.....	301.0	307.23	Tourette's disorder.....	307.23
301.20	schizoid.....	301.20	312.39	Trichotillomania.....	312.39
301.22	schizotypal.....	301.22			
300.23	Phobia, social.....	300.23	V		
300.29	Phobia, simple/specified.....	300.29	306.51	Vaginismus.....	306.51
			302.82	Voyeurism.....	302.82

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5.1 Background

This section describes the current OMH requirements for outpatient record keeping time frames. The areas addressed are needs assessment, comprehensive assessment, treatment/service plan (ISP) development and review, progress notes, utilization review and discharge planning. The requirements vary according to program type and if the recipient is enrolled in Medicaid "Fee for Service", Medicare or PMHP (Medicaid Managed Care).

5.2 Clinic

- **Treatment/Service Plan Development and Review**

Medicaid: shall be reviewed and updated as necessary based upon the recipient's progress, changes in circumstances, the effectiveness of services, or other appropriate considerations. Such reviews shall be completed not later than 30 days after admission, and then shall occur no less frequently than every 90 days, or the next scheduled service, whichever shall be later.

Medicare: Within 30 days of admission and then reviewed every 6 months or more frequently whenever a significant change in the recipient's condition or treatment occurs.

PMHP and Others Whose Mental Health Care Is Covered by a Managed Care Plan: Within 30 days of admission and then reviewed every 12 months or more frequently whenever a significant change in the recipient's condition or treatment occurs.

Note: An existing treatment plan for a licensed program may be transferred to treatment under the PMHP, and vice versa. The treatment/service plan does not have to be redone upon enrollment in the PMHP or upon disenrollment, although changes should be made if necessary.

- **Progress Notes**

For services provided face to face, a note is required to document each contact. For other type services, a note is required at least once per month and more often when of significance; group notes are permitted as per provider-specified format.

A progress note needs to document:

- date and duration of service
- participants
- goals and objectives that were addressed
- progress since last appointment
- interventions that were discussed or provided
- need for complex care
- management, if applicable

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- **Utilization Review**

- **Medicaid:**

- Performed, at a minimum, on a random 25 percent sample of recipients

- Within 30 days after admission, then within 7 months after admission and every 6 months thereafter.

- If discharged and readmitted, the review cycle begins again.

- If medication therapy and medication education services only, continued treatment review every 12 months, within 30 days of admission.

- PMHP and Others Whose Mental Health Care Is Covered by a Managed Care Plan:** No utilization review is required.

5.3 Continuing Day Treatment (CDT)

- **Treatment/Service Plan Development and Review**

- Developed prior to the twelfth visit after admission or within 30 days of admission, whichever occurs first, then every 3 months

- **Progress Notes**

- Note required at least every 2 weeks.

- **Utilization Review**

- By the twelfth visit or within 30 days after admission, then within 7 months and every 6 months thereafter.

5.4 Childrens Day Treatment

- **Treatment/Service Plan Development and Review**

- Developed within 30 days of admission, then every 3 months

- **Progress Notes**

- Note required at least every week.

- **Utilization Review**

- Within 30 days after admission, then within 7 months after admission and every 6 months thereafter.

- If discharged and readmitted, review cycle begins again

- If medication therapy and medication education services only, continued treatment review every 12 months, within 30 days of admission

- Continued stay reviews to be completed annually thereafter.

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5.5 Partial Hospitalization (PH)

- **Treatment/Service Plan Development And Review**
Developed prior to the fourth visit and reviewed every 2 weeks
- **Progress Notes**
A note is required to document each direct or indirect contact.
- **Utilization Review**
By the fourth visit after admission and every two weeks thereafter.

5.6 Intensive Psychiatric Rehabilitation Treatment (IPRT)

- **Treatment/Service Plan Development And Review**
Developed within five visits after admission and reviewed every month.
- **Utilization Review**
Within 30 days after admission, then within 4 months after admission and every 3 months thereafter.

If discharged and readmitted, review cycle begins again

If medication therapy and medication education services only, continued treatment review every 12 months, within 30 days of admission

Continued stay reviews to be completed annually thereafter.

5.7 Assertive Community Treatment Programs (ACT)

- **Needs Assessment**
Within 7 days of the receipt of a referral
- **Comprehensive Assessment**
Within 30 days of admission and updated every 6 months or as needed.
- **Treatment/Service Plan Development and Review**
Developed within 30 days of admission and reviewed every 6 months or whenever a significant change in the recipient's condition or treatment occurs.
- **Progress Notes**
Note required for all service contacts and attempted contacts. The psychiatrist and/or PNP documents information at least monthly.
- **Utilization Review**
A systematic plan must be in place to monitor, analyze and improve the performance of the ACT team in assisting recipients to achieve their treatment outcomes

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- **Discharge Planning**

Documentation must be present that identifies the on-going efforts to engage the recipient in planning and progress toward recovery and goal attainment.

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6.1 Background

The Comprehensive Outpatient Billing System (COBS) was originally designed to aggregate daily services into patient, collateral and crisis visits. These could be billed on a fee for service basis depending on the payer. In fee-for-service billing, reimbursement is directly related to the type of service provided, the total duration of the services for the day, and the program type where the service was provided.

With the introduction of the PMHP program/reimbursement model, another category of billing Medicaid for outpatient services - a capitated method was developed. The capitated reimbursement method for outpatient services is not linked directly to the provision of services. A monthly rate is paid once the recipient is officially enrolled in PMHP.

With the introduction of ACT in 2003, we now have another method of billing Medicaid. ACT is billed on a monthly case basis rather than the fee-for-service billing or capitated method. ACT recipients must meet specific service utilization levels before a bill is produced. A minimum of six face-to-face contacts per month are required in order to bill at the full intensive level. Three of the six contacts may be collateral contacts, the rest must be with the recipient. The reported duration of each contact must be at least 15 minutes to count toward the monthly minimum number needed for billing.

In January 2006, Risperdal Consta became a Medicare and Medicaid reimbursable drug in State Operated Clinics, ACT and CDT programs. As of January 2011, two other injectable drugs, Invega Sustenna and Zyprexa Relprevv, were added, plus they could also be administered in a partial hospitalization program. OMH can bill Medicaid for both the cost and the administration of the drug. Medicare can be billed for the cost, injection and administration of the drug.

In 2009 we added procedure billing which allows individual services to get billed rather than aggregating daily services into visits. This was added to accommodate the Medicare coding guidelines. Procedure billing is used for billing clinic services to Medicare, as well as third party and full private party payers. Fee for service billing continued to be used to bill Medicaid and all payers for programs other than clinics.

October 1st 2010, Medicaid billing for clinics was also changed to bill procedures rather than visits. Visits are not longer billed to any payer for clinics services.

For all OMH outpatients, billing and reimbursement are dependent on accurate and timely recording of services in MHARS.

6.2 PMHP Billing

Since PMHP is a capitated model, billing is not directly related to service recording as it is under fee-for-service or procedural billing. Monthly reimbursement is based on a recipient's enrollment. However, service recording is still essential to the PMHP encounter data system. Uses of data include monitoring service utilization, evaluating

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access and continuity of service, and costing/staffing assignments. The service utilization and encounter data is available for review on an aggregate level by external review bodies, including DOH and Counties, as well as for review internally within OMH for planning and evaluation as well as monitoring staff work productivity.

6.3 Fee for Service Billing

Services which have been entered into MHARS for licensed programs other than **clinic** are uploaded to DMHIS on a regular basis. These services pass thru the DMHIS service edits before getting stored in DMHIS. The services then must pass a series of billing system edits to determine which services will eventually be billed. Some services are dropped and not passed to billing while other services are recycled until additional action is taken. See [appendix 2.1](#) for a list of valid services allowed by program type.

Services Which Are Dropped and Not Passed to Billing

- Services provided to recipients who are not admitted or pre-admitted to the program which recorded the service.
- Services provided to inpatients.
Outpatient services can be provided to OMH inpatients and these services can be entered into MHARS but outpatient billing is not permitted for recipients in inpatient status.
- Indirect services are not billable thus are not passed
- “No Show” services
- Rehabilitation, support and self help services reported in clinics are not passed thru for billing. They are available for those patients enrolled in PMHP

Services Which Are Recycled

- Services for recipients that do not have a designated mental illness diagnosis in DMHIS. All diagnoses entered in MHARS are migrated to DMHIS. A designated mental illness diagnosis must be in DMHIS either as the principal or other psychiatric diagnosis and must be effective for the current episode of treatment for the recipient.
- Services for recipients without an attending physician in DMHIS. The attending physician must be entered in MHARS and attached to the service dates. This data is migrated to DMHIS (Attending physician is not required for children’s day treatment programs.)
- Services provided to recipients with no billing account (established by the Patient Resource Office) in effect at the time the service was provided.

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Recycled services remain in the system for two years and appear on reports awaiting action by facility staff or Patient Resource staff. If no action is taken within the two year period, the services are dropped.

Aggregating Services to Visits

All services which were not dropped or recycled are aggregated into visits by recipient and date based on:

- Program – all units of a licensed program.
- Participant – patient, collateral, group patient, group collateral or patient crisis.
- Patient Status – admitted or pre-admitted.
- Place of Service – onsite, offsite, home

Eliminating Visits from Billing

There are several reasons why potentially billable visits are not billed.

- **Minimum Duration Not Met**
Visits must meet minimum durations based on program type and visit category to be billable. [Appendix 6.6](#) shows the visit durations required for billing.
- **More Than Three Preadmission Visits**
Only three preadmission visits per licensed program are billable and these visits must occur within the month the first visit is provided and the next full calendar month. Regular, group, collateral, group collateral and crisis visits count towards this preadmission visit limit.
- **Visits in More Than One Program on The Same Day**
If a recipient is admitted or pre-admitted to more than one program and the same type of visit is provided by both programs on the same day (an example is when a patient visit was provided in both an IPRT and a CDT), the highest cost visit is billed.
- **Clinic Utilization Reached**
For those recipients co enrolled in a clinic and a CDT, a clinic and an IPRT or a CDT and an IPRT, only five visits per month to the clinic, to the CDT or to the IPRT are permitted to be billed. Those visits which exceed the five visit limit per month are not billed.
- **Partial Hospitalization Limits**
Outpatient regulations limit billing in Partial Hospitalization programs to 180 hours of service per six week course of treatment and 360 hours of service per year.

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- Intensive Psychiatric Rehabilitation Treatment (IPRT) Limits
Outpatient regulations limit billing in IPRT programs to 72 hours per month and 720 hours per year.

6.4 ACT Billing

The ACT program and billing system were implemented in 2003. Monthly bills are produced and rely on who received the service (patient or collateral) and number of services rather than the type of services. All services must be greater than fifteen minutes in length to qualify for billing.

Bill Production

Medicaid is the only payer that is billed for recipients in ACT programs.

There are two types of monthly bills produced under the ACT billing system:

- The first bill represents the core services. Both client and collateral visits can count as core services. The maximum core services possible in any given day cannot be greater than two, one client and one collateral. There are two types of monthly core service bills:
 - A full bill is a bill with six or more core services. This full bill must include at least three client visits.
 - A partial bill has at least two but no more than five core services within a month.
- The second type of bill represents number of services provided in the month. This bill documents the total number of services for the month, client or collateral. Each service has a value of \$1 and the total amount of the bill cannot exceed \$24.

A retroactive addition or subtraction of a service may cause an adjusted bill to get submitted if it changes the threshold number of core services or type of bill.

There is a two year statute of limitations on all billing.

6.5 Injectable Drug Billing

Beginning in 2006, the OMH began billing and getting reimbursed for the cost, the injection and the administration of Risperdal Consta. Beginning January 1, 2011, reimbursement will be provided for two other injectable drugs, Invega Sustenna and Zyprexa Relprevv. The cost of the drug is entered into MHARS as the service "Risperdal Consta", "Invega Sustenna" or "Zyprexa Relprevv". The administration of the drug is recorded as a "Psychotropic Injection" for clinics and billed as a procedure, or recorded as a "Medication Treatment" for ACT, PH, CDT and billed as fee-for-service.

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Note: Risperdal Consta, Invega Sustenna and Zyprexa Relprevv services are not stored in DMHIS but are extracted directly from MHARS for billing.

Bill Production

Risperdal Consta, Invega Sustenna and Zyprexa Relprevv can only be billed to OP Medicare and ACT Medicaid. They are billed for both the drug and the injection. All three will also reimburse for any other type of service that may be recorded on the same day.

Prior to January 1, 2011, you need a prior authorization (PA) for the Risperdal Consta service for Medicaid if the recipient does not have Medicare.

Injectable drugs can only be recorded and billed if enrolled in ACT, Clinic, PH or CDT.

6.6 Procedure Billing

In February of 2009, the OMH added procedure billing to their billing methodologies. This new methodology was developed to accommodate the billing requirement from **Medicare** for on-site clinic services only. **Third Party Insurance Companies** and **Full Private Payers** are billed using this method on any day that has a valid procedure.

Starting October 1st of 2010, new treatment services were created for clinics. These new services crosswalk to procedures for billing **all** payers, including Medicare, Medicaid, third party insurance companies and private payers.

Health physicals and health monitoring received federal approval for reimbursement starting 1/1/2012. Outreach and support did not receive federal approval so even though the service can be recorded, it will not be billed.

Procedures That Bill

Each clinic treatment service crosswalks directly to a procedure. These services are extracted directly from MHARS, billing edits performed, and all billable procedures are stored in COBS and billed to any open payer. See [appendix 6.6](#) for a list of services/procedures that can be recorded and billed.

Each day we can bill a total of 3 procedures excluding crisis. This includes a maximum of 2 health services, plus 2 psychotherapy services, plus additional medication services that would total to 3, plus a crisis service.

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Procedures That Are Dropped and Not Sent to Billing

- Services provided to recipients who are not admitted or pre-admitted to the program which recorded the service.
- Services can be provided to inpatients and entered into MHARS but outpatient billing is not permitted
- Indirect services are not billable thus are not passed, excluding complex care
- “No Show” services
- Outreach and support did not receive federal approval so that service is dropped
- Recovery services reported in clinics are not passed thru for billing. They are available for those patients enrolled in PMHP.
- Minimum duration was not met (see [appendix 6.6](#) for minimum durations)
- All offsite services for adults excluding crisis
- The following offsite services for children are dropped (the remaining clinic services are billable if provided to children offsite)
 1. Psychiatric consultations
 2. Complex care
 3. Developmental testing
 4. Any Psychological testing
 5. Health physicals
 6. Health monitoring
 7. Smoking cessation counseling
- Invalid service recorded in a group setting. The only treatment services that are allowed in a group are psychotherapy, health monitoring and smoking cessation counseling
- Overlapping service with the same provider or a different provider
- Service was provided by non-qualified staff. See [appendix 2.2A](#) for a list of who can provide what services.
- Service not allowed for preadmitted patient. The following services are only allowed if the patient is admitted: any testing services, health physicals, health monitoring and smoking cessation counseling.

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- Psychotropic medication treatment and clozapine medication management are not billable the same day as a psychiatric assessment or psychiatric consultation
- Smoking cessation counseling is not billable the same day as psychotherapy
- Only one health physical is allowed a year, additional are dropped
- Only 6 smoking cessation services are allowed within a 12 month period, additional are dropped
- Complex care must be provided within 5 working days of either a psychotherapy or crisis visit
- For adults, only 3 preadmission procedures per clinic episode are billable, no more than one of which may be a collateral procedure
- For children, only 3 preadmission visits (days) per clinic episode are billable
- For adults, no more than 3 preadmission assessment procedures may be billed within a 12 month period
- For children, no more than 3 preadmission assessment visits (days) may be billed within a 12 month period

6.7 Bill Production

Billing occurs on a monthly basis. Bills are created for the payer accounts that have been set up in COBS. Accounts are created by the Patient Resource Office after an investigation of the recipient's financial situation is completed.

Bills are unique by program and by payer. Appendix 6.2 thru 6.5 outlines the process flow for [ACT](#), [Clinic](#), [Continuing Day Treatment](#), [Childrens Day treatment](#), [PH and IPRT](#), from the recording of services in MHARS to the production of bills in COBS. [Appendix 6.6](#) is a summary of the types of bills with rate codes.

A hierarchy exists to facilitate the order of billing. Payers with lower payer codes are billed first. Once a payment has been received or the receivable has been written off, then the payer with the next higher payer code will be billed. See [appendix 6.7](#) for a list of payer codes.

Primary Third Party Insurance (PTPHI)

Primary third party insurance has the lowest payer code and therefore is billed first if one exists. Examples of TPHI payers are worker's compensation, no fault, veteran's liability and major medical insurance. Procedures are billed for clinic services and fee for service visits are billed for all other licensed programs. PTPHI can bill for the following licensed

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programs: clinic, continuing day treatment, intensive psychiatric treatment, childrens day treatment, and partial hospitalization. The bills are submitted on paper.

Medicare

Medicare is the next payer in the billing hierarchy. If a PTPHI payer exists, then a Medicare bill is not produced until a PTPHI payment is received or the PTPHI receivable is written off. An adjusted bill is created and sent to Medicare if a primary third party payment comes in after the Medicare bill has been sent. Bills are sent through an electronic data interchange (EDI) transfer.

Medicare will reimburse for on-site clinic services, Risperdal Consta, Invega Sustenna and Zyprexa Relprevv only.

Third Party Insurance (TPHI)

TPHI bills the same as PTPHI but follows Medicare in the hierarchy in that if a recipient has Medicare and TPHI, the TPHI is not billed until we get a remittance from Medicare.

Private Party

- **Full Private Party** bills the same as PTPHI but follows PTPHI, Medicare and TPHI in the hierarchy. The bills are sent on paper
- **Rated Private Party** bills a daily rate with a monthly max for services provided in one of the following programs: clinic, continuing day treatment, intensive psychiatric treatment, childrens day treatment or partial hospitalization. The bills are submitted on paper.

Medicaid

Medicaid is payer of last resort. If any other payers exist, Medicaid must wait until they have all been adjudicated before sending out a bill. Medicaid is the only payer that reimburses for all licensed programs: ACT, PMHP, clinic, continuing day treatment, intensive psychiatric treatment, childrens day treatment and partial hospitalization. Also, Medicaid will reimburse for Risperdal Consta, Invega Sustenna and Zyprexa Relprevv. Bills are sent via an electronic data interchange (EDI) transfer.

6.8 Reimbursement from Medicaid

Each procedure is given a weight depending on intensity and complexity of the service. Weights are used to determine payments. See [appendix 6.8](#) to see the services/procedures and anticipated weights.

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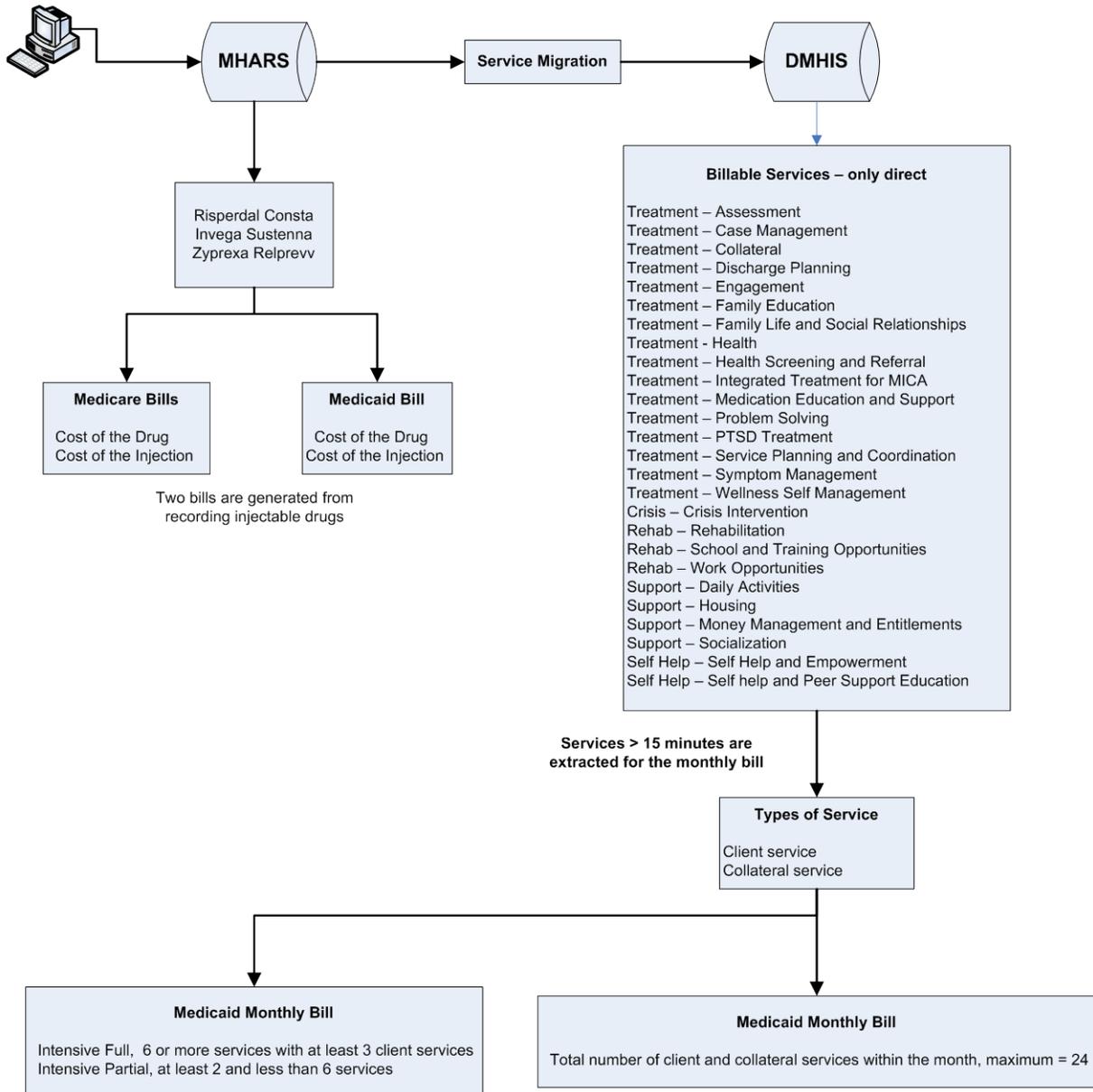
Medicaid will pay more if the service was provided:

- Off-site (allowed for children only)
- After hours, between 6:00 PM and 8:00 AM and on weekends
- In a language other than English
- If a physician or nurse practitioner participated for at least 15 minutes in select services.

Assertive Community Treatment Billing Flowchart Appendix 6.2

4/2009

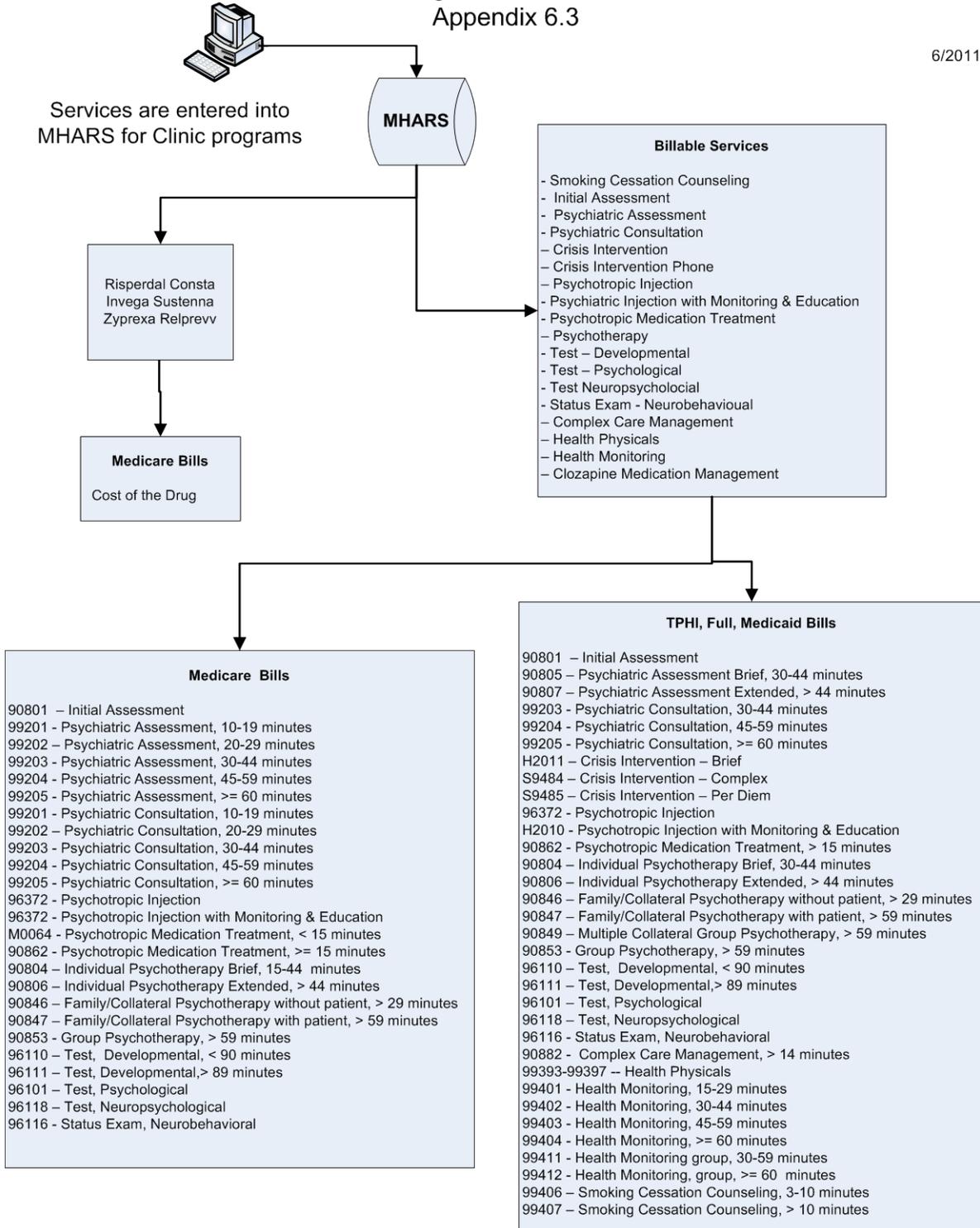
Services are entered into MHARS for ACT programs



Clinic Billing Flow - After 10/1/2010

Appendix 6.3

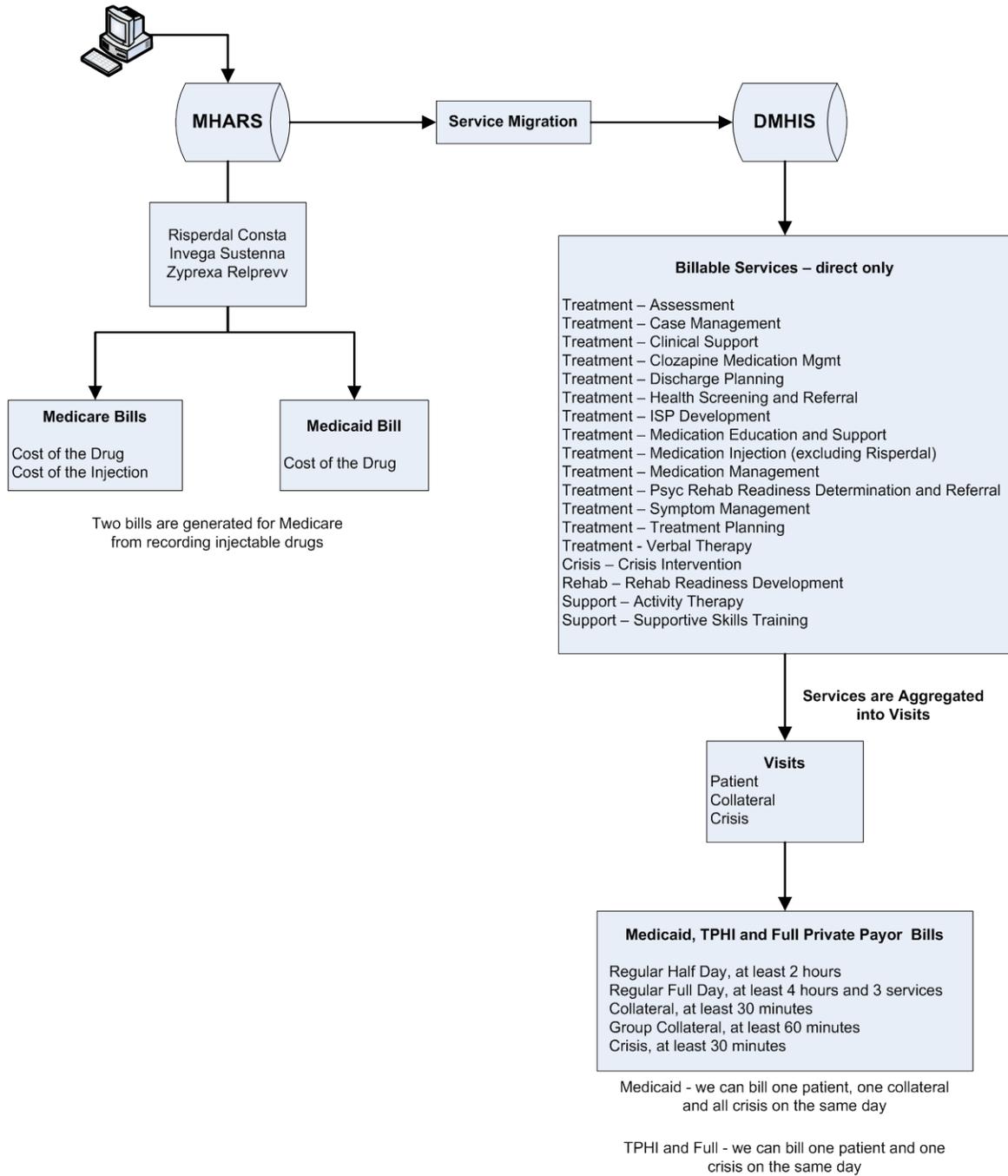
6/2011



Continuing Day Treatment Billing Flowchart Appendix 6.4

Services are entered into
MHARS for CDT programs

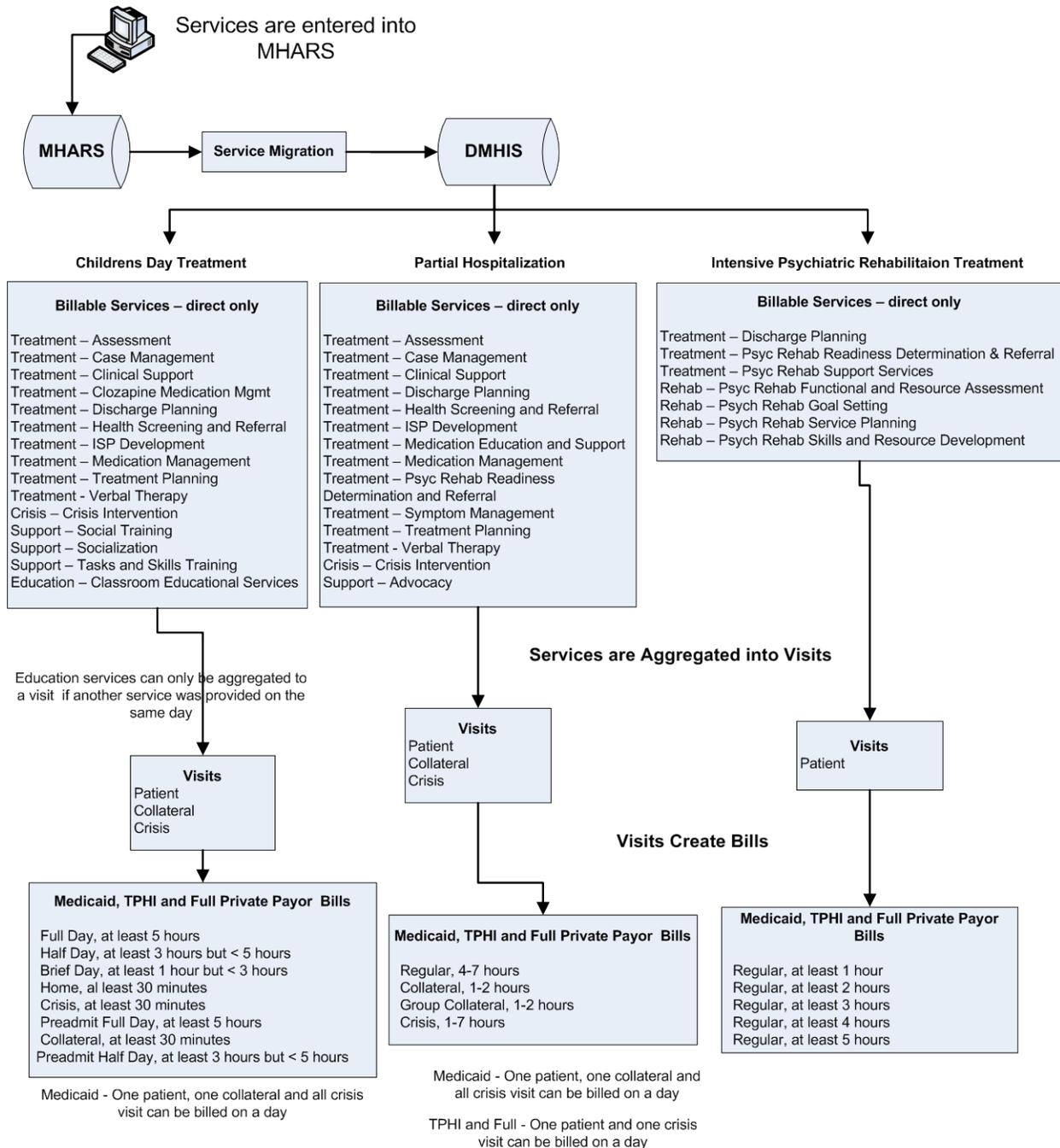
4/2009



Childrens Day Treatment, Partial Hospitalization and Intensive Psychiatric Rehabilitation Treatment Billing Flowchart

Appendix 6.5

4/2009



**Billable Outpatient Visits / Procedures
Appendix 6.6**

Clinic Programs – fee for service billing, before 10/1/2010

Visit Type	Minimum Duration to Produce a Bill	Rate Code
Regular	At least 30 minutes	4301
Brief	15-29 minutes	4302
Group	At least 60 minutes	4303
Collateral	At least 30 minutes	4304
Group Collateral	At least 60 minutes	4305
Crisis	At least 30 minutes	4306

Clinic Programs – procedure billing, after 10/1/2010

Procedure	Minimum Duration to Produce a Bill	Medicare	Medicaid and other payers	
Initial MH Assessment	45 minutes	90801	90801	
Psychiatric Assessment	30-44 minutes	90805	90805	
	>= 45 minutes	90807	90807	
	New patient			
	10-19 minutes	99201		
	20-29 minutes	99202		
	30-44 minutes	99203		
	45-59 minutes	99204		
	>=60 minutes	99205		
	Established patient			
	10-14 minutes	99212		
	15-24 minutes	99213		
	25-39 minutes	99214		
	>= 40 minutes	99215		
Psychiatric Consultation	New patient			
	10-19 minutes	99201		
	20-29 minutes	99202		
	30-44 minutes	99203	99203	
	45-59 minutes	99204	99204	
	>=60 minutes	99205	99205	
	Established patient			
	10-14 minutes	99212		
	15-24 minutes	99213	99213	
	25-39 minutes	99214	99214	
	>= 40 minutes	99215	99215	
	Crisis Intervention Complex	1 hour, >=2 staff		S9484
	Crisis Intervention Per Diem	3 hours, >=2 staff		S9485
Crisis Intervention Brief	15 minutes, limit of 6		H2011	
Psychotropic Injection		96372	96372	
Psychotropic Injection with Monitoring & Education	No limit for Medicare 15 minutes for Medicaid	96372	H2010	
Psychotropic Medication Treatment	< 15 minutes	M0064		
	15 minutes	90862	90862	

Psychotherapy	15-44 minutes 30-44 minutes ≥ 45 minutes	90804 90806	90804 90806
Psychotherapy with Collateral	30 minutes	90846	90846
Psychotherapy with Collateral and patient	1 hour	90847	90847
Group Psychotherapy – patients	1 hour	90853	90853
Group Psychotherapy – collaterals	1 hour		90849
Developmental Testing	< 90 minutes ≥ 90 minutes	96110 96111	96110 96111
Psychological Testing		96101	96101
Neuropsychological Testing		96118	96118
Neurobehavioral Status Exam		96116	96116
Complex Care Management	15 continuous minutes		90882
Health Physicals	Age 5-11 Age 12-17 Age 18-39 Age 40-64 Age ≥65		New / established 99383 / 99393 99384 / 99394 98385 / 99395 99386 / 99396 99387 / 99397
Health Monitoring Patient	15-29 minutes 30-44 minutes 45-59 minutes ≥ 1 hour		99401 99402 99403 99404
Health Monitoring Group	30-59 minutes ≥ 1 hour		99411 99412
Smoking Cessation Counseling	3-10 minutes > 10 minutes		99406 99407
Smoking Cessation Counseling Group	> 10 minutes		99407

Intensive Psychiatric Rehabilitation Programs

Visit Type	Minimum Duration to Produce a Bill	Rate Code
Regular	1 Hour	4364
	2 Hours	4365
	3 Hours	4366
	4 Hours	4367
	5 Hours	4368

Partial Hospitalization Programs

Visit Type	Minimum Duration to Produce a Bill	Rate Code
Regular	4-7 hours	4349 - 4352
Collateral	1-2 hours	4353 - 4354
Group Collateral	1-2 hours	4355 - 4356
Crisis	1-7 hours	4357 - 4363

Children's Day Treatment Programs

Visit Type	Minimum Duration to Produce a Bill	Rate Code
Full Day	At least 5 hours	4060
Half Day	At least 3 hours but < 5 hours	4061
Brief Day	At least 1 hour but < 3 hours	4062
Home	At least 30 minutes	4063
Crisis	At least 30 minutes	4064
Pre-Admit Full Day	At least 5 hours	4065
Collateral	At least 30 minutes	4066
Pre-Admit Half Day	At least 3 hours but < 5 hours	4067

Assertive Community Treatment Programs

Visit Type	Minimum Duration to Produce a Billable Service (# services aggregated to monthly bill)	Rate Code
Intensive Full	15 minutes (6+ services)	4508
Intensive Partial	15 minutes (2+ services)	4509
ACT Services	Total # encounters per month	4512

Continuing Day Treatment Programs

Visit Type	Minimum Duration to Produce a Bill	Rate Code		
		HRs 1 - 40	HRs 41 - 64	HRs 65+
Regular Half Day	2 hours	4310	4311	4312
Regular Full Day	4 hours, 3 services	4316	4317	4318
Collateral	30 minutes	4325	4325	4325
Group Collateral	1 hour	4331	4331	4331
Crisis	30 minutes	4337	4337	4337

Appendix 6.7
Valid Outpatient Payor Codes in COBS

PTPHI

Worker's Compensation	510-519
Veteran's Liability	520-529
No Fault	530-539
Basic Medical Insurance (MSP)	540-549
Major Medical Insurance (MSP)	550-559

Medicare

Outpatient, Technical Component	600
Medicare - Physician	601

TPHI

Crossover Medigap	609
Champus (Note: CHAMPUS codes are inactive)	610-619
Basic Hospital Insurance	620-629
Major Medical Insurance	630-638
Medicare HMO	639
No Billing - "Zero Credit" to Medicaid	
- Basic/Blue Cross Blue Shield	698
- Commercial	699

Private Party

Patient	
- Based on SS or RR benefits	710-712
- Based on VA benefits	713-714
- Based on other Federal benefits	715-716
- Based on Employment or other non-Federal benefits	717-719
Parent	720-729
Spouse	730-739
Patient's Assets Handled Formally	740-749
SOCR/RCCA Rents	750-751
Misc Private Party	752-758

Medicaid

Medicaid Program (Regular Outpatient)	810
Medicaid Spend down	850

Medicaid PMHP

Prepaid Mental Health Plan (before 5/1/07)	860
Prepaid Mental Health Plan (after 4/30/07)	861

ACT Medicaid

Assertive Community Treatment	870
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State Charge

Full State Charge Account	900
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**Appendix 6.8
Services and Anticipated Weights**

Service Category	Service Weight
Outreach and Engagement	0.70
Initial Assessment	1.03
Psychiatric Assessment	1.03 - 1.24
Crisis Intervention	4.00 – 5.79
Psychotherapy	.62 - .83
Family/Collateral Psychotherapy	.62 – 1.24
Group Psychotherapy	0.32
Complex Care Management	0.29
Psychotropic Medication Administration	0.41
Psychotropic Medication Treatment	.66
Psychiatric Consultation	Depends on diagnosis
Developmental Testing	.83 – 1.24
Psychological Testing	1.66
Health Physicals	Depends on diagnosis
Smoking Cessation Counseling	.1267