

5.9 Evidence-Based Practice (EBP) Services for Adults

Service Coverage

An evidence-based practice (EBP) is a practice or service that is recognized by MHA and the Substance Abuse and Mental Health Services Administration (SAMHSA) as an EBP; has standardized and replicable clinical or rehabilitative interventions that:

- 1) Are derived from rigorous, scientifically controlled research,
- 2) Can be applied in mental health practice settings with a defined clinical population, and
- 3) Permit the evaluation of successful program implementation by means of a fidelity scale;
- 4) and has demonstrated evidence that successful program implementation results in improved, measurable outcomes for recipients of the service intervention.

In order to be eligible to deliver EBP services, the program must be approved by the Office of Health Care Quality (OHCQ) for a specific program, as identified below, and meet established program fidelity standards, as delineated below. The fidelity standard means the threshold on the fidelity scale which community mental programs must achieve in order to be eligible to receive the differential EBP rate for a specific practice recognized by MHA. The fidelity scale refers to the standardized and validated evaluation tool approved by the MHA to evaluate the degree of adherence to the principles and essential program elements of a specific, EBP recognized by MHA.

- 1) Assertive Community Treatment (ACT) provides intensive, mobile, assertive mental health treatment and support services delivered by a multidisciplinary treatment and support team to an adult whose mental health treatment needs have not been met through routine, traditional outpatient mental health programs. To be designated as an EBP Assertive Community Treatment Programs, a program must be approved by OHCQ and in substantial compliance with COMAR 10.21.19 for Mobile Treatment Services; and shall be reviewed annually and found to be meeting established fidelity standards determined by MHA approved evaluators. This includes receipt of an average fidelity score of 4.2 out of a possible 5.0 overall on the corresponding fidelity scale and a minimum average score of 4.0 in each MHA-identified category.
- 2) Family Psychoeducation (FPE) programs assists families and consumers better understand mental illness while working in partnership with the family towards the consumers' recovery by providing training in problem solving, social skills, communications skills and coping skills. To be designated as an EBP Family Psychoeducation, a program must be approved by OHCQ and in substantial compliance with COMAR 10.21.20 Outpatient Mental Health Centers; and shall be

reviewed annually and found to be meeting established fidelity standards determined by MHA approved evaluators. This includes receipt of an average fidelity score of 4.0 out of a possible 5.0 overall on the corresponding fidelity scale.

- 3) Supported Employment (SE) programs is an evidence-based practice that is integrated and coordinated with mental health treatment and rehabilitation and is designed to provide individualized placement and support to engage individuals with mental illness in a rapid search to attain, to maintain, and to advance within independent competitive employment positions in the general labor market that pay at least minimum wage, are permanent, and are not set aside or reserved for individuals with disabilities. To be designated as an EBP Supported Employment, a program must be approved by OHCQ and in substantial compliance with COMAR 10.21.21 for Psychiatric Rehabilitation Programs for Adults; and COMAR 10.21.28 for Mental Health Vocational Programs; and shall be reviewed annually and found to be meeting established fidelity standards determined by MHA approved evaluators. This includes receipt of a cumulative score of 66 on the corresponding fidelity scale, and a minimum score of 3.0 on a 5.0-point scale in the evaluation of community-based services; and a minimum score of 4.0 on a 5.0-point scale in each remaining item on the corresponding fidelity scale.

EBP-Specific Services for Supported Employment:

Clinical Coordination (for EBP designated Programs only)(S9445-52): This includes direct or indirect efforts on behalf of the consumer to coordinate and to integrate the consumer's supported employment services with psychiatric rehabilitation and treatment services through regular meetings and contact with members of the individual's multidisciplinary treatment team, shared responsibility for employment outcomes, and integrated and congruent planning, intervention, and service delivery. . . The following goals have been identified for the clinical coordination service:

- in pursuit of the consumer's goals for competitive employment, to establish a working alliance with the clinician and to enlist his or her support for the consumer's interests and desires;
- to enhance the program's ability to engage and to retain consumers in supported employment through assertive engagement and follow-up;
- to facilitate effective, efficient communication between the consumer and clinical, rehabilitation, and treatment providers as a means to coordinate care;
- when desired by the consumer, to encourage timely, fully integrated interventions which collectively support the individual in identifying and selecting employment options, resolving employment-related crises, and in preserving employment placements; and
- to incorporate employment-related issues in treatment and rehabilitation plans and to ensure congruence of rehabilitation and treatment goals, interventions, activities, and plans (1 unit per month of authorized service.).

Ongoing Support Services Phase (PRP-SE for EBP designated Programs only) (H2026-21): This includes those psychiatric rehabilitation service interventions needed to assist the individual to restore and to improve coping skills, assertiveness skills, interpersonal skills, and social skills necessary to function adaptively in the work environment or to develop compensatory strategies to minimize the impact of the individual's mental illness on his or her behavior while on the job. The service must be provided on the job, unless the individual has chosen not to disclose his or her disability to the employer. At the individual's request, the service may be performed at a mutually agreed upon community-based location, as indicated in the Individual Rehabilitation Plan (IRP) or disclosure plan. The individual must be competitively employed to receive this service (1 unit per month of authorized service; minimum of 3 encounters for EBP providers.)

Service Eligibility

Consumers with MA, PMHS-eligible Medicare recipients, and Uninsured Eligible consumers may be eligible for this service. For eligibility for ACT, please refer to Section 7.6. For eligibility for SE, please refer to Section 7.7.

Service Rules

For those interested programs, which have not participated in the original EBP Pilot Project, but which desire to be designated as an EBP Program for a specific, MHA-identified EBP, a comprehensive training plan must be submitted for review to the local Core Service Agency (CSA) of the jurisdiction in which EBP services are to be provided. After CSA review, the CSA will forward the proposed training plan to MHA for approval. Upon completion of the requisite training, then at the request of the agency, a fidelity assessment of the EBP program will be scheduled and conducted by MHA fidelity monitors.

If the program fails to meet established fidelity standards, the program may submit a request to MHA for redetermination of the fidelity rating, no earlier than six months from the date of the initial fidelity assessment. If the program continues not to meet the fidelity threshold at its second review, the MHVP may request further determinations of fidelity, at intervals no sooner than one year from the date of the most recent fidelity assessment.

Only a MHA designated Evidence-Based Practice (EBP) Program which is in substantial compliance with applicable COMAR regulations AND which meets fidelity to the EBP service approach, is eligible to receive the EBP rates. Fidelity to the EBP service approach must be evidenced by receipt of established threshold scores on the approved fidelity scale, as delineated above.

The EBP program will be approved by MHA by receipt of a letter to deliver EBP-specific services and to bill at the EBP-differential rate for a period of time not to exceed one year or until the date of the next scheduled fidelity assessment. It is the responsibility of the EBP program to self-monitor its SE program in order to ensure continued compliance with established fidelity standards.

At such time as the EBP program is determined to no longer meet the established fidelity standards either by self-assessment or MHA's re-assessment, the agency must then discontinue billing for SE services at the EBP rates for the billing months immediately following and subsequent to the date of the corresponding fidelity assessment and, as such, in accordance with MHA policy, will submit claims only for the designated non-EBP rates and services.

EBP-Specific Services Supported Employment:

- **Clinical Coordination (for EBP designated programs only):** Please reference **Mental Hygiene Administration (MHA) Evidence-Based Practice (EBP) in Supported Employment (SE) Policy Implementation Memorandum dated January 12, 2009** There are three discrete service components which must be present in order for the MHVP to bill for the Clinical Coordination service: 1) a weekly treatment team structure; 2) a minimum of one monthly contact with a member of individual's treatment or rehabilitation team; and 3) face-to-face contact with the individual's psychiatrist, treating clinician, or therapist, at a minimum of every six months.
- Each agency must have a designated weekly treatment team meeting structure in place, with existing capability to address shared consumers who are receiving either psychiatric rehabilitation or treatment services concurrently with supported employment services, either within the same agency or externally from separate agencies or practitioners. The meeting must include, at a minimum, representatives from at least two distinct services or disciplines, inclusive of supported employment services; however, there is no expectation that every consumer will be discussed or represented at every meeting.
- The service must include a minimum of **one monthly direct or indirect contact**, with the consumer's informed consent, with a member of the individual's treatment or rehabilitation team, to include the individual's treating psychiatrist (or primary care physician, if serving as the primary mental health treatment provider), therapist or clinician, case manager, psychiatric rehabilitation counselor, residential or housing specialist, family member, or peer support advocate (or AA/NA sponsor), with or without the presence of the consumer. The mode of such contact may be in-person or by means of telephone or e-mail correspondence. The contact may occur within the context of a treatment team meeting, in the course of a regularly scheduled outpatient therapy or medication management visit, at a mutually agreeable time and location for the express purpose of clinical coordination, or by asynchronous electronic communication, such as e-mail.
- **In addition, face to face contact with the individual's psychiatrist, treating clinician or therapist with the consumer's consent must occur, at a minimum of every six months** to facilitate fully integrated service delivery and to ensure

congruence of rehabilitation and treatment goals, interventions, activities, and plans.

- **Clinical coordination encounters must be substantive in nature and constitute more than mere incidental contact, to include the exchange of relevant clinical and employment -related information necessary and sufficient for the consumer to attain, to maintain, and to advance within competitive employment, as it relates to the consumer’s rehabilitation or treatment goals.**

MHVP agencies will be permitted to bill for Clinical Coordination, with the consumer’s consent, for only those months in which they have actually facilitated clinical coordination services and for which documentation exists in the medical record to support the substantive exchange of information. For instance, if the MHVP sustained substantive monthly contact with a member of the treatment team on behalf of a given consumer for ten (10) out of twelve (12) months, but is unable to facilitate the face-to face contact with the psychiatrist or treating clinician, then only ten months of the Clinical Coordination service may be billed. **Likewise, if the consumer is unwilling to engage in or receive psychiatric treatment services (i.e. outpatient therapy or medication management services), the service should not be billed for sixth or twelfth months in which the contact with the treating clinician would have occurred, had the individual been actively receiving treatment services. However, if the consumer receives rehabilitation services or supports from another member of his or her treatment team, then the service may be billed for the remaining months in which substantive contact is facilitated and documented.**

Ongoing Support Services (for PRP-SE for EBP designated programs only):

The service must meet all applicable requirements for psychiatric rehabilitation program (PRP) services, as delineated in COMAR 10.21.21. This includes PRP services provided on the job or at a community-based location in order to assist the individual to attain and to maintain competitive employment, in accordance with the Individual Vocational Plan (IVP) and the Individual Rehabilitation Plan (IRP), which plan may be integrated into one document. .

Services must be for a minimum of 15 minutes duration, for a minimum of three (3) discrete service contacts per month per consumer, based on consumer needs, with a maximum of one service contact per day. The three service contacts for PRP Services to Individuals in Supported Employment include those services required for Extended Support Services, as outlined in COMAR 10.21.28. For those individuals for whom only two service counts have been attained in a given month, the MHVP may bill for service code H2026 and be reimbursed at the designated non-EBP rate for Extended Support

Services. However, it is MHA's expectation that, on balance, most consumers will have significantly more employment support needs than can be reasonably addressed by services which are limited to established service delivery minimums of frequency and intensity. It is, therefore, reasonable to expect that the average service count per consumer served across all consumers served within a given supported employment program will exceed the established minimum service delivery standards.

At least one service must be performed on the job unless the consumer has chosen not to disclose the presence of a disability to the employer. When this occurs, the service may be performed in a mutually agreed upon community-based location, as indicated in the rehabilitation or disclosure plan. It is not expected that the service be performed on-site at the PRP facility.

In the event that the individual elects not to disclose his or her disability status, documentation must exist in the medical record to support the informed choice of the individual not to disclose, to include, at a minimum, a collaborative plan for providing such services, and the expected location for service provision.

The service must meet all applicable requirements for psychiatric rehabilitation program (PRP) services, as delineated in COMAR 10.21.21. This includes the presence of an Individual Rehabilitation Plan (IRP) which contains a bona fide psychiatric rehabilitation goal and intervention to be implemented on the job, unless the individual elects to disclose, as above, and which is congruent with and cross-referenced to goals and interventions identified in the Individual Vocational Plan (IVP). The selection of a goal is based on a comprehensive, focused assessment with each individual of his or her demonstrated rehabilitation needs, which assessment addresses specific skills deficits or functional limitations which impede independent or adaptive functioning on the job. The intervention is designed to restore independent functioning on the job and to reduce the impact of the individual's mental illness on his or her adaptive functioning within the work environment.

Each service phase in SE must be clearly delineated, individually documented, and sufficiently disaggregated from the array of vocational and support services delivered to that individual as to identify within the documentation the discrete service and the nature of the service intervention. As a Medicaid-funded service, the SE –PRP contact note must also meet the same requirements as a PRP contact note. .

Authorization Process

Preauthorization is required. To obtain initial authorization for EBP services, the provider must submit a preauthorization request through ProviderConnect for the specific, MHA-identified practice. .

FPE services are not included in the initial twelve (12) mental health outpatient visits in ValueOptions® Maryland Programs requesting FPE will receive an initial twelve (12)

visits. When medically necessary, the program may request an additional twenty-four (24) visits. Requests for authorization for FPE may be entered in ProviderConnect at the same time as requests for authorization for other mental health services the individual may be receiving from the requesting provider.

Mental Health Vocational Program (MHVP) providers submit the authorization request for SE through ProviderConnect for CSA review within 48 hours of the request.. The DORS referral and application are completed coincident with the request for authorization of the Pre-placement or Placement Phases. Upon CSA review and approval, DORS eligibility is presumed. The MHVP sends an e-mail to the DORS counselor, and the counselor's supervisor, containing the authorization number of the consumer applying for DORS services and requests an initial interview within 2 weeks. Any individual who is otherwise eligible for SE services and who gives written consent may receive the Clinical Coordination service coincident with the receipt of any other approved supported employment service type, to include any one of the following, either individually or in combination: pre-placement; intensive job coaching services; placement in a competitive job

Based on the CSA's authorization, ValueOptions[®] Maryland assigns an authorization number. The provider then submits the claim to ValueOptions[®] Maryland for reimbursement.

Providers obtain additional authorizations through the submission of a Continuing Review Authorization prior to the expiration of the previous authorization time span.

Claims Process

Claims must be submitted on a CMS 1500 form (See Chapter 16.) Claims must specify an ICD-9 code, not DSM IV-TR code.

Encounter data must be submitted to establish the actual number of Ongoing Support Services (PRP-SE for EBP designated Programs only) (H2026-21). Any claims submitted for PRP-SE for EBP providers in the absence of corresponding encounter data which reflect compliance with the established service minimum of three discrete service counts per month for non-EBP SE providers will be subject to denial of claims payment and subsequent retraction of payment, for claims already reimbursed. For those consumers for whom **only two service counts have been attained in a given month, the MHVP may bill for service code H2026 and be reimbursed at the designated non-EBP rate for Extended Support Services**

Claims for unauthorized services will be denied.