

5.17 Outpatient Mental Health Services (OMHCs, FQHCs, Hospital Based Clinics, Individual Practitioners, and Private Group Practices)

Service Coverage

Outpatient Mental Health Services such as assessment and evaluation, and individual, group and family therapies are provided by Outpatient Mental Health Centers (OMHCs) regulated under Code of Maryland Regulations (COMAR 10.21.20), and by individual mental health professionals authorized and/or licensed by the appropriate practice boards.

Authorization Process

Outcomes Measurement System (OMS)

Consumers ages 6 to 64, who are treated in an OMHC, FQHC, or Hospital-based clinic, will receive authorizations for outpatient services through the Outcomes Measurement System. The consumer will initially receive an authorization for two services. Prior to the 3rd service, and every six months thereafter, the provider must complete an OMS interview questionnaire with the consumer in order to obtain authorizations. Authorizations will be granted in a service bundle that includes 150 units of service for six months. For services included in the OMS service bundle, refer to the Service Matrix.

For services outside of the OMS service bundle, a separate authorization request must be submitted.

For complete information on OMS, refer to the OMS Chapter and OMS Appendix in this Provider Manual, as well as any updates that are posted on the ValueOptions[®] Maryland Web site.

Non-OMS authorizations (individual practitioners, group practices, and OMHCs)

A consumer who is not included in the OMS may receive authorization for up to 24 services after the consumer's initial registration. Four preauthorized visits are given to providers when a consumer is changing providers.

In circumstances where consumers have been authorized for the 12 auto-authorized services, the first 12 outpatient services submitted for reimbursement will comprise the auto authorized services. Authorizations are given in service code bundles (see Service Matrix). These auto authorized services must be service bundle 100 or 110 services only. Refer to the Service Matrix to review what services are included in these service code

bundles. For services not included in the 100 or 110 service bundles, a separate authorization request must be submitted.

After the initial 12 auto-authorized services, all outpatient services must be pre-authorized by submitting a concurrent review request. The end date of the previous authorization will be changed to end one day before the start date of the new authorization. When the new authorization is completed, any unused units from the previous authorization will be forfeited and will not be added to the units included in the new authorization.

Non-OMS authorizations are provided for a specific number of units over a one-year time span. A new authorization is required when either the number of units is exhausted or the time span has expired. For continued authorization, a continuing review authorization request must be submitted prior to providing additional services. The start date for the new authorization will be the date the request is submitted or another, future date requested by the provider. If the care requested meets medical necessity criteria, the ValueOptions[®] Maryland will approve the authorizations.

When the ASO receives an authorization request that meets the medical necessity criteria, the ASO will authorize services to begin the day after the last, previously authorized date, unless otherwise specified.

Authorizations are given in service code blocks (see Service Matrix) for specific time frames. The services must be used within the given time frame and the number of sessions may not exceed the number of sessions authorized.

Discharge

The above-described process is continued for authorizations until the consumer is no longer in treatment. Upon discharge, the provider must discharge the consumer from their service by going to ProviderConnect and entering a discharge by searching for the consumer authorization and choosing the discharge consumer option.

Service Rules

Initial Evaluation/Diagnostic Interview (CPT Code 90801)

This procedure is not time defined. The initial evaluation/diagnostic interview session is expected to include face-to-face consumer contact, and encompasses activities critical to the evaluation process, such as communicating with the consumer and the primary care physician and ordering laboratory tests when clinically appropriate.

Only one initial evaluation/diagnostic interview (90801) may be rendered as part of the initial 12 services. A maximum of two diagnostic interviews may be rendered as part of the OMS service bundle for OMS consumers. An additional 90801 may be requested and approved if the additional 90801 is to be provided by a different rendering provider. The different rendering provider may be part of the same OMHC or practice group, or

independent of the OMHC or practice group. The primary consideration is that one of the providers is a physician and the other is a non-physician.

- The PMHS will not reimburse, as the primary payer, for services covered by Medicare for Medicare recipients served by Outpatient Mental Health Clinics (OMHC) or individual practitioners. The PMHS will only reimburse services delivered to individuals who are dually eligible, Medicaid and Medicare, when the service is provided by a independent Licensed Professional Counselor who is not part of an OMHC after the Licensed Professional Counselor has explored all other billing options, such as billing according to the Medicare “incident to” provisions and when the jurisdiction has limited access to other types of mental health professionals.
- Eye movement integration therapy (EMI) and eye movement desensitization and reprocessing (EMDR) are not services reimbursed by the PMHS.
- All PMHS services require preauthorization except emergency services and some initial psychiatric inpatient consultation services. Please refer to March 2, 2009 memorandum. No exceptions will be granted
- For OMHCs, a diagnosis (not diagnostic impression) needs to be rendered by the individual's second visit by a licensed mental health professional following a face-to-face evaluation. (COMAR 10.21.20.06A). Refer to Maryland Health Occupations that govern scope of health care practice. The Social Work licensing regulations stipulate that an LGSW can only provide diagnostic impressions; they cannot render a diagnosis. Refer to Annotated Code of Maryland - Health Occupations Article - Title 19 -19-307(c) (2)

Other reasons to request an additional 90801 within the same year of treatment include:

- A significant change in the consumer’s condition. Reasonable clinical judgment will be applied by the ASO to determine whether the service is medically necessary.
- The consumer is admitted to a crisis bed.
- The consumer selects a different provider.
- Prior to psychological testing performed by a psychologist.

Combination of Services

For a description of services which may be reimbursed on the same day, please see COMAR 10.21.25

A physician who combines a medication management session within a session that also includes individual therapy must use a code which combines both services such as 90805 or 90807.

Family therapy may be billed for only one member of a family at a time (i.e., CPT codes 90846 or 90847). For example, if two children in a family have mental health diagnoses and are identified consumers, authorization and reimbursement will be made for only one child per each family therapy session.

For transition purposes, a consumer may be authorized for traditional outpatient services in conjunction with mobile treatment. This overlap of services should not exceed one month.

If there is an open authorization for outpatient treatment services with another provider when a second provider requests an initial registration, then either the previous provider must discharge the client from their outpatient services or the consumer must speak with an ASO customer service representative and confirm that the he/she no longer wishes to receive services from the first provider. The first provider's authorization request must be closed by either the first provider or a customer service representative before the second provider will be able to register the client.

If a provider is seeing a consumer for one service (such as 90806) and knows that the consumer is seeing another provider for another outpatient service (such as 90853), the provider must document this information in the authorization request.

Family Psychoeducation (FPE) is a reimbursable service under the Public Mental Health System only if the agency/provider is an approved Outpatient Mental Health Center and approved a MHA approved Evidence Based Practice (EBP) program. FPE is targeted to individuals with serious mental illness and their families or significant others. It is a multi-family group that provides education and support. FPE is not age restricted and is available to both Medicaid consumers and Uninsured Eligible consumers. The groups meet bi-weekly and may extend for up to two years.

Place of Service

OMHCs, individual practitioners and those in private group practice may provide services in any location except a hospital medical unit, a nursing home, an adult medical daycare center, and emergency rooms (if included in the hospital rate). However, the fee remains the same as on-site service rates.

Mental health treatment services delivered by a mental health provider or OMHC under the PMHS are not reimbursed when provided in adult medical day care centers.

Services provided to a nursing home consumer who has been transported to a provider's office will not be reimbursable under the PMHS, unless the service is approved by the ASO as a diversion from inpatient services.

General mental health services within nursing homes are included as a part of the nursing home reimbursement rate. When authorized by the ASO, a psychiatrist may bill specialized mental health services to avoid an inpatient psychiatric admission. (See Chapter 5, Section 22.)

Claims Process

Claims should NOT be submitted for services requiring registration or preauthorization unless there is an initial registration or a continuing authorization for the service. Claims should be submitted on a CMS 1500 form or a UB 04 for hospital-based clinics (See Chapter 16). Date spans will not be accepted. Each date of service must be entered on a separate transaction line. Claims must specify an ICD-9 code, not a DSM IV-TR code.

Claims for unauthorized services will be denied.

Billing under a private practitioner's or group practice's license for services provided by individuals who do not have their own Medicaid provider number will not be reimbursed by the ASO.

Only physicians providing services in an OMHC or HSCRC regulated outpatient service may be reimbursed for prolonged services. Prolonged services require a separate authorization request. If a consumer has a psychiatric crisis which requires the provider to spend more time (more than 30 minutes) with the consumer than the already authorized CPT code(s) specifies, providers may submit an authorization request for the prolonged service and submit a claim. For additional time between 30-74 minutes, CPT code 99354 should be requested. For each additional increment of 30 minutes (beyond the 30-74 minutes) required to manage the consumer's crisis, another unit of CPT code 99355 should be included in the authorization request for the prolonged services. A provider may submit an authorization request for the prolonged services within two working days of the prolonged services. HSCRC Clinics should refer to the Service Matrix for appropriate corresponding revenue codes.

Outpatient services will only be authorized for registered PMHS consumers who have a mental health diagnosis covered by the PMHS. If the consumer does not have a mental health diagnosis covered under the PMHS, claims will be denied.

Private practitioners of any discipline are not allowed to bill for services delivered by non-licensed/certified mental health professionals (e.g. students or interns). Only OMHCs, FQHCs and hospitals with formal training programs and supervision may receive reimbursement for other types of-licensed/certified mental health professionals and professional students who are in a formal training program.

ECT services are authorized to the facility or physician performing the service. The anesthesiologist charges related to the ECT do not require a separate authorization, and may be billed using CPT code 00104.

The Mental Health Service provider is expected to exchange information and coordinate care with the consumer's primary care physician and other treatment (e.g., substance abuse treatment) providers when clinically appropriate.

Service Eligibility

Services for consumers with MA, certain dually eligible Medicare recipients and Uninsured Eligible consumers are eligible for reimbursement from the PMHS..

Service Providers

Outpatient Mental Health Services are provided by OMHCs and individual practitioners rendering services through individual or group practices. Individual practitioners, licensed under Health Occupations in the state of Maryland, include physicians, psychologists, social workers, advanced practice nurses, and Licensed Professional Counselors. All providers are required to have an active Maryland Medicaid provider number and a signed provider agreement with the DHMH.

Problems and Solutions

Authorizations can expire either when all authorized visits of a consumer and provider have been used or when the authorized time frame for services has ended. To ensure reimbursement of services, if additional services are needed beyond the time frame originally authorized by the ASO, the provider must submit an authorization request for continued services. This authorization request must be submitted prior to the expected date that all previously authorized services would be used.

If the services requested do not meet Medical Necessity Criteria and care is non-authorized, please refer to Chapter 9, Grievances and Appeals.

Individual Practitioners, Group Practices

Outpatient Mental Health Services such as assessment and evaluation, and individual, group and family therapies are provided by individual mental health professionals authorized and licensed by the appropriate practice boards to practice independently.

Group Practices and Physician Groups

Group practices are only to include licensed mental health professionals who are authorized under health occupations to practice independently. Physicians are to have either an individual MA provider number or a physician group practice MA number. If you have a physician currently in your group practice under one MA group practice provider number, a new MA Provider application is to be submitted to MA Provider Enrollment Unit for a separate MA Provider number for the physician.

Service Rules

- Amendments to COMAR 10.21.25 were adopted March 23, 2009. This includes rules for billing that apply to all PMHS providers. Regulations may be downloaded on www.dsd.state.md.us