COMMUNITY MENTAL HEALTH MEDICAID PROCEDURE MANUAL

TABLE OF CONTENTS

I. INTRODUCTION 1

II. FEDERAL AUTHORITY FOR SERVICE COVERAGE 2

III. CLIENT ELIGIBILITY 3

- **A. CATEGORIES OF ELIGIBILITY** 3
- **B. INTENT TO FILE/RETROACTIVE ELIGIBILITY** 3
- **C. MEDICALLY NEEDY CLIENTS AND THE "FLEX TEST"** 4
  - 1) General 4
  - 2) Utilization of RIACT-I/RIACT-II Per Diem Bills 4
  - 3) Utilization of Bills For CMAP Medications And Inpatient Services At Butler Hospital 5

IV. PROVIDER ELIGIBILITY AND CERTIFICATION 6

V. COVERED SERVICES 7

- **A. RESTRICTIONS APPLICABLE TO ALL SERVICES** 7
- **B. COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT (CPST)** 9
  - 1) Definition 9
  - 2) General Program Guidelines 9
  - 3) Qualified Staff 10
  - 4) Reimbursement 10
- **C. PSYCHIATRIC REHABILITATION DAY PROGRAM** 13
  - 1) Definition 13
  - 2) Program Guidelines 13
  - 3) Qualified Staff 14
  - 4) Reimbursement 14
- **D. CRISIS INTERVENTION SERVICES** 16
  - 1) Definition 16
  - 2) Program Guidelines 16
  - 3) Qualified Staff 16
  - 4) Reimbursement 16
- **E. CLINICIAN SERVICES** 18
  - 1) Definition 18
  - 2) Program Guidelines 18
  - 3) Qualified Staff 18
  - 4) Reimbursement 20
- **F. MENTAL HEALTH PSYCHIATRIC REHABILITATIVE RESIDENCE** 22
  - 1) Definition 22
  - 2) Exclusions 22
  - 3) Provider Certification 22
  - 4) Service Authorization 23
  - 5) Medical Records/Treatment Planning 23
  - 6) Reimbursement 23
- **G. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT I** 26
  - 1) Definition 26
  - 2) Exclusions 26
  - 3) Certification 27
  - 4) Reimbursement 27
- **H. SPECIALIZED MENTAL HEALTH CONSULTATION TO NURSING FACILITIES** 29

1) Definition 29
2) General Program Guidelines 29
3) Qualified Staff 30
4) Reimbursement 30

I. MULTI-DISCIPLINARY MENTAL HEALTH TREATMENT PLANNING 31
1) Definition 31
2) Qualified Staff 31
3) Program Guidelines 31
4) Reimbursement 31

J. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT II (RIACT-II) 33
1) Definition 33
2) Exclusions 34
3) Certification 34
4) Reimbursement 35

VI. GENERAL REQUIREMENTS AND LIMITATIONS FOR ALL SERVICES 37

VII. BILLING 38

A. GENERAL PROCEDURES 38
B. SPECIFIC BILLING INSTRUCTIONS 38

VIII. DOCUMENTATION REQUIREMENTS 39

IX. MONITORING AND QUALITY ASSURANCE 42

APPENDIX 1: SAMPLE PROVIDER AGREEMENT 43
APPENDIX 2: SAMPLE MHPRR SERVICE AGREEMENT 44
APPENDIX 3: SAMPLE MHPRR PROVIDER CERTIFICATION APPLICATION 45
APPENDIX 4: PERSONAL CARE CHECKLIST 46
APPENDIX 5: MEDICAL RECORD DOCUMENTATION GUIDELINES 49
APPENDIX 6: CONTACT LIST 53
APPENDIX 7: MEDICAID RECORD SCORING WORKSHEET 54
APPENDIX 8: COMMONLY ASKED QUESTIONS AND ANSWERS 62
APPENDIX 9: RIACT I MEDICAID RECORD SCORING WORKSHEET 68
APPENDIX 10: FEE SCHEDULE 78

I. INTRODUCTION

The Department of Mental Health, Retardation and Hospitals, Division of Behavioral Healthcare (DBH), administers Community Mental Health Medicaid Services in Rhode Island in collaboration with the Department of Human Services (DHS). DHS is the single state agency for Medicaid and is responsible for the oversight and administration of the Medicaid program.

DHS and DBH have an inter-departmental agreement in place specifying the role that each agency plays in the operation of the program. Under this agreement, DHS is administratively responsible for processing payments, for ensuring that certified vendors are reimbursed for services provided to eligible clients, and in ensuring compliance with applicable state and federal Medicaid policies, rules and regulations. DBH handles the day-to-day operations of the program including negotiating fees; monitoring compliance with state and federal regulations and guidelines; recommending policies and procedures and ensuring compliance; and authorizing services where required.

This manual sets forth the procedures established for the program in a straightforward manner so that providers can operate it with a minimum of difficulty. A "Question and Answer" section dealing with questions raised by providers that don't fit well into any specific area of the manual can be found in Appendix 8.

II. FEDERAL AUTHORITY FOR SERVICE COVERAGE

Mental Health Medicaid Services are provided under the following Federal laws and/or regulations:

A. Section 440.130(d) of the Code of Federal Regulations (CFR), the "Rehabilitative Services Option", defined as follows:

Rehabilitative Services, except as otherwise provided under this sub-part, includes any medical or remedial services recommended by a physician or other Licensed Practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his highest possible functional level.

B. 42 CFR 440.167, "Personal Care Services", defined as follows:

(a) "Personal care services" means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

(2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and

(3) Furnished in a home, and at the State's option, in another location.

(b) For purposes of this section, "family member" means a legally responsible relative.

III. CLIENT ELIGIBILITY

A. CATEGORIES OF ELIGIBILITY

In order to receive Community Mental Health Medicaid services, a client must be eligible for Medical Assistance coverage as either "categorically needy" or "medically needy only". Eligibility for the Rhode Island Medical Assistance Program can be confirmed by contacting the Recipient Eligibility Verification System (REVS) at the number shown in Appendix 6.

B. INTENT TO FILE/RETROACTIVE ELIGIBILITY

Mental Health Medicaid provider agencies often provide services to clients for an extended period of time before they are able to gather enough information to generate an application for SSI, and for an even longer period before the client is actually approved. The mechanisms of "intent to file for SSI" and "retroactive eligibility for Medicaid" can be used to allow the agency to bill for services rendered prior to the actual date that the completed application, with all required documentation, is submitted to the SSI office.

Starting with "intent to file", SSI eligibility, with automatic concurrent Medicaid eligibility, is retroactive to <u>either</u> the date that the actual paperwork is filed with SSI <u>or</u> the date that the client provides SSI with notification of their <u>intent</u> to file for benefits. The "intent to file" must be in the form of a written statement indicating that the client intends to file for SSI and must be delivered to the same location as the actual paperwork. For purposes of Medicaid, the month of SSI eligibility becomes the first month of ongoing Medicaid eligibility.

Therefore, if you determine on May 29, for example, that a client is likely to be eligible for SSI, you should ensure that they deliver a written declaration of their intent to file to the appropriate SSI office on that same day. This will establish a "protected filing date" of May 29, even if the actual paperwork for the application isn't completed and turned into the SSI office until sometime in June.

With regard to "retroactive eligibility", clients may be eligible for Medicaid coverage (but not cash benefits) for the three months prior to the month of their application for SSI if they would have been determined eligible had they applied. That is, if a client has been at the same level of disability for four months and doesn't apply for SSI until the end of the fourth month, they can still potentially get Medicaid eligibility for the entire period assuming that all other Medicaid criteria are met.

While the application for this 3-month retroactive eligibility does not have to be made until after the basic SSI eligibility is established, it is best to handle it at the time of application. One of the questions on the SSI application form asks whether the client has any unpaid medical expenses during the three months prior to the month of application. (Using the May 29 protected filing date, that would mean bills for the period February 1–April 30.) Encourage the client to answer "yes" to this question if your agency has provided any services during that period. For practical purposes, you will probably want to limit attempts to claim retroactive eligibility to those clients who have used a substantial amount of services for which you have not been reimbursed.

As an example of how these two mechanisms can be used together, assume that you have a client who has consumed large amounts of crisis intervention and CPST time in each of the months of February, March, and April. Assume further that, on May 29, the CPST team meets with the client and determines that he is likely to be eligible for SSI. By giving SSI the client's <u>intent to file</u> on May 29, and indicating on the actual application when filed that the client has outstanding bills for each of the three months prior, you will have opened the window for potential Medicaid billing for all of the services provided during the period February 1–May 29 assuming that the client is eventually determined to be eligible.

While this does not solve the problem of occasional extensive delays in the actual determination of SSI eligibility, it does give you the opportunity to be reimbursed for services rendered.

C. MEDICALLY NEEDY CLIENTS AND THE "FLEX TEST"

1) General

States participating in the Medicaid program must provide Medicaid to categorical groups of individuals who are eligible to receive cash payments under one of the existing cash assistance programs established under the Social Security Act. In addition, states may also provide Medicaid to the medically needy and other categorical optional eligibility groups such as low-income aged and disabled individuals.

The "medically needy" group consists of those individuals who meet the categorical group requirements; have sufficient income to meet basic living expenses and, thus, are ineligible for a cash assistance program; but who have insufficient income to pay for medical expenses. Sections 1902(a)(17) and 1903(f)(2) of the Act provide that, for individuals applying as medically needy, certain incurred medical expenses must be deducted from income if income exceeds the eligibility standard established by the State. The process is commonly referred to as "spend-down" or the "flex test."

Eligibility for Medically Needy status is established when the applicant has presented a) receipts for medical services incurred during the period of determination and/or b) unpaid bills incurred whether during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income. These bills must be a) charged at the appropriate fee; b) be tied to specific services rendered; and c) not have been used before in determining eligibility. In the case of a provider under the Community Mental Health Medicaid Program, the "appropriate fee" is the amount that the provider would bill any other client in the same circumstances for the same identical service.

In general, the bill must be tied to specific services rendered and the provider must have appropriate documentation on hand to support the billing. Additionally, clients must have a legal liability for payment.

2) Utilization of RIACT-I/RIACT-II Per Diem Bills

In order to make the process of dealing with the per diem billing methodologies utilized in dealing with RIACT-I and RIACT-II teams more uniform, agencies must adhere to the following guidelines:

a) It is not necessary to submit a bill containing specific dates and times of the hours of face-to-face service provided to meet the minimum requirements. However, the bill must contain documentation that the required minimum hours indeed <u>were</u> provided and the date on which the required minimum was reached.

b) To ensure that all RIACT-I/II bills meet these requirements in a uniform manner, your bill must clearly contain the following language <u>exactly</u> as stated below:

> *(Enter Agency Name)* hereby certifies that *(Enter client name)* met the minimum service requirements necessary for per diem RIACT-I/RIACT-II billing for the month of *(Enter month, year)* as specified in the Community Mental Health Procedure Manual at the standard Medicaid fee on (*Enter date that required service hours were reached*).
>
> You are therefore liable for a bill for RIACT-I/RIACT-II services in the amount of *(Enter amount in format $xxx.xx),* accumulated over the period (*Enter date 1*) through (Enter *date 2*) at the rate of (*Enter applicable rate in format $yy.yy*) per diem. This amount may be used as proof of spend-down under Medicaid flex test requirements.

c) The bill must be submitted to the client. A copy may be submitted to DHS for Medicaid flex test purposes

d) The maximum allowable billing for RIACT-I or RIACT-II services is set at an amount equal to the Medicaid fee that was in effect for the service on the day that the liability was incurred.

e) Community mental health agencies may <u>not</u> bill Medicaid the "amount due" on bills that are submitted to qualify for spend-down under the flex-test, as these bills are the legal liability of the client.

f) The client must be clearly liable for all bills used to meet the requirements of the Medicaid flex test and the agency must expend the same effort to collect those bills as it makes to collect any other client bill.

3) Utilization of Bills For CMAP Medications And Inpatient Services At Butler Hospital

Both the cost of medications provided to clients under the State's CMAP program and the cost of inpatient services provided in State beds at Butler Hospital may be used to reduce an MA applicant's excess income under the following provisions of Section 0368.05 of the DHS Manual:

> Eligibility as Medically Needy is not established, however, until the applicant has presented
>
> 1) receipts for medical services incurred during the period of determination and/or;
>
> 2) unpaid bills incurred either during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income.
>
> The only exception is in the case of medical expenses that are paid by, or are the liability of, other medical care programs that are funded 100% with State funds. For example, an applicant's medical expenses that have been paid (or are to be paid) by the RIPAE or Rite Care programs are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spend-down liability.

The Department of Human Services provided DBH with an opinion on March 19, 1998 that CMAP medications fall under this exception as they are paid for with 100% State funds. In order to avoid any potential confusion at the DHS office, the bills generated for CMAP medications should be dated; have a dollar amount; and include a statement to the effect that "This medication was provided with 100% State funds". It would also be helpful if staff members and/or clients approaching DHS field office with this request were provided with the policy reference above.

Additionally, the Department of Human Services provided DBH with an opinion on July 12, 1999, that inpatient stays provided in State beds at Butler Hospital also fall under this exception as they are also paid for with 100% State funds. In order to avoid any potential confusion at the DHS office, the bills generated for inpatient episodes at Butler should be dated; have a dollar amount; and include a statement to the effect that: "This inpatient stay occurred in State beds which are paid for utilizing 100% state funds". It would also be helpful if staff members and/or clients approaching DHS field office with this request were provided with the policy reference above.

IV. PROVIDER ELIGIBILITY AND CERTIFICATION

In order to receive reimbursement from the Rhode Island Medical Assistance Program for the services outlined in this manual, providers must be Community Mental Health Centers or other private, not-for-profit providers of mental health services who:

1. Are licensed by the Rhode Island Department of Mental Health, Retardation and Hospitals and;
2. Are licensed for participation in the Rhode Island Medical Assistance Program by the Department of Human Services.

Agencies must enter into a written agreement with DBH to establish overall eligibility for reimbursement for mental health services provided under this program. A sample agreement is included as Appendix 1. Additionally, further certification procedures for the provision of specific services might be required (e.g. there are additional requirements that must be met prior to billing for RIACT-I or RIACT-II Services).

All providers must conform to the Rules, Regulations and Standards for Licensing of Mental Health Facilities and Programs, as well as the procedures in this manual and all other applicable state and local fire and safety codes and ordinances. Additionally, all programs under contract to DMHRH must meet all applicable contractual requirements as specified by the Department including, but not limited to, timely submission of all reports, data extracts, audits and plans of correction required by the Department.

V. COVERED SERVICES

A. RESTRICTIONS APPLICABLE TO ALL SERVICES

The Rhode Island Medical Assistance Program will reimburse qualified providers for those medically necessary services provided to eligible recipients who meet the following criteria that are applicable to all services:

1) Service Authorization

In general, services are reimbursable only when provided in accordance with a treatment plan approved by a physician or other licensed practitioner of the healing arts.

For purposes of this program, a "licensed practitioner of the healing arts" is defined as a:

a) Physician;

b) Licensed Psychologist;

c) Registered Nurse licensed to practice under Rhode Island State Law;

d) Licensed Independent Social Worker (LISW) as defined in Rhode Island General Laws, Chapter 39;

e) Marriage and Family Therapist as licensed by the Rhode Island Department of Health;

f) Mental Health Counselor as certified by the Rhode Island Department of Health. (This is not a "Counselor" or "Principal Counselor" as certified by the Rhode Island Department of MHRH, Division of Behavioral Healthcare.)

Exclusions to this general rule include:

a) Crisis Intervention Services, which may be both recommended and delivered by the mental health professional on duty at the time of the crisis without the need for a treatment plan or approval by a licensed practitioner of the healing arts;

b) Mental Health Psychiatric Rehabilitative Residence services which requires physician authorization on both the treatment plan and on the Psychiatric Rehabilitative Individual Care Checklist;

c) Rhode Island Assertive Community Treatment I (RIACT-I) and Rhode Island Assertive Community Treatment II (RIACT-II), both of which require physician authorization on the treatment plan and;

d) Multi-Disciplinary Treatment Planning.

2) Service Setting

Providers are mandated to provide services in the setting that is most appropriate to the client's needs as prescribed in the treatment plan or, in the event of the necessity for crisis intervention services, wherever needed, and have the full authority and responsibility to do so.

3) Covered Diagnostic Categories*

At the current time, clients being treated for a primary diagnosable mental, behavioral, or emotional disorder that meets criteria of DSM-IV are eligible for services under the Community Mental Health Medicaid Program except that clients with any of the following primary diagnoses (see DSM-IV, pp. 15-24 for a listing by category) are excluded:

a) Any disorder characterized by "V" codes;

b) Any disorder listed in the section entitled "Substance Related Disorders" unless there is a concomitant primary mental, behavioral or emotional disorder not otherwise excluded in this procedure manual;

c) Any disorder listed under the sub-section entitled "Mental Retardation" unless there is a concomitant primary mental, behavioral or emotional disorder not otherwise excluded in this procedure manual;

d) Any disorder listed under the section entitled "Impulse-Control Disorders Not Elsewhere Classified."

e) Axis II Anti-Social Personality Disorder (301.7)

Note that clients falling into classification 799.9, "Diagnosis Deferred On Axis I/II", are initially covered due to the extreme difficulty often involved in diagnosing certain categories of mental illness. Cases in which clients remain in this category for an extended period of time, or in which an agency has an unusually large number of clients in which the diagnosis is deferred, will be identified during the quality assurance and utilization review processes.

It is possible, however, that services may not qualify under the Mental Health Rehabilitative Services portion of the Medicaid State Plan but do qualify under another authorization within the State Medicaid Program. An example of this would be the range of substance abuse services.

All questions on which diagnosis codes might be considered permissible in addition to those listed above should be addressed to the Medicaid Project Officer, Division of Behavioral Healthcare, at the address in Appendix 6.

* The excluded diagnostic categories may be waived on a case-by-case basis by DBH for individuals who have had at least one admission lasting 180 days or more to the Adult Psychiatric Unit of Eleanor Slater Hospital or the former Institute of Mental Health. All applications for a waiver must be made in writing to the Medicaid Project Officer and contain a client history, including dates of hospitalization, as well as specific clinical and/or administrative justification for the request.

B. COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT (CPST)

1) Definition

Community Psychiatric Supportive Treatment (CPST) is a service provided to community-based clients and collaterals by professional mental health staff in accordance with an approved treatment plan for the purpose of ensuring the client's stability and continued community tenure by monitoring and providing medically necessary interventions to assist them to manage the symptoms of their illness and deal with their overall life situations, including accessing needed medical, social, educational and other services necessary to meeting basic human needs. Interventions provided under CPST may include, but are not necessarily limited to:

a. Assisting in the development of symptom self-management, communication skills and appropriate social networks to assist clients in gaining effective control over their psychiatric symptoms and their life situations, including minimizing social isolation and withdrawal brought on by mental illness, to increase client opportunities for leading a normal, socially integrated life;

b. Maintaining up-to-date assessments and evaluations necessary to ensure the continuing availability of required services;

c. Participating in the treatment planning process including tracking and monitoring client progress in meeting the goals and objectives of the plan;

d. Assisting the client in locating and effectively utilizing all necessary community services in the medical, social and psychiatric areas and ensuring that services provided in the mental health area are coordinated with those provided through physical health care professionals;

e. Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their illness that affect their performance at a work-site. These interventions will fall primarily in the areas of achieving required levels of concentration and task orientation and facilitating the establishment and maintenance of effective communications with employers, supervisors and co-workers;

f. Assistance with other activities necessary to maintain personal stability in a community setting and to assist the client to gain mastery over their psychiatric symptoms and disabilities in the context of daily living.

2) General Program Guidelines

a. CPST services may be provided to all adult clients (i.e. clients who are 18 years of age or older), either CSS or GOP, assuming that the services are determined to be medically necessary and appropriate; that they are specified and justified in the client's individual treatment plan; and that they are properly documented. However, individuals classified as “General Outpatients” who receive CPST services must have their charts reviewed for reclassification as “Community Support” after every 30 individual days on which they receive a community-based CPST intervention. The results of this review must be clearly documented in the client record. If this documentation is accomplished through the use of progress notes, the treatment plan itself must refer the reviewer to said note(s).

b. Prior written authorization from the Division of Behavioral Healthcare is required before billing for CPST utilizing the “per diem” methodology for clients classified as “General Outpatients” for days in excess of 30, whether or not they are consecutive, in any given calendar year. It is the responsibility of the provider to track all services provided and to request appropriate authorization from DBH at least one-week in advance of service provision.

3) Qualified Staff

Each staff member providing CPST interventions must be a mental health professional with at least an Associate's Degree in the social sciences, or possess equivalent experience, or have a combination thereof. Each staff member must also receive specialized training, including a comprehensive orientation to other community services/agencies in Rhode Island, as well as meeting all other requirements specified in the Rules, Regulations and Standards for Licensing of Community Mental Health Facilities and Programs. This training must be documented in the worker's personnel record. In addition, participation in the R. I. Community Support Professional Training Program is strongly encouraged as a means of providing a base from which additional skills may be developed.

Providers of CPST services must also work for an eligible provider in a program unit that is directed by a qualified mental health professional as defined in the Rhode Island General Laws, or by a person possessing equivalent experience in working with seriously mentally disabled individuals in community settings.

4) Reimbursement

a. Payments made for CPST interventions may not duplicate payments made under other program authorities for this same purpose. Billing for CPST interventions that are included and billed as an integral part of another provider service is prohibited. Additionally, billing under CPST for clients who are being served by a RIACT team and for whom either the RIACT-I or RIACT-II per-diem rate is being billed, is specifically prohibited.

b. It is not permissible to request reimbursement for CPST under both the unit-of-service and per-diem mechanisms for the same client on the same day.

c. Service time billed must be for direct, face-to-face contact with a client or collateral. Travel time and telephone time have already been taken into consideration in the overall calculation of the fee paid for CPST and are therefore not billable.

d. It is permissible to bill for CPST interventions provided to individuals in some hospitals under certain conditions. Specifically, if the client is in a hospital that is eligible to be reimbursed by Medicaid for their care, providers may bill for any CPST services that they provide for that individual as long as those services:

   1) Are specified in the client's individual treatment plan;

   2) Are limited to the last 30 days before discharge from the hospital and;

   2. Will not duplicate the discharge planning activities required of the institution.

e. Reimbursement for CPST interventions may be requested either on a "unit-of-service" or a "per diem" basis.

   For unit of service billing, providers should bill in one-half (1/2) hour units, rounding to the nearest half hour. Therefore, a visit must last 15 minutes or longer in order to bill for a half-hour unit. It is not permissible to add together several shorter visits to reach the minimum for a billable unit.

   Per diem billing may be used, but is not required, for individuals living in residential settings licensed by the Department of MHRH but for whom providers are not billing under the Mental Health Psychiatric Rehabilitative Residence coverage. This latter category will most commonly include General Outpatients who are experiencing a severe exacerbation of their symptom and require short-term care with 24-hour supervision. For purposes of this program, "group residence" is defined as "any congregate living program that is licensed as a community residence by DMHRH". It is not permissible to bill both the MHPRR per diem and the CPST per diem for the same client on the same day.

f. Per diem CPST may be billed for each day that the client is at the residence. You may claim per diem reimbursement for days on which residents are temporarily absent for 3 consecutive days or less for reasons other than hospitalization (e.g. home visit, etc.) as long as they return to the

residence after the absence. You may not claim reimbursement for days over 3, or in situations in which the client does not return within to the residence within 30 days of the date of departure.

g. Reimbursement for CPST interventions may be requested on a unit-of-service basis for clients living in group residences for whom the CMHC is also billing under the MHPRR provisions outlined in this manual in certain circumstances. Overall, it is expected that residents of MHPRRs will get their basic service package from the staff of the MHPRR. This would include the development of basic social skills and support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized activities in the community. It is, however, expected that other specialty services, such as psychiatry and intensive psychiatric rehabilitation, will normally be provided outside of the setting of the home by separate specialty staff.

Specifically, there are several model approaches to psychiatric rehabilitation that provide clients with intensive, individualized service in a community setting rather than dealing with them in a group approach such as that used in a traditional "psychiatric rehabilitation" setting. The level of service provided by these programs is well beyond that which is required of the MHPRR staff either under the "Skill Assessment and Development" section of the MHPRR service description or under state contract. Therefore, services provided to MHPRR residents by staff members of these programs for the purposes of psychiatric rehabilitation are reimbursable under CPST provided that:

1. A member of a clearly defined psychiatric rehabilitation team performs the services on a 1:1 basis.
2. A maximum monthly average of 20% of the total CPST time billed for any given client may be for service provided in the MHPRR or in any other CMHC setting. The remainder must be provided in a natural community setting.
3. The provider is not on the staff of any MHPRR for which Medicaid reimbursement is being claimed;
4. The services do not duplicate the basic services that are required of MHPRR staff;
5. The services are clearly identifiable; adequately documented; specifically recommended in the treatment plan; and easily distinguished from the core services provided by MHPRR staff.

CPST interventions should be provided on an "as needed basis" with each individual getting the amount that they require. While there are no maximum caseload standards for <u>reimbursement</u> purposes, providers should check the program requirements of their individual State contracts to see if there are any specific <u>program</u> standards that must be met.

h. There is a cap of an average of four (4) hours per day, calculated on a monthly basis, on reimbursement for CPST interventions billed on a unit-of-service basis. That is, the total hours billed for a given client in any calendar month cannot exceed the number of days that the client was in service during that month multiplied by four (4). Units provided in excess of the cap will not be reimbursed.

Additionally, clients for whom you bill unit-of-service CPST in excess of 10 hours/day for more than 2 consecutive days must have an immediate treatment plan review, appropriately documented in the medical record.

i. Some examples of CPST billing are as follows:

1. A Community Support Professional drives 1/2 hour to the client's home, spends 1/2 hour with the client, drives 1/2 hour back to the office and then spends 1/2 hour on the phone with the client's landlord. [Bill 1/2 hour of community-based CPST as travel and phone time are already accounted for in the fee and are therefore not reimbursable as separate items.]

2. A Community Support Professional spends 1 hour with a client every Monday during the last 6 weeks of a client's hospitalization at a general hospital, working on issues that are not considered to be part of the hospital discharge team's responsibility. [Calculate 30 days back from the client's date of discharge and bill for any visits that fall within that time period. Billing for services provided outside of the 30-day time frame is prohibited.]

3. A Community Support Professional provides one hour of service to a group of 3 eligible recipients. [There is no fee for "group CPST". Therefore, bill each client for 20 minutes of CPST, which will actually translate to 3 bills for 1/2 hour each after rounding.]

4. A Registered Nurse drives 15 minutes to a client's home, takes approximately 40 minutes to provide both medication maintenance and CPST interventions, and then drives 15 minutes back to the office. [The travel time is not reimbursable. Billing for the remainder of the time depends on the amount of time that the nurse spends on each activity, i.e. medication and CPST. Assuming that he spends 20 minutes doing the medication and 20 minutes doing CPST, you would bill for one individual RN visit minimum 15-20 minutes and one unit of CPST arrived at by rounding 20 minutes to the nearest half hour.]

5. A community client who is not living in a licensed residential program was in service for the entire month of November and received a total of 125 hours of CPST services during the month. [Multiply the number of days in the month (30) by the maximum allowable hours per day (4) to get the maximum billable hours per month (120). The remaining 5 hours are not billable.]

6. A resident of an MHPRR receives 10 hours of intensive, 1:1 psychiatric rehabilitation, 2 hours of which takes place in the living room of the MHPRR, from a member of a clearly defined psychiatric rehabilitation team who is not on the staff of any MHPRR during the month of November. [Bill the MHPRR rate for the month. In addition, bill for 10 hours of CPST, as the provision of this intensive, individualized psychiatric rehabilitation is not covered in the basic MHPRR fee. If the provision of service had been divided into 3 hours in the MHPRR and 7 hours in the community, only 9 hours would be billable as a maximum of 20% (2 hours, in this case) of total billings in a month can be in the MHPRR or other CMHC setting.]

C. PSYCHIATRIC REHABILITATION DAY PROGRAM

1) Definition

A Psychiatric Rehabilitation Day Program may be composed of the following components:

a. Medication Program: A program providing for the prescription, administration and monitoring of medication, primarily psychotropic in nature, for the purpose of mitigating or eliminating symptoms of mental illness. Said program shall include periodic medication reviews which shall examine, as required, the following:

1. The reason for prescribing each medication;
2. Whether the medication is effective in treating the client;
3. Whether the prescribed dosage is the minimum required to effectively treat the client;
4. Whether there are any signs of adverse side effects and plans to address them;
5. All medication that the client is currently taking, including those of a non-psychotropic nature, to ensure that the mixture of medications is efficacious and safe.

b. Structured Therapeutic Program: A program that may include any or all of the following as determined to be medically necessary by specifying the need for the treatment in the client's individual treatment plan approved by a physician or other Licensed Practitioner of The Healing Arts as defined in this manual:

1. Occupational therapy;
2. Development and maintenance of necessary community and daily living skills including grooming, personal hygiene, cooking, nutrition, health and mental health education, money management and maintenance of the living environment;
3. Development of appropriate personal support networks;
4. Structured socialization activities to diminish tendencies towards isolation and withdrawal;
5. Development of the basic language skills necessary to enable the client to function independently;
6. Training in appropriate use of community services;
7. Physical therapy;
8. Expressive therapy.

2) Program Guidelines

a. All community support clients must routinely be assessed to determine their need for the Psychiatric Rehabilitation Day Program (PRDP) upon admission to the Community Support Program and at least every six (6) months thereafter at their semi-annual treatment plan review. The results of this assessment shall be entered in the individual case record and may take the form of a simple recommendation for further participation in the program.

While PRDP services are seen to be primarily for clients classified as Community Support, it is possible that clients classified as General Outpatients might also be referred for service. In the event that a PRDP participant is a GOP client, an assessment to determine the continuing need for PRDP services must be routinely conducted at least once every three calendar months during which the client is in service. The results of this assessment, which must be entered in the individual case record, must include specific documentation of the appropriateness of the utilization of PRDP for treating the client.

b. The PRDP must either offer, or ensure access to, all of the service components contained in the section above entitled "Definition".

c. The PRDP must ensure that outreach and follow-up are provided for those clients who fail to attend scheduled PRDP activities as specified in their individual treatment plans. However, this outreach/follow-up need not be done by PRDP staff and will, in most cases, be handled by a Community Support Professional. In the event that the PRDP staff does not do it, the PRDP progress notes should document the referral to the appropriate program for follow-up.

d. The PRDP must offer the Structured Therapeutic Program at least four (4) days each week.

e. The overall program must comply with the Rules, Regulations and Standards for the Licensing of Mental Health Facilities and Programs, as well as with all other applicable guidelines and/or standards.

f. Psychiatric Rehabilitation Day Programs may not be provided in a client's place of residence except in extenuating circumstances, and then only with prior written approval from DBH.

g. A Psychiatric Rehabilitation Day Program does not necessarily have to include a medication maintenance component. If it does, however, providers must take steps to ensure that they keep adequate records to allow them to differentiate between hours to be billed at the base STU fee and those to be billed at the "STU with Physician/RN Visit" fees.

3) Qualified Staff

The overall psychiatric rehabilitation day program must be directed by a qualified mental health professional as defined in Rhode Island General Laws, with appropriate training and experience to work with individuals with serious and persistent mental illness in psychiatric rehabilitative settings, or by a person possessing equivalent experience. There shall be an adequate number of professional staff to provide the planned services.

4) Reimbursement

a. PRDP billing must be done in full 60-minute hours of Structured Therapeutic Programming. These hours may be either a basic Structured Therapeutic Unit (STU); an STU with a physician medication visit; or an STU with a RN medication visit. It is not permissible to aggregate several visits of less than one hour to make up the one-hour unit. There is no minimum requirement regarding the number of hours that a client must attend the PRDP in order to bill.

b. Basic educational services and services that are either strictly vocational or solely recreational in nature are not reimbursable.

c. The physical location of the PRDP must meet all applicable state and local fire and safety codes and ordinances.

d. You may bill for PRDP services provided to individuals for whom you are billing MHPRR services as long as MHPRR staff are not also providing services at the PRDP.

e. You may bill for PRDP services provided to individuals for whom you are billing CPST on a per diem basis.

f. You may not bill for clients who are receiving RIACT-I services if those clients are being billed at the RIACT-I per diem. You may not bill for clients who are receiving RIACT-II services if those clients are being billed at the RIACT-II per diem subject to the exception for new teams contained in V.J.(4)(a)(5).

g. Some examples of PRDP billing are as follows:

1. A client arrives at the Structured Therapeutic Program (STP) at 9 a.m. and leaves at 12:00 noon. [Bill for 3 one-hour Structured Therapeutic Units (STUs).]

2. A client arrives at the STP at 9 a.m. and leaves at 12 noon. During that time, he received a medication visit from a physician as a part of the STP. [Bill for 2 one-hour STUs and 1 one-hour STU with physician medication visit.]

3. A client arrives at the STP at 9 a.m., leaves at 11 am for a one-hour therapy session with an MSW, returns at noon and leaves for the day at 1 p.m. [Bill for 3 one-hour STUs. Also, bill for the MSW visit if recommended by the client's treatment plan.]

4. A client arrives at the Structured Therapeutic Program (STP) at 9 a.m. and leaves at 12:00 noon. The client returns to the STP from 2–4 p.m. and from 7–8:45 p.m. [Bill for 6 one-hour STUs. The 45-minute segment is <u>not</u> billable, as the minimum is a full hour.]

D. CRISIS INTERVENTION SERVICES

1) Definition

Crisis Intervention Services are short-term emergency mental health services, available on a twenty-four hour basis, seven days a week. These services shall include, but are not limited to, evaluation and counseling; medical treatment, including prescribing and administering medications; and intervention at the site of the crisis when clinically appropriate.

2) Program Guidelines

a. Frequent face-to-face (i.e. more than once in a single week or more than three times in a single month) use of emergency services by a client must trigger a prompt review of the client's treatment plan. The results of this review, whether or not a change is indicated, must be entered in the client's case record. Note that the entire treatment plan need not be re-written at this point but must be reviewed and, if so indicated, modified to meet the client's needs.

b. Crisis intervention services are, by nature, of an emergency, non-routine nature. This service is not meant to be a substitute for aggressive outreach and CPST but should be used to respond on occasions when a client suffers an acute episode despite the provision of those services. It is permissible, however, to provide a maximum of three (3) crisis contacts immediately following the initial contact, provided that they are aimed at resolving the immediate crisis situation. Each individual contact is limited to a maximum of 16 reimbursable ½-hour units, meaning that a client may receive 8 total reimbursable hours of service for each of the 3 contacts following the initial crisis contact.

c. It is possible that an agency might use crisis intervention personnel in order to help alleviate a situation in which a waiting list precludes the immediate provision of routine services such as counseling and therapy or even as "central intake" for the agency as a whole. These services are not considered "crisis intervention", even though crisis staff provides them. It is possible, however, that they might be billable under the "Clinician Services" section of the Community Mental Health Medicaid Program.

3) Qualified Staff

Crisis intervention services shall employ staff as specified in Section MHPS 300.4 of the Rhode Island Rules, Regulations, and Standards for Licensing of Mental Health Facilities and Programs. MHPS 300.4, Section D, "Other Professional Staff", shall be interpreted to include either:

a) A QMHP who has been approved to sign an application for emergency certification to an inpatient facility by DBH or;

b) An individual with at least a Bachelor's Degree in the human services field who is either a full-time or "on-call" employee of an Emergency Services Unit with at least 6-months supervised experience as an emergency services worker in Rhode Island.

Unless one of the staff members on duty is a physician, twenty–four hour medical backup is required.

4) Reimbursement

a. Billable crisis intervention services can include an emergency intake on a new client if that client is in crisis, but cannot include the routine intakes that occur when this service is also used as the central intake point for the provider.

b. Crisis intervention services delivered by telephone are not reimbursable, as the need for extensive telephone work has been calculated into the overall fee structure.

c. A crisis worker can bill for only one eligible client at any given time. There is no provision for "group crisis intervention".

d. Crisis contacts must be performed by Emergency Service Clinicians in order to be billable. The designation of "emergency service clinician" can include an individual who has been assigned to be "on call" by the agency provided that the individual meets the minimum criteria specified under "Qualified Staff".

In the event that an Emergency Service Clinician is not available and another qualified individual handles the contact, that individual may be eligible to bill under the Clinician Services section of this plan. This emergency intervention need not be specified in the client's individual treatment plan.

e. Examples of proper billing for Crisis Intervention are as follows:

1. A crisis worker drives 15 minutes to the local YMCA spends 30 minutes evaluating an eligible individual and drives 15 minutes home. [Bill for the minimum 1/2 hour of crisis intervention as travel time is not reimbursable.]

2. Under the same circumstances, the evaluation takes 40 minutes. [Bill for 1/2 hour of crisis intervention due to rounding to the nearest 1/2 hour.]

3. Under the same circumstances, the evaluation takes 45 minutes. [Bill for 1 hour of crisis intervention due to rounding to the nearest 1/2 hour.]

4. The client's family brings him to the crisis unit. The worker spends 1/2 hour with the client, 1/2 hour with the family and then sends him home with the family temporarily until other housing can be arranged. The worker then spends two hours on the phone attempting to place the client in a more appropriate living situation. [Bill for one full hour. Crisis intervention nearly always involves working with a collateral or significant other to resolve the situation so the face-to-face contact with the family is billable. However, the follow-up telephone contacts are not.]

E. CLINICIAN SERVICES

1) Definition

"Clinician Services" are clinical diagnostic and treatment services to individuals with mental or emotional disorders, the individual's families, and others with significant ties to the clients.

These mental health services include, but are not limited to, assessment and evaluation; individual, family, couple, and group therapy; and medication treatment and review. With the exception of medication treatment and review, clinician services do not include those services that are part of another Community Mental Health Service such as Psychiatric Rehabilitation, Crisis Intervention services, or services defined as CPST.

2) Program Guidelines

There is no arbitrary maximum placed on the number of clinician's visits that a client may receive in a given period of time. However, all visits must be medically necessary and appropriately documented.

3) Qualified Staff

A. Defined in MHPG 800.3-800.5:

Services provided by any of the following clinicians, as defined in Sections MHPG 800.3–800.5 of the Rules, Regulations, and Standards for Licensing of Mental Health Programs and Facilities, are reimbursable: Physician; Psychologist; Social Worker; Psychiatric Nurse; Principal Rehabilitation Counselor; Principal Occupational Therapist; Registered Nurse.

The following restrictions apply:

a. Registered Nurses and Psychiatric Nurses must be registered by the R. I. Board of Registration for Nurses.

b. Psychologists must be licensed by the R. I. Board of Registration for Psychologists.

c. "Social Worker" means a Licensed Clinical Social Worker (LCSW) or a Licensed Independent Clinical Social Worker (LICSW).

Clinicians who have not received the LCSW or LICSW accreditation but who hold a Master's Degree in clinical social work from a program that is accredited by the Council on Social Work Education and who are working towards achieving their LCSW/LICSW accreditation and are employed by a provider eligible under the Mental Health/Medicaid program will be reimbursable for a period not to exceed one year from the date on which they are hired. In rare instances, DBH may extend the one-year period upon receipt of written materials adequately documenting the reason for the request for an extension.

In order to ensure that adequate and appropriate care is provided to clients during that period, each employee qualifying under this exception must be supervised for at least one hour each week by a qualified professional staff member meeting the requirements for his or her profession as set forth in the Regulations. This supervision must conform to the guidelines set forth in MHPG 800.5 and must also include a review of all cases after the third kept appointment and every twelfth kept appointment thereafter, as well as a review of a 25% sample of cases discharged. The results of these reviews must be documented and must be made available to DBH upon request.

Agencies must provide DBH with the names and hire dates of all clinicians that qualify under this exception process and must further notify the Project Officer at the time that the LCSW/LICSW designation is received. It is the responsibility of the agency to ensure that it only bills for eligible clinicians.

Details on the LCSW/LICSW process are available from the RI Department of Health, Division

of Professional Regulation (see Appendix 6).

B. Defined By The Division of Behavioral Healthcare:

Psychiatric and Mental Health Nurse Clinical Specialist With Prescription Privileges;

A Psychiatric and Mental Health Nurse Clinical Specialist With Prescription Privileges shall have a masters degree in nursing; an active license as a registered nurse; and certification as a "Psychiatric and Clinical Nurse Specialist" by the American Nurses Credentialing Center. Additionally, this individual must have current prescriptive privileges granted under the governance and supervision of the Rhode Island Department of Health, Division of Professional Regulation, Board of Nurse Registration and Nursing Education and operate in collaboration with a physician.

Licensed Chemical Dependency Professional/Licensed Chemical Dependency Supervisor;

A Licensed Chemical Dependency Professional shall be currently certified as an Advanced Chemical Dependency Professional (ACDP) in accord with the Rhode Island Certification Board for Chemical Dependency Professionals and shall be licensed by the State of Rhode Island, Department of Mental Health, Retardation and Hospitals.

A Licensed Chemical Dependency Supervisor shall be currently certified as a Chemical Dependency Clinical Supervisor (CDCS) in accord with the Rhode Island Certification Board for Chemical Dependency Professionals and shall be licensed by the State of Rhode Island, Department of Mental Health, Retardation and Hospitals.

Marriage and Family Therapist;

A Marriage and Family Therapist shall be certified in the provision of marriage and family therapy by the Rhode Island Department of Health and shall be listed on the active register of therapists in marriage and family practice as maintained by the Administrator of Professional Regulations, Department of Health.

Mental Health Counselor

A Mental Health Counselor shall be certified in the provision of mental health counseling by the Rhode Island Department of Health and shall be listed on the active register of counselors in mental health as maintained by the Administrator of Professional Regulations, Department of Health.

Principal Counselor

A Principal Counselor shall have at least a Master's degree from an accredited program in counseling or clinical psychology and the equivalent of two years of full-time supervised clinical experience in a mental health setting and be certified by DBH. Standards for certification are available from DBH.

Notes:

1. An "accredited program" must be accredited by the New England Association of Schools and Colleges, or an equivalent regional accrediting agency, and must have the approval of a recognized national or regional certifying authority. Examples of acceptable programs are the Master's in Rehabilitation Counseling offered by RIC, BU and Assumption; the Master's in Agency Counseling offered by RIC; and the Master's in Marriage and Family Therapy offered by URI.
2. It is not necessary for individuals to work full-time during their supervised clinical experience. For example, individuals working only half-time would simply take four years to accumulate the equivalent of two years of full-time supervised clinical experience.

Counselor

A Counselor shall have at least a Master's degree from an accredited program in counseling or clinical psychology and the equivalent of one year of full-time supervised clinical experience in a mental health setting and be certified by DBH. Standards for certification are available from DBH.

Notes:

1. An "accredited program" must be accredited by the New England Association of Schools and Colleges, or an equivalent regional accrediting agency, and must have the approval of a recognized national or regional certifying authority. Examples of acceptable programs are the Master's in Rehabilitation Counseling offered by RIC, BU and Assumption, the Master's in Agency Counseling offered by RIC, and the Master's in Marriage and Family Therapy offered by URI.

2. It is not necessary for individuals to work full-time during their supervised clinical experience, although individuals working only part time would take more than a year to accumulate the equivalent of one year of full-time supervised clinical experience.

3. A Counselor must be supervised until the equivalent of a total of two years of experience is earned. Supervision must be provided for at least one hour each week by a qualified professional staff member at a level of training and experience higher than that of "Counselor" meeting the requirements for his or her profession as set forth in the Regulations and in the Community Mental Health Medicaid Procedure Manual.

   This supervision must conform to the guidelines set forth in MHPG 800.5 and must also include a review of all cases after the third kept appointment and every twelfth kept appointment thereafter, as well as a review of a 25% sample of cases discharged. The results of these reviews must be documented and must be made available to DBH upon request.

4) Reimbursement

a. Medication treatment and review is reimbursable ONLY when provided by a physician or registered nurse.

b. In cases where more than one member of the family receives counseling, reimbursement depends on which family member is being treated for a mental disorder according to a treatment plan and also on who is Medicaid eligible. (In most cases, an entire family would be eligible.) As a general rule, you should use the service code that matches the client whose treatment plan is being addressed by the service.

   For example, if the child has a mental disorder and the child's treatment plan calls for counseling of the parents in order to treat the disorder, then the clinician's visit with the parents would most likely be billable under the child's record. Therefore, if a social worker saw the child for 30 minutes and the mother for 30 minutes consecutively, that would be billed as one 40-50 minute visit to the child. The treatment notes would document who was actually seen and the services provided.

   Alternatively, assume in the above example that the mother also has a mental disorder and her own individual treatment plan and it was her disorder and that was being treated in the second session. In that case, the agency should bill two individual 25-30 minutes social worker visits, provided that both the mother and child were Medicaid eligible.

   Note that group therapy billing codes should not be used for family therapy, but only for services rendered to groups of unrelated clients, all of who have their own individual treatment plans.

c. The time categories for therapy used in the Mental Health Medicaid Fee Schedule are set in terms of <u>minimums</u>. For example, a standard therapy session that lasts for one and one-half hours would be billed as one single 40-50 minute session of therapy, because the fee is for a <u>minimum</u> of 40-50 minutes.

   In general, clients should not get more than a single one-and-one-half (1.5) hour assessment every six months in conjunction with their treatment plan review. Where sudden changes in symptoms

require an additional assessment, the clinical necessity for the assessment should be fully documented in the client's case record. The “assessment” category may not be used as a mechanism for billing 1.5-hour units of standard psychotherapy at a rate higher than that provided for the 40-50 minute minimum unit.

d. All medically related duties performed for eligible clients by Registered Nurses are reimbursable providing that those services are prescribed in the client's individual plan of care. That is, the portion of a nurse's duties in which they meet with individual clients to monitor and record physical vital signs; administer any type of prescription medication; discuss new or ongoing physical problems; monitor the effects of psychotropic medications prescribed by a physician; or supervise the provision of recommended services, are reimbursable.

   Additionally, the portion of the nurse's duties in which they work to educate individual clients in the areas of medication, nutrition, exercise, etc. are reimbursable when these activities are prescribed as an integral part of the overall treatment regimen in the client's individual treatment plan.

e. The portion of any clinician's duties in which they offer consultation to other staff in the agency or act as a liaison between staff and community medical personnel is not reimbursable as “clinician's services”. However, the liaison portion of this type of activity may be consistent with the services provided by a Community Support Professional and, depending on the specific circumstances, may therefore be billable under the CPST section of this manual.

f. Individuals billing under the LCDP/LCDS classification may be reimbursed only for chemical dependency assessment and counseling services provided to clients who carry both a primary diagnosis of mental illness and a clear secondary diagnosis of substance abuse. Both diagnoses must be clearly visible in the client’s individual record and the chemical dependency services must be clearly specified in the client’s treatment plan.

F. MENTAL HEALTH PSYCHIATRIC REHABILITATIVE RESIDENCE

1) Definition

A Mental Health Psychiatric Rehabilitative Residence (MHPRR) is a licensed residential program with no more than sixteen (16) beds which provides 24-hour staffing for Community Support clients (as defined by the Division of Behavioral Healthcare) in which the clients receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services. Beds may be designated as Intensive, Specialty, Basic, Crisis/Respite, or any combination thereof.

Specific services may include, but are not limited to:

a. Counseling: Individual, group and family;

b. Medication: Education, administration and monitoring;

c. Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized treatment planning and skill teaching; income maintenance; and medical care assistance;

d. Limited physical assistance as required: Mobility; assistance with non-injectable medications; dressing; range-of-motion exercises; transportation; and household services;

e. Skill assessment and development: Personal hygiene; health care needs; medication compliance; use of community resources; social skills development and assistance; support in the development of appropriate behaviors to allow the residents to participate, to the fullest extent possible, in normalized community activities.

The "24-hour staffing" requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff shall be on site for programs housed in a single building but may be situated in a central location in an apartment program. In all cases, response time to any individual unit (e.g. bedroom or apartment) shall be no greater than five minutes.

2) Exclusions

a. Any programs or services provided to residents that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking residents with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, programs geared towards developing appropriate behaviors for operating in an overall social or work environment are reimbursable. An example of a non-reimbursable service would be one in which a resident is taught to cook with the intent of securing a job in a restaurant. An example of a reimbursable service would be one in which a client learns to cook as an integral part of an overall rehabilitation program designed to teach the client how to plan nutritious meals; budget money; shop; perform tasks according to a schedule and under a deadline; sharpen sequential thinking skills; and interact with other individuals in a cooperative, task-oriented effort.

3) Provider Certification

Providers must be certified by DBH before they can bill for MHPRR services. This certification is in addition to any other requirement for participation in the Mental Health Medicaid Program.

In order to be certified, each Provider must submit an "Application for Provider Certification-MHPRR" (see Appendix 3) along with the following items to DBH:

a. A copy of a current license issued by MHRH to operate each individual residential program for which certification is desired. Note that if a licensed program submits a complete and timely application for license renewal to the appropriate section of MHRH, the existing license remains in effect until the request for renewal has been processed. This circumstance should be documented by submitting a letter from the Office of Licensure and Standards, MHRH, certifying that timely and sufficient application for license renewal has been made. The Provider is responsible for ensuring that DBH has these materials on file at all times.

b. A copy of a current variance from MHRH if the program has more than 12 beds.

c. A signed and dated copy of the "Service Agreement: Mental Health Psychiatric Rehabilitative Residence" (see Appendix 2).

Certification, if awarded, will be for a maximum of two years. It is the responsibility of the Provider to apply for re-certification at least sixty (60) days before the current certification expires by resubmitting all required documents.

4) Service Authorization

A physician must authorize all MHPRR services. To document physician authorization, the "Psychiatric Rehabilitative Residence Individual Care Checklist" (see Appendix 4); the resident's Individual Treatment Plan; and all 6-month plan reviews must be completed or countersigned by a physician.

However, in the case of clients who enter a crisis/respite bed in an MHPRR on a short-term basis, authorization may be obtained by means of a telephone consultation with the physician with the results of said consultation, including the date, time, duration, and detailed and specific clinical reasons for which the client is being admitted to the MHPRR, being recorded in the client's case record. This authorization remains in effect for a period not to exceed 3 days after which base authorization requirements apply. If the "progress note" section of the record is used to document the consultation, it must also be clearly referenced in the treatment plan itself.

Be aware that the Checklist is not an exhaustive listing of all of the care that the individual requires. Rather, it is a basic listing of individual hygiene, dietary, household, financial and related needs that must be assessed and addressed where required. It does not replace a thorough psychiatric/psycho-social needs assessment and treatment plan.

5) Medical Records/Treatment Planning

Medical records must comply with the overall Medical Record Documentation Guidelines contained in the Community Mental Health Medicaid Procedure Manual. In addition, they must contain the materials required under the "Authorization" section of the MHPRR program. Finally, new MHPRR residents require either a new treatment plan or a treatment plan review, signed by a physician, as close to the date of admission to the MHPRR as possible, but in no case more than 21 days before or 30 days after the actual date of admission.

Note that the treatment plan must contain detailed and specific reasons for which the client is being referred to the MHPRR. It is not sufficient to make a general statement to the effect that the individual needs residential rehabilitative care due to his/her overall psychiatric condition. The plan must spell out the specific aspects of the client's condition that necessitate MHPRR treatment and lay out detailed, measurable goals and objectives for that treatment. Progress notes, written at a minimum according to the schedule prescribed in the Medicaid "Medical Record Documentation Guidelines" (see Appendix 5), must address progress towards the goals and objectives, including the overall response of the resident to the recommended treatment and the outcome thereof.

6) Reimbursement

a. The MHPRR rate is structured to capture all of the staff costs associated with providing the basic, routine day-to-day rehabilitative care uniformly provided to all residents that either takes place in the program, or is provided by staff of the program. This would include basic social skills development and support in the development of appropriate behaviors to allow the residents to

participate, to the fullest extent possible, in normalized activities in their community.

As these costs do not include the cost of psychiatry, you may be reimbursed separately for any physician's services provided. Additionally, you may be reimbursed for nursing activities (medication administration, counseling, diet management, etc.) as long as the nurse is not on the staff of <u>any</u> MHPRR for which Medicaid reimbursement is being claimed. You may also be reimbursed for any other non-residence based services provided to the client such as Structured Therapeutic Units or CMHC-based counseling and therapy, as long as they are not provided by staff of <u>any</u> MHPRR for which Medicaid reimbursement is being claimed.

b. Reimbursement for CPST interventions is also available on a unit-of-service basis for residents for whom MHPRR is being billed under certain circumstances.

Specifically, there are several model approaches to psychiatric rehabilitation that provide clients with intensive, individualized service in a community setting rather than dealing with them in a group approach such as that used in a traditional "psych rehab" setting. The level of service provided by these programs is well beyond that which is required of the MHPRR staff either under the "Skill Assessment and Development" section of the MHPRR service description or under state contract. Therefore, services provided to MHPRR residents by staff members of these programs for the purposes of psychiatric rehabilitation are reimbursable under CPST provided that:

1. A member of a clearly defined psychiatric rehabilitation team performs the services on a 1:1 basis;
2. A maximum monthly average of 20% of the total CPST time billed for any given client may be for service provided in the MHPRR or in any other CMHC setting. The remainder must be provided in a natural community setting;
3. The provider is not on the staff of any MHPRR for which Medicaid reimbursement is being claimed;
4. The services do not duplicate the basic services that are required of MHPRR staff;
5. The services are clearly identifiable; adequately documented; specifically recommended in the treatment plan; and easily distinguished from the core services provided by MHPRR staff.

However, you may <u>not</u> claim separate reimbursement for:

1. RIACT-I or RIACT-II services, regardless of who provides them or the amount provided;
2. Crisis intervention, unless provided by a physician;
3. Counseling or therapy provided either in the residence or by the staff of the residence except as specified in section "a" above

c. You may claim MHPRR reimbursement for days on which clients who are residents of the MHPRR are temporarily absent for 5 consecutive days or less for reasons other than hospitalization (e.g. home visit, etc.) as long as they return to the residence within 30 days. You may not claim reimbursement for days over 5 or in situations in which the client does not return within 30 days of the date of departure.

d. When clients are hospitalized, the following restrictions apply:

1. If the client is in Butler Hospital or any other facility classified as an IMD (Institution for Mental Disease) you may <u>not</u> bill Medicaid for services that you provide regardless of what those services are.
2. If the client is in any hospital that is being reimbursed by Medicaid for their care, you may not bill the MHPRR per diem rate. You may, however, be eligible to bill CPST on a unit-of-service basis for services that you provide to that individual as long as those services are:

a) Limited to the last 30 days before discharge from the hospital and;

b) Will not duplicate the discharge planning activities required of the institution.

d. You may bill for both the day of admission to, and the day of discharge from, the MHPRR.

f. Examples of billing for MHPRR are as follows:

1. A client lives in the MHPRR for the entire month of October although he went home on Friday and Saturday night one weekend. [Bill for 31 days of MHPRR per diem.]

2. A client lives in the MHPRR for the entire month of October although he went home on Friday and Saturday night one weekend. This client also received one-on-one services from a Community Support Professional as a part of his intensive psychiatric rehabilitation program for three hours in the afternoon on four consecutive Thursdays at the local community center. Additionally, the client required the services of a crisis intervention team for two hours one night. [Bill for 31 days of MHPRR per diem. If a physician provided the crisis intervention service, bill separately for those two hours. If a physician did not provide it, the hours are not billable. Also, bill for the 12 hours of CPST as it is part of an intensive, individualized psychiatric rehabilitation program that is above the level of service normally expected of residential programs.]

3. Jack Smith lived in the MHPRR from August 1 through August 15. He was then discharged to the CMHC's Independent Apartment Program where he received basic CPST services for the remainder of the month. [Bill for 15 days of MHPRR service on a per diem basis as service should be counted from the day of admission through the day of discharge. As Jack was <u>discharged</u> from the home on August 15, you should bill separately for any CPST services provided <u>after</u> that date using the appropriate forms and procedures for CPST billing.]

G. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT I

1) Definition

A Rhode Island Assertive Community Treatment I (RIACT-I) team is a self-contained program that is the fixed point of responsibility for providing the treatment, rehabilitation, and support services to identified consumers with severe and persistent mental illness. Using an integrated service approach, RIACT-I merges clinical and rehabilitation staff expertise (e.g., psychiatric, substance abuse, employment, etc.) within a single service delivery team supervised by a qualified program director. Accordingly, there will be minimal referral of consumers to other program entities for treatment, rehabilitation, or support services.

A RIACT-I program assists consumers who have severe and persistent mental illness with a wide variety of activities including, but not limited to, the following:

a. Symptom stability, with services to include ongoing assessment of each consumer's symptoms of mental illness and response to treatment as well as education and support to enable each consumer to develop the self-monitoring and personal coping skills necessary to help manage his/her mental illness symptoms and internal or external stressors.

b. Maintenance of substance free lifestyles with services to include assessment of each consumer's substance use; provision of substance abuse treatment and education to help each consumer identify the interactive effects of substance use, psychiatric symptoms, and psychiatric medications; and provision of assistance in recognizing and managing substance abusing behavior.

c. Maintenance of safe, affordable housing in normative settings that are clean, attractive, and promote personal stability and well-being.

d. Establishment of natural community-based support networks to combat the isolation and withdrawal that persons with severe and persistent mental illness often experience.

e. Minimizing involvement with the criminal justice system, with services to include identifying precipitants of a consumer's criminal involvement; providing necessary treatment, support, and education to help eliminate any unlawful activities which may be a consequence of the consumer's mental illness; and advocating and collaborating with police, court personnel, and jail/prison officials to ensure appropriate use of legal and mental health services.

A more complete, but not exhaustive, listing of the types of problems that RIACT-I staff is expected to assist clients to deal with is contained in the Rhode Island Assertive Community Treatment I Standards which are available from DBH.

Key services to be provided by Rhode Island Assertive Community Treatment I program in helping clients deal with these problems include, but are not limited to: community psychiatric supportive treatment; crisis assessment and intervention; symptom assessment, management and supportive counseling; and medication prescription, administration, monitoring, and documentation. A more complete, but not exhaustive, listing of the type of services that the RIACT-I is expected to provide can be found in the Rhode Island Assertive Community Treatment I Standards.

Outreach to consumers and provision of services according to individual consumer needs and desires shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of the offices of the Rhode Island Assertive Community Treatment I program.

2) Exclusions

a. Any programs or services provided to clients that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking clients with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, support activities and activities directly related to assisting a client to cope with his mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment are reimbursable. An example of a reimbursable service would be one in which a team member spends time at the client's place of employment assisting the client to work out problems with his supervisor or co-workers brought about as a result of his mental illness.

3) Certification

a. Rhode Island Assertive Community Treatment I programs must be certified by DBH prior to billing for RIACT-I services. This certification is in addition to any other requirement for participation in the Mental Health Medicaid Program. Complete certification requirements are contained in the Rhode Island Assertive Community Treatment I Certification Survey, which is available from DBH.

b. Rhode Island Assertive Community Treatment I certification, if awarded, will be for a period of a maximum of two years, although it may be for less as determined by DBH. It is the responsibility of the provider to apply for re-certification at least thirty (30) days before the current certification expires by written request to the RIACT-I Project Director at DBH. Note that you may not bill for any services provided by an uncertified team, including a team whose certification has expired due to non-compliance with the requirements of this section. In the event that DBH is not able to complete the re-certification process for a team that submitted a complete and correct request within the timeframe given above, the current certification shall remain in effect until completion of the re-certification process by DBH.

4) Reimbursement

a. It is anticipated that RIACT-I staff will provide the bulk of the everyday services required by the clients served by the team. Therefore, providers are prohibited from billing the Mental Health Medicaid Program for any costs over and above the RIACT-I per diem with the following exceptions:

1. It is permissible to bill for infrequent Crisis Intervention Services provided by CMHC Emergency Services staff, as long as all of the appropriate requirements are met.

2. It is permissible to bill separately for any services above and beyond the normal levels of RIACT-I service provision that are specifically required to maintain an individual on Clozaril.

There are no circumstances other than those listed above in which any provider may bill the Community Mental Health Medicaid program separately for physicians services, nursing services, psychiatric rehabilitation, psychotherapy, substance abuse treatment, CPST, etc. for any RIACT-I client who is being billed under the per diem method.

b. In the event that services are provided and billed under one of the “exception” categories listed above, the service time may not be counted towards the minimum RIACT-I contact hours required for per diem RIACT-I billing. That is, in the event that RIACT-I staff accompanies the client to a program billable under an “exception category”, agencies may count either the RIACT-I contact hours or bill for the program services provided but may not do both.

c. There are occasions on which RIACT-I staff might conduct group activities that also involve individuals who are not RIACT-I clients but who are eligible for Medicaid. If the clinician is a full-time RIACT-I staff member, it is not permissible to bill Medicaid separately for services provided to the clients who are not enrolled in the RIACT-I program.

If the clinician is a part-time RIACT-I staff member, you may EITHER a) bill Medicaid separately for services provided to the non-RIACT-I clients in the group setting OR b) count the

group time as contact time for the RIACT-I clients. You may not, however, do both.

d. You may not bill RIACT-I per diem rates for hospitalized clients regardless of the circumstances of the hospitalization. You might, however, be able to bill unit-based CPST for services that meet the standards in Section V of this manual.

e. The RIACT-I Standards require that an average of 2 hours of face-to-face service per week be provided to a client or collateral in order for that individual to be considered as a RIACT-I client. In order to operationalize this for Medicaid billing purposes, please apply the guidelines, which are based on a monthly billing cycle, contained in the following chart. The service hours required should be adjusted downward to reflect instances in which an individual is in RIACT-I for less than the full month (e.g. 2 hours are required for a client in the program for 1 week, 4 hours are required for a client in the program for 2 weeks, etc.)

Monthly Service Hours	Billing Procedures	
8 or more		Bill as indicated in the "Billing Instructions: RIACT-I" (i.e. per diem)
5.0--7.9	First Month	Bill as indicated in the "Billing Instructions: RIACT-I" (i.e. per diem) but include clinical justification for the reduced service level in the client's individual case record.
	Three or More Months	For a client who receives less than 8 hours, but at least 5 hours, for three or more consecutive months, bill the first two months as instructed above (i.e. per diem). The third month must be billed at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation. (E.g. Bill the community-based CPST rate if the practitioner is an MSW providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)
< 5.0		Bill at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation. (i.e. Bill the community-based CPST rate if the practitioner is an MSW providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)

H. SPECIALIZED MENTAL HEALTH CONSULTATION TO NURSING FACILITIES

1) Definition

Specialized Mental Health Consultation to Nursing Facilities is a service designed to allow NFs to access expert clinical psycho-geriatric consultation from Community Mental Health Centers on psychiatric and/or behavioral concerns designed to impact both on an individual case and, by logical extension, on the operation of the NF as a whole. Typical concerns may be related to, but are not limited to, depression (e.g. sad mood, poor self-esteem, suicidal thoughts, apathy, crying, unremitting grief, lack of interest in activities and environment, weight loss, sleep disturbance and fatigue); dementia (e.g. confusion, thievery and increasing memory problems); and behavioral problems (e.g. demanding of staff attention, agitation, wandering, yelling and verbal and physical abuse of staff and/or other residents).

2) General Program Guidelines

a) Concerns/behaviors leading to a request for this service must be of such severity as to require a level of expertise beyond that which the NF would normally be expected to provide and must not duplicate services usually provided by the nursing facility under their basic rate.

b) All consultation must be face-to-face, either with the professional staff of the NF or with the resident who is the subject of the consultation. Telephone contacts are not billable regardless of their length.

c) "Specialized Mental Health Consultation To Nursing Facilities" is separate and distinct from the ongoing treatment services that are generally provided by the facility and may not be used either as a substitute for, or a supplement to, same. Consultation is limited to assisting the professional staff of the NF in the diagnosis, assessment and overall handling of difficult, complex cases that have not responded to standard approaches. As a part of this process, it is strongly recommended that the consultant conduct periodic examinations of the resident as required in order to assist in specifying or altering the course of treatment.

d) Each consultation may be provided only at the written request of the facility with the originator of the request being limited to the client's physician of record; a staff mental health professional (e.g. social worker, psychologist, etc.); the Director of Nursing; or the facility administrator. The request must document the medical necessity of the consult and clearly delineate that the service requested is beyond that which the NF would normally provide. CMHCs may respond to phone requests on an emergency basis provided that written back up follows within 7 calendar days.

e) Both the original request and the result of the consultation must be documented with proper signatures in the resident's individual case record maintained at the facility. A copy of both the original request and the result of the consultation must also be provided to the consultant and filed in such a manner as to provide a clear audit trail at the CMHC between the facility's request; the actual provision of consultation; the documentation of same; and the submission of a bill to Medicaid.

f) Each resident is entitled to twelve (12) consults at a maximum duration of four (4) hours/consult per calendar year or episode in a single NF, whichever is shorter, without prior authorization. Consults in excess of twelve (12) require prior authorization from DBH.

g) It is strongly recommended, but not required, that the facility attempt to reduce the need to use this service by assuring that consultation is provided to all staff dealing with the type of case in question with an emphasis placed on the generalizability of the knowledge transmitted. That is, each individual case should be seen as an opportunity to broaden the knowledge base of key NF staff members so as to enhance their ability to deal with future difficult cases within their own resource base.

3) Qualified Staff

Each staff member providing consultation must be a Licensed Practitioner of The Healing Arts as defined in this manual and must have specialized expertise in the provision of mental health services to the elderly.

4) Reimbursement

a) Payments made for Specialized Mental Health Consultation to Nursing Facilities may not duplicate payments for service made under other program authorities. Specifically, this service must be separate and distinct from those services covered under the overall Medicaid facility rate paid to the NF.

b) It is not permissible to bill for a "group consultation". Each consultation must be billed individually.

c) Court testimony is not billable under this coverage.

d) Each consultation must last for a minimum of 30 minutes, with no rounding permitted, for each individual case, exclusive of travel time, in order to be billable. Consultation provided on multiple cases at the same facility on the same day may be billed provided that a minimum of 30 minutes is spent on each individual case. After the first 30 minutes on each case, time billed for that case should be rounded up or down to the nearest 30-minute interval. (e.g. 40 minutes is billed as one 30–minute unit; 50 minutes is billed as two 30–minute units.)

e) Some examples of SMHCNF billing are as follows:

1. A Registered Nurse drives 25 minutes to a NF, spends 30 minutes assessing the client; an additional 20 minutes consulting with the social worker and a nurse's aide; and then drives 25 minutes back to the center. [Bill two 30–minute units as a) travel time is not reimbursable and b) the time after the initial 30 minutes is rounded up to the nearest half-hour.]

2. A physician spends 30 minutes on the phone with a social worker at a NF discussing the details of a case. [Bill $0. Phone time is not billable.]

3. An Elderly Specialist/MSW travels 25 minutes to a NF that is experiencing difficulty in dealing with 3 Medicaid eligible residents who are physically abusive to both staff and other residents. The MSW selects one specific case and uses it as the basis of a one-hour meeting for all staff members that deal with the clients, instructing them in specific behavioral interventions that have proven to be effective in the past and that are viewed as state-of-the-art. As a part of the meeting, participants actually engage in role-playing scenarios designed to enhance their skills in dealing with this type of situation effectively without additional outside consultation. The MSW then travels 25 minutes back to the CMHC. [Bill two 30-minute units of SMHCNF as travel time is not billable. The use of a single client's situation as a "case study" to help enhance worker's skills in dealing with an overall type of patient is strongly encouraged.]

I. MULTI-DISCIPLINARY MENTAL HEALTH TREATMENT PLANNING

1) Definition

A mental health treatment plan is a document that identifies the individual's mental health treatment needs; lists the strategy for providing appropriate services to meet those needs; documents treatment goals and objectives; and outlines the criteria for termination of specified interventions. Multi-Disciplinary Mental Health Treatment Planning is the formulation, maintenance, monitoring and modification of this plan by a multi-disciplinary team of mental health professionals in conjunction with the client whenever possible.

2) Qualified Staff

Treatment planning may be provided by a wide variety of mental health professionals from areas such as psychiatry, nursing, counseling, rehabilitation, social work or other mental health specialty areas involved in the individual client's care/treatment. Staff members directly supervising the provision of care to the client, or the overall program in which the care is provided, may choose to participate in the treatment planning process regardless of their degree or area of specialty.

3) Program Guidelines

a) Treatment plans billed under this coverage must meet all requirements of the Medical Record Documentation Guidelines contained in this Manual, in addition to any other requirements imposed by the client's individual program (e.g. MHPRR, RIACT-I, etc.).

b) Each individual client is restricted to a maximum of six (6) billable hours of service under this coverage per calendar year.

c) All aspects of the treatment planning process may be billed under this coverage including, but not limited to, the development of the initial plan; formulation of the comprehensive master plan; routine reviews; reviews necessitated by a significant change in the client's condition; reviews required at the end of the estimated length of treatment; and discharge or termination planning. Additionally, the development of a sub-plan in a specialty area under the overall plan (e.g. the formulation of a specific, detailed rehabilitation-oriented component of the plan) is considered to be a billable component.

d) It is strongly recommended, but not required, that the client be present and participate fully in the formulation of their individual treatment plan. At a minimum, the client's own perceptions of his or her needs must be taken into consideration during the formulation of the plan, whether or not the client is present during all aspects of planning process.

4) Reimbursement

a) Treatment planning may be billed as either a 50-60 minute session or a 25-30 minute session. Sessions must last at least the minimum amount of time prescribed in the category and may not be added together to generate reimbursement for, for example, a 75 minute session. Note also that the fee varies depending on whether or not a physician participates in the session.

b) A billable unit requires the participation of a minimum 3-member team, not including the physician, for the entire session. The team must include at least one Licensed Practitioner of The Healing Arts as specified in this manual.

The documentation for this service must include a mechanism by which Medicaid can easily confirm that the minimum number of professionals participated in each unit billed. Additionally, it must show clear evidence of physician participation in those sessions for which the higher "with physician" fee is billed. The simplest way to handle this would be to have at least 3 of the team members, including at least one Licensed Practitioner of the Healing Arts and the physician,

if present, sign the plan.

All reviews billed under this coverage must be documented in the client's individual medical record either as an addendum/amendment to the treatment plan; in a progress note; or by utilizing an alternative, agency-specific method.

Regardless of the method chosen, evidence of the MDTP, complete with all required signatures, must either appear somewhere in its entirety in the medical record or the record must note that the MDTP took place and clearly direct the reviewer to a specific location where complete documentation can be easily found.

c) It is not permissible to bill under this coverage for clients who are also being billed under RIACT-I or RIACT-II as both of these programs are self-contained services that include comprehensive treatment planning in their overall fee structure.

d) It is permissible to bill under this coverage for clients who are also being billed under MHPRR coverage, provided that at least two of the team members, not including the physician, are not on staff of any MHPRR for which the agency is billing Medicaid.

J. RHODE ISLAND ASSERTIVE COMMUNITY TREATMENT II (RIACT-II)

1) Definition

The Rhode Island Assertive Community Treatment II (RIACT-II) program is a service delivery practice that provides comprehensive community based treatment to persons with serious mental illness to enable them to live autonomous, integrated, safe and healthy lives in their natural community environments. RIACT-II integrates a wide range of services including Community Psychiatric Supportive Treatment, Psychiatric Services and Individual Placement and Support Services into a single program unit. It is a self-contained program which is the fixed point of responsibility for providing treatment, rehabilitation and family supportive services to an identified group of clients with mental illness who, while not experiencing functional impairment of the degree of severity which would require the service intensity offered by a Rhode Island Assertive Community Treatment I, nevertheless require a complex, coordinated array of services.

The RIACT-II team is organized as an accountable mental health team that functions interchangeably to provide treatment, rehabilitation and support in partnership with the client to address the client's comprehensive mental health and rehabilitative support needs in a way that empowers clients to live a life style of their choice.

A RIACT-II team assists consumers who meet DBH criteria for community support with a wide variety of activities including, but not limited to, the following:

a. Symptom stability, with services to include, but not necessarily be limited to, ongoing assessment of each consumer's symptoms of mental illness and response to treatment; individual supportive therapy; crisis intervention; and education and support to enable each consumer to develop the self-monitoring and personal coping skills necessary to help manage his/her mental illness symptoms and internal or external stressors.

b. Maintenance of drug/alcohol free lifestyles with services to include assessment of each consumer's substance use; provision of substance abuse treatment and education to help each consumer identify the interactive effects of substance use, psychiatric symptoms, and psychiatric medications; developing coping skills and alternative daily activities to minimize substance use; and provision of assistance in recognizing and managing the difficulties associated with substance use.

c. Acquisition and maintenance of safe, affordable housing in normative settings that are clean, attractive, and promote personal stability and recovery.

d. Establishment and maintenance of natural community-based support networks to combat the isolation and withdrawal that accompanies severe mental illness and to facilitate the recovery process in a community-based setting. Services might include, but not be limited to, CPST services, family supportive services,

e. Minimizing involvement with the criminal justice system, with services to include identifying precipitants of a consumer's criminal involvement; providing necessary treatment, support, and education to help eliminate any unlawful activities which may be a consequence of the consumer's mental illness; and advocating and collaborating with police, court personnel, and jail/prison officials to ensure appropriate use of legal and mental health services.

f. Assisting in the development and implementation of a plan for assuring client income maintenance, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the client to manage the symptoms of their illness that affect their performance at a work-site. These interventions will fall primarily in the areas of achieving the required levels of concentration and task orientation necessary to locate and maintain employment as well as facilitating the establishment and maintenance of effective communications with employers, supervisors and co-workers. In order to facilitate recovery, these interventions will also follow the elements of the Individual Placement and Support model.

A more complete, but not exhaustive, listing of the types of problems that RIACT-II staff is expected to assist clients to deal with is contained in the Rhode Island Assertive Community Treatment Team II Standards which are available from DBH.

The principle elements of treatment, rehabilitation and supportive services utilized in RIACT-II include the following: community treatment specialist services, psychopharmacology, individual supportive therapy, substance abuse treatment, crisis intervention, rehabilitation and family supportive services. All members of the team assist in the provision of all services. However, specific responsibilities are determined by the expertise or credential that is required for a particular service.

Outreach to consumers and provision of services according to individual consumer needs and desires shall be the team's highest priority, with the majority of clinical contacts occurring in settings outside of the offices of the RIACT-II program.

2) Exclusions

a. Any programs or services provided to clients that are strictly academic in nature are not reimbursable. These include such basic educational programs as instruction in reading, science, mathematics, GED, etc. However, services provided for the purpose of linking clients with academic and/or basic educational programs are reimbursable.

b. Any programs or services provided to clients that are strictly vocational in nature are not reimbursable. However, support activities and activities directly related to assisting a client to cope with his mental illness to the degree necessary to develop appropriate behaviors for operating in an overall work environment are reimbursable. An example of a reimbursable service would be one in which a team member spends time at the client's place of employment assisting the client to solve interpersonal problems with his supervisor or co-workers brought about as a result of his mental illness.

3) Certification

a. RIACT-II teams must be certified by MHRH, Division of Behavioral Healthcare, prior to billing for RIACT-II services. This certification is in addition to any other requirement for participation in the Mental Health Medicaid Program. Complete certification requirements are contained in the RIACT-II Certification Survey, which will be available in the near future from DBH.

b. RIACT-II certification, if awarded, will be for a period of a maximum of two years, although it may be for less as determined by DBH. It is the responsibility of the provider to apply for re-certification at least sixty (60) days before the current certification expires by written request to the RIACT-II Project Director at DBH. Providers may not bill for any services provided by an uncertified team, including a team whose certification has expired due to non-compliance with the requirements of this section. In the event that DBH is not able to complete the re-certification process for a team that submitted a complete and correct request within the timeframe given above, the current certification shall remain in effect until completion of the re-certification process by DBH.

c. RIACT-II programs must operate in accordance with the Rhode Island Assertive Community Treatment Team II Standards with the following exception:

Section II-B-1 of the Standards states that a client shall be discharged from RIACT-II when the client moves out of the geographic area of responsibility. However, Medicaid requirements relating to state-wideness and freedom-of-choice do not allow for termination of service based on geographic area alone.

For purposes of Medicaid billing, a client may be discharged when they move out of the area in which the team is capable of providing service. In such cases, the RIACT-II team shall arrange for the transfer of mental health service responsibility to a provider who is capable of providing

service in the location to which the client is moving, either in RI or out of state. The RIACT-II team shall maintain contact with the client until the client completes the intake process and services have been established.

4) Reimbursement

a. It is expected that RIACT-II staff will provide the bulk of the everyday services required by the clients served by the team. Therefore, providers are prohibited from billing the Mental Health Medicaid Program for any costs over and above the RIACT-II per diem with the following exceptions:

1. It is permissible to bill for infrequent Crisis Intervention Services provided by CMHC Emergency Services staff, as long as all of the appropriate requirements are met.

2. It is permissible to bill separately for any services above and beyond the normal levels of RIACT-II service provision that are specifically required to maintain an individual on Clozaril.

3. Each consumer's experience of mental illness is unique and is accompanied by complex psychological issues. In order to maintain continuity of care, all new admissions to the team may be allowed to complete any current course of time-limited, disorder-specific therapy for up to 12 visits after admission. This therapy must have begun prior to team admission, with RIACT-II progress notes tracking progress and integrating the care provided in this therapeutic relationship with RIACT-II efforts.

4. While the team should have the capacity to provide the vast majority of individual supportive therapy required by its clients, there may be unique disorders that need to be treated but do not occur often enough in the RIACT-II population to justify the team's adding that specific capacity (e.g. eating disorders). In these rare instances, the team may refer the client to appropriate, disorder-specific specialized therapy. The clinical record must contain clear documentation substantiating these referrals and must also comprehensively address the integration of team and specialty treatment

5. Many of the clients who will be eligible for RIACT-II are currently enrolled in Psychiatric Rehabilitation Programs that often provide an overall structure for their lives. While DBH anticipates that provider agencies will develop viable alternatives within, or as an adjunct to, the RIACT-II program, it is also aware that abrupt movement to a new service modality can be disruptive to the therapeutic process. Therefore, in order to allow for a smooth and orderly transition to the new service modality, providers will be allowed to continue to bill for Structured Therapeutic Units provided to RIACT-II clients after they begin to bill the RIACT-II per diem for a brief period to be determined by DBH.

There are no circumstances other than those listed above in which any provider may bill the Community Mental Health Medicaid program separately for any other covered service including, but not limited to, physicians services, nursing services, psychiatric rehabilitation, psychotherapy, substance abuse treatment, CPST, etc., for any RIACT-II client who is being billed under the per diem method.

b. In the event that services are provided and billed under one of the "exception" categories listed above, the service time itself may not be counted towards the minimum RIACT-II contact hours required for per diem RIACT-II billing. That is, in the event that a RIACT-II staff member accompanies the client to a program billable under an "exception category", agencies may count either the RIACT-II contact hours or bill for the program services provided but may not do both.

c. There are occasions on which RIACT-II staff might conduct group activities that also involve individuals who are not RIACT-II clients but who are eligible for Medicaid. If the clinician is a full-time RIACT-II staff member, it is not permissible to bill Medicaid separately for services provided to the clients who are not enrolled in RIACT-II.

If the clinician is a part-time RIACT-II staff member, you may EITHER a) bill Medicaid separately for services provided to the non-RIACT-II clients in the group setting OR b) count the group time as contact time for the RIACT-II clients. You may not do both.

d. You may not bill RIACT-II per diem rates for hospitalized clients regardless of the circumstances of the hospitalization. You might, however, be able to bill unit-based CPST for services that meet the standards in Section V of this manual.

e. The RIACT-II Standards require that an average of 4 hours of face-to-face service per month be provided to a client or collateral in order for that client to be considered as a RIACT-II client. In order to operationalize this for Medicaid billing purposes, please apply the guidelines contained in the following chart, which are based on a monthly billing cycle. The service hours required should be adjusted downward to reflect instances in which an individual is served by the RIACT-II team for less than the full month (e.g. 1 hour is required for a client in the program for 1 week, 2 hours are required for a client in the program for 2 weeks, etc.)

Monthly Service Hours	RIACT-II Billing Procedures	
4 or more		Bill as indicated in the "Billing Instructions: RIACT-II" (i.e. per diem)
2.5--3.9	First Month	Bill as indicated in the "Billing Instructions: RIACT-II" (i.e. per diem) but include clinical justification for the reduced service level in the client's individual case record.
	Three or More Months	For a client who receives less than 4 hours, but at least 2.5 hours, for three or more consecutive months, bill the first two months as instructed above (i.e. per diem). The third month must be billed at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation (i.e. Bill the community-based CPST rate if the practitioner is a caseworker providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)
<2.5		Bill at the applicable fee-for-service rate for the service being provided with appropriate supporting documentation (i.e. Bill the community-based CPST rate if the practitioner is a caseworker providing CPST; the Social Worker rate if the practitioner is an MSW doing therapy; etc.)

VI. GENERAL REQUIREMENTS AND LIMITATIONS FOR ALL SERVICES

A. All services listed in this manual, other than Crisis Intervention; Mental Health Psychiatric Rehabilitative Residence; RIACT-I; RIACT-II and Multi-Disciplinary Treatment Planning are reimbursable only when prescribed in the client's treatment plan that has been approved by a physician or other Licensed Practitioner Of The Healing Arts as defined in this manual. Crisis Intervention Services may be both recommended and delivered by the mental health professional on duty at the time of the crisis. Mental Health Psychiatric Rehabilitative Residence services require physician authorization as specified in section V(F)(4) of this manual. Both RIACT-I and RIACT-II require physician authorization as specified in the respective program standards issued by DBH. Multi-Disciplinary Treatment Planning does not require any authorization.

B. Providers can only bill for the clinician actually providing the service. For example, if a Registered Nurse who is supervised by a physician sees a client, the agency can only bill for a RN visit unless the physician was physically present and participating in the service provision. The agency may not, however, bill for two clinicians providing a service to the client at the same time other than in the special circumstances described in the section of this manual dealing with Multi-Disciplinary Treatment Planning.

C. Claims for clients with a primary alcohol or drug diagnosis, without an accompanying primary mental health diagnosis, will be denied unless they fall under the waiver provisions of Section V(A)(3) of this manual. However, if a client with a primary psychiatric diagnosis has a secondary diagnosis of substance abuse and the secondary problem is treated during the course of therapy for the primary psychiatric diagnosis, the portion of service related to the secondary problem is billable.

D. Each client's individual treatment plan must, at a minimum, conform to and be reviewed at appropriate intervals as prescribed by the "Medical Record Documentation Guidelines for Medicaid Mental Health Services" contained in Appendix 5 of this manual. Additionally, the treatment plan must meet any specific requirements for individual services such as Mental Health Psychiatric Rehabilitative Residence or RIACT-I/RIACT-II.

E. The Department of Human Services requires providers to maintain professional control in a manner that will ensure reasonable and proper utilization of medical services and supplies.

F. Providers must utilize all other third party resources, such as Federal Medicare, Blue Cross/Blue Shield or other private health or casualty insurance coverage, when available, prior to billing the Medical Assistance Program. For example, if a client has Medicare, you must bill Medicare first for all services that it covers. Specific billing instructions can be found in the Rehabilitative Services Provider Reference Manual available from the Department of Human Services' fiscal agent.

G. There are no restrictions against eligible clients receiving several simultaneous, reimbursable services from the RI Medical Assistance Program except where specifically prohibited in this manual. For example, while the manual specifically prohibits providers from billing for RIACT-I services while also billing for MHPRR, there are no prohibitions against an MHPRR resident receiving Adult Day Care services from another entity provided that medical necessity is present. The overall guideline to be applied is that the services may not be duplicative. Additional services might include, for example, the full range of services provided for physical illness, home health aides, adult day care, visiting nurses, etc.

Contact the DBH directly with questions regarding this policy.

VII. BILLING

A. GENERAL PROCEDURES

All billing must be done in accordance with the Rehabilitative Services Provider Reference Manual, which is available from the State's fiscal agent.

B. SPECIFIC BILLING INSTRUCTIONS

1. Collateral Contacts

Providers may bill for collateral contacts. A collateral contact is a contact made on behalf of the client with someone other than the client, such as a family member, landlord, personnel at another social service agency, or other person with significant ties to the client. However, "case consultation" provided to other agencies, or to other professionals in the same agency, is not billable as a collateral contact, nor are telephone contacts of any type.

2. Multiple Services in One Day

There is no general restriction against billing for multiple services provided to the same client in a single day provided that they are medically necessary and stay within the guidelines for individual services set forth in this manual.

There is, however, a general prohibition against billing for two or more services simultaneously. That is, it is not allowable to bill both a one-hour unit of psychiatric rehabilitation and a one-hour physician's visit for the same hour of service. It would, however, be allowable to bill for the one-hour unit of psychiatric rehabilitation immediately followed by a one-hour physician's visit

VIII. DOCUMENTATION REQUIREMENTS

A. Providers are required to keep all records necessary to fully disclose the nature and extent of the services provided to Medical Assistance recipients and to furnish to the State Medicaid Agency, the State Mental Health Agency, and/or the Medicaid Fraud and Abuse Unit of the Attorney General's Office such records and any other information regarding payments claimed or services rendered as may be requested.

B. A clear audit trail must be maintained. Each provider is responsible for devising a system that documents all services provided. This back-up information is usually contained in the clinical record, daily attendance logs, or both. It must be sufficiently detailed to show, for example, that a client was in a day program for the number of hours for which Medicaid was billed for this service on any given day. Documentation of this nature must be retained by the agency, must adhere to the document retention policy of the Department of Human Services, and must be promptly provided to the State or its authorized agents upon request.

C. All Medicaid Mental Health Services, with the exception of Crisis Intervention Services and Multi-Disciplinary Treatment Planning, must be provided in accordance with a comprehensive treatment plan, or individual plan of care, that clearly documents the medical necessity of the services. Treatment plans must conform to the "Medical Record Documentation Guidelines for Medicaid Mental Health Services" contained in Appendix 5 of this manual, as well as to any other service-specific requirements.

D. All entries in the client's individual plan of care shall be signed and dated within a reasonable time after they were written/dictated by the individual who performed the service. The Department does not consider facsimile signatures, initials or undated entries to be valid.

E. Written treatment or progress notes shall be maintained in chronological order in the client's individual case record and must conform to the "Medical Record Documentation Guidelines." The following guidelines also apply:

1) <u>Community Psychiatric Supportive Treatment (Unit-of-Service)</u>

Written treatment or progress notes shall be maintained for CPST being billed on a unit-of-service basis in one of the following formats:

a. Minimal contact notes, weekly and monthly summaries.

In this format, each individual contact with the client must be documented as follows at a minimum:

1. Client's name, unless evident;
2. Community Support Professional's name, unless evident;
3. Place of visit (e.g. home, center, etc.);
4. Type of visit (e.g. group, individual, etc.);
5. Service provided (e.g. coordinating medical services, assistance with income maintenance, etc.);
6. Date, time (unless kept elsewhere) and duration of service (e.g. 9/9/99, 10-11 a.m.).

This information can be entered onto a coded sheet with no narrative required for the individual notes. However, weekly and monthly summaries of the overall relationship of the services to the treatment regimen described in the treatment plan, with an update describing the client's progress and containing the clinician's assessment of the effects of the treatment, must be contained in the plan. The weekly summary for the last week of the month can also be incorporated into the monthly summary.

Note also that significant events and/or significant changes in the client's condition should be documented with a full narrative note whenever they occur.

b. Complete contact notes.

A complete progress note conforming to the requirements of the Medical Record Documentation Guidelines, including the clinician's assessment of the effects of the treatment, is entered for each individual contact. In this format, weekly and monthly summaries are not required.

2) Community Psychiatric Supportive Treatment (Per Diem):

Written treatment or progress notes shall also be maintained for CPST being billed on a per diem basis for individuals in licensed residential programs. Documentation of each individual intervention in this setting would be prohibitive however, as it is so thoroughly woven into the overall program at the residence. Therefore, these notes may take the form of a weekly summary of the overall relationship of the services to the treatment regimen described in the treatment plan, with an update describing the client's progress provided that full back-up documentation, such as census reports, is readily available. While it is not necessary to keep any documentation of day-to-day CPST provided in this setting, unusual incidents or significant events that impact on the client's condition must be recorded as they occur in addition to being reported in the monthly summary.

3) Clinician Services and Crisis Intervention

A separate entry is required for each individual service billed under Clinician Services or Crisis Intervention. This entry shall include, at a minimum:

a. A complete description of the specific service rendered and its effect on the client's condition.

b. The date the service was rendered;

c. The name and credentials of the individual rendering the service;

d. The setting in which the service was rendered;

e. The actual time service was rendered, specifying a.m. or p.m.;

f. The amount of time it took to deliver the service.

Note that items d, e, and f do not have to be recorded in the client's medical record provided that the same information is recorded elsewhere in the provider's records and is readily accessible to an auditor. Items a, b, and c, however, must be recorded in the medical case record itself.

4) Psychiatric Rehabilitation Day Programs

Written treatment or progress notes for Psychiatric Rehabilitation Day Programs may take the form of a monthly summary of the overall relationship of the services provided to the treatment regimen prescribed in the treatment plan. This summary must contain an update describing the client's progress. If this approach is taken, full back-up documentation such as an attendance log must also be maintained.

As is the case with progress notes in general, PRDP progress notes should not be overly narrative in nature and should reflect a medical assessment being made by a mental health professional regarding the results of the treatment rendered. That is, the writer is expected to make a professional assessment as to why the interventions prescribed are/are not working. The notes should also show that the writer is aware of why things were done rather than merely what was done. For example, it is not enough to simply list the groups that the client participated in during a given month. Rather, the clinician should clearly note the effect that participation had on those aspects of the client's illness for which it was prescribed in the treatment plan.

Additionally, progress notes should clearly document any deviation from the services specified in the treatment plan. In the event that the deviations result in the client receiving services in excess of those recommended in the plan, the notes must provide adequate information for Department staff to assess whether or not those services were appropriate and medically necessary. In the event that the deviations result in the client receiving less service than recommended in the

treatment plan, they must provide adequate information for reviewers to assess whether the client subsequently received appropriate outreach and follow-up, if necessary.

A separate progress note is required whenever clients receive a medication maintenance visit as part of their psychiatric rehabilitation program. This note should meet the requirements of the section Chapter V of this manual entitled "Medication Program".

5) Mental Health Psychiatric Rehabilitative Residence

Medical records for MHPRR must conform to the overall Medical Record Documentation guidelines contained in this manual, as well as meeting all of the requirements of the MHPRR program as outlined in the standards and program descriptions. Of specific note is the requirement for physician authorization on the treatment plan, treatment plan reviews, and the Psychiatric Rehabilitative Residence Individual Care Checklist.

6) RIACT-I and RIACT-II

Medical records for RIACT-I and RIACT-II must conform to the overall Medical Record Documentation guidelines contained in this manual as well as meeting all of the requirements of the RIACT-I and RIACT-II programs as outlined in the standards and program descriptions. Of specific note is the requirement for physician authorization on the treatment plan and treatment plan reviews.

IX. MONITORING AND QUALITY ASSURANCE

The overall Utilization Review and Quality Assurance activities of MHRH and the Department of Human Services as authorized by the CFR are as follows:

A) Implement a statewide community mental health services surveillance and utilization control program that:

1. Safeguards against unnecessary or inappropriate use of community mental health services and against excess payments;
2. Assesses the quality of community mental health services;
3. Provides for control of utilization of Medicaid services (CFR 456.3).

B) Establish and use written criteria for evaluating the appropriateness and quality of Medicaid services (CFR 456.5).

C) Establish a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services (CFR 456.6).

D) Provide for the ongoing evaluation of the need for, and timeliness of, community mental health services on a sample basis (CFR 456.22).

E) Conduct a post-payment review process that allows state personnel to develop and review recipient utilization profiles, provider service profiles, and exceptions criteria. The process must identify exceptions so that the state agency can correct improper utilization practices of recipients and providers (CFR 456.23).

Major site visits will be conducted at least annually by MHRH and/or DHS staff to monitor appropriate use of Medicaid services and compliance with the policies and procedures in this manual. During these visits, staff will review client records and treatment plans as well as internal policies and procedures relating to Medicaid service provision, billing and documentation. Providers will be notified of major MHRH site visits at least one week in advance where possible.

Unannounced site visits may also be conducted at any location at which Medicaid services are being billed if determined to be necessary by Department. Any Medicaid service is subject to review during these visits.

Adverse findings from the site visits will be dealt with in a manner to be determined by MHRH, in consultation with DHS.

In addition to monitoring conducted by MHRH and DHS, providers are subject to periodic fiscal and program audits by the Health Care Financing Administration.

Appendix 1: Sample Provider Agreement

AGREEMENT WITH COMMUNITY MENTAL HEALTH SERVICES VENDORS PARTICIPATING IN THE RHODE ISLAND MEDICAL ASSISTANCE PROGRAM ENACTED IN ACCORDANCE WITH THE PROVISIONS OF TITLE XIX OF THE SOCIAL SECURITY ACT

For the purpose of establishing eligibility for payment for the provision of mental health services under the Rhode Island Medical Assistance Program enacted in accordance with the Provisions of Title XIX of the Social Security Act, from the Division of Behavioral Healthcare Services, Department of Mental Health, Retardation and Hospitals, _____ hereafter referred to as the Provider, hereby agrees:

1. To keep such records as are necessary to fully disclose the extent of the services provided to eligible recipients of the Rhode Island Medical Assistance program.
2. To furnish the State of Rhode Island with such information regarding any payments claimed by such persons or institutions for providing services under the Rhode Island Medical Assistance Program.
3. To accept payment from the Rhode Island Medical Assistance Program according to the fee schedule contained in the "Community Mental Health Medicaid Procedure Manual" for only those services provided in accordance with the guidelines established in said manual. These fees shall represent full and total payment for the services provided.
4. To allow personnel of the Rhode Island Department of Mental Health, Retardation and Hospitals; Rhode Island Department of Human Services; the Medicaid Fraud Unit of the Attorney General's Office; and agents and representatives of these departments, as well as agents and representatives of the Federal Government, access to the premises of the Facility and access and private interviews with eligible recipients of the Rhode Island Medical Assistance Program, and to allow audits of all their records at all reasonable times by persons cited above and to treat such persons with courtesy as benefits their professional status.
5. To comply with Title VI of the Civil Rights Act of 1964; and with all other state and federal laws and regulations which prohibit discrimination on the grounds of race, sex, age, religion, color, national origin or handicap; and with the State of Rhode Island Executive Order Number 19 dated December 15, 1977, which provides in part as follows:

   "The State Equal Opportunity Office shall review the equal opportunity activity of all private health care facilities licensed or chartered by the State, including hospitals, nursing homes, convalescent homes, rest homes and clinics. Such State licensed or chartered facilities shall be required to comply with the State policy or equal opportunity and non-discrimination in patient admission, and employment and health care services. Such compliance shall be a condition of continued participation in any State program, or in any educational program licensed or accredited by the State, or of eligibility to receive any form of assistance."
6. This agreement shall be in effect from _____and binding for a period of _____unless revoked with a thirty-day written notice by either party, or upon material breach. In the event of unavailability of funds to pay for the program, all obligations of the parties pursuant to this agreement shall cease.

Accepted For Service Provider by:	Accepted for Rhode Island Department of Mental Health, Retardation and Hospitals by:
_____	_____
Name	Name
_____	_____
Title	Title
_____	_____
Date	Date

SPA-06/12/02

Appendix 2: Sample MHPRR Service Agreement

Service Agreement: Mental Health Psychiatric Rehabilitative Residence
Rhode Island Department of Mental Health, Retardation and Hospitals

Provider Name: _____

Provider Address: _____

Provider FID #: _____

For purposes of being certified by the Division of Behavioral Healthcare to provide MHPRR services and to bill for these services under the Mental Health Medicaid Program, (provider name)_____ _____, hereinafter referred to as the Provider, certifies that:

1. The name, location and bed capacity of the program(s) to be billed is as follows:

Program Name	Program Location	Beds

The Provider will not submit MHPRR bills for residents in any program other than those listed above.

2. The Provider will meet all requirements of the current standard "Provider Agreement" for the Mental Health Medicaid Program.
3. The Provider will adhere to all regulations, policies, procedures and/or guidelines regarding service provision, documentation and billing disseminated by the Division of Behavioral Healthcare.
4. The Provider will inform the Medicaid Project Officer, Division of Behavioral Healthcare, if the residence becomes unlicensed for any reason and will cease Medicaid billing immediately pending resolution.

Authorized Signature: _____

Date: _____

PRR-SA 06/12/02

Appendix 3: Sample MHPRR Provider Certification Application

Application for Provider Certification
Mental Health Psychiatric Rehabilitative Residence
Rhode Island Department of Mental Health, Retardation and Hospitals

(Provider Name)_____ hereby applies for certification as a provider of Mental Health Psychiatric Rehabilitative Residence services.

We have enclosed the following:

_____ 1. A copy of a current license issued by MHRH to operate each individual rehabilitative residence program for which certification is desired. (The Provider is responsible for ensuring that the Division of Behavioral Healthcare has a copy of a current license for the residence on file at all times.)

_____ 2. A copy of a current variance for the operation of any rehabilitative residence of more than 12 beds for which certification is desired.

_____ 3. A single, signed and dated copy of the "Service Agreement: Mental Health Psychiatric Rehabilitative Residence".

We understand that certification, if given, will be for a period of a maximum of two years and that it is our responsibility to apply for re-certification at least sixty (60) days before the current certification expires. In the event that the provider complies with all requirements for re-certification within the prescribed timeframes, the current certification shall remain in effect until MHRH completes the process and makes a determination as to whether or not the program will be re-certified.

Signature: _____

Date: _____

Return completed application to the Medicaid Project Officer,
Division of Behavioral Healthcare
Department of Mental Health, Retardation and Hospitals
Incomplete applications will not be processed.

PRR-CA
06/12/02

Appendix 4: Personal Care Checklist

Psychiatric Rehabilitative Residence Individual Care Checklist
Rhode Island Department of Mental Health, Retardation and Hospitals

Client Name: _____ Residence Admit Date: _____

This checklist must be completed within one (1) week of the individual's admission to the program and at least every six (6) months thereafter. It is the responsibility of the provider to ensure that a current checklist, either conducted or countersigned by a physician, is maintained in the client's record at all times. An incomplete or outdated checklist may be cause for disallowances under the Mental Health Medicaid Program.

This checklist is not an exhaustive listing of all of the care that the client requires and is not meant to serve as a replacement for a comprehensive set of assessments as required in the Treatment Planning Guidelines included in the Community Mental Health Medicaid Procedure Manual.

Check the box that most closely describes the client's status with regard to each item at the current time. Use the space at the end of page 2 for additional comments if necessary. You must have one and only one check for each item.

Service Name/Description	**No Assistance Needed**	**Needs Counseling/ Monitoring**	**Needs Some Direct Supervision**	**Needs Substantial Supervision**
PERSONAL HYGIENE/APPEARANCE				
Hair Care–Regular shampooing, brushing, combing.				
Facial Maintenance–Use of makeup, dental care, shaving.				
Clothing and Dressing–Cleaning, ironing, sewing, storage, coordination of colors and style, purchasing within budget, dress appropriate for weather and age.				
Personal Cleanliness–Keeping self and area clean.				
DIETARY MANAGEMENT				
Proper meal preparation.				
Proper meal planning.				
Food shopping.				
Food storage and handling.				
Maintenance of special diet if required.				
Appropriate eating skills and habits.				
HOUSEHOLD MANAGEMENT				
Using laundry facilities, caring for clothes.				
Changing/making bed on a regular basis.				
Maintaining clean, safe and appropriate kitchen.				
Maintaining clean, safe, appropriate bedroom.				
Maintaining clean, safe and proper common areas.				
Caring for own possessions				

Client Name: _____

Service Name/Description	No Assistance Needed	Needs Counseling/ Monitoring	Needs Some Direct Supervision	Needs Substantial Supervision
FINANCIAL MANAGEMENT				
Money management and banking.				
Bill paying and record keeping.				
OTHER ASSOCIATED TASKS				
Self medication (understanding purpose; taking as prescribed; recognizing and dealing with side effects; symptom recognition and management)				
Use of physical healthcare services.				
Use of dental services.				
Recognizing and avoiding common dangers (e.g. fire, electrical shock, traffic, etc.)				
Use of community resources (e.g. Public transportation)				
PSYCHOSOCIAL/INTERPERSONAL				
Establishing meaningful activities and relationships in normative community settings.				
Productive use of leisure time.				
Relating to friends, neighbors, and other community members effectively and appropriately.				
Demonstrating appropriate levels of assertiveness and self–esteem.				
CLIENT RIGHTS/AUTONOMY				
Contributing productively to the development and modification of program policies and procedures.				
Undertaking activities to increase personal living skills and independence.				
Accessing and participating in self–help, mutual support, and/or advocacy organizations as appropriate.				
Exercising personal choice and control in key life domains (e.g. Selection of roommates, relationships, program activities, etc.)				
COMMENTS AND RECOMMENDATIONS				
(Continue comments and recommendations on next page)				

Client Name: _____

(Comments and recommendations continued)

Completed By: Name (Print): _____

Signature: _____

Date: _____

If not completed by physician, physician countersignature:

Name (Print): _____

Signature: _____

Date: _____

PRR/4/7/98

Appendix 5: Medical Record Documentation Guidelines

RHODE ISLAND DEPARTMENT OF
MENTAL HEALTH, RETARDATION AND HOSPITALS
DIVISION OF BEHAVIORAL HEALTHCARE

MEDICAL RECORD DOCUMENTATION GUIDELINES FOR MEDICAID MENTAL HEALTH SERVICES

All medical records for individuals receiving services through the Community Mental Health Medicaid Program must conform to the guidelines listed below as well as meeting any other applicable Medicaid and/or MHRH requirements:

Basic Guidelines:

1. Each client shall have a written, comprehensive, individualized treatment plan (or individual plan of care) that documents the medical necessity of services to be provided. The plan shall be prospective in nature and shall be completely re-written at least once every 12 months. It shall be signed by and dated by appropriate professional staff, with their credentials and date clearly shown, within 2 weeks of its effective date. "Appropriate professional staff" shall include, at a minimum, a Licensed Practitioner of the Healing Arts as defined in Section V of the Community Mental Health Medicaid Procedure Manual.

   All mental health services covered by the Community Mental Health Medicaid Program, with the exception of Crisis Intervention Services and Multi-Disciplinary Mental Health Treatment Planning, must be provided in accordance with this plan.

2. The treatment plan shall be based on a comprehensive assessment of the client's clinical needs, including a listing of strengths, weaknesses, and problems. The assessment shall be reviewed in its entirety at least once every 12 months and rewritten in its entirety at least once every 60 months. The findings of the assessment review shall be clearly documented in the client's individual record. The assessment shall contain, at a minimum, the following components: Psychological (Behavioral/Emotional); Psychosocial (Environment/Family); Physical (Developmental/Medical); Vocational/Educational (if appropriate to the individual client).

   Assessments from other agencies may be used provided that they are current; meet these minimum requirements; and are either included as a part of the treatment plan or clearly referenced. If incorporated by reference only, the full assessment must be made available to DBH staff on request.

3. The DSM diagnosis must be clearly evident in the treatment plan, both written and coded, and there must be evidence that the diagnosis was considered as the overall plan was developed. There must be a clear, observable connection between the diagnosis; the symptoms of the condition for which the client is being referred for specific interventions; and the medical judgment of the mental health professional observing the effect of those interventions and documenting it in progress notes.

4. Responsibility for the overall development and implementation of the treatment plan must be assigned to an appropriate member of the professional staff and this staff member must be clearly identified in the plan.

5. The treatment plan must be formulated when clinical information becomes available and as soon as possible after the client's admission to the program. A preliminary treatment plan, developed upon completion of the intake process, will suffice up to the 4th visit or 30 days after intake, whichever comes first.

6. The treatment plan must be reviewed at least after every six months of treatment, as well as at major decision points in each client's course of treatment including:

   a) At the time of admission; internal transfer between programs (e.g. from OPS to CSS; from RIACT-I to RIACT-II; etc.); and upon discharge.

   b) Upon a major change in the client's condition, including frequent use of crisis intervention services.

   c) At the end-point of the estimated length of treatment, and at regular intervals thereafter until the treatment modality is terminated.

A plan shall be judged to be in compliance with the "6-month review" requirement if it is reviewed within 30 days of the end of the calendar month during which the "sixth month of treatment" occurs. For example, a treatment plan written on either January 1 or January 31 would be due for a review by July 31 but would be found in compliance with the review requirement if it was completed by August 30. That same plan would still be due for a complete re-write on January 31. Once again, however, the 30-day window will allow the agency until March 2 to complete the re-write.

The results of all treatment plan reviews shall be documented in the medical record and shall be signed and dated by appropriate professional staff, with their credentials and date clearly shown, as soon as possible, but in no case more than 2 weeks, after the review is completed. The results of the review may be entered on the treatment plan itself; added as a supplement to the treatment plan; or entered in a detailed progress note which is clearly labeled "Treatment Plan Review" and is specifically referenced in the treatment plan itself.

The review shall contain updates to problem statements; specific treatment goals; treatment objectives; and specific services as necessary and shall take into account data contained in progress notes in order to make an informed evaluation of treatment efficiency and effectiveness. Note that the term "efficiency" is used to describe the relationship between the resources required to deliver a specific program of care and the outcomes generated.

The term "appropriate professional staff" shall include, at a minimum, a Licensed Practitioner of the Healing Arts as defined in Section V of the Community Mental Health Medicaid Procedure Manual.

7. The treatment plan must reflect the client's clinical needs and condition and identify both functional strengths and limitations.

8. The treatment plan must clearly and objectively specify the services, activities, and programs necessary to meet the client's needs.

9. The treatment plan must contain <u>specific goals</u> that the client must achieve to attain, maintain and/or re-establish emotional and/or physical health as well as maximum growth and adaptive capabilities. These goals must be based on periodic assessments of the client and, as appropriate, the client's family. While they may encompass overall life goals that the client will continue to strive for after the termination of treatment, they must also include specific goals to be achieved during the course of treatment.

10. The treatment plan must contain the <u>objectives</u> for treatment, described in terms of <u>specific, measurable and observable changes</u> in behavior, skills, and/or circumstances that relate to the goals and include measurable indices of progress along with a projected date of achievement.

11. The treatment plan must clearly document the specific reason or rationale for all treatment procedures, including each individual problem being addressed, with the frequency, amount and duration of each specific intervention clearly evident in the plan. Significant discrepancies between interventions prescribed and those actually delivered must be clearly documented in the medical record with the documentation signed by a Licensed Practitioner of the Healing Arts at a minimum.

12. The treatment plan must specify the criteria to be met for the discontinuation of each specific treatment modality, as well as for termination from the program as a whole.

13. The provider must actively seek the participation of the client in the development of his or her treatment plan and such participation must be documented in the individual client record.

    This documentation should include a signed statement by the client indicating that they have both a) participated in the process of treatment plan development and b) understand the results. However, as mere client signature does not necessarily mean adequate involvement, it is expected that there will also be ongoing documentation in the progress notes of consistent client participation in the development of the plan, describing the individual's perceptions of their needs, their degree of participation in the planning process and their specific contributions to the development of the goals and objectives of the plan. Additionally, an entry in the client record by the client themselves describing their part in the treatment planning process should also be encouraged.

    In rare instances, where the client either could not or would not participate in the planning process, a note by the clinician describing the opportunities given to the client and the circumstances around their lack of participation should be inserted into the record.

14. The treatment plan must include referrals for needed services that are not provided directly by the agency and, where possible, progress notes for those services.

15. The client's progress and current status in meeting the goals and objectives of his or her treatment plan must be regularly recorded in the client record in the form of progress notes. Said notes must be legible and signed by the individual making the entry with their both their credentials and the date of the entry clearly shown.

16. Progress notes must include at a minimum:

    a) Documentation of the implementation of the treatment plan;

    b) Chronological documentation of the client's clinical course of treatment including a description of significant events;

    c) Descriptions of significant changes in the client's condition;

    d) Periodic documentation of all treatment provided to the client and;

    e) Descriptions of the response of the patient to treatment as well as the outcome(s) of treatment.

    Progress notes should not be overly narrative in nature and should reflect a medical judgment made by a mental health professional regarding the results of the treatment rendered. This judgment shall demonstrate that the writer is aware of why specific interventions were made, rather than merely what the interventions were, and shall contain an assessment of why those interventions are or are not working.

17. The information recorded in the progress notes shall be taken into consideration throughout the treatment planning/review process.

18. A discharge summary must be entered into the client record within a reasonable period of time, but not longer than 21 days, after discharge. In general, a CSS client should be discharged if they have had no contact in a 90-day period while a GOP client should be discharged if they have had no contact in 120 days.

19. The discharge summary must contain:

    a) Significant findings including both the final primary and secondary diagnoses;

    b) General observations about the client's condition initially, during treatment and at discharge;

    c) Whether the discharge was planned or unplanned (i.e. one in which the client discontinued treatment either without notifying the clinician or against advice) and, if unplanned, the circumstances including a listing of any outreach attempts made;

    d) Assessment of attainment of the service objectives;

    e) Documentation of referral to other appropriate service(s), program(s) or agency/agencies.

20. At the time of their 6-month treatment plan review, all Community Support Clients for whom you are billing Medicaid must:

    a) have the “staff” portion of the Rhode Island Outcome Evaluation Instrument (OEI) fully completed and submitted to DBH by the end of the calendar month following the month in which the review was due and;

    b) be given the opportunity to complete and submit the “client” portion of the OEI at that same time.

Notes:

1. The “treatment plan” section of the medical record is regarded by Medicaid as the overall prescription for services to be provided and acts as authorization for Medicaid payment for services delivered. Therefore, it is important to ensure that the plan is kept current and meets all requirements for signatures.

2. Objectives, the smaller steps that the goals of the plan are broken down into, must be specific, measurable and time-limited so that Medicaid can observe the positive results or lack thereof, of a specific treatment regimen. In addition, the plan must establish the frequency of treatment procedures and criteria for

termination of specific interventions.

For example, a plan specifying “Individual Therapy” is as unacceptable as a prescription specifying “Prolixin”. Rather, the plan must specify the amount, the frequency, and the duration of the intervention. The recommendation of “Individual therapy teaching relaxation techniques aimed at control of inappropriate outbursts due to schizophrenia, once a week for the next three months or until the client can attend psychiatric rehabilitation for 3 consecutive days without an outburst, whichever comes first.” would meet all criteria.

7/1/01

Appendix 6: Contact List

MEDICAID PROJECT OFFICER

DIVISION OF BEHAVIORAL HEALTHCARE:

Medicaid Project Officer
Barry Hall 3rd Floor
14 Harrington Road
Cranston, RI 02920
Phone 401-462-1714
FAX 401-462-0339

STATE MEDICAID AGENCY:

Liaison–Clients Under 21Years of Age:

Beth O'Reilly, Case Manager
Center For Child and Family Health
Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-462-6351

Liaison–Clients 21Years of Age and Over:

Paula Avarista
Center For Adult Health
Department of Human Services
600 New London Avenue
Cranston, RI 02920
401-462-2183

Recipient Eligibility Hotline:

1-800-347-3322 (8:20 A.M.--6:30 P.M. Mon--Fri)

RIteCare Hotline:

1-800-346-1004

FISCAL AGENT:

Electronic Data Systems (EDS)
1471 Elmwood Avenue
Cranston, RI 02910

Help Desk: 401-784-8100 (local to Cranston)
1-800-964-6211 (outside Cranston area)

REVS Line: 1-800-964-6211 (24 hours for provider calls only)

HEALTH DEPARTMENT:

Division of Professional Regulation: 222-2827

06/12/02

Appendix 7: Medicaid Record Scoring Worksheet

Case #: _____ Client Type: CSP___ GOP

Agency: _____ Date: _____

Reviewer's Name and Degree: _____

Use the following scoring guideline for questions utilizing the 1-4 rating scale unless a separate scale is provided with the question:

1 Compliance: In compliance with requirements of item between 85% and 100% of the time.
2 Substantial compliance: In compliance with requirements of item between 70% and 84% of the time.
3 Partial compliance: In compliance with requirements of item between 50% and 69% of the time.
4 Noncompliance: In compliance with requirements of item less than 50% of the time.
NA Not applicable: Item does not apply to record in question. Rarely used.

Please clarify all items graded 2, 3 or 4 in the "Comments" section of the item.

1. Does the record contain a section(s) designated as an assessment of the client's clinical needs? ..... Y N
If "Yes", continue with Item #2. If "No", skip ahead to Item #3.

Comments:_____

_____

Use the following scale for Questions #2a and #2b only.

1. Comprehensively lists strengths, weaknesses, and problems.
2. Briefly documents assessment results; would benefit from expansion/clarification.
3. States that assessment was written (2a)/reviewed(2b) but provides inadequate documentation of results.
4. No assessment or documentation that a review was done in this area.

Suggested Content of Individual Components of Assessment:

Psychological:	History, diagnosis, diagnostic formulation, treatment, presenting problem, behavior, affect, mood, mental status if needed, neurological examination if indicated.
Psychosocial:	Functioning, supports, community resources used, environment, leisure activity, cultural, additional functional assessments if required.
Physical:	Physical health review, including listing of current medications and problems, to identify if further medical examination is indicated.
Vocational/ Educational:	History, potential for employment/additional education.

2a. Does the assessment contain each of the following components written or rewritten within the past 60 months?

	Compliance		Non-Compliance		Most Recent
Psychological (Behavioral/Emotional)	1	2	3	4	_____
Psychosocial (Environment/Family).....	1	2	3	4	_____
Physical (Developmental/Medical).....	1	2	3	4	_____
Vocational/Educational (if indicated) .....NA	1	2	3	4	_____

2b. Was each of the following components of the assessment either written or reviewed within the last year or, if the client has been discharged, within 12 months prior to the date of discharge?

	Compliance		Non-Compliance		Most Recent
Psychological (Behavioral/Emotional)	1	2	3	4	_____
Psychosocial (Environment/Family).....	1	2	3	4	_____
Physical (Developmental/Medical).....	1	2	3	4	_____
Vocational/Educational (if indicated) .....NA	1	2	3	4	_____

Scoring Note: Assessments from other agencies may be used to meet the requirements of these items.

Comments:_____

_____

---

3. Is there a **current** (i.e. written or rewritten within 12 months prior to survey date or, if the client has been discharged, within 12 months prior to the date of discharge), comprehensive **treatment plan**?..... Y N

Date of most recent treatment plan (MM/DD/YY): _____

Scoring Note: A preliminary treatment plan will suffice only up to the 4th visit or 30 days after intake, whichever comes first.

Comments:_____

_____

**** COMPLETE ITEMS 4-18 ONLY IF THERE IS A CURRENT TREATMENT PLAN AS DEFINED ABOVE ****

Use The Following Scale For Item 4 Only

1. The treatment plan was reviewed within the last 6 months, and every 6 months within the past year, with the results of the review either entered on the treatment plan itself; as a supplement to the treatment plan, or in a detailed progress note referenced in the treatment plan which is clearly labeled "treatment plan review". The review is comprehensive and updates problem statements, goals, treatment objectives, and evaluates treatment efficiency and effectiveness.

2. The plan was reviewed within the required time frame but not labeled/referenced correctly or; doesn't update problem statements, goals or treatment objectives or; doesn't evaluate treatment efficiency and effectiveness.

3. The plan was reviewed within the required time frame but documentation is insufficient, e.g. extremely brief or limited to a statement that plan was reviewed with no further supporting documentation.

4. The plan was not reviewed within the required time frame.

NA It has not been six months since the plan was originally written.

In all cases, please list the review date(s) meeting the requirements. A plan shall be judged to be in compliance with the "6-month review" requirement if it is reviewed within 30 days of the end of the calendar month during which the "sixth month of treatment" occurs. For example, a treatment plan written on either January 1 or January 31 would be due for a review by July 31 but would be found in compliance with the review requirement if it was completed by August 30. That same plan would still be due for a complete re-write on January 31. Once again, however, the 30-day window will allow the agency until March 2 to complete it.

4. Has the treatment plan been either reviewed or completely rewritten at least every six months? ..... NA 1 2 3 4
(Mark NA only if this is an initial treatment plan written within the last six months.)

List dates that fulfill the six month review requirement during the past year (MM/DD/YY): _____

Comments:_____

5. Is the treatment plan/treatment plan review signed and dated by a licensed practitioner of the healing arts, as defined in the Community Mental Health Medicaid Procedure Manual, with the practitioner's qualifying degree/title clearly indicated? Y N

Scoring Note: The plan requires that the signature, degree and date be present. The plan must also be signed within two weeks of its effective date. Grade this item as "N" if any 1 of these 4 requirements is not met. Note that a treatment plan for an MHPRR client requires a physician's signature and degree. Use "Comment" section below to detail all records marked "N".

Detail: ___ Signed/dated outside of two-week window ___ missing date ___ missing degree ___ missing signature

Comments:_____

Use The Following Scale For Item 6 Only

1. The diagnosis, goals, and objectives in the treatment plan accurately reflect the current problems and needs as listed in the current assessment.

2. The plan accurately reflects most of the priority problems related to the diagnosis and/or described in the assessment .

3. Priority problems that are addressed in the treatment plan are not on the assessment, or priority problems identified elsewhere in the record are not addressed in the plan and/or assessment.

4. The treatment plan is not based on the assessment or there is no assessment.

6. Is the current treatment plan based on the most recent assessment? 1 2 3 4

Comments:_____

7. If this is an initial treatment plan, was the plan formulated upon completion of the intake process and as soon as possible after the patient's admission? (Score "NA", if this is not an initial plan) ..... Y N NA

Scoring Note: The treatment plan must have been formulated when clinical information became available and as soon as possible after the client's admission into the program. A preliminary treatment plan will suffice up to the 4th visit or 30 days after intake, which ever comes first.

Comments:_____

8. Has the treatment plan been reviewed at the following intervals? (circle one answer per item)

		Compliance	Non-Compliance		
a.	Upon transfer between treatment programs	NA	1	2	3	4
b.	Upon any major change in the client's clinical condition (i.e. when there has been a significant improvement or decline)	NA	1	2	3	4
c.	Upon the achievement of an identified goal (i.e. when goals are meet, discontinued)	NA	1	2	3	4
d.	At the end of the estimated length of treatment (i.e. at the target date in the plan).....	NA	1	2	3	4

Scoring Notes: Reviewers should take into account both the periodicity and the quality of the review. With regard to quality, a good review should document the reason for the review; comment on the client's clinical condition; comment on

the results of treatment to date; and both document and justify any changes made to the plan. A simple statement to the effect that "this plan was reviewed on (date) should be graded as a "3"

.

Comments:_____

_____

---

9. Is there clear evidence in all treatment plan reviews that the reviews are based on:

			Compliance		Non-Compliance	
a.	An assessment of the individual's current clinical problems/needs?	NA	1	2	3	4
b.	The individual's response to treatment? (the outcome of care provided, to what extent were goals reached)	NA	1	2	3	4
c.	The overall activity recorded in the progress notes?	NA	1	2	3	4

Scoring Notes: Reviews must reflect changes in the client's condition; whether the prescribed interventions have been effective or not; and any other pertinent information contained in the progress notes.

Mark "NA" if there are no reviews contained in the plan.

Comments:_____

_____

Use The Following Scale For Items 10a-10c Only

1. Identifies problems/strengths/limitations; behavior oriented; client -focused; individualized to patient; notes severity/impact on life.

2. Items are addressed in the plan but in a brief, generalized manner. Possibly not readily identifiable or clearly documented.

3. Vague or missing major components

4. No documentation of element at all.

10. Does the treatment plan contain a clear indication of the client's:

	Compliance		Non-Compliance	
a. Clinical needs/Condition?	1	2	3	4
b. Functional strengths?	1	2	3	4
c. Limitations?	1	2	3	4

Scoring Note: Award a "1" if the items in 10d below are behaviorally focused and clearly describe for each activity, the type of session, treatment methods and procedures**.**

d. Prescribed services, activities and programs?	1	2	3	4

Comments:_____

_____

---

11. Does the treatment plan contain a clearly visible DSM-IV diagnosis, both written and coded? (Answer "N" if not shown both written and coded.) ..... Y N

Comments:_____

_____

---

12. Do the client's symptoms and the recommended interventions bear a clear relationship to the DSM-IV diagnosis? 1 2 3 4

Scoring Note Award a "1"only if the client's listed diagnosis is supported by a description of symptoms, other needs and problems which reflect same and if the interventions prescribed address the priority behavioral symptoms in relationship to that diagnosis.

Comments:_____

_____

Use The Following Scale For Item 13 Only

1. Contains specific goals/targets that the client must achieve to attain, maintain and/or re-establish emotional and/or physical health, as well as maximum growth and adaptive capabilities. Similar needs identified in the assessment may be grouped and addressed by a single goal that encompasses the entire group.

2. Contains general goals, possibly excessive in number, most of which are reflective of the client's problem and specified treatment regimen**.**

3. Vague, generalized goals, most of which are not reflective of the client's problem(s) or specified treatment regimen**.**

4. No goals or goals are not related to the client's problems or treatment regimen.

13. Does the treatment plan clearly indicate specific goals that the patient must achieve during the course of treatment?..... 1 2 3 4

Comments:_____

_____

---

14. Are the goals in the treatment plan clearly based on the most recent assessment?..... 1 2 3 4

Scoring Note: Score a "1" only if the plan contains goals that clearly and accurately reflect current problems and needs as listed in the current assessment.

Comments:_____

_____

---

15. Does the treatment plan contain individualized and realistic objectives for treatment that provide:

Measurable indexes of progress (both individualized and measurable in steps of progress)..... 1 2 3 4
A projected date of achievement 1 2 3 4
The recommended frequency for each specific treatment procedure..... 1 2 3 4
The criteria to be met for terminating specific interventions? (behavioral objective of treatment) 1 2 3 4

Scoring Note: Objectives must be both individualized and current in all cases. They should also be behaviorally focused as well as being specific and measurable. All recommended interventions must have their frequency and duration specified. As an example, the recommendation of "Cognitive & behavioral therapy, aimed at control of inappropriate outbursts, once a week for the next three months, or until the client can attend psychiatric rehabilitation for 3 consecutive days without an outburst, whichever comes first" would meet all criteria.

Comments:_____

_____

---

16. Does the treatment plan clearly and specifically contain the criteria to be met for terminating the treatment program?. Y N

Scoring Note: Answer "Y" only if plan contains specific, individualized criteria for termination of the treatment program which reflects the achievement of the individual's treatment plan goals.

Comments:_____

_____

Use The Following Scale For Item 17 Only

1. The record documents consistent and adequate efforts to gain the individual's participation in the development of the treatment plans. While this may include a statement signed by the client to the effect that they participated in the development of the plan, a signature alone does not necessarily document the degree of involvement and/or understanding of the planning process.

2. Signed statement by client acknowledging participation in the planning process but no other documentation available.

3. Signed statement by client agreeing to the plan itself but not acknowledging participation.

4. No client participation documented.

17. Has the client had the opportunity to participate in the development of the treatment plan as evidenced by specific documentation in the clinical record? 1 2 3 4

Scoring Note: Score a "1" on this item if you judge that the agency made adequate efforts, well-documented in the medical record, to engage the client in the planning process even if those efforts were not successful.

Comments:_____

_____

---

18. Are referrals for services not provided directly by the agency, when required by the client's condition, clearly documented? ..... Y N NA

Scoring Note: The treatment plan must include referrals for needed services that are not directly provided by the facility and, if possible, progress notes for those services. Answer "NA" if no referrals were needed.

Comments:_____

_____

---

19. Does the client record contain progress notes? ..... Y N .
Are the progress notes legible? ..... Y N NA

If you've answered "Yes" to BOTH of the above, do the progress notes:
(Leave a-h blank if there are no progress notes or if they are not legible.)

a. Have signatures, degrees, dates? 1 2 3 4
b. Appear in chronological order? 1 2 3 4
c. Describe significant changes in the client's overall condition or life situation. ..... NA 1 2 3 4
d. Describe significant changes in the client's clinical condition. ..... NA 1 2 3 4
e. Provide consistent, periodic documentation of all treatment clearly tied to the objectives contained in the treatment plan? (NA if no Tx plan)..... NA 1 2 3 4
f. Document the response of the client to treatment? (NA if no Tx plan)..... NA 1 2 3 4
g. Describe the overall outcome of treatment? 1 2 3 4
h. Avoid being excessively narrative in nature? 1 2 3 4

Scoring Notes 19c-h: Progress notes should be individualized, specific and avoid excessive repetition.

19-c: Should document the client's overall situation including significant life events (e.g. death of a parent) even though these changes do not necessarily indicate the need for a treatment plan review.

Answer "NA" if no significant events occurred.

19-f: Describes the client's satisfaction, motivation, resistance, etc.

Comments:_____

_____

---

20. Do progress notes reflect a professional assessment made by the writer as to why the interventions prescribed are or are not working? (score "NA" if no there are no progress notes) ..... 1 2 3 4 NA

Scoring Note: Progress notes must reflect the results of the treatment rendered, detailing why things were done as opposed to simply what was done, and record the effect that the treatment had on the client's symptomatology. Notes should include documentation of client stressors; limitations; influencing social factors; and an evaluation of the effectiveness/appropriateness of treatment interventions. Finally, there must be a clear path linking the assessment, the treatment plan, the goals, the objectives and the progress notes.

Comments:_____

_____

---

21. Do the progress notes explain any significant deviations from the interventions prescribed in the treatment plan? (Answer "NA" if there were no significant deviations or if there are no progress notes)..... NA 1 2 3 4

Comments:_____

_____

---

22. Has the client been discharged?..... Y N
If "Yes", date of discharge (MM/DD/YY): _____

If "Yes", is there a discharge summary in the record?..... Y N

If there is a discharge summary, does it:

a. Appear in the record within 21 days of actual discharge?..... 1 2 3 4
b. Contain all significant findings? 1 2 3 4
c. Contain the final primary and secondary diagnoses? 1 2 3 4
d. Contain general observations about the clients' condition at intake, during treatment and at discharge?..... 1 2 3 4
e. Assess the degree of attainment of treatment goals and objectives? 1 2 3 4
f. Document referral to other programs/agencies as needed? ..... NA 1 2 3 4
g. Indicate whether the discharge was planned ..... Y N

Scoring Notes: 22b. Significant findings are pertinent facts relative to either the client's condition or illness that have been uncovered during the course of treatment.
22g. An "unplanned discharge" is one in which the client discontinued treatment.

Comments:_____

_____

*****QUESTIONS 23—25 TO BE COMPLETED FOR CLIENTS IN MHPRRS ONLY*****

23. Does the client's individual record include a current Psychiatric Rehabilitative Residence Individual Care Checklist? ..... Y N

Comments:_____

_____

24. Has the client's MHPRR service been authorized by a physician as evidenced by having a physician's signature on:

The client's overall treatment plan?..... Y N

The Psychiatric Rehabilitative Individual Care Checklist?..... Y N

Comments:_____

_____

25. Does the treatment plan contain detailed and specific reasons for which the client is being served in the MHPRR, including the specific aspects of the client's condition that require MHPRR treatment as well as detailed, measurable goals and objectives for that treatment?..... 1 2 3 4

Comments:_____

_____

****QUESTIONS 26—27 TO BE COMPLETED FOR CLIENTS WHOSE 6-MONTH TREATMENT ****

**** PLAN REVIEW DATE IS JANUARY 1, 1999 OR LATER ****

26.. Was the staff portion of the OEI **fully** completed and received by DBH no later than the end of the calendar month occurring two months after the month during which the treatment plan review was conducted? (Answer "NA" for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of April, use "NA" for all treatment plans due in February or March) Y N NA

Comments:_____

27. Did the client have the opportunity to complete the OEI as evidenced by:

a) Receipt of a client OEI by DBH that was completed no later than the end of the calendar month occurring two months after the month during which the treatment plan review was conducted? (Answer "NA" for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of April, use "NA" for all treatment plans due in February or March.) Y N NA

OR

b) An entry in the client's individual medical record indicating that the client was given the opportunity to complete the survey during the aforementioned timeframe. (Answer "NA" for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of April, use "NA" for all treatment plans due in February or March.) Y N NA

Comments:_____

( ) Check this box if this record is NOT recorded on the OEI Tracking list. Tremper 2/01

Appendix 8: Commonly Asked Questions and Answers

COMMONLY ASKED QUESTIONS AND ANSWERS ABOUT COMMUNITY MENTAL HEALTH MEDICAID COVERAGE

Q1. What is a "Licensed Practitioner of the Healing Arts?"

A1. The listing of specific disciplines included under the title of "Licensed Practitioner" may be changed periodically. Please refer to the "Covered Services" section of the Community Mental Health Medicaid Procedure Manual for the latest definition.

Q2. Does a Psychiatric Rehabilitation Day Program have to include a Medication Maintenance component?

A2. No, it does not. If it does, however, agencies should have a tracking system in place that clearly separates out and documents those hours during which a client receives a medication visit, which are billed at a higher fee.

Q3. Two reimbursable clinicians see a client at the same time. Can we bill for both?

A3. No. You may bill for one or the other but not both. Assuming that both practitioners had equal input, it is advisable to bill for the one commanding the highest fee. It is possible, however, to bill for a group of clinicians under the codes for Multi-Disciplinary Treatment Planning.

Q4. Are we subject to audit or review by agencies other than the Department of Mental Health, Retardation, & Hospitals?

A4. Yes. You are subject to fiscal and program audits by HCFA and by DHS. Additionally, in rare instances, you may also be subject to review by the Fraud and Abuse Unit of the Office of the Attorney General.

Q5. Does a medical doctor have to authorize service by signing the treatment plan?

A5. A physician's signature is required for clients being served by MHPRRS or RIACT-I/RIACT-II teams. In all other cases, the plan may be signed by any Licensed Practitioner of the Healing Arts as defined in Chapter V of this manual. Keep in mind that all treatment plan reviews carry with them the same authorization requirements as the original plan. That is, they must also be signed by the appropriate professional within the specified time frame.

Q6. How do we bill when an individual who is both a "clinician", as defined by Medicaid, and a Community Support Professional provides multiple services in a single visit? For example, suppose that a Registered Nurse drives 15 minutes to a client's home, takes approximately 40 minutes to provide both medication maintenance and CPST, and then drives 15 minutes back to the office.

A6. To begin with, the travel time is not reimbursable. Billing for the remainder of the time would depend on the amount of time that the nurse spent on each activity, i.e. medication and CPST.

Assuming that he spent 20 minutes doing the medication and 20 minutes doing CPST, you would bill for a) one individual RN visit minimum 15-20 minutes and b) one unit of CPST, arrived at by rounding 20 minutes to the nearest half hour. In cases like this, the breakdown of billing is essentially left to the individual provider.

Q7. The manual states that progress notes must be maintained in chronological order. Can the progress notes of different disciplines be maintained in different sections of the record?

A7. Yes, provided that those notes are in chronological order within each discipline. For example, you may keep physician notes on a separate sheet from nursing notes if the notes on each sheet are in chronological order. In most cases, however, we find that the basic progress notes are maintained in chronological order without regard to discipline while a separate set might be maintained for any major sub-components of the plan such as a psychiatric rehabilitation program.

Q8. Does the time of day, duration and physical setting of the service have to be included in the actual clinical record to document services? Must these items be included in the treatment or progress notes?

A8. While it would be convenient to have this information contained in the clinical record for the purposes of an audit, it is not required. However, if it is not contained in the clinical record, it must be recorded in such a manner as to make it readily accessible to an auditor. This requirement might be met by recording the information on monthly service cards and then adding the cards to the client's clinical record at the end of each month. Alternatively, the information could be collected on service tickets and than entered and maintained on computer until a printout is required provided that the source documents (service tickets) are also available as back-up.

Q9. Can the service information recorded on the computer take the place of a progress note?

A9. No, unless the provider is using a DMHRH-approved system of computerized medical records. Otherwise, there must be a dated progress or treatment note in the client's clinical record for each service billed to Medicaid unless otherwise specified in this manual. For example, there are specific allowable mechanisms for billing for MHPRR and CPST services that do not require a note for each individual service.

Q10. Is a chart indicating which medications were given by which clinician sufficient documentation to justify a 15-minute nurse or physician visit?

A10. No. There must be a progress for each service rendered. In the course of a typical 15-20 minute medication visit, a clinician does more than give a simple injection including things such as ascertaining whether the medication is having the desired effect on the client's psychiatric condition; checking for signs of adverse side effects; gathering input on the client’s overall progress, etc. The progress note must fully describe the service and should include the clinician’s observations as well as the administration of an injection.

Q11. What is the definition of a collateral contract?

A11. A collateral contact is a contact made on behalf of the client with someone other than the client, such as a family member, landlord, personnel at another social service agency, or another person with significant ties to the client. However, "Case Consultation" provided to other agencies or to other professionals in the same agency is not billable as a collateral contact. Be aware that you can bill only for face-to-face contacts and not for phone calls.

Q12. Does an "assessment" have to be face-to-face or can it be a "paper" review of the case?

A12. An assessment must involve face-to-face contact but can also include any of the non-routine paperwork that is required. The rates for assessments were calculated by determining the actual cost of the professional in question and then adjusting for the number of hours that they would actually have available for direct client contact after administration and routine paperwork were accounted for. Thus, time spent on routine record keeping is already calculated into the fee paid. However, we recognize that a comprehensive assessment often includes an extraordinary amount of document review as well as calling for excessive time to be spent in preparing the results of the process. Therefore, it is reasonable to assume that providers should be compensated for this additional time. As a general rule, the face-to-face portion of the assessment must last a minimum of 60-70 minutes in order for this service to be billed.

Q13. Our Emergency Services unit covers nights and weekends by means of a "beeper" that is rotated between qualified and willing CMHC staff. At times, BA level social workers who have been working in the unit several years are on call. Can we bill for crisis intervention services that they might provide?

A13. Yes. The minimum staff qualifications for this service are now a BA in the human services field and at least 6 months of supervised experience in a CMHC emergency services unit. Keep in mind, however, that while these clinicians meet the requirements for Medicaid billing, they might not meet the requirements for requesting psychiatric inpatient hospitalization.

Q14. What does the requirement for "24–hour staffing" in the MHPRR program mean?

A14. The "24-hour staffing" requirement is interpreted to mean that the Provider must provide staff coverage 24-hours a day, 7 days a week as long as there are clients physically present in the living quarters of a program. Staff shall be <u>on site</u> for programs housed in a single building. In all cases, response time to any individual unit (e.g. bedroom or apartment) shall be no greater than five minutes.

Q15. How is MHPRR billing affected if the client goes home for a weekend visit?

A15. You should continue to bill for the client. The weekend visit is a part of the client's treatment and the MHPRR staff serves as the back up in the event of difficulty.

Q16. Why do GOP clients require a chart review for transfer to CSP status after every 30 days of CPST service?

A16. We found via a survey of the system that only 0.5% of GOP clients were projected to need more

than 30 hours of CPST on an annual basis. Given the rarity of this occurrence, we determined that it is reasonable to place a requirement for closer scrutiny on cases of this nature. In this instance, that consists of a mandatory review of the case for potential transfer to CSP status.

Q17. Why is there a limit of 4 hours per day on CPST and what happens if my client needs 6 hours of service one day and none the next?

A17. The limit is not set at "4 hours per day" but at "an average of 4 hours per day calculated on a monthly basis". Thus, if client A is in service for the entire month of December, he is eligible to receive up to a total of 124 hours of service during the month (31 days multiplied by 4 hours per day). This might be provided at the rate of 4 hours a day for 31 days; 8 hours a day for 15 days and 4 hours on 1 day; etc. Remember that provision of more than 10 hours of unit-based CPST per day for 2 consecutive days must trigger an immediate treatment plan review.

Q18. We determined that the hospital to which we send our client's does not bill Medicaid for any physician's visits. Can we therefore bill for the time that our psychiatrist spends at the hospital with our clients?

A18. If the psychiatrist's visits are for services by the attending physician, they can be billed as any other attending physician would bill. If they are not attending physician services, they would have to meet the requirements outlined in the CPST section of this manual and be billed according to the fee schedule for CPST.

Q19. We sometimes take clients into our program who have been released to the community from an IMD for several days on a "trial" basis. Can we bill Medicaid for these services?

A19. Possibly, depending on the client's age. 42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. If a patient is released to a community setting for a trial visit, this is "convalescent leave." If the patient is released on the condition that they receive outpatient treatment or on other comparable conditions, the patient is on conditional release. If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services could be covered under Medicaid because the individual is not considered an IMD patient during these periods.

However, the regulation contains a separate provision for individuals under age 22 who have been receiving inpatient psychiatric services under 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he is unconditionally released or the date that he reaches age 22, whichever comes first.

Q20. We spend a lot of time when an RIACT client is hospitalized at Butler working towards their discharge. If we can't bill Medicaid for this time due to the IMD prohibition, can we at least count these hours towards the client's monthly RIACT service minimum?

A20. MHRH realizes that hospitalization of a client, whether it be in the psychiatric unit of a general hospital or in an IMD, is a serious matter and that all of the team's resources are brought to bear. This can involve extensive face-to-face contact with both the client and collaterals, all of which may

be counted towards the minimum monthly hours required, providing that those contacts do not duplicate the services that the hospital is required to provide.

Q21. We spend a lot of time when a RIACT client is incarcerated at the ACI or hospitalized at the ESH Forensic Unit trying to get things set up for their discharge. Can we bill Medicaid for these days?

A21. No. You may not bill RIACT for days that clients spend in a public institution. However, as is the case for clients who are hospitalized in an IMD, involvement in the criminal justice system is a serious matter that may require a major expenditure of resources on the part of the team. Any face-to-face contact with either the client or collaterals while they are these settings may be counted towards the minimum monthly hours required for RIACT per diem billing. For example, if a RIACT-I client spends December 1-5 at the ACI and the team spends 8 hours over that period working with the client and/or collaterals in order to achieve a smooth transition back into the community, you may begin billing RIACT-I per diem on the first day that the client returns to the community as the monthly minimum contact requirement has been met.

Q22. The Community Mental Health Medicaid Procedure Manual indicates that "Treatment plan reviews must contain the same signatures as are required for the base treatment plan." What does this mean and do we need to sign even if the plan isn't changed?

A22. All treatment plan reviews, whether they be the routine 6-month review; the annual re-write; or an interim review based on a change in the client's condition or other issue, must contain at least a) the signature of a Licensed Practitioner of the Healing Arts (or, in the case of MHPRR or RIACT-I/RIACT-II services, a physician) and b) the signature of the client. If the client is unwilling or unable to sign, the review must contain the signature of an appropriate staff member attesting to the fact that the client was given the opportunity to sign and declined.

Note however that the mere presence of the client's signature in the plan does not signify that they have been given adequate opportunity to participate in the development of the plan. Therefore we would also expect to find that the client's medical record documents consistent and adequate efforts to gain their participation in the development of the plan as well as some indication that they understand the planning process. This documentation must be present whether or not the plan is actually changed as a result of the review.

Be aware also that reviews that are billed under the provisions of Multi-Disciplinary Mental Health Treatment Planning have additional documentation requirements.

Q23. Our center has many cases in which the client is only seen by a physician. Given the comprehensive nature of the physician's follow-up notes, is a treatment plan review necessary every six months? Additionally, do we actually have to re-write these plans in their entirety every 12 months?

A23: A treatment plan review is required every 6 months for all Medicaid clients regardless of the setting in which they are seen. However, the Medicaid Scoring Worksheet notes that the results of a treatment plan review may be entered in a detailed progress note, which shall be referenced in the treatment plan.

Based on this, the results of the treatment plan review could be incorporated in the physician's notes if they are a) referenced in the treatment plan and b) contain appropriate documentation of client participation.

In reference to the need to rewrite the treatment plan, the entire master treatment plan must be re-written at least once every 12 months. There are no exceptions to this requirement and failure to comply can be grounds for a Medicaid audit exception.

Q24. A client in our MHPRR suffered a broken arm, is in a cast, and needs assistance in bathing. Are we required to provide this?

A24. You are responsible for providing limited physical assistance, on a temporary basis, to MHPRR residents. In this instance, we would expect that MHPRR staff would assist the resident in covering the cast with a waterproof material and assist them in and out of the shower if required. We would also expect that you would also help them with cutting their food, getting dressed, etc. However, we realize that MHPRRs are staffed primarily to handle the mental health care needs of their clients and not to handle residents with heavy physical care needs on an ongoing basis. For example, staff would not be expected to actually change diapers in the case of incontinent clients or to deal with oxygen in the case of clients with respiratory conditions. Clients with ongoing conditions that require extensive physical care should be carefully assessed for relocation to a facility that is appropriately staffed. Alternatively, procurement of the services of a home health aide or personal care attendant might be explored with the State Medicaid Agency.

Q25. Should the OEI be included in the client's individual medical record?

A25. The completed survey itself need not necessarily become a part of the client's medical record. In fact, we recommend that the portions of the survey dealing with the client's opinion of services not be stored in a location that is accessible to the individual clinician.

Q26. Is it necessary to document in the medical record that the client was given the opportunity to complete the OEI?

A26. Documentation in the medical record is only necessary in cases in which the client both refuses to complete the OEI <u>and</u> refuses to put the uncompleted OEI in the envelope, sign the seal, and return it to staff. In all other cases, receipt of the instrument by MHRH, whether complete or incomplete, will be considered to meet the requirement of giving the client the "opportunity to complete".

Q27. Who do we call if we have questions?

A27. It depends on the question. Questions regarding specific procedural items in this manual should be directed to the Medicaid Project Officer, Division of Behavioral Healthcare, MHRH. All billing questions should be directed to EDS. If you're not satisfied with the response that you get from either of the above, contact the DHS liaison. Phone numbers for contacts are in the Appendix.

Tremper—07/10/02

Appendix 9: Rhode Island Assertive Community Treatment I Medicaid Record Scoring Worksheet

Case #: _____ Client Type: CSS_____ GOP____

Agency:_____ Date:

Your Name and Degree:

RIACT-I Admission Date: _____

ASSESSMENT

1. Is there a comprehensive assessment of the client's clinical, rehabilitation, and support needs, completed by the RIACT-I staff? (If no assessment, skip to #6) . . . . . Y N

2. If admitted within the past 12 months, was the assessment completed within 30 days of admission to RIACT-I? . . . . . Y N NA

Use the following scale for Questions #3a and #3b only.

1. Comprehensively lists strengths, weaknesses, and problems.
2. Briefly documents assessment results; would benefit from expansion/clarification.
3. States that assessment was written (2a)/reviewed(2b) but provides inadequate documentation of results.
4. No assessment or documentation that a review was done in this area.

3a. If there is a comprehensive assessment, does it include an evaluation of the following areas:

	Compliance		Non-Compliance		Most Recent
Current psychiatric symptoms and mental status?.....	1	2	3	4	_____
Psychiatric history, including compliance with and response to prescribed medical/psychiatric treatment?.....	1	2	3	4	_____
Medical, dental and other health needs?.....	1	2	3	4	_____
Extent and effect of drugs and/or alcohol use?.....	1	2	3	4	_____
Housing situation and conditions of daily living?).....	1	2	3	4	_____
Employment and educational functioning?	1	2	3	4	_____
Extent and effect of criminal justice involvement?	1	2	3	4	_____
Social functioning/recent life events/family?	1	2	3	4	_____

3b. Was each of the following components of the assessment either written or reviewed within the last year or, if the client has been discharged, within 12 months prior to the date of discharge?:

	Compliance		Non-Compliance		Most Recent
Current psychiatric symptoms and mental status?.....	1	2	3	4	_____

Psychiatric history, including compliance with and response to prescribed medical/psychiatric treatment?.....	1	2	3	4	_____
Medical, dental and other health needs?.....	1	2	3	4	_____
Extent and effect of drugs and/or alcohol use?.....	1	2	3	4	_____
Housing situation and conditions of daily living?).....	1	2	3	4	_____
Employment and educational functioning?	1	2	3	4	_____
Extent and effect of criminal justice involvement?	1	2	3	4	_____
	Compliance		Non-Compliance		Most Recent
Social functioning/recent life events/family?	1	2	3	4	_____

4. Is there evidence that each assessment area has been completed by RIACT-I staff with skill and knowledge in the area being assessed and is based upon all available information, including self-reports, reports of family members and other significant parties, and written summaries from other agencies, including police, courts, and inpatient facilities where appropriate? 1 2 3 4

5A. If there is a written assessment, does the written assessment reflect the input of other RIACT-I staff as outlined in #5 above? Y N

Comments:

5B. Indicate which discipline completed it i.e., M.D., Voc. Spec., SA Spec., RN, CM, Clinical Spec.

TREATMENT PLANNING

6. Is there a current (within the last 6 months) comprehensive, written treatment plan? . . . . . Y N

Date of last plan:_____ Date of current plan:

7. Is there evidence that the treatment plan was developed through a treatment planning meeting attended by the primary case manager, program director, psychiatrist, staff person responsible for overseeing employment services, and all other RIACT-I staff members involved in regular tasks with the consumer? . . . . . Y N

Comments:

COMPLETE ITEMS 8-24 ONLY IF THERE IS A CURRENT TREATMENT PLAN

8. If there is an assessment, is the treatment plan based on it? . . 1 2 3 4

N/A

Comments:

9. If this is an initial treatment plan, was the plan formulated upon completion of the RIACT-I intake process and within one month after the client's admission to RIACT-I? . . . . . Y N N/A

Comments:

10. Has the treatment plan been reviewed at the following intervals? (Circle one answer per item)

Upon any significant change in client's condition . . .	1	2	3	4
At 6 month intervals	1	2	3	N/A 4
Upon discharge		Y	N	N/A
At the end of the estimated length of treatment		Y	N	N/A

Case Number:_____ Page 2

11. Is there a written "treatment plan review" describing the consumer's progress since the last treatment planning meeting as well as outlining the consumer's current functional strengths and limitatons? . . . . . Y N N/A

Date of last treatment plan review:_____ Date of current treatment plan review:_____

12. Is the treatment plan signed by the consumer, primary case manager, program director, and psychiatrist? . . . . . Y N N/A

13. After each practitioner's signature, is his/her degree/title clearly indicated? (Answer "N" if degree/title is not clearly shown) . . . . . Y N N/A

Comments:

14. Does the treatment plan contain a clear indication, written in behavioral versus diagnosis or in general terms of the client's:

Needs or problems	1	2	3	4
Functional strengths	1	2	3	4
Limitations	1	2	3	4

15. Does the treatment plan address the following need/problem areas:

Symptom stability	1	2	3	4
				N/A
Symptom education and management	1	2	3	4
				N/A
Housing	1	2	3	4
				N/A
Employment/daily structure	1	2	3	4
				N/A
Family/social relationships	1	2	3	4
				N/A
Financial	1	2	3	4
				N/A
Substance Abuse	1	2	3	4
				N/A
Physical Health	1	2	3	4
				N/A

Comments:

16. Does the treatment plan contain a clearly visible DSM diagnosis both written <u>and</u> coded? (Answer "N" if not shown written <u>and</u> coded.) . . . . . Y N

Comments:

17. Do the client's symptoms and the recommended interventions bear a clear relationship to the DSM-III-R diagnosis? 1 2 3 4

Comments:

Case Number:_____ Page 3

18. If there is an assessment, are the goals/objectives clearly based on it? 1 2 3 4

N/A

Comments:

19. To assess whether the proposed interventions are eliminating the problem, does the treatment plan include

specific goals/objectives for each problem area, indicating clearly what is expected to be different for the client at the end of the six month period? . . . . . Y N

Comments:

20. In follow-up to #21, do the objectives for treatment describe specific, observable changes in behavior that are:

Measurable 1 2 3 4
Time Limited 1 2 3 4

Comments:

21. Does the treatment plan clearly and specifically indicate:

When/with what frequency all treatment interventions will be carried out? . . 1 2 3 4

Which staff will perform the intervention? 1 2 3 4

Where the intervention will occur? (e.g. community or office-based) . . . 1 2 3 4

22. Does the treatment plan also clearly indicate the criteria to be met for termination of treatment? 1 2 3 4

Comments:

23. Have the client and other pertinent agencies and members of the client's social network had the opportunity to participate in the development of the treatment plan as evidenced by specific documentation in the clinical record? . . . . . 1 2 3 4 N/A

Comments:

24. Are referrals for services not available directly through the RIACT-I program, where required by the client's condition, clearly documented? . . . . . 1 2 3 4 N/A

Comments:

PROGRESS NOTES

25. Are the progress notes completed via: (please circle one)

a. Format 1 Or b. Format 2

a. If the notes are completed via Format 1 (Weekly and Monthly Summary Format), is there documentation of each contact with the client or collateral, including:

Client's name (unless evident)	Y	N
Staff's name (unless evident)	Y	N
Place of visit (e.g., home, CMHC)	Y	N
Type of visit (e.g., group, individual)	Y	N
Service Provided (e.g., symptom management, food shopping) . .	Y	N
Date and time (unless kept elsewhere)	Y	N
Duration of service	Y	N

Note that the information above may be entered onto a coded sheet.

In addition, under Format 1, are there Weekly and Monthly Summaries which include the following:

Document the implementation of the treatment plan?	1	2	3	4
Have signatures, degrees, dates?	1	2	3	4
Appear on chronological order?	1	2	3	4
Describe significant changes in the client's clinical course or condition (answer "N/A" if no significant changes.)?	1	2	3	4
Provide consistent, periodic documentation of all services/treatment clearly tied to the objectives contained in the treatment plan? . .	1	2	3	N/A

			4
Document the response of the client to treatment?	1	2	3
			4
Describe the overall outcome of treatment?	1	2	3
			4
Avoid being excessively narrative in nature?	1	2	3
			4

b. If the progress notes are completed via Format 2 (Notes for Each Individual Contact), is there documentation of each contact with the client or collateral, including:

Client's name (unless evident)	Y	N	
Staff's name (unless evident)	Y	N	
Place of visit (e.g., home, CMHC)	Y	N	
Type of visit (e.g., group, individual)	Y	N	
Service Provided (e.g., symptom management, food shopping) . .	Y	N	
Date and time (unless kept elsewhere)	Y	N	
Duration of service	Y	N	
Documentation of the implementation of the treatment plan? . .	1	2	3
			4
Signatures, degrees, dates?	1	2	3
			4
Documentation of services in chronological order?	1	2	3
			4
Description of significant changes in the client's clinical course or condition (answer "N/A" if no significant changes.)	1	2	3
			4

			N/A
Consistent, periodic documentation of all services/treatment clearly tied to the objectives contained in the treatment plan? . .	1	2	3
			4
Response of the client to treatment?	1	2	3
			4
Description of the overall outcome of treatment	1	2	3
			4

Avoidance of being excessively narrative? 1 2 3 4

Comments:

26. Do progress notes reflect a professional assessment made by the writer as to why the interventions prescribed are or are not working? 1 2 3 4

Comments:

27. Do the progress notes explain any significant deviations from the interventions prescribed in the treatment plan? (Answer "N/A" if there were no deviations.) . . . . . 1 2 3 4 N/A

Comments:

28. Is there clear evidence in all treatment plan reviews that the reviewers have taken into account the activity recorded in the Progress Notes? . . . . . 1 2 3 4 N/A

Comments:

DISCHARGE

29. Has the client been discharged? . . . . . Y N

30. If "Yes", is there a discharge summary in the record? . . . . . Y N

31. Does the discharge meet one of the following two criteria for termination from RIACT-I services:

    a) Moved outside the geographic area of responsibility? . . . . Y N

    b) Demonstrated an ability to function in all major role areas (work, social, self-care) without requiring assistance from the program, with this determination made by both the

consumer and program? . . . . . Y N

32. If there is a discharge summary, does it:

Appear in the record within 15 days of discharge?	1	2	3	4
Contain all significant findings?	1	2	3	4
Include the reason for discharge?	1	2	3	4
Contain the final primary and secondary diagnoses?	1	2	3	4
Contain general observations about the clients' condition at intake during treatment, and at discharge?.	1	2	3	4
Assess the degree of attainment of treatment goals and objectives? . .	1	2	3	4

Case Number:_____ Page 6

Contain a plan developed, in conjunction with the consumer, for care after discharge and for follow-up?	1	2	3	4
Document referral to other programs/agencies as needed?	1	2	3	4
Indicate whether the discharge was planned or unplanned? . . .	1	2	3	4
Contain the signature of the primary case manager, program director, and psychiatrist?	1	2	3	4

Comments:

****QUESTIONS 33—34 TO BE COMPLETED FOR CLIENTS WHOSE 6-MONTH TREATMENT ****

**** PLAN REVIEW DATE IS JANUARY 1, 1999 OR LATER ****

33.. Was the staff portion of the OEI **fully** completed and received by DBH no later than the end of the calendar month occurring two months after the month during which the treatment plan review was conducted? (Answer "NA" for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of April, use "NA" for all treatment plans due in February or March) Y N NA

Comments:_____

_____

34. Did the client have the opportunity to complete the OEI as evidenced by:

a) Receipt of a client OEI by DBH that was completed no later than the end of the calendar month occurring two months after the month during which the treatment plan review was conducted? (Answer "NA" for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of

April, use “NA” for all treatment plans due in February or March.) Y N NA

OR

b) An entry in the client’s individual medical record indicating that the client was given the opportunity to complete the survey in the aforementioned timeframe. (Answer “NA” for clients whose treatment plan review date falls in either of the two calendar months preceding that of the site visit. For example, if the site visit takes place during the month of April, use “NA” for all treatment plans due in February or March.) Y N NA

Comments:_____

_____

( ) Check this box if this record is NOT recorded on the OEI Tracking list.

Appendix 10. Fee Schedule

A. Federal regulations mandate that payment for a given service by the Medical Assistance Program must not exceed the amount allowed by the Federal Medicare Program for the same identical service. If, in any instance, the amount allowed by the Federal Medicare Program is less than the amount specified in this fee schedule, payment will be made in accordance with the lower reimbursement rate.

B. Federal Regulations and the requirements of the Rhode Island Medical Assistance Program mandate that payment made in accordance with the allowances listed in this fee schedule must be considered as full and total payment for the service rendered. The Department of Human Services cannot allow any arrangement that would require eligible recipients of the Medical Assistance Program, or any other party, to provide supplementary payment for these services.

C. The fee for each service shall be the fee listed on the Mental Health Medicaid Fee Schedule as published by the Division of Behavioral Healthcare; **or** the provider's allowed Medicare charge for that same identical service; **or** the provider's customary charge to other third party insurers or self-paying individuals for that same identical service, **whichever is lowest**.

Providers may not bill Medicaid for an amount greater than their lowest charge for any specific service under any circumstances, regardless of the fee listed in the Mental Health Medicaid Fee Schedule. Providers who submit bills with charges higher than the lowest of either their allowed Medicare charge or their customary charge will be required to make repayments to the Department of Human Services or will have their bills rejected.

R. I. COMMUNITY MENTAL HEALTH MEDICAID PROCEDURE MANUAL

R. I. DEPARTMENT OF MHRH
DIVISION OF BEHAVIORAL HEALTHCARE
July 22, 2002