



Psychiatric Rehabilitation Program - Minor

Optum Maryland Provider Training &
Education

Training Participant Guide



Key Learning Points

- PRP Overview
- Medical Necessity Criteria
- Required Documentation
- Auth Service Requests
- Incedo Forms Demonstration
- Tips for Claim Success



Program Overview

Psychiatric Rehabilitation Program - Minor

PRP Overview

Psychiatric Rehabilitation Program (Minor):

- Psychiatric rehabilitation program (PRP) services provide rehabilitation and support to minor patients in developing community and independent living skills.
- Services must be goal-directed and outcome-focused; are time-limited interventions to reduce symptoms of mental illness and to restore individuals to appropriate functional level.
- Services may be provided on-site or in a setting most conducive to promoting participation of youth in community life.
- Requests for this level of care are completed within the Incedo Provider Portal and reviewed by Optum Care Advocates.



PRP Overview

Psychiatric Rehabilitation Program (Minor):

- Services are designed to complement outpatient (OP) mental health therapy treatment where there is clinical evidence that current intensity of OP therapy treatment isn't sufficient.
- The request for PRP must be initiated by the youth's treating clinician and identified rehabilitation goals must be integrated and supported with the treatment plan.
- PRP services are only covered for payment if the youth remains ongoing active outpatient therapy.
- PRP services for the youth must be based on an assessment of functioning that is age and developmentally appropriate.



PRP Overview

Eligibility and Funding

State funded and uninsured participants must meet additional criteria for an initial PRP request, in addition to meeting medical necessity criteria.

The participant must meet **1 of the following 4 criteria:**

1. Stepdown from a state hospital and are on conditional release
2. Discharge from an acute psychiatric hospitalization within the last six months
3. Release from jail within the last six months
4. Discharge from an RRP within the last six months

Medical Necessity Criteria

Psychiatric Rehabilitation Program - Minor

Medical Necessity Criteria

PRP Corner – Source of Truth

- PBHS Provider Manual
- Medical Necessity Criteria (Psychiatric Rehabilitation Program – Child and Adolescent)
- PBHS Specialty Diagnosis
- PRP FAQs

Admission Criteria

- Public Behavioral Health System (PBHS) specialty mental health DSM-5 diagnosis
- Youth's emotional disturbance causing serious dysfunction as services are intended for youth with serious functional impairments in multiple areas where OP therapy/medication management is not sufficient to address.
- The impairment as a result of the youth's emotional disturbance results in:
 - a) Current threat to the youth's ability to stay in customary setting, or
 - b) Emerging/impending risk to the safety of the youth and others, or
 - c) Other evidence of significant psychological or social impairments (*i.e.: inappropriate social behavior causing serious problems with peer relationships and/or family members*)
- Due to dysfunction, youth is at-risk for requiring a higher level of care or is returning from a higher level of care.

Medical Necessity Criteria

Admission Criteria

- Youth condition requires integrated program of rehab services to progress accordingly
- Youth does not require a more intensive level of care and is deemed to be able to maintain in the rehab program benefiting from services
- A documented crisis response plan is in progress or completed (including family and treating provider)
- PRP services are rendered by trained staff supervised by a licensed mental health professional or certified family resilience practitioner (CFRP)
- There is evidence that the use of pharmacotherapy, if deemed appropriate, has been considered by the primary treating clinician

Medical Necessity Criteria

Admission Criteria

- AND either

OP Therapy/Medication Management treatment is:

- Insufficient
- Not preventing clinical deterioration
- Not averting the need for a more intensive level of care

or

Youth is:

- Transitioning from IP, Day Hospital, or RTC
- In need of PRP services to prevent clinical deterioration
- Referred to avert need for more intensive level of care

Medical Necessity Criteria



Continued Stay Criteria

- The individual continues to meet admission criteria
- There is clinical evidence justifying ongoing services
- Signed and dated IRP with specific information about participant's symptoms/impairments/dysfunction, progress on measurable goals.
- Goals should be active including status:
 - If goals are not being met, modifications to goals and/or interventions should be addressed.
 - Active planning for transition to less intensive level of care
- The individual must be engaged in mental health treatment with an outpatient clinician that does not work in or receive remuneration in any form from the PRP.

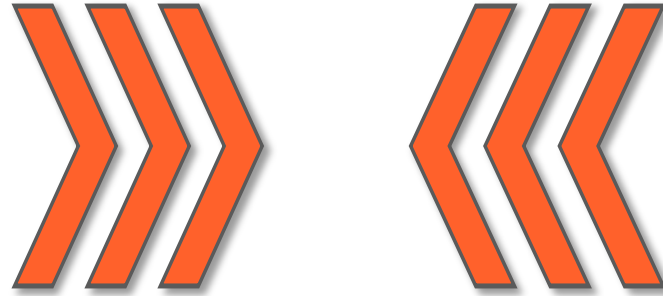
Medical Necessity Criteria

Exclusionary Criteria

- Youth's mental status or development level cannot be reasonably accommodated (*impairment severity precludes individual from benefiting from services*)
 - Youth is
 - Eligible for full funding for Developmental Disability Administration services, or
 - Actively receiving autism waiver funded services, or
 - Active in Applied Behavioral Analysis treatment

**Please note: a diagnosis of Autism Spectrum Disorder (ASD) is considered a neurodevelopmental disability. Therefore, PRP should not be in place to address symptoms related to a diagnosis of Autism Spectrum Disorder, if ASD is a secondary diagnosis*
 - Primary etiology of dysfunction related to:
 - Organic process or syndrome
 - Intellectual disability
 - Neurodevelopmental disability
 - Neurocognitive disorder
 - Youth meets criteria for higher level of care and cannot be effectively served through PRP
 - Youth can be effectively served with less intensive formal services or natural support
- **Admission and continued stay requests must meet the Combination of Service rules***

Medical Necessity Criteria



Conflicting Services

PRP may not be routinely provided in conjunction with:

- Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)
- Targeted Case Management (TCM) – *TCM 1 not allowed under any circumstance*
- Inpatient Psychiatric Services
- Crisis Residential Services
- Psychiatric Residential Treatment Facility (PRTF)/ Residential Treatment Center (RTC)
- Mental Health- Intensive Outpatient Program (IOP)
- Mental Health- Partial Hospitalization Program (PHP)
- Therapeutic Behavioral Services (TBS)
- Residential Substance Use Disorder Treatment Level 3.3 or higher
- Substance Use Disorder-Intensive Outpatient Program/Partial Hospitalization (IOP/PHP)

Medical Necessity Criteria



TAY Psychiatric Rehabilitation Programs (PRP-M) and School Systems

Coordinate with Special Education system as these services are more appropriately under the youth's Individual Education Plan (IEP) and not the Public Behavioral Health System (PBHS).

Additional information in Provider Alert:

[Child, Adolescent & Transition Age Youth \(TAY\) Psychiatric Rehabilitation Programs \(PRPs\) & School Systems and Reminder Concerning the PRP Corner](#)

Required Documentation

Psychiatric Rehabilitation Program - Minor

Required Documentation

In addition to the service request form completed within Incedo, the following documentation is required:

Initial PRP Requests:

- PRP referral signed by a licensed mental health provider who is actively treating the individual and enrolled as a provider in the Medicaid program, either as an individual provider or as part of a Medicaid enrolled program.
- Referrals must include the following information:
 - Must be dated within the last 60 days
 - Clinical rationale for why individual is being referred for PRP
 - Signature of referring behavioral health clinician who has been actively treating the participant (e-signature acceptable)
 - Referring behavioral health clinician must not be affiliated with PRP program
 - Must explicitly state PRP (Psychiatric Rehabilitation Program)
 - Referring clinician **MUST** be a mental health professional enrolled in Maryland Medicaid either directly or through a program enrollment, e.g., OHMC

Referrals must be from a licensed mental health professional which is defined in [PRP FAQ](#)

Required Documentation

Concurrent PRP Requests:

- Documentation of Clinical Collaboration or PRP referral dated within the last 60 days.
- Referrals must include:
 - Clinical rationale for why individual is being referred for PRP
 - Signature of referring behavioral health clinician (e-signature/typed signature is acceptable)
 - Referring behavioral health clinician must not be affiliated with the PRP program
 - Must explicitly state PRP (Psychiatric Rehabilitation Program)
 - Referring clinician **MUST** be a mental health professional enrolled in Maryland Medicaid either directly or through a program enrollment, e.g., OHMC
- Individualized Rehabilitation Plan (IRP) which indicates the participant and/or guardian participated in the planning and agrees with the plan.
- DLA-20 must be completed in the Incedo Provider Portal within 30 days prior to the requested start date (*TAY Participants only*)

Authorization Service Request Info

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Service Request Information

Modifier	Description
U2	PRP for all children (up to age 18), adults age 18-25 in a BHA TAY-designated PRP, or adults with a legal guardian
U3	PRP for adults with no legal guardians
U4	A RRP client in the general level of care who is either on or off-site
U5	A RRP client in the intensive level of care who is either on or off-site
U6	A RRP client in the general level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity
U7	A RRP client in the intensive level of care who receives services from a provider who has the capacity to render services in onsite and off-site capacity

Admin Denial Checklist



Used to determine Administrative Denial Reasons for PRP requests



Found on [PRP Corner](#) homepage under Provider Resources

Participant's Name:
Incedo ID:

Administrative Denial Checklist

This case was administratively denied for the following reasons:

- 1. Participant does not have an eligible diagnosis for admission
 - a. There is no Category A or Category B priority population diagnosis (adults), and the diagnostic waiver criteria are not met (not competent to stand trial, in psych facility for longer than 3 months who requires PRP on discharge) (adult)
 - b. There is no Public Behavioral Health System diagnosis (child/adolescent/TAY)
- 2. Category A diagnosis and indication of SSI/SSDI, but no acceptable documentation of SSI/SSDI eligibility attached to service request (**First concurrent only**). Acceptable documentation of SSI/SSDI eligibility is detailed in [Q.11 of the PRP FAQ](#).
- 3. Participant does not have Federal Medicaid and does not meet additional funding criteria (i.e., none of the following met):
 - Stepped down from a state hospital and are on conditional release
 - Discharged from an acute psychiatric hospitalization within the last six months
 - Released from jail within the last six months
 - Discharged from a RRP within the last six months
- 4. Referral and/or collaboration of care document was incomplete for the following reason:
 - a. Referral/Collaboration of Care was not attached to service request
 - b. Referral was not signed (original or electronic) by MH professional making the referral
 - c. Referral/Collaboration of Care not dated within 60 days prior to or on requested start date
 - d. The referral date was after the requested start date of the authorization
 - e. Inadequate documentation of clinical collaboration (concurrent) [\[See alert dated 8/4/21\]](#)
 - f. A LM/LG referred without a supervisor's name and credentials provided in the Incedo form
 - g. The referral source is not enrolled in Medicaid or is not working at Medicaid enrolled licensed mental health program
- 5. The request does not include information about the following less intensive services having been

Admin Denial vs. Medical Necessity Denial

Incedo ID:

Administrative Denial Checklist

This case was administratively denied for the following reasons:

- 1. Participant does not have an eligible diagnosis for admission
 - a. There is no Category A or Category B priority population diagnosis (adults), and the diagnostic waiver criteria are not met (not competent to stand trial, in psych facility for longer than 3 months who requires PRP on discharge) (adult)
 - b. There is no Public Behavioral Health System diagnosis (child/adolescent/TAY)
- 2. Category A diagnosis and indication of SSI/SSDI, but no acceptable documentation of SSI/SSDI eligibility attached to service request (**First concurrent only**). Acceptable documentation of SSI/SSDI eligibility is detailed in [Q.11 of the PRP FAQ](#).
- 3. Participant does not have Federal Medicaid and does not meet additional funding criteria (i.e., none of the following met):
 - Stepped down from a state hospital and are on conditional release
 - Discharged from an acute psychiatric hospitalization within the last six months

Administrative Denial

- Denial Checklist via Email/Incedo Provider Portal
- Next Steps:
 - Review completed checklist
 - Re-submit authorization request with corrected/supplemental information

Good Morning/Afternoon,

We are writing to inform you that after clinical review, your authorization **SR ID** [REDACTED] has been denied due to medical necessity criteria not being met. You have the right to request a level 1 appeal within 10 business days of this notification. Further information can be found in the denial notification letter which will be attached directly to the service request in Incedo and a copy will be mailed to the address on file. Please visit the Incedo Provider Portal to review details of this denial.

If you are unsure how to find the authorization using the SR ID above, please follow the steps on page 14 of the reference guide below:

- [Incedo Provider Portal Quick Reference Guide](#)

You can contact customer service at 1-800-888-1965 with questions. Thank you.

Optum Authorization Team

Medical Necessity (MNC) Denial

- Denial Letter
- Next Steps:
 - Initiate Appeals Process
 - Refer to PBHS Provider Manual

Common Denial Reasons



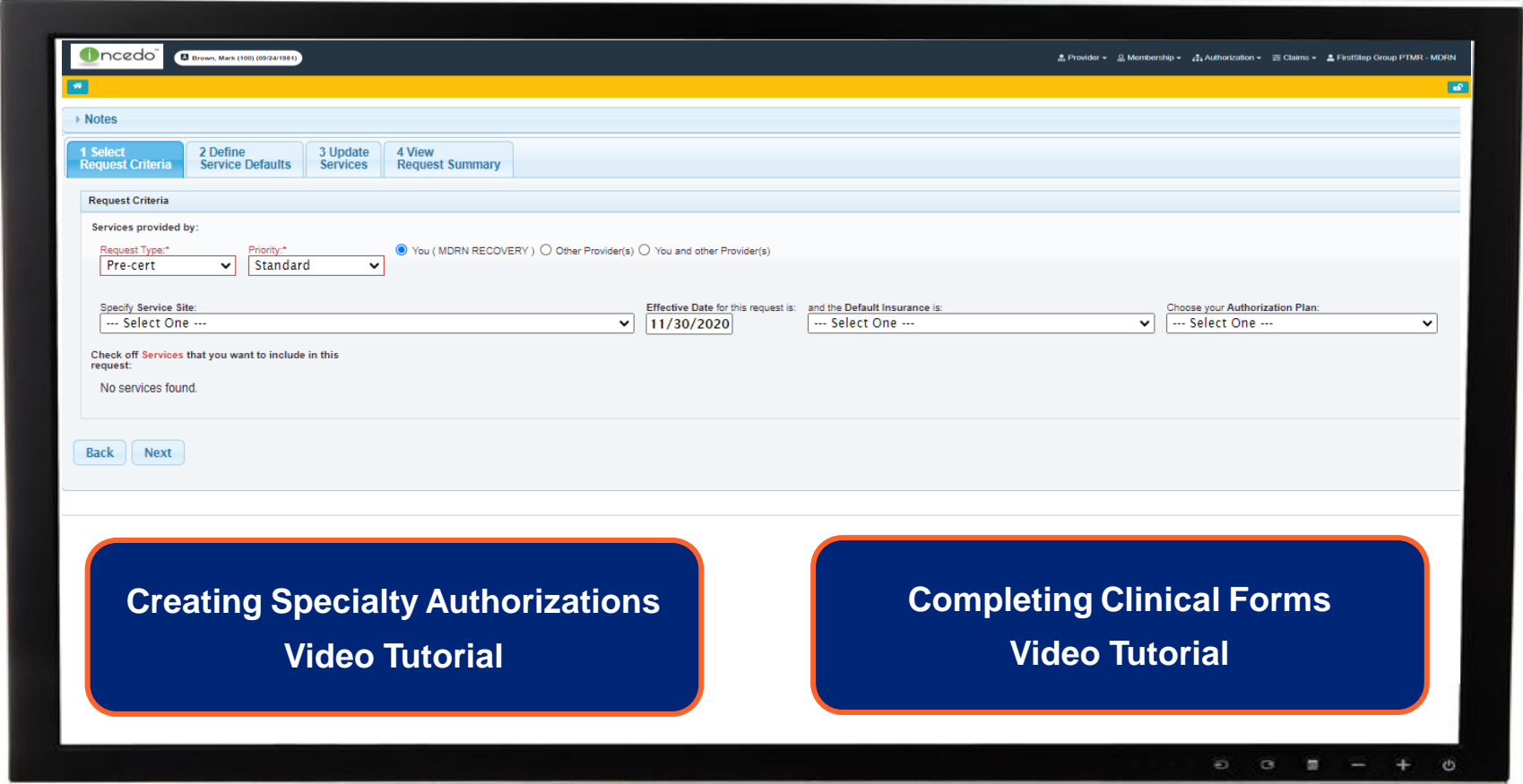
Top Denial Reasons

- **Lack of clear explanation of why outpatient therapy is not sufficient to address the participant's symptoms**
 - The participant should have been in active, consistent outpatient therapy (currently engaged in ongoing active treatment), with limited to no improvement, prior to referring to PRP.
 - When appropriate, this should include a referral for an evaluation for pharmacotherapy to address the youth's symptoms/behaviors.
- **Functional Impairments are not explained adequately, or report outdated historical information**
 - Requests should explain:
 - How the specific symptoms of the condition in the PBHS approved diagnosis cause serious problems with family members and/or peers, along with examples of these problems, and/or
 - How the specific symptoms of the PBHS approved diagnosis place the youth at risk for loss of their current residential placement OR result in a safety risk for the youth or others.
 - Information in the request should be current (should not refer to a history of symptoms or behaviors that are not present at the time of the PRP referral).

Incedo Demonstration

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Incedo Demonstration



Claim Submission

Psychiatric Rehabilitation Program - Minor

Resources for Claims Success

Link to Incedo Training Videos
 (Locate the CMS 1500 Form Claim Entry Tutorial Video)

Link to Provider Resources
 (Diagnosis Codes)

Link to the Fee Schedules

Link to the PRP Corner

24 A. DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.	H.	I.	J.
From	To	PLACE OF SERVICE	EMG	CPT/HCPCS	(Explain Unusual Circumstances) MODIFIERS		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL	RENDERING PROVIDER ID.#	
-- Select One --		-- Select One --											NPI	
///	///												NPI	
-- Select One --		-- Select One --											NPI	
///	///												NPI	
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Check out the Claim Entry Tutorial Video linked above to fill out the CMS1500 form. The following pages are an example of sections 24 A-J filled out. Make sure to fill out the form based on your participant and services.

Tips for Claims Success

Box 24 A: Each CMS1500 form has 6 lines of service.

- Each date of service on which a service was rendered must be listed on a separate line. Ranges of dates are not accepted.

Example:

- *Correct:* 1/1/2023 - 1/1/2023
- *Incorrect:* 1/1/2023 - 1/7/2023

Encounters and Case Rate

- When billing encounters and the case rate, the date of service of the encounter(s) must be rendered before the date of service on the case rate.

24.A. DATE(S) OF SERVICE	
From	To
-- Select One --	
<u>1 / 1 / 2023</u>	<u>1 / 1 / 2023</u>

Tips for Claims Success

Box 24 B: Enter the appropriate 2-digit Place of Service (POS) code. Based on the services that are being rendered, determine if it is On-Site, Off-Site, or Blended. The POS can be found on the most up to date Fee Schedule.

See examples below:

Encounter Example

B.	C.
PLACE OF SERVICE	EMG
-- Select One --	
15	

Check the POS for On-Site and Off-Site as they have different POS digits.

H2016	Encounter (only bill w/ POS 15 (off-site) or 52 (on-site))
-------	--

Case Rate Example

B.	C.
PLACE OF SERVICE	EMG
-- Select One --	
49	

Check the POS for On/Off Site, On-Site, or Off-Site as they have different POS digits.

H2018-U3	Any combination of on/off-site PRP svcs for Supported Living client (i.e. adult living independently). (Must use POS 49 & min 6 encounters) (Monthly rate)
H2018-U3	On-site PRP svcs only for Supported Living client. (Must use POS 52 & min 3 encounters) (Monthly rate)
H2018-U3	Off-site PRP svcs only for Supported Living client. (Must use POS 15 & min 5 encounters) (Monthly rate)

Box 24 C: Not required.

Tips for Claims Success

Box 24 D: Enter a valid CPT or HCPCS code for each service rendered.

Enter a valid CPT or HCPCS code modifier, as applicable, for each service entered. This can be seen on the Fee Schedule.

See an example below:

H2018-U3	Any combination of on/off-site PRF independently). (Must use POS 49
----------	---

Box 24 E: Locate the diagnosis pointer (one alpha character) from Box 21 to relate the date of service and the procedures performed to the primary diagnosis.

Enter diagnosis code(s) without a period.

D. PROCEDURES, SERVICES, OR SUPPLIES					E.
CPT/HCPCS	(Explain Unusual Circumstances)	MODIFIERS		DIAGNOSIS POINTER	
H2018		U3			

E.
DIAGNOSIS POINTER
A

Box 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Related A-L t service line below (24E)

A. F322	B. F200
E.	F.
I.	J.

Tips for Claims Success

Box 24 F: Enter the provider's usual and customary charges.

Invented Scenario: A blended (on-site, off-site) PRP Provider had 11 encounters in one month. For a U3 service that maximum payment threshold is at a minimum of 6 visits. The provider performed at least 6 encounters for the participant which is the maximum threshold at the U3 level, so the provider billed the encounters and the H2018-U3. Participant continued to receive services within the month and ended the month with 11 encounters, therefore the provider must bill ALL 11 encounters.

Encounters

F	
\$ CHARGES	
1	00

- Provider will use one service line per encounter. In this invented scenario they would fill out 11 service lines which would take two CMS-1500 forms to do.
- The charge in Box 24F will be \$1.00 per encounter. *(The form does not accept \$0.00 entries.)*

Case Rate

F	
\$ CHARGES	
500	00

Enter provider's usual and customary rate here

- Provider will enter a charge amount equal to the provider's usual and customary rate for the service that is being rendered. The case rate will take up 1 service line.

Tips for Claims Success

G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
1		NPI	

Note: Procedure Codes with "Monthly Rates" such as H2018 must be entered with 1 unit.

Box 24 G: Enter the total number of units of service for each procedure. The number of units must be for a single visit or day. (Multiple, identical services rendered on different days should be billed on separate lines.)

Box 24 H: Not required.

Box 24 I: Not required.

Box 24 J: Only applicable for specific provider types.

Refer to the [Claims Participant Guide](#) for more information.

Contact Us

Contact Provider Relations at
MarylandProviderRelations@optum.com

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