

HCCA'S 12TH ANNUAL COMPLIANCE INSTITUTE

APRIL 13-16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

Partial Hospitalization

Programs

Deborah C. Hiser
Brown McCarroll, L.L.P.
111 Congress Avenue, Suite 1400
Austin, TX 78701-4043
512-703-5718 direct
512-480-5020 direct fax
dhiser@mailbmc.com



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What is a PHP?¹

A PHP is:

- A program furnished by (1) a hospital to its outpatients or (2) by a Community Mental Health Center that provides partial hospitalization services
- A distinct and organized treatment program offering less than 24-hour/day care
- A program used to treat mental illnesses and substance abuse issues
- Where patients continue to reside at home, but commute to a treatment center up to 7 days/week

¹Rev.1, 05-21-04



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Medicare Requirements for PHPs

In order to be reimbursed by Medicare as a legitimate PHP, the particular services must be:

- Reasonable and necessary for the diagnosis or active treatment of the individual's condition
- Reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization



Medicare Requirements for PHPs

May be incorporated into any of the following:

- Individual and group therapy
- Occupational therapy
- Services of others trained to work with psychiatric patients
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes
- Individualized activity therapies that are not primarily recreational or diversionary
- Family counseling
- Patient Training and education
- Medically necessary diagnostic services



Distinguishing PHPs from Other Services

- An instance of any one of these services does not in and of itself constitute the delivery of a covered partial hospitalization service
- Programs comprised primarily of diversionary activity, social activity, or recreation therapy does not constitute a PHP



Exclusions

- The following services are excluded from PHPs:
 - Services to hospital inpatients
 - Meals, self-administered medications, transportation
 - Vocational training



What is a Community Mental Health Center or “CMHC”?

A CMHC is:

- An entity that meets applicable licensing or certification requirements in the state in which it is located; and
- Provides “Core Services” such as:
 - Outpatient services, including specialized services for children, the elderly, the chronically mentally ill, and residents of the CMHC’s mental health service area who have been discharged from inpatient treatment at a mental health facility;
 - 24 hour-a-day emergency care;
 - Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and
 - Screening for patients being considered for admission to State mental health facilities



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CMHC Core Services - Outpatient

- Separate from PHP services and contain the elements of diagnosis, treatment, and follow-up (as appropriate)
- Do NOT include screening and referral
- Children defined as 21 years or younger
- Elderly defined as 62 years or older
- Chronic Mental Illness evidenced by a psychiatric diagnosis as defined by the American Psychiatric Association
- Services to patients discharged from a mental health facility must be supported by evidence of a prior psychiatric inpatient hospitalization



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CMHC Core Services – 24 Hour Care

- Must provide access to a clinician and appropriate disposition with follow-up documentation of the emergency in the patient's medical record
- Patient must have access to evaluation and stabilization services after normal business hours



CMHC Core Services – Day Treatment

- Structured day programs (less than 24 hours/day) that use a multidisciplinary team approach to develop treatment plans that vary in intensity, frequency and duration of services
- Provided based on the needs of the patient



CMHC Core Services – Day Treatment

- Treatment program of a PHP is:
 - Similar to that of a highly structured, short-term hospital inpatient program
 - More intense level than outpatient day treatment or psychosocial rehabilitation
 - Active treatment that incorporates an individualized treatment plan coordinating services based upon the particular needs of the patient
 - Provided through a multi-disciplinary team approach under the direction of a physician
 - High degree of structure and scheduling
 - Treatment goals developed for each PHP patient should be measurable, functional, time-framed, medically necessary, and directly related to the reason for admission
- PHP programs must be distinct from other outpatient programs, day treatment, or psychosocial rehabilitation programs



Texas Law - Single Portal Authority

- Screening for admission to state mental health facilities may only be performed by an entity designated by the Texas Department of Mental Health and Mental Retardation (TDMHMR) as a "Single Portal Authority"
- TDMHMR designates Mental Health Authorities (MHAs) within each local service area
- A MHA is the entity designated to direct, operate, facilitate or coordinate services to persons with mental illness as required by state law and by TDMHMR contract



Texas Law - Single Portal Authority

- A MHA may request designation by MHMR as a single portal authority if it:
 - Provides or contracts for an appropriate array of core services;
 - Serves its priority population; and
 - Is in compliance with terms of its performance contract with the department



CMHC Core Services – Screening for Admission to State Mental Health Facilities

Definition:

- “The performance of at least one of the steps in a process by which an individual is clinically evaluated, pursuant to State law, for the appropriateness of admission to a State mental health facility by an entity that has both the appropriate clinical personnel, and authorization under State law, to perform all of the steps in the clinical evaluation process except those required to be provided by a 24-hour facility”¹
- Some states only allow certain entities to perform this type of screening
 - If precluded, may screen under a contract approved by CMS

¹Rev. 1, 05-21-04



Threshold and Service Requirements for CMHCs

- Applicant CMHC must provide core services at the same time of certification, not at some future point
 - Fully operational for one entire business quarter
 - Served a sufficient number of persons to reasonably assure the facility is complying with basic program requirements (at least ten (10) non-Medicare patients)



CMS Certification Process

- CMHC submits Form CMS-855A
- Form verified by Fiscal Intermediary (FI)
- FI forwards any request for a site visit to CMS
- CMS approves or denies CMHCs Medicare participation
 - Looks to ensure applicant provides required core services and meets threshold service requirements



Compliance Plan - Fraud and Abuse Laws

- 42 U.S.C. 1320a-7b(b)
- No remuneration given in order to induce a referral to a PHP
- PHP prohibited from knowingly and willfully offering, paying, asking for or receiving any money or other benefit, directly or indirectly, in return for referrals, purchases, leases or orders
- Must be considered whenever something of value is offered, given or received by a PHP that is in any way connected to client services, or any program funded in whole or in part by any federal, state, or local governmental agency



Compliance Plan - Confidentiality

- Health Insurance Portability and Accountability Act (HIPAA) requires:
 - Client authorization to use protected health information (PHI) unless specific exception exists
 - Client notification of their rights under HIPAA
 - Use of PHI by a PHP is generally restricted to minimum amount necessary
- Clients have the right to:
 - Agree to the use of PHI
 - Inspect and copy their records
 - Amend their records
 - Obtain certain limited audits of the disclosures of their records
- Privacy Officer designated to oversee compliance with the privacy regulations



Compliance Plan – Records Retention

- Separate medical record for each client
- Records filed alphabetically
- Files contain both medical and financial information
- Legible entries in blue/black ink
- Signatures and date of entry



Compliance Plan – Records Retention

- Each client's medical record should include:
 - Office visits (date, reason for visit, etc.)
 - Phone calls
 - Prescription refills or samples
 - Instances where client or guardian disobeys physician's orders or fails to return for follow-up visits
 - Cancellations and missed appointments
 - Attempts made to contact the client regarding missed visits
 - Treatment
 - Health history
 - Chief and secondary client complaints
 - Special conditions (allergies, precautions, etc.)
 - Use of assistance devices



Compliance Plan – Records Retention

- Information integrity is crucial
- Periodic review of electronic storage systems
- Conflict and contractual requirements
- Vital records
- Records maintained for 7 years after the last date of treatment and/or death



Compliance Plan – Billing Policy

- Fraud and abuse prohibitions
- Reasonable effort to collect all client co-payments and/or deductibles
- Waiver decisions made by Compliance Officer or Hardship Form
- Refund overpayments within 90 days



Optional State Plan Case Management Services

- CMS proposed rule effective March 3, 2008
- Strict limits on when child welfare agencies, juvenile justice agencies, and others may bill for case management or targeted case management
- Limits on when schools may bill for case management
- No individual may have more than one case manager, even when the person has a combination of impairments
- Restrictions on payment methodology and units of service for case management that require fee-for-service payment only and payment for 15-minute units of service



Optional State Plan Case Management Services – Definition of Case Management

- Services furnished to assist individuals who reside in a community setting or are transitioning to a community setting to gain access to needed medical, social, educational and other services, such as housing and transportation
- Can be furnished without regard to Medicaid's state-wideness or comparability requirements (may be limited to a specific group or area)
- Cannot be furnished to an individual not yet determined eligible for Medicaid



Optional State Plan Case Management Services – Elements of Case Management

- Comprehensive assessment to determine the need for medical, educational, social or other services
- Development of a specific plan of care based on information collected through the assessment
- Referral and related activities to help individuals obtain needed services
- Monitoring and follow-up activities



Optional State Plan Case Management Services – Transition to the Community

- CMS authorized, as a separately covered case management service, services to transition an individual from an institution to community services
- Case management may be furnished during the last 60 days of a Medicaid-covered long-term stay of 180 days or longer
- Prohibits payment for case management services provided to individuals under age 65 who reside in an IMD or to inmates in a public institutions



Optional State Plan Case Management Services – Single Case Manager Required

- When an individual falls within more than one state target group, only one case manager bills Medicaid
- Case manager must coordinate necessary services and link with providers in both systems
- States have the lesser of two years or one year after the close of the first regular session of the legislature before CMS will enforce the rule



Optional State Plan Case Management Services – Payment Methodology

- States must specify the methodology they will use to reimburse for case management services
- Payment must be fee-for-service
- Rates calculated employing a unit of service not exceeding 15 minutes



Optional State Plan Case Management Services – Consumer Protection

- States must allow individuals free choice of any qualified Medicaid provider within the geographic area identified
- State may limit providers for some groups



Optional State Plan Case Management Services – Case Records: Documentation

- States must require case management providers to maintain case records that include:
 - Name and date of service
 - Name of provider agency and person providing services
 - Whether the individual declined services in the care plan
 - Services received and whether specified goals were achieved
 - Need for coordination with other case managers and a timeline for obtaining services
 - Timeline for reevaluation of the plan



Optional State Plan Case Management Services – State Plan Amendment Requirements

- Separate state plan amendment required for each target group of Medicaid beneficiaries receiving case management services
- Each separate plan amendment must describe:
 - Case management services to be furnished
 - Qualifications of case managers
 - Methodology case management providers are paid



Optional State Plan Case Management Services – State Plan Amendment Requirements

- State must:
 - Define eligible group
 - Identify geographic service area
 - Describe furnished services
 - Specify frequency of assessments justify those assessments
 - Specify qualifications of service providers
 - Specify whether transition case management services are to be provided



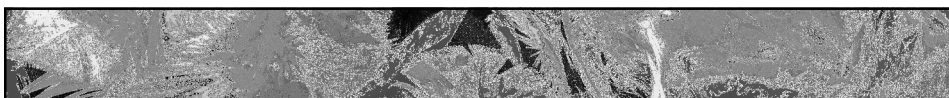
Optional State Plan Case Management Services – State Plan Amendment Requirements

- State must:
 - Specify time period or other conditions for services
 - Include assurance that amount of activities will be documented
 - Specify that case management is only provided by and reimbursed to community case management providers
 - Specify that federal financial participation can only be claimed until discharge from the institution and individual's enrollment in community service
 - Describe the system and process to monitor providers compliance with the provisions




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End of Presentation



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The slide features a background image of a rocky, mountainous landscape. The text is centered and includes the event title, dates, location, and contact information. Two logos are positioned at the bottom: the standard HCCA logo on the left and a special 2008 New Orleans event logo on the right.