

New CPRP Assessment Process Q&A

1. Q: Scenario-We do an intake and assign the client to the maintenance level of care based on his/her need. Things change for the client and s/he would be best served by working with a CSS in Rehab - Do we do another assessment?

A: If it's been less than six months bill behavioral health assessment for any assessment activities you do to complete the rest of the content requirements for the comprehensive psychosocial assessment. If it's been more than six months you can complete and bill a psychosocial assessment.

2. Q: In the Rehab program, our QMHP Assessors bill H0002 for the DLA-20©. This is also the code for the new maintenance eligibility determination - Will there be an issue with billing that code and the rehab annual assessment code (H003152) concurrently?

A: No, when we see 1-2 units of H0002 billed by a QMHP it is common for this to be for completing the DLA. Documentation review can confirm this.

3. Q: For clients that were in the Maintenance program but referred to the Rehab program before October 1, are we okay with billing a rehab assessment intake for them (H0031)?

A: If it's been less than six months bill behavioral health assessment for any assessment activities you do to complete the rest of the content requirements for the comprehensive psychosocial assessment. If it's been more than six months you can complete and bill a psychosocial assessment.

4. Q: When the client sees a psychiatrist, what do we do if there is a discrepancy in diagnosis, and the psychiatrist diagnosis is no longer CPRP eligible?

A: You need to agree upon a diagnosis internally. An individual must be diagnostically eligible either according to standards or according to the expanded diagnosis list with the DLA-20© score of 40 or less for adults or 50 or less for youth. If an individual is not eligible for CPRP they would need to be discharged from CPRP.

5. Q: If an LMSW's or a PLPC's supervisor is out of the office for maternity leave, would the LMSW still be considered "under registered supervision" and able to render a diagnosis for the duration of the supervisor's maternity leave?

A: The applicable licensing board would be better able to answer this question.

6. Q: Initial Referral Questions - What is involved in the "specialized training?"

A: The individual needs training in how to provide and appropriately document the service (T1023).

New CPRP Assessment Process Q&A

7 Q: What specific initial demographic/referral information needs to be included in the progress note?

A: There really isn't anything in standards or the psychiatric services catalog that specifically outlines what to include regarding initial demographic/referral information. However, there is information that might point you in the right direction on the CIMOR guidance document. This document has a demographics section that starts on page 8: <http://dmh.mo.gov/ada/provider/docs/cimorguidance.pdf>

8 Q: How would we bill in a situation where an existing client is in the maintenance program but then needs to be transitioned to the Rehab level of care?

A: That has not changed. If a person is in the maintenance level of care and needs to be transitioned to the rehab level of care, a note by a QMHP would be completed that justifies the level change.

9 Q: We have reviewed the new process for assessment and treatment planning in CPRP. I just want to make sure that the initial and annual comprehensive (rehab level) and brief assessment (maintenance level) do NOT require the signature of the physician or APN. It is clear that the treatment plan requires their signature (within 90 days of eligibility determination).

A: You are correct. A licensed diagnostician is required to sign at eligibility determination and on the annual assessment (to re-confirm eligibility at the year mark). For some agencies this may continue to be the physician or APN as the licensed diagnostician. A physician/APN must sign the treatment plan but is not required to sign the assessment.

10 Q: When people come to our agency for services but have had CPRP services from another CMHC (at some point in their life), we do our initial assessment, but we can't bill it as the initial assessment because that once in a lifetime service has already been completed and billed as such. So, while it is our initial assessment, we bill it as an annual. Would the doctor have 90 days to sign the tx plan in that case? We may or may not have records from previous treatment, so the only difference from all people who are new to CPRP is how we bill it.

A: Yes, you would still follow the assessment workflow process for an individual presenting new to your agency - eligibility determination, then the initial (meaning first, more comprehensive assessment with your agency) and would have 90 days to get the physician's signature – even if it is billed as an annual because they have already had

New CPRP Assessment Process Q&A

their once in a lifetime initial CPRP assessment.

11. Q: I am working on the new assessment and treatment plan process in our EMR. Currently we require the assigned CSS to sit in on the initial and to sign the initial assessment and treatment plan for CPRP Rehab. We thought that this was in the CSR that this was required. In looking through the standards, I believe that we were applying this given 9 CSR 30-4.035 (10), but at a closer look it appears that this is the requirement for the annual, which matches what you have in the bulletin in 5.7.7 and 5.8.7. Is this correct? I think that this makes sense since the CSS would have a lot of knowledge of the consumer's strengths, needs, abilities and preferences after working with the person for a year and they likely wouldn't have that insight for the initial.

A: You are right. Historically, the thought was that people may not have a CSS assigned at the time of their initial assessment. The CSS isn't required in standards for assessment until the annual.

12. Q: Under 4.1 of the bulletin, I noticed APNs were not listed as mental health professionals approved to render diagnoses. Was that an oversight or are they not to be used?

A: You are right that we overlooked Advanced Practice Nurse as a profession that should be on the list of licensed diagnosticians.

13. Q: 5.3.12 - Who were you thinking would be "all service providers?" For us, we would have one person gathering the information in 5.3 and determining eligibility - so we would only have one signature. Were you thinking that several people might be involved in determining eligibility?

A: Since there is the option for a non-licensed QMHP to gather information with a licensed QMHP sign-off, we wanted to make sure all involved parties signed the document. Additionally, for cases where one person may start the process and hand off to another to complete, we want to ensure all service providers sign the document. Different agencies have different processes, so we were looking at a way to cover all scenarios. For you it sounds like it would be one signature.

14. Q: If we already have a confirmed diagnosis do we need to do an eligibility determination? I.e. hospital records, records from another provider, documentation from an outpatient therapist referring either within or externally.

A: Yes. The eligibility determination, including diagnostic formulation, must be made internally at the agency.

New CPRP Assessment Process Q&A

15. Q: When you state the eligibility determination is not billable if the individual is assigned to the rehab level how would you bill for time of this staff? I understand if they qualify it will be considered a bundled rate but you are talking about a lot of time to gather the information.

A: Staff time completing the eligibility determination is paid through the bundled assessment rate. All of the information gathered from the eligibility determination is the start of the bundled assessment. CPRP assessments pay \$600-\$800 so it is expected that they would be time consuming.

16. Q: If our agency does not bill CPRP services prior to our initial psychosocial assessment (PSA), can our PSA count as our Eligibility Determination?

A: Yes, as long as you have the components of the eligibility determination covered at that time. You must have an initial treatment goal identified to meet immediate needs prior to the treatment plan being completed. You would also need the licensed diagnostician involvement for the diagnosis on the initial PSA. Services cannot be billed until the eligibility determination requirements are met.

17. Q: Just to make sure I know you said the initials are different than annuals....With annuals do we have to ensure the doctor has signed the treatment plan prior to assessment/treatment plan bundle being billed?

A: Yes, that is correct. Both assessment and treatment plan are to be fully developed/written and all required signatures are to be obtained prior to being billed.

18. Q: I have another question regarding the recent assessment and treatment planning memo that came out. Prior to this memo we were obtaining Dr. signatures on assessments so we did not bill the assessment until the dr. signed the assessment. For example client was seen on August 20 and Dr. signed assessment August 30th. Progress note was dated and completed for August 30th saying that client was seen on Aug 20th, Dr. signature obtained Aug 30th. In the memo it states that assessments cannot be billed until the treatment plan is complete and signed by all parties (with the exception of the doctor). So my question is if we do an assessment on Aug 20th and treatment plan is completed and then signed by all parties on September 20th (30 days after) what date should that assessment be billed (i.e. progress note dated)? Should it be Aug 20th and then we don't submit the billing until September 20th? Or do you date it on September 20th? My concern with dating the progress note on September 20th is that it will mess up the billing for the following year. We try to get

New CPRP Assessment Process Q&A

clients in for their assessment 335 days after their past assessment so in this instance July 20th but the assessment cannot then be billed again until August 20th regardless of when treatment plan is completed (for instance if it is completed and signed by July 30th).

A: The initial assessment/treatment bundled rate plan can be billed on the day it is complete – meaning both documents are fully written and all required signatures are obtained. The next annual assessment/treatment plan can be billed and considered timely if it is within a timeframe of 30 days before to 30 days after the date the previous assessment bundle was billed.

19. Q: Question on PSA effective date: If a PSA is finished by staff on 9/11/15 and that PSA is signed by a physician on 9/25/15, when can the treatment plan be written and signed by client (and others)? Could it be on 9/12/15? Or do we have to wait until after the physician signs the PSA on 9/25/15? The treatment plan cannot be dated before a PSA “effective date.”

A: Remember that the physician is now only required to sign the treatment plan unless you are using the physician as the licensed diagnostician on the assessment. You have 45 days from the date of eligibility determination to complete the treatment plan. The bundle rate can be billed after the assessment and treatment plan are complete including all signatures (except for the initial assessment you have 90 days to obtain the physician’s signature).

20. Q: Question about outside provider signatures: The new memo regarding assessment procedures and the bundled rate does not address outside of the CMHC physician signatures. Previously, DBH has ruled that if reasonable attempts were made to get an outside of the CMHC physician signature on a PSA and treatment plan and these attempts were unsuccessful (documented of course), then the bundled rate would be allowed. The new memo on assessment procedures simply states that without a physician signature the bundled rate will be disallowed. Is the previous rule regarding outside of the CMHC physician signatures still in effect?

A: You must obtain a physician signature on the treatment plan. This is required by our state plan. If an outside physician will not sign it, your agency’s medical director should sign. Failure to obtain a physician signature on the treatment plan will result in disallowance of the bundle billing.

21. Q: Do we bill the PSA effective the date it was conducted, as we always have, or do we now bill differently i.e. the date that all signatures are done on the Tx Plan (minus

New CPRP Assessment Process Q&A

provider due by 90 days)? My thinking is we still stick to the date that the PSA was conducted. Is this correct?

A: You bill the bundle initial PSA/ITP once both the assessment and treatment plan are complete and all signatures (except the physician's) are obtained. The assessment codes have always been a bundled rate that included completion of both the assessment and treatment plan. This has not changed. The annual assessment/treatment plan can be billed once both the assessment and treatment plan are complete and all signatures including the physician's signature are on the treatment plan.

22. Q: On the annual PSA, if the 90 day timeframe for physician/APN signature requirement does not apply, what is the timeline?

A: You have 30 days before or after the annual date to complete both the assessment and treatment plan and obtain all required signatures including the physician signature.

23. Q: Intensive Level of CPRP for Youth is not mentioned throughout this document. Is it assumed that it follows the same rules as the rehab level?

A: Yes, correct.

24. Q: With walk in clinic processes, our staff will be completing the psychosocial at the first visit and therefore not doing an "eligibility determination" as such. Would all of the timelines then feed off the psychosocial date?

A: It would be the date that the requirements for eligibility determination are fulfilled.

25. Q: What specialized training is required for clerical staff to bill for screening?

A: They need to be trained on how to conduct and document the initial referral service.

26. Q: If a consumer is not being seen by a physician for psychiatric medications, can the treatment plan be signed off by a licensed psychologist?

A: Yes.

New CPRP Assessment Process Q&A

27. Q: Are you saying we cannot bill DMH/Medicaid for the psychosocial until the treatment plan is completed and signed? With EMRs, I'm not sure how we can trigger this to not submit the billing when it is contingent on a secondary factor related to a totally different document.

A: The assessment procedure code has always been a bundled rate that included completion of both the assessment and treatment plan. This has not changed.

28. Q: Consumers may drop out of service prior to the treatment plan being completed and in some cases based on how this is written, prior to the psychosocial being completed. What happens to billings that occur within this 30-45 day window of time? If the treatment plan is not completed, the physician cannot sign and the document says the psychosocial can't be billed without a treatment plan or doctor signature. This appears to create quite a potential for lost revenues. Producing a billing system contingent on future occurrences will increase administrative burdens/manual tracking mechanisms and result in lost revenues.

A: Program services may be billed when eligibility determination is complete and signed off by a licensed diagnostician or a physician. The assessment/treatment plan bundle cannot be billed unless it is complete.

29. Q: Our QM staff is working on creating a summary of the work flow that we developed surrounding the DMH memo dated June 30, 2015 regarding the New Assessment and Treatment Planning Process Changes. We have a question regarding the physician signature on the Annual PSA document, under the guidelines outlined in the memo we understand that the physician has 90 days to review and sign the initial PSA. For the Annual PSA, does the provider now have a 90 day window to review and sign the annual PSA document or is it still required to obtain their signature within 30 days?

A: The physician does **not** have the 90 day timeframe for the annual assessment/treatment plan. For annual assessment/treatment plans the physician's signature must be on the treatment plan in order for it to be considered complete/billable. To be considered timely, the assessment/treatment plan bundle rate is complete and billed in the window of 30 days before to 30 days after the last assessment/treatment bundled rate was billed.

30. Q: Our current work flow does not include a separate Eligibility Determination step. All consumers who enter services complete an adult or child psychosocial assessment to determine the consumer's eligibility for services and level of care. We would like to confirm that this process is okay and that we are not required to complete a separate document and billing step for the Eligibility Determination. We would also like to confirm that we can continue to begin service delivery (and billing) before the

New CPRP Assessment Process Q&A

assessment is complete and the treatment plan is fully developed. We appreciate your assistance with confirming our process to ensure that we are providing the correct support and direction to our staff.

A: The content and process of eligibility determination must be completed in order to begin billing CPRP services. The particular areas listed as eligibility determination must be assessed, including an initial goal, and the licensed diagnostician must provide a diagnosis and sign in order for the individual to be determined eligible for CPRP services. This does not have to be a separate document if the person is admitted to CPRP as it is typically part of the psychosocial assessment. It cannot be billed separately if the person is admitted to CPRP. An agency has 30 days from the date of eligibility determination to complete the rest of the psychosocial assessment and 45 days from the date of eligibility determination to complete the treatment plan. Services can be billed before the assessment and treatment plan are complete, but not before the eligibility determination process has been completed. This is a change in process from the way assessment has happened historically in CPRP.

-
31. Q: Our question revolves around the billing for screening. It is not clear to me if the intent behind the revised Assessment and Treatment Planning process is to give providers the opportunity to be reimbursed for the time and effort taken to screen potential consumers for eligibility as a Call Center which fields any call regarding services (rehabilitation, case management, housing, clinical, employment, etc.)? Based upon our typical numbers would we be billing for all 300 calls where only 25 are eligible for services? Or are we billing for 150 calls because they are specific to our agency with only 25 being eligible? Or are we billing for the 50 calls where we actually start a formal screening process where 25 will become eligible. Even if we end up billing screening for 50 individuals, we would still need to gather enough information to do a Community Services admission in CIMOR for 50 individuals and then for 25 of them we would do a discharge because they were not admitted into the CPRC Maintenance or Rehabilitation level.

A: You may bill the 50 where a formal screening process occurs. The 25 who, when determined eligible through a full screening, go on to other services are enrolled in CIMOR and billed consumer specific (T1023), and the 25 who receive the full screening but are screened out are billed non-consumer specific (0100H). The other 250 calls are not billable. Each of the 50 in this example must receive a screening service that meets the service definition of the service code billed.

-
32. Q: Should eligibility determination be completed for initials CPRC evaluations only or for re admits too?

New CPRP Assessment Process Q&A

A: Eligibility determination should be completed on anyone admitted to CPRP even if they have been admitted to your agency's CPR program previously.

33 Q: And can we do a brief evaluation without eligibility for re admits?

A: Eligibility determination can be completed and billed as behavioral health assessment when an individual leaves CPRP services and then returns and it has been less than six months.

35. Q: As I read 5.4.2 it says that an initial assessment can be BILLED without the doctor's signature as the doctor has up to 90 days to sign off. So we can BILL without the doctor's signature?

A: Yes, an initial assessment can be billed without the prescriber's signature. This signature must be obtained within 90 days of eligibility determination. Failure to obtain a physician signature on the treatment plan will result in disallowance of the bundle billing.
