Hancock Daniel Behavioral Health Newsletter

November 2023

CMS Establishes New IOP Benefit

On November 2, 2023, the Centers for Medicare & Medicaid Services ("CMS") issued a Hospital Outpatient Prospective Payment System ("OPPS") final rule expanding Medicare coverage of behavioral health services. Most critically, the OPPS final rule establishes coverage for Intensive Outpatient Program ("IOP") services effective January 1, 2024. Outpatient mental health services have traditionally been covered under Medicare as partial hospitalization and outpatient service benefits. While outpatient service benefits cover isolated encounters, partial hospitalization program ("PHP") benefit eligibility requires certain mental health services to be provided for 20 or more hours per week. The Consolidated Appropriations Act of 2023 ("CAA") requires coverage of this intermediate level of services that are provided between 9 and 19 hours per week. This new Medicare benefit is designed to bridge the gap in coverage for individuals with Medicare requiring more frequent care than standard outpatient therapy but less intensive than a PHP.

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Opening Psychiatric Distinct Part Units ("DPU")

On July 27, 2023, CMS issued a final rule to allow hospitals to open a new psychiatric DPU at any time during the cost reporting period so long as a 30-day written notice is provided to the CMS Regional Office and Medicare Administrative Contractor. This change would remain in effect for the rest of that cost reporting year. **Effective October 1, 2023,** hospitals no longer have to time the opening of their new psychiatric DPU with the first day of the hospital's cost reporting year.

Contact HD's Behavioral Health Team for more information

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The Q&A below provides a summary of the final rule, highlighting key aspects such as applicable care settings, covered services, coverage requirements, and reimbursement rates.

Q: In what care settings will Medicare cover IOP services?

A: Covered IOP services, as defined by CMS in the final rule, must be a distinct and organized intensive ambulatory treatment program designed for individuals with acute mental illness or substance use disorder. These services cannot be delivered in the patient's home or in an inpatient or residential setting. Covered IOP services may be provided in the following settings:

- Hospital Outpatient Departments (“HOPDs”)
- Community Mental Health Centers (“CMHCs”)
- Federally Qualified Health Centers (“FQHCs”)
- Rural Health Clinics (“RHCs”)
- Opioid Treatment Programs (“OTPs”)

Q: What are the Medicare coverage requirements for IOP services?

A: Medicare will cover IOP services when a physician certifies, at least once every 60 days, that a patient needs IOP services for a minimum of 9 but no more than 19 hours per week. The patient's plan of care must demonstrate that the patient has received a mental health or substance abuse disorder diagnosis, is not a danger to themselves or others, has a separate support system outside of the IOP, and has the cognitive and emotional ability to tolerate IOP services.

Additionally, to qualify for payment, the patient must receive at least three IOP services per day, with at least one service from the list of Final PHP/IOP Primary Services (see Table 99 on p. 695 of the HOPPS Final Rule), and the remaining services from the Final HCPCS Applicable for PHP and IOP list (see Table 98 on p. 693 of the HOPPS Final Rule).

IOP services rendered in OTP settings must be deemed medically reasonable and necessary and not duplicative of any service covered under bundled payments for a given episode of care in a week. Additionally, a physician or non-physician practitioner must certify that the beneficiary requires a higher level of care intensity compared to existing OTP services.

Q: How will IOP services be paid by Medicare?

A: Medicare will pay for IOP services in HOPDs and CMHCs under the Outpatient Prospective Payment System (“OPPS”). Two Ambulatory Payment Classifications (“APC”) are established for both HOPDs and CMHCs: one for 3-IOP services per day and one for 4-IOP services per day.

- HOPDs will receive $266.35 for 3-IOP services per day and $367.79 for 4-IOP services per day.
- CMHCs will receive $90.02 for 3-IOP services per day and $161.80 for 4-IOP services per day.

RHCs and FQHCs will be paid for 3-IOP services under their applicable payment systems.

- RHCs will receive a flat rate of $266.35, equal to the 3-IOP services per day APC paid to HOPDs.
- FQHCs will receive the lesser of $266.35, equal to the 3-IOP services per day APC paid to HOPDs, or their actual costs.

Lastly, services rendered in OTP settings will receive a weekly payment adjustment of $778.20 based on the Medicare Economic Index and adjusted by the Geographic Adjustment Factor, when at least nine hours of IOP services are furnished in a week.

For additional information on coverage and reimbursement, please reach out to our team at Hancock Daniel.

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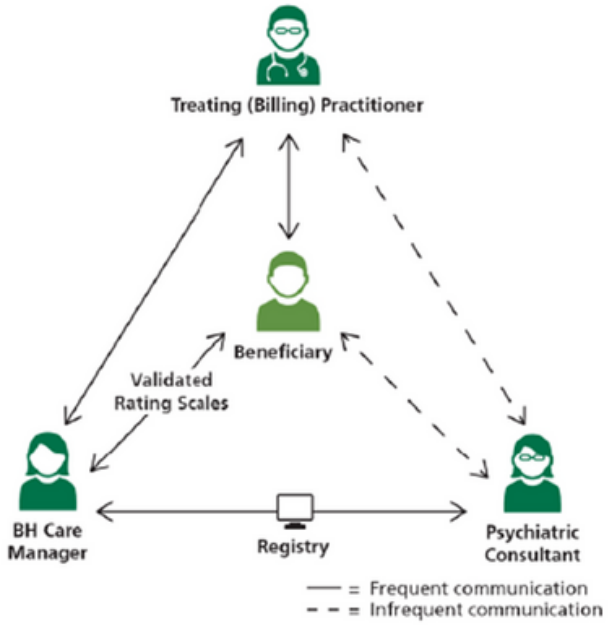
Behavioral Health Integration and the Psychiatric Collaborative Care Model

Starting in 2017, the Centers for Medicare and Medicaid Services ("CMS") began making separate payments to physicians and non-physicians for Behavioral Health Integration ("BHI") services provided under a Psychiatric Collaborative Care Model ("CoCM"). CMS describes BHI as a type of care management service for addressing mental, behavioral health, or psychiatric conditions through systematic assessment and monitoring, care plan revision, and maintenance of continuous relationships with team members involved in treatment. The Psychiatric CoCM is a more specific model for the provision of BHI, describing a coordination of care directed by a primary, billing practitioner who employs/engages a behavioral health care manager with specialized training to provide patient assessments and interventions, with a licensed psychiatrist available to consult with the manager, through the use of a patient registry, where appropriate. Psychiatric CoCM services are billable under the following CPT Codes (these descriptions are in summary form and are not comprehensive of all criteria that must be met):



99492: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs.

99493: Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs (list separately from the code for the primary procedure).

CMS also pays for "General BHI" under CPT Code 99484, which is intended to apply to BHI models of care other than Psychiatric CoCM that also include the above core elements (assessment/monitoring, care plan revision, and relationships among clinical team members). Additionally, as of 2023, CMS implemented a new HCPCS Code G0323 (Care Management Services for Behavioral Health Conditions) for general BHI that a clinical psychologist or clinical social worker performs to account for monthly care integration.

BHI and the Psychiatric CoCM represent special incentives and opportunities to better manage patients' mental health needs in a holistic, effective manner. These opportunities may be of particular interest and value to primary care and other providers not specialized in mental health wishing to engage mental health professionals to assist in managing and treating patients experiencing mental, behavioral, psychiatric conditions that may be negatively impacting other aspects of care (e.g., lack of healthy diet/personal habits, substance abuse, medication management, and related issues). Providers across the spectrum are encouraged to review the Medicare Learning Network Booklet on Behavioral Health Integration Services, available at: www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf.

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Safeguarding Our Healthcare Heroes with Legislation on Workplace Violence Prevention

The stories are not new, but they become more frequent every year. Nurses assaulted in the emergency room by a patient being evaluated for treatment,[1] surgeons shot to death in their clinics,[2] dental staff threatened by patients over wait times,[3] hospital employees shot to death by coworkers in hospital stairwell,[4] and countless others. While possible everywhere, emergency departments and behavioral health facilities are at the most risk for an incident to occur.[5] According to the World Health Organization, it is estimated that between 8% and 38% of healthcare workers suffer physical violence at some point in their careers.[6] Additionally, per the US Bureau of Labor Statistics, healthcare and social service workers were victims of 76% of all nonfatal injuries from workplace violence in 2020.[7]

The Occupational Safety and Health Administration ("OSHA") defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. Workplace violence ranges from threats and verbal abuse to physical assaults and even homicide. Patients are the largest, but not the only source of violence as family members, visitors, intruders, or even coworkers are also potential instigators. Most incidents are created by systemic factors such as overcrowded areas, staff shortages, long wait times, inflexible visiting hours, and differences of language and culture.[8] When healthcare workers require treatment or miss work because of an injury, employers' workers' compensation insurance (whether private or self-insured) will typically bear the expense of continuing to compensate the injured provider while away from work. Non-economic costs include provider stress, fatigue, burnout, and turnover, all of which have been shown to relate to decreased patient satisfaction and an increased risk of error.

Workplace Violence Prevention for Healthcare and Social Service Workers Act

On April 18, 2023, both the Senate and the House reintroduced the Workplace Violence Prevention for Health Care and Social Service Workers Act (HR 2663 and S 1176) that was previously considered in 2021 and 2019. It has been sent by both houses for committee review. The new legislation would require the Secretary of Labor to issue a standard requiring healthcare providers to write and implement a workplace violence prevention plan. If it becomes law, it will apply to many healthcare settings, including hospitals, psychiatric treatment facilities, and substance use disorder treatment centers. The requirements include unit-specific assessments and implementations of prevention measures, including physical changes to the environment, staffing for patient care and security, hands-on training, robust record-keeping requirements, and protections for employees to report workplace violence to their employer and law enforcement.

Many states are also passing legislation surrounding workplace violence prevention in healthcare. Additionally, The Joint Commission revised workplace violence prevention requirements effective January 1, 2022. The increase in legislation and attention around workplace violence in healthcare recognizes that identifying risk factors and providing education can help to prevent or minimize incidents from occurring.

Hancock Daniel's Security, Workplace Violence, and Crisis Management Team provides assistance in assessing or creating a compliant program for your organization. Our team provides the full continuum of services from risk assessment to crisis management as well as handling the legal, regulatory, and operational aspects resulting from safety related events occurring in the healthcare setting.

[1] Samantha Kummerer, 'I don't remember what happened after that.' Nurse demands change after being attacked by patient, Raleigh-Durham ABC 11 News (Dec. 15, 2022) https://abc11.com/nurse-attacked-patient-duke-emergency-room-multiple-injuries/12575609/.
[2] Jacob Wilt and Jeanine Santucci, Patient kills surgeon Benjamin Mauck in shooting at suburban Memphis clinic, police say, USA Today Network (July 12, 2023) https://www.usatoday.com/story/news/nation/2023/07/12/dr-benjamin-mauck-shooting-memphis/70405343007/.
[3] Zaria Oates, Dental patient detained after referencing Campbell clinic doctor who was killed: "I see why the patient shot the doctor", Memphis ABC 24 News (July 19, 2023) https://www.localmemphis.com/article/news/crime/dental-patient-i-see-why-the-patient-shot-the-doctor-campbell-clinic-shooting/522-5ff6d693-2051-4867-8382-6bb446312deb.
[4] Rolynn Wilson, Jury trial begins for deadly VCU hospital shooting, Richmond WRIC 8 News (September 19, 2023) https://www.wric.com/news/local-news/richmond/jury-trial-begins-for-deadly-vcu-hospital-shooting/
[5] Mei Ching Lim et al., Workplace violence in healthcare settings: The risk factors, implications and collaborative preventive measures, 78 Annals of Medicine and Surgery (2022). Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9206999/pdf/main.pdf.
[6] Id.
[7] Christopher Cheney, Healthcare workplace violence legislation introduced in Congress, HealthLeaders (Apr. 18, 2023) https://www.healthleadersmedia.com/clinical-care/healthcare-workplace-violence-legislation-introduced-congress.
[8] See Supra note 4.

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OIG Report Found $580M in Improper Medicare Payments for Psychotherapy Services

The Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") released a May 2023 report which found that Medicare improperly paid an estimated $580 million for psychotherapy services during the COVID-19 public health emergency ("PHE"). The report audited Medicare Part B data for psychotherapy services, including telehealth services, from March 2020 to February 2021. The audit included 13.5 million psychotherapy sessions. According to the report, more than half of those services did not comply with Medicare requirements. Most of the improper payments were for telehealth services ($348 million for telehealth services, or about 60% of the payments, and $232 million for non-telehealth services). The report included examples of improper payments.

PRACTITIONER GUIDE

Example #1: Example of Psychotherapy Time That Was Not Documented

On June 25, 2020, a provider billed Medicare for a 60-minute psychotherapy service in conjunction with an E&M service provided in the office. Medicare paid $99 for the psychotherapy service and $172 for the E&M service. The enrollee's medical record stated that the provider spent a total of 60 minutes with the enrollee. The provider did not document how much of that time was spent specifically on the psychotherapy service or if the psychotherapy service was at least 16 minutes long (the minimum amount of time to bill any psychotherapy CPT code). Therefore, the $99 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $25.

Practitioner Tip:

Some patients receive an E&M service on the same day as a psychotherapy service provided by the same physician or other qualified health care professional. To report both E&M and psychotherapy, the two services must be significant and separately identifiable (AMA, CPT 2020–2021). Time associated with activities used to meet criteria for the E&M service is not included in the time spent on the psychotherapy service (i.e., the time spent by the psychotherapist on the patient's medical history, examination, and medical decision making when used for the E&M service is not part of the time spent on psychotherapy (AMA, CPT 2020–2021).

Example #2: Example of an Incomplete Treatment Plan

On December 18, 2020, a provider billed Medicare for a 60-minute psychotherapy service provided via telehealth, for which Medicare paid $125. The provider furnished a medical record that included an entry for the sampled enrollee day and the treatment plan dated September 14, 2020. The treatment plan included the type of service (e.g., individual psychotherapy), the anticipated goals (e.g., to facilitate adjustment to current cognitive changes and decrease anxiety), and the diagnosis (e.g., adjustment disorder with anxiety). However, the treatment plan did not include the amount, frequency, or duration of the services to be furnished. As a result, the $125 for the psychotherapy service was unallowable. The associated enrollee coinsurance for this service was $31.

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Practitioner Tip:

The individualized treatment plan must state the:

- Type
- Amount
- Frequency
- Duration of the services to be furnished
- Indicate the diagnoses of a mental disorder or disease (e.g., generalized anxiety disorder)
- Show the anticipated goals of the psychotherapy treatment (e.g., to reduce symptoms) (CGS's LCD L34353 and NGS's LCD L33632)

The provider must also have a periodic summary of:

- Treatment goals
- Progress toward those goals
- An updated treatment plan must be included in the medical record (WPS's LCD L34616 and CGS's LCD L34353)

Example #3: Examples of Providers That Billed the Incorrect Number of Services and Billed the Incorrect CPT Code

On May 28, 2020, a provider billed for 30 psychotherapy services provided via telehealth on one date of service for a single enrollee. Each service was for CPT code 90832 (for 30 minutes of psychotherapy), and Medicare paid the provider $1,202. However, according to the supporting documentation, only one psychotherapy service was provided. Therefore, we determined that the remaining 29 services were billed in error. (Based on our review of the documentation, the service that was provided complied with Medicare requirements.) As a result, the $1,138 for the 29 psychotherapy services that were not provided was unallowable. The associated enrollee coinsurance for the 29 services was $285. The provider stated that its billing system incorrectly billed the time spent on the psychotherapy service as the number of units.

Practitioner Tip:

Payment must not be made to a provider for an item or a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)). Providers must bill the CPT code with the number of minutes closest to the actual time that was spent on psychotherapy:

- Providers must not bill for psychotherapy of less than 16 minutes
- 16 to 37 minutes: CPT codes 90832 and 90833
- 38 to 52 minutes: CPT codes 90834 and 90836
- 53 or more minutes: CPT codes 90837 and 90838

HALTING RECOUPMENT DURING THE APPEAL PROCESS

Before a provider begins the Medicare appeal process, the provider can halt recoupment of an overpayment To halt the recoupment, the provider must file a rebuttal within 15 calendar days from the date of the MAC's demand letter. The rebuttal must explain and provide evidence why the MAC should not recoup the payment. The MAC will promptly evaluate the rebuttal statement. In addition, the provider can initiate the appeal process. Medicare has 5 appeal levels in Fee-for-Service ("FFS")(Original Medicare) Parts A and B. The appeal process itself is time sensitive and may be complicated. In our next edition of this publication, we will take an in-depth look at the appeal process itself.

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Capacity Determinations & Consent for Behavioral Health Patients

A patient's right to consent to or to refuse health care treatment is a fundamental patient right. Behavioral health patients often have special protections regarding informed consent since a behavioral health diagnosis alone does not take away an individual's capacity or right to authorize or decline treatment. However, some behavioral health conditions may result in a patient's lack of capacity to make medical decisions and provide informed consent. As a result, consenting a behavioral health patient has practical challenges since a patient must have capacity to provide consent and certain behavioral health conditions may impatient such capacity.

Informed Consent Basics

Informed consent must be obtained prior to any behavioral health exam or treatment, absent an emergency. While the laws regarding informed consent will be state specific, the general requirements for obtaining informed consent include the following elements: explanation of the treatment or service and its purpose; a description of any adverse consequences and risks associated with the proposed treatment or service; a description of any benefits that may be expected from the treatment or service; a description of any alternative procedures that might be considered, along with their side effects, risks, and benefits; notification of right to refuse or withdraw consent; and an opportunity for the patient to ask questions and have those questions answered.

Documentation

Informed consent should be documented in a well-constructed consent form that contains the elements of informed consent set forth above. Certain types of behavioral health treatment may require specialized or state mandated consent forms such as consent to electro convulsive treatment (ECT) or counseling therapy provided through telehealth. The issue as to who should sign those consent forms (the patient or someone else) is usually driven by the patient's capacity to make health care decisions.

Capacity Determinations

Whether or not a patient has capacity to consent to medical treatment, including behavioral health treatment, is driven by state law. It is important to understand the process in the applicable state, which may be challenging for providers operating in multiple states. However, since capacity is a threshold question when considering whether a patient can provide informed consent, it is imperative to understand the applicable state law for making capacity determinations. Capacity determinations should be made prior to provision of behavioral health services or treatment, except in emergencies, which may trigger state laws regarding those situations.[1]

Measures When Patient Lacks Capacity and Ability to Provide Informed Consent

If a patient is determined to lack capacity, then there may be other mechanisms to obtain informed consent to treatment including a legally valid healthcare directive executed prior to the patient losing capacity. If a healthcare directive is not available, then a provider can look to see who can serve as a surrogate decision maker. Requirements for who can serve as a surrogate and the decision-making priority of surrogates are usually set forth by state law.[2] If a surrogate decision maker is identified, state law may limit certain types of behavioral health treatment to which a surrogate may consent. In the absence of an individual willing or able to serve as a surrogate, or in a case where a surrogate cannot consent to specific behavioral health treatment or service, the appointment of a guardian or obtaining a court order for the treatment may be necessary.

Conclusion

It is important to understand the requirements for obtaining informed consent for the treatment of behavioral health patients. The failure to do so may, depending on state law, result in liability exposure for behavioral health providers and facilities. The best practice is to (1) determine the patient's capacity to provide consent; (2) determine, based on that determination, who may provide consent; and (3) obtain and document that consent following applicable state law requirements.

[[1] Most states have requirements for patients who are experiencing behavioral health emergencies but who are not willing to consent to treatment (i.e., laws which allow for "detaining" patients and providing emergency treatment).

[2] Currently, all but the following states have surrogate decision making statutes: Massachusetts, Minnesota, Missouri and Rhode Island.

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Behavioral Health Service Offerings

Behavioral health providers face unique industry challenges, further fueled by the COVID-19 pandemic. Hancock Daniel's team has extensive experience providing legal services in all facets of the behavioral health space including:

- Regulatory support in the planning and development of behavioral health services
- Licensure and certification of new providers/suppliers and/or new service lines
- Integration for population health strategies
- Telehealth/Telepsychiatry
- Medicare approval of IPPS excluded psychiatric distinct part units ("DPU")
- Behavioral Health Patient Safety Organizations ("PSO")
- 42 CFR Part 2 expertise
- HIPAA/HITECH compliance assessments, breach analysis, and breach notifications
- EMTALA behavioral health issues and surveys
- Advice on psychiatric Emergency Departments
- State licensure requirements and surveys
- Risk management for behavioral health
- Compliance
- Behavioral health reimbursement, billing and audits
- Issues related to substance abuse and residential treatment centers
- Clinician scope of practice
- Fraud and abuse
- Guardianships
- Changes of ownership, mergers, acquisitions, consolidations and joint ventures
- Issues surrounding consent and patient rights
- Value-based care models/programs
- Employment and labor issues
- Litigation

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