Pinnacle Health Management, LLP

Clinician's Manual

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PINNACLE HEALTH MANGEMENT, LLP

MISSION STATEMENT

Pinnacle Health Management, LLP is committed to providing the highest quality behavioral health care to residents of nursing and assisted living facilities. Care is provided through an interdisciplinary team approach to ensure that services are comprehensive, coordinated and appropriate for each resident referred to PMH for behavioral health services.

As consultants to the home staff, PHM clinicians endeavor to enhance each resident's care by providing psycho-pharmacological assessment and management, individual and family therapy, and continuous support of the educational development of staff.

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Initiation of Services

I. Medical Necessity

Services are to be provided to patients only when there is a medical need. Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT Code (CMS Manual, Publication 100-4, Chapter 12, Section 30.6.1). Medicare will only allow payment for medically necessary and reasonable services as defined by Section 1862(a) (1)(A) of the Social Security Act. Medicare Regulations indicate that no Medicare payment shall be made for items or services that are not *"reasonable"* and *"necessary"* to the diagnosis or treatment of illness… Services performed "*in the absence of signs or symptoms"* are excluded from payment under the Medicare Program. These guidelines are provided, in part, to aid the practitioner in meeting these Medicare requirements.

II. Pharmacological Assessment and Management

A. Physician's Order

Initiation of services from PHM begins with a "referral" by way of an **order** requesting consultation from the resident's primary care physician. Without this order, the PHM clinician cannot engage as a consultant. Typically the order will be written as a request for mental health consultation and follow-up as determined necessary.

B. Informed Consent

Prior to the involvement of a PHM clinician in the care and treatment of a client referred for services, the assigned clinician must determine whether "consent for services" has been signed by the client or his/her legally authorized representative. Consent is required to affect the clinician-patient relationship and enable the release of health care information for billing purposes. The home may elect to approach this issue in one of two ways:

a. The home "consent form" is comprehensive and speaks directly to the involvement of consultants in the care and treatment of the resident and the resident or guardian has signed the "consent".

b. The home consent pertains only to the home and not its consultants. In this instance, it is incumbent on either the PHM clinician or the nursing home staff to obtain a signed **Consent and Authorization for Release of PHI, PHM-010** from the resident or his/her legally authorized representative (attachment 1).

C. Initial Consultation

a. Once the primary care physician has provided a written order requesting consultation from PHM, the psychiatrist, nurse practitioner or clinical nurse specialist will open the case at the time of his/her next scheduled visit to the home. Should the referral be time sensitive, the home is to contact the clinician assigned to the residence and discuss/arrange for an earlier visit or telephone consultation.

b. In undertaking the initial diagnostic assessment, the clinician will discuss the resident's case with staff and other consultants having knowledge of the patient, review the information contained in the resident's medical record, and interview the patient.

c. In conducting the initial diagnostic evaluation, the clinician may elect to use various diagnostic tools to aid in the determination of the diagnosis and treatment. The clinician may use the **Mini-Mental Status Examination (MMSE)** to aid in the assessment of cognition; the **Geriatric Depression Scale (Patient Version)** to assess affect, and for patients receiving anti-psychotic

medication, the **Abnormal Involuntary Movement Scale (AIMS)** (attachments 2-4).

d. The clinician's findings and recommendations are documented in the medical record on the **Initial Psychiatric Evaluation**, **PHM-004** (attachment 5).

e. Recommendations are to consider the appropriateness of psychotropic medications and the tapering of these medications where clinically appropriate and in accordance with OBRA[1] guideline, engagement of a therapist where the patient would benefit from concomitant therapy and other tests, lab work, etc…

D. Diagnosis and Medications

a. The population served by PHM frequently presents with one or more medical co-morbidities. Prior to recommending the use of medication for the treatment of a behavioral issue, the clinician must consider and rule out:
   i. Acute medical pathology
   ii. Behavioral interventions

b. A resident prescribed a psychotropic medication must have a corresponding DSM-IV diagnosis. For example, a resident started on an antidepressant must be diagnosed with a mood disorder. Particular attention must be paid to residents with dementia being treated with anti-psychotic medications. The rationale for such recommended treatment must be reflected in the diagnosis and appropriate descriptors. For example, Alzheimer's Dementia with psychotic features will support the use of an anti-psychotic medication. Similarly, the use of medication to aid a resident in sleep must be supported by a diagnosis of insomnia or sleep disturbance.

E. Follow-up Visit

a. At the conclusion of the initial diagnostic evaluation and each subsequent encounter thereafter, the clinician will determine, based on the patient's need (medical necessity), the schedule of future or follow-up visits. Once the clinician has documented the frequency of visits, it is imperative that the clinician see the patient as planned.

b. Encounters may occur earlier than the planned follow-up visit where the patient's medical/mental health status has changed necessitating the encounter.

c. Each follow-up visit will be documented in accordance with the PHM Documentation Guidelines set forth below using the **Psychopharmacology Review, PHM-001 or the Interval History, Exam and Decision making, PHM-002** (attachments 6-7).

F. Physician Orders

As consultants to the primary care physician (PCP), the clinician's findings and recommendations are reviewed by the PCP. If the PCP is in agreement with the clinician's recommendations, the PCP is responsible for writing the order.

G. Quarterly AIMS

Residents receiving anti-psychotic medication must be re-evaluated every **90 days** to assess for abnormal movements and extra-pyramidal symptoms. Depending on the results of the assessment, changes in drug therapy may result.

H. Termination of Services

a. Consultation services are to be terminated when the medical necessity of services ceases to support continued involvement of the clinician.

b. Documentation of the basis for the decision to discontinue service must be

[1] The Omnibus Budget Reconciliation Act (OBRA) includes regulations regarding the tapering of certain psychotropic medications at specific intervals. The clinician is responsible for assessing patients for dose reduction and documenting according to these guidelines.

entered in the clinician's final progress note and communicated to the primary care physician and nursing staff.

III. Documentation Guidelines and Procedure Codes

A. Documentation

a. General

All encounters must be documented by the clinician providing the service. Evaluations and progress notes are filed in the resident's medical record before the clinician leaves for the day. Documentation should be succinct and address the elements to support the procedure code selected by the clinician.

b. PHM forms are provided in either duplicate or triplicate, depending on the preferences of the home.

i. The **white copy** (original), and the original, non-replicating MMSE, GDS, AIMS are to be filed in the resident's medical record;

ii. The **yellow copy** is sent to PHM with the clinician's invoice, which is a summary identifying each encounter, change in diagnosis, procedure code and date of service.

iii. In certain cases, the designated liaison of the home may want a copy of the note, if so, a photocopy can be provided.

B. E/M Coding Requirements

The E/M codes recognize seven components that translate into the work involved and, subsequently, determine the actual code selection. The first three (3) of these components (history, exam, and medical decision making) are considered the **key components** in selecting a level of E/M services. The next four components (counseling, coordination of care, nature of the presenting problem, and time) are considered contributory factors in the majority of encounters.

Chief Complaint or Reason for Encounter

The medical record should clearly reflect the chief complaint: A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter (usually stated in the patient's words).

a. History

History of Present Illness (HPI) – *a chronological description of the patient's present illness from the previous encounter to present. It includes the following elements:*

- *Location-describe where the body symptom is occurring*
- *Quality-is the character of the symptom*
- *Severity-is the rank of the symptom/pain on a scale of 1-10 or descriptor (severe, slight, worse)*
- *Duration-describes how long symptom presented or lasts*
- *Timing-describes when the symptom occurs*
- *Context-is the situation associated with the symptom*
- *modifying factors-are things done to make the symptom better or worse*
- *associated signs and symptoms-describe symptom and other things that happen when this symptom occurs*

(Brief HPI consists of 1-3 elements; Extended HPI consists of at least 4 elements of the HPI or the status of at least 3 chronic or inactive concerns.). *(Example: Location= Butterflies in stomach; Quality=Fear of death, dread; Severity= 10 on a scale of 1-10; Duration=Brief spells 2-3 times per day for past 3 weeks; Timing=Mostly afternoon/ early evening; Context=Often when leaving the house; Modifying factors=Better with a*

stiff drink; Associated signs and symptoms=With palpitations, sweaty palms, calls to 911).

Review of Systems (ROS) – *inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For purposes of the Psychiatry ROS, the following systems are recognized: Musculoskeletal and Psychiatric.* (Problem pertinent inquires about the system directly related to the problem in the HPI – document patient's positive responses and pertinent negatives for the system related to the problem; extended and complete inquires about the system related to the problem(s) identified in the HPI plus the additional system. – document patient's positive responses and pertinent negatives for both the psychiatric and musculoskeletal systems as related to the problem.

Past, family and/or social history (PFSH) - omit

The extent of history of present illness and review of systems (PFSH does not have to be addressed for interval history) what is obtained and documented is dependent on clinical judgment and the nature of the presenting problems:

HPI	ROS	Type of History
Brief (1-3 elements)	N/A	Problem Focused (affected)
Brief	Problem Pertinent (1)	Expanded Problem Focused (limited exam of affected and symptomatic)
Extended (4 or more)	Extended (2-9)	Detailed (extended exam of affected and symptomatic)
Extended	Complete (all)	Comprehensive (multi-system exam)

b. Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** - *a limited examination of the affected organ system*
- **Expanded Problem Focused** - *a limited examination of the affected organ system and other symptomatic or related organ system(s).*
- **Detailed** - *an extended examination of the organ system and other symptomatic or related organ system(s).*
- **Comprehensive** - *a general multi-system examination or complete examination of a single organ system.*

The extent of examinations performed and documented is dependent on clinical judgment and the nature of the presenting problems:

- *Specific abnormal and relevant negative findings of the examination of the organ system should be documented. A notation of "abnormal" without elaboration is insufficient.*
- *Abnormal or unexpected findings of the examination of the unaffected or asymptomatic organ system should be described.*
- *A brief statement or notation indicating "normal" or "negative" is sufficient to document normal findings related to asymptomatic organ systems.*
- *A general multi-system examination should include findings about both the psychiatric and musculoskeletal systems.*

c. Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making: straight forward, low complexity, moderate complexity and high complexity. Medical decision making refers to the complexity of establishing a diagnosis and/or selecting management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and mortality, as well as co morbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and or the possible management options.

The chart below shows the progression for each level of decision making. To qualify for a given type of decision making, 2 of the 3 elements in the table must be met or exceeded:

Number of Diagnosis or Management Options	Amount or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Multiple	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

C. Coding SNF-E/M-Initial Consultative Visit

The initial consultation CPT Code may **only be used once per admission**. Factor in amount of time spent counseling and/or coordination of care with other providers:

99304 – A 25" intervention that requires 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of low complexity

99305 – A 35" intervention that requires 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of moderate complexity

99306 – A 45" intervention that requires 3 key components:

- A ***comprehensive*** history;
- A ***comprehensive*** examination;
- Medical decision making of ***high*** complexity

D. Coding SNF-E/M-Follow Up Care

Documentation of subsequent nursing home care includes reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (i.e. changes in history, patient condition, and response in management) since the last visit. Factor in amount of time spent counseling and/or coordination of care with other providers:

99307 – A 10" intervention that requires 2 of 3 key components:

- A problem focused interval history
- A problem focused examination
- Straightforward decision making

99308 – A 15" intervention that requires 2 of 3 key components:

- An expanded problem focused interval history
- An expanded problem focused examination
- Medical decision making of low complexity

99309 – A 25" intervention that requires 2 of 3 key components:

- An detailed interval history
- An detailed examination
- Medical decision making of moderate complexity

99310 – A 35" intervention that requires 2 of 3 key components:

- A comprehensive interval history
- A comprehensive examination
- Medical decision making of high complexity

E. Add-On Codes

Add on codes describe additional intra-service work associated with the primary procedure and must never be reported as the primary procedure, that is, an add on code cannot stand alone.

- + 90833, psychotherapy 30" / E&M
- + 90836, psychotherapy 45" / E&M
- + 90838, psychotherapy 60" / E&M

"Add-on" codes (+) are used to report psychotherapy when performed with an E & M service and must be separately identifiable as follows:

- Type and level of E&M is selected first based upon the key components of history, examination and medical decision making.
- Therapy add-on code is selected on the basis of time which must be documented.

F. Prolonged Services Codes

Codes 99356 and 99357 are used to report the total duration of time spent by a physician or other qualified healthcare professional at the bedside and on the patient's floor or unit in the nursing facility on a given date providing prolonged services to a patient, even if the time spent is not continuous.

99356, 60" – 74", first hour

99357, each additional 30"

G. Suggestions

a. Documentation must be legible

b. Words to Avoid

- Routine
- Scheduled

- Simple
- Normal
- Quarterly, annual…
- OBRA requirement…

c. Words to Use:

- Patient seen to: Monitor, Assess, Evaluate
- Asked to re-evaluate patient by nursing
- Staff called …seen to assess
- Talked with staff, patient and/or family
- Discussed in team meeting
- Because of behavioral problems…
- Patient seen to address…

d. **Therapists**, be sure to document:

- Patient's ability to benefit from treatment
- Treatment plan-revise/update every 90 days
- Start and end time
- Issues/themes/general content
- Evidence of change/benefit
- Goals
- Expected duration of treatment, review periodically

H. Encounter Dominated by Counseling or Coordination of Care

In the case where counseling and/or coordination of care dominates (>50%) of the physician/patient and/or family encounter (face-to-face time), time is considered the key or controlling factor to qualify for a particular level of E/M services. If you elect to report the level of service based on this factor, the total length of time must be recorded and the documentation should describe the counseling and/or activities to coordinate care.

IV. Therapy (Psychologist and LICSW)

A. Referral and Initiation of Services

a. Referral of nursing home residents to PHM for therapy will normally be consequent to the findings and recommendations set forth in the initial evaluation completed by the psychiatrist/nurse practitioner/clinical nurse specialist. Once identified, it is imperative that the referral be communicated to the therapist by the clinician that has established the need. A referral for therapy may also be initiated by the primary care physician, nursing or social work staff knowledgeable of the resident's presenting needs.

b. Prior to initiating coverage, the therapist must determine that the primary care physician has written an order for mental/behavioral health consultation and that a valid "consent", signed by the resident or his/her legal representative is present in the medical record. If the 'consent" does not exist, it is incumbent on the therapist to obtain the requisite consent before engaging the client in services.

c. The LICSW must also establish the resident's insurance coverage on the day of service, as residents on Med A/skilled cannot be billed out to Medicare under Part B. In this situation, the liaison must approve the session and authorize PHM to "bill the facility".

d. Once the physician's order has been confirmed, consent verified and insurance/payment issue addressed, the therapist may proceed with the initial diagnostic evaluation.

e. In undertaking the initial diagnostic assessment, the clinician will discuss the

resident's case with staff and other consultants having knowledge of the patient; review the information contained in the resident's medical record, and interview the patient.

f. In conducting the initial diagnostic evaluation, the clinician may elect to use various diagnostic tests to aid in the determination of the diagnosis and treatment. The clinician may use the Mini-Mental Status Examination (MMSE) to aid in the assessment of cognition or the Geriatric Depression Scale to assess affect and mood.

g. The clinician's findings and recommendations are documented in the medical record on the **Initial Psychological Assessment, PHM-005** (attachment 8).

h. Based on the therapist's findings, a determination will be made as to whether the resident would benefit from individual or family therapy.

i. When the therapist has concluded that the resident is not an appropriate candidate for therapy, she/he will record the basis for the decision and provide further recommendations as may be indicated.

j. Residents meeting the 'medical necessity criteria" will be accepted into therapy and the therapist will develop a **Treatment Plan, PHM-006** (attachment 9) using the prescribed PHM form delineating the goal(s) of therapy, the frequency (weekly, bi-weekly, etc…). Once established, it is imperative that the frequency of sessions be consistent with the treatment plan. The plan is to be updated every **90 days** and therapy is to be terminated upon realization of the established goals.

k. The Treatment Plan serves as the communication mechanism to the primary care physician (PCP) requesting authorization of services. It is incumbent upon the therapist to have (and verify) a written order from the PCP that reflects the Treatment Plan (eg… 12 session of weekly counseling) and the therapist must obtain a renewal order concurrent with the reformulation of the Treatment Plan, at minimum, every 90 days.

B. Follow-up Visits

a. The frequency of visits is predicated on "medical necessity". Once the schedule has been established (e.g. bi-weekly sessions) every effort must be made by the therapist to maintain the integrity of the plan. Should the resident experience an acute change in behavior requiring more frequent visits, the treatment plan must be updated, and the behavioral changes documented on both the revised treatment plan and in the **Therapist Progress Note, PHM-007** (attachment 10).

b. Unless the resident is unstable and at high risk of decompensation, therapy should be limited to once weekly.

C. Procedure Codes

- **90792** – Initial Diagnostic Evaluation – time will vary depending on complexity of case and availability of information (typically 1-hour)
- **90832**[2] – Individual psychotherapy, insight oriented, behavior modifying and / or supportive, in a residential or inpatient setting, approximately **16-37 minutes** face-to-face with the patient
- **90834** – Individual psychotherapy, insight oriented, behavior modifying and / or supportive, in a residential or inpatient setting, approximately **38-52 minutes** face-to-face with the patient
- **90846** – Family therapy <u>without</u> patient, approximately **38-52 minutes** face-to-face with the patient's family. *(Note is written consequent to a meeting with resident's family or significant other to review discuss treatment plan, results from PHM*

[2] *Documentation must reflect the "meaningful relationship" which exists between therapist and resident. The note must include target symptoms, rationale for the service, and progress since last encounter, summary of session content and goal of next session.*

assessments and, as appropriate, engage the family in the therapeutic process.)

- **90847** - Family therapy with patient, , approximately **38-52 minutes** face-to-face with the patient and family
- **90837** – Individual psychotherapy, greater than **53"** insight oriented, behavior modifying and / or supportive, in a residential or inpatient setting, face-to-face with the patient. This code is not recognized by many managed care insurances including Tufts, Beacon, and UBH. It is appropriate to use this code when the session includes therapy and the development or reformulation of the treatment plan or behavior plan and the total length of time exceed 53".

D. Termination/Transfer

a. On determination that the therapeutic goals have been achieved, the therapist will close the case. Documentation of the cessation of therapy is to be reflected in the therapist's final progress note and by updating the treatment plan.

b. When the therapist will no longer be available to continue working with a resident who remains appropriate for ongoing therapy, the case will be transferred to another therapist. The departing therapist is responsible for writing a transfer note/summary and "hand-off" communication to the incoming therapist.

V. Behavior Plans

According to OBRA (F329**)**, **behavioral plans** (attachment 11) are a necessary step in arriving at a decision to prescribe medication in order to address agitated, combative or assaultive behavior. In addition, behavioral interventions can be useful with residents who are depressed or isolative, anxious or paranoid. In general, behavior plans – written concise interventions for use by nursing staff – formulate a way by which the entire nursing home can organize, given its resources, in order to address a particular resident's problem behavior in a consistent way. Behavior plans can provide nursing home staff with strategies for prevention, engagement and intervention. Plans should include a problem statement and be geared toward environmental change rather than resident change. For example, if a resident is agitated, the plan should focus on those things in his/her environment which may be contributing to the agitation.

The **Psycho Geriatric Dependency Rating Scale** (attachment 12) is one instrument designed to aid in the identification of behavioral issues to be addressed in the Behavioral Plan. The PDRS is intended to be completed by the nursing staff by considering observations of the resident's behavior over the previous 5 days or 5 shifts.

The development of the plan can be tasked to either the therapist of nurse practitioner based on his/her thorough assessment of the resident's behavioral concerns. The plan should be developed in collaboration with the nursing staff to ensure that suggestions are feasible given the home's resources. Once a plan is developed it should be reviewed with the resident and nursing home staff, revised as needed (minimum every 90 days) to reflect progress or lack thereof.

VI. Care Plan Meetings

a. Care plan meetings are held at each home. Your participation will depend on scheduling and availability on the days meetings convene. Each resident's comprehensive care plan is developed shortly following admission and revised, at minimum, every 90 days. Your participation in the formulation of the plan, either through direct involvement or communication through documentation in the medical record, serves to promote the establishment of shared treatment objectives.

b. The time spent in care planning should be captured in the progress notes of residents "teamed" and subsequently seen and evaluated. This time can be factored in to the procedure code used for this encounter.

VII. Clinician Schedules

A. General

Frequency of visits to the home will vary depending upon such variables as caseload, acuity and admission activity. Practitioner schedules are flexible; however, when a practitioner must alter his/her planned schedule, it is imperative that she/he notifies the home staff by telephone and reschedule the visit.

B. Vacation Coverage

Vacation coverage serves to maintain continuity of care while providing coverage for new admissions and emergency situations. While it is anticipated that practitioners will arrange his/her own coverage, PHM can assist in this regard where necessary.

VIII. Emergency Coverage

A. General

a. While PHM does not provide on-site emergency coverage to homes under contract, every effort is to be made to assist the staff in managing acute episodic situations that may arise. Typically, these events will result in a telephone consultation to the clinician. In many cases, the clinician will be able to provide recommendations that will be successful in managing the event. In those cases where the situation requires transfer to a higher level of care, hospitalization will be required.

b. The clinician providing telephone consultation will attempt to discern the likely basis for the acute change in the resident's condition. In matters where a medical basis is believed to be the precipitating factor, emergency transfer to the local hospital emergency room should be recommended.

c. In situations where the behavioral change is acute, the underlying precipitant is either undetermined or likely a mental health condition, and hospitalization is indicated, the clinician is to facilitate the transfer.

B. Emergency Transfer for Geriatric Psychiatric Inpatient Treatment

a. While each home manages the process somewhat differently, depending on factors such as time of day, expertise of staff, etc…, PHM clinicians play an important role in assisting home staff in managing the transfer process.

b. Once it has been determined that hospital level of care is required, the PHM clinician is to complete the front sheet of DMH Form AA-3, "Application for and Authorization of Temporary Involuntary Hospitalization (sic MGL C 123, § 12).

i. To complete the form, a determination must be made as to which hospital the resident is to be referred to. This determination may be based on factors which include family preference, proximity to the nursing home, and continuity of care and bed availability.

1. Once the preference has been established, either home staff or the clinician will call the inpatient service (see attached list of geri-psych inpatient programs) to determine bed availability. If a bed at the preferred hospital is not available, the next option is to be visited.

2. Once a program with a bed has been identified, home staff and the PHM clinician will be required to provide information to the intake coordinator. Home staff will communicate demographic and insurance information and the clinician will provide the clinical justification in support of the admission decision.

3. The program's intake coordinator will advise as to whether the resident's insurance is accepted by the hospital (i.e., whereas a Tuft's insured client has limited options [call **800 208-9565** to

determine which **Tuft's contracted hospital** is aligned with the patient], a Medicare/Medicaid insured member can be served by every geri-psych programs).

4. The intake coordinator will review the clinical information with the admitting psychiatrist and make a determination as to whether to accept the referral or not.

ii. The process for emergency hospitalization may take time in excess of what would be reasonably safe for the resident in acute distress. The value of pre-determining placement, assures the resident of placement at the destination hospital. In situations where delay in hospitalization would create undue risk, immediate transportation by ambulance to the nearest emergency room may be the best alternative.

Location	Phone	Specialty	# Beds
Good Samaritan Hospital, Brockton	(508) 427-2525	Geriatric-Psych	16
Arbour-Fuller Hospital, Attleboro	(800) 222-2237	Adult	49
Caritas Hospital, Norwood	(781) 278-6670	Adult & Geri	28
Carney Hospital, Dorchester	(617) 296-4000	Adult & Geri	61
Jordan Hospital, Plymouth	(508) 732-8700	Geri & Dementia	21
McLean Hospital, Belmont	(617) 855-3141	Geri & Dementia	36
MetroWest Medical Center	(508) 650-7380	Adult & Geri	
Pembroke Hospital, Pembroke	(800) 222-2237	Adult & Geri	81
Quincy Medical Center, Quincy	(617) 376-5440	Geriatric-Psych	20
South Coast Hospital, New Bedford	(508) 961-5915	Adult	31
St. Anne's Hospital, Fall River	(877) 437-7792	Geriatric-Psych	16

IX. Insurance

A. Communication

PHM has contracted with the home to provide behavioral health services on a fee-for-service basis. Accordingly, it is imperative that timely communication of insurance information occur. Unless other arrangements exist at a home, the responsibility to collect and transmit insurance information to PHM resides with the practitioner that opens the case. As the process for obtaining this vital information does vary between organizations, the specific steps will be discussed between the clinicians and PHM.

B. Eligibility for Services; Limitations

a. **Medicare A** – nursing home residents receiving skilled services under Medicare A benefits, sub-acute care, are not eligible for services from a social worker. Therefore, social workers are not to initiate services with a resident on Medicare A unless a prior agreement has been reached between the Administrator and PHM.

b. **Medicaid only** – PHM will not receive payment for social worker services furnished to nursing home residents whose only insurance coverage is Medicaid. Therapy by a social worker can only be initiated with the prior approval of PHM.

c. **In-Network Only** - Certain managed care organizations require that members see in-network providers only. For example, BMC Healthnet, Network Health and MBHP have not opened their network to PHM; these clients cannot be followed by PHM clinicians without prior agreement of the home to pay for these services.

d. **Prior Authorization** – Certain managed care organizations (i.e. Tufts, Harvard-Vanguard, UBH) require prior authorization before services can be rendered. It is incumbent on the PHM clinician to communicate with the billing office and secure prior authorization before initiating services. Typically, the number of

session is finite and a re-authorization is required once depleted. PHM will track the use of these sessions and request additional sessions as may be medically necessary.

e. **Same day billing** – Medicare will allow only one service per day per specialty. PHM clinicians are responsible for avoiding this situation.

f. **Provider Enrollment** – Eligible PHM clinicians are required to become in-network providers of managed care organizations serving the facilities under agreement with PHM. PHM will assist the clinician in the enrollment process.

g. **Non-covered services** – certain services requested of PHM clinicians are not covered by insurance (guardianship evaluation or annual re-evaluation). These services are provided under terms of the "agreement" between PHM and the home. The clinician is to identify the service provided on the clinician's encounter form when rendered.

X. In-service Education

A. Informal

PHM clinicians are encouraged to engage the nursing home staff in discussion intended to foster staff understanding of neurological and mental health disorders, the disease process and therapeutic approach. Nursing rounds are an excellent venue for the PHM clinician to share their expertise, insight and clinical strategies.

B. Formal

PHM endeavors to be responsive to the educational interests of the staff in facilities that have engaged our team. In recognition of the value placed on education, PHM will reimburse sponsoring clinicians providing in-service education twice each year. Prior approval of PHM is required.