A conversation with District of Columbia clinicians

A clinician-facing brief for District of Columbia behavioral-health programs

The referral conversation

When a patient may need more structure than routine office visits, an intensive outpatient program (IOP) assessment can help the treating clinician and receiving program evaluate the appropriate next step. A referral is a request for assessment, not a guarantee of admission or a replacement for clinical judgment.

IOP can provide coordinated psychiatric care, counseling and therapy while the patient remains in the community. Program schedules, clinical services, populations served and coordination with the existing psychiatrist vary. [1]

IOP, PHP and inpatient are different

IOP: Medicare describes care between traditional weekly therapy and inpatient or partial hospitalization care. Its coverage guidance refers to a care plan requiring at least 9 hours of therapeutic services per week; inpatient eligibility is not required. [1]

PHP: a more intensive structured outpatient alternative to inpatient care. Medicare guidance refers to at least 20 therapeutic hours per week and provider certification that the patient would otherwise need inpatient treatment. [2]

These are Medicare benefit distinctions, not universal commercial-insurance or District of Columbia Medicaid admission rules. The receiving clinician determines level of care and the payer determines applicable coverage requirements.

A simple discussion prompt

“Would an IOP assessment be useful for any of your patients who need a more structured treatment schedule? We can first clarify the assessment process, coverage and how your office would receive updates.”

No patient identifiers should be exchanged during a marketing visit. Use the program’s approved secure referral channel, with applicable consent and privacy safeguards.

Safety first

For immediate medical danger, call 911 or use emergency services. For a mental-health or suicide crisis, call or text 988. A routine referral or sales visit must not delay urgent assessment. [2]

Make the handoff practical

A referral-readiness checklist for the rep and receiving program

Confirm before leaving the office

Verify the program’s admissions contact and approved secure referral method; current assessment availability; age groups and conditions served; actual service location; schedule; and transport or virtual-care arrangements, if offered.

Confirm whether the program coordinates medication management with the existing psychiatrist and how assessment decisions, attendance and discharge updates are communicated. Do not promise capabilities that the program has not verified.

Coverage is patient- and plan-specific

Ask the program to verify the exact insurance product, network status, benefits, authorization requirements and estimated patient responsibility. An insurer’s published negotiated rate does not prove a patient is covered or that the program is in network.

Medicaid benefits and delivery arrangements in District of Columbia must be checked with the patient's specific plan and receiving program. This paper does not verify state Medicaid IOP/PHP benefits, authorization rules or payment rates. Medicare's national benefit definitions do not establish Medicaid or commercial coverage.

Clinical information travels securely

The referring clinician and receiving program should determine what information is clinically needed: reason for assessment, relevant history and safety concerns, current medications, treating clinicians and coverage information. Follow organizational policy and applicable privacy requirements.

Do not collect records or patient details in RepVector, a rep’s notes, email used for outreach, or a marketing spreadsheet. RepVector does not send referrals, assess patients or make admission decisions.

Close the loop

Agree on an office contact, the expected assessment-response process and how the referring psychiatrist will learn the disposition. Confirm who handles clinical follow-up if the program cannot accept the patient. Availability and turnaround times must come from the program, not this paper.

District of Columbia: the evidence

How RepVector identifies referral prospects - and what it cannot establish

A billing-evidence starting point

RepVector’s District of Columbia referral searches use the same outpatient diagnostic-evaluation, psychotherapy and crisis-care preset. Codes include 90791, 90792, 90832-90834, 90836-90840, 90846, 90847 and 90853. These are referral-prospect signals, not IOP facility billing codes or confirmed referral relationships.

Matching Medicare clinicians can include psychiatrists, psychiatric NPs, psychologists and clinical social workers. The preset does not establish diagnoses, IOP eligibility, commercial activity or a complete referral-source census. Missing CMS records are not zero activity.

Statewide reach, local outreach

The District of Columbia search uses clinician practice geography in the available billing evidence. Narrow the search to a city when planning visits; city-radius searches use practice-city centres and straight-line distances, not door-to-door drive distances. Current counts, evidence years and coverage limitations appear with the search results rather than being frozen into this handout.

District of Columbia prospects: repvector.com/find?q=IOP%20referrals%20across%20District%20of%20Columbia

Full provider lists, saved territories and exports retain their existing account and membership rules. This educational paper itself is free.

Sources and scope

[1] Medicare: Intensive outpatient program services
https://www.medicare.gov/coverage/mental-health-care-outpatient-intensive-outpatient-program-services

[2] Medicare: Partial hospitalization
https://www.medicare.gov/coverage/mental-health-care-outpatient-partial-hospitalization

About this paper

Prepared by RepVector for educational referral conversations in District of Columbia. Not a program endorsement, treatment recommendation, payer authorization, legal advice or patient-specific clinical guidance. No local admission, patient-volume or outcome estimates are made. State Medicaid policy has not been verified in this edition.

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