SECTION II - OUTPATIENT BEHAVIORAL HEALTH SERVICES CONTENTS

200.000 OUTPATIENT BEHAVIORAL HEALTH SERVICES GENERAL INFORMATION

201.000 Introduction 7-1-15

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Outpatient Behavioral Health Services are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers.

Outpatient Behavioral Health Services may be provided to eligible Medicaid beneficiaries at all provider certified/enrolled sites. Allowable places of service are found in the service definitions located in Section 252, Section 253, Section 254 and Section 255.

202.000 Arkansas Medicaid Participation Requirements for Outpatient Behavioral Health Services 7-1-15

In order to ensure quality and continuity of care, all behavioral health providers approved to receive Medicaid reimbursement for services to Medicaid beneficiaries must meet specific qualifications for their services and staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.

Behavioral Health Providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Providers must be located within the State of Arkansas.

B. A provider must be certified by the Division of Behavioral Health Services (DBHS). (See Section 202.100 for specific certification requirements.)

C. A copy of the current DBHS certification as a Behavioral Health provider must accompany the provider application and Medicaid contract.

D. The provider must give notification to the Office of the Medicaid Inspector General (OMIG) on or before the tenth day of each month of all covered health care practitioners who perform services on behalf of the provider. The notification must include the following information for each covered health care practitioner:

1. Name/Title
2. Enrolled site(s) where services are performed
3. Social Security Number
4. Date of Birth
5. Home Address
6. Start Date
7. End Date (if applicable)

Notification is not required when the list of covered health care practitioners remains unchanged from the previous notification.

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320a-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320a-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

202.100 Certification Requirements by the Division of Behavioral Health Services (DBHS) 7-1-15

In order to enroll into the Outpatient Behavioral Health Services Medicaid program as a Behavioral Health Agency, Behavioral Health Home, and Performing Provider, all performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division of Behavioral Health Services (DBHS), unless expressly exempted from this requirement. The DBHS Certification Rules for Providers of Outpatient Behavioral Health Services is located at <url> and the DBHS Behavioral Health Home Certification and Standards is located at <url>.

National accreditation must recognize and include all the applicant's programs, services and service sites. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation. Providers must meet all other DBHS certification requirements in addition to accreditation.

202.200 Providers with Multiple Sites 7-1-15

Providers with multiple service sites must apply for enrollment for each site. A cover letter must accompany the provider application for enrollment of each site that attests to their satellite status and the name, address and Arkansas Medicaid number of the parent organization.

A letter of attestation must be submitted to the Medicaid Enrollment Unit by the parent organization annually that lists the name, address and Arkansas Medicaid number of each site

affiliated with the parent. The attestation letter must be received by Arkansas Medicaid no later than June 15 of each year.

Failure by the parent organization to submit a letter of attestation by June 15 each year may result in the loss of Medicaid enrollment. The Enrollment Unit will verify the receipt of all required letters of attestation by July 1 of each year. A notice will be sent to any parent organization if a letter is not received advising of the impending loss of Medicaid enrollment.

210.000 PROGRAM COVERAGE

211.000 Coverage of Services 7-1-15

Outpatient Behavioral Health Services are limited to certified providers who offer core behavioral health services for the treatment and prevention of behavioral disorders. All performing providers, provider groups, and business entities participating in the Medicaid Outpatient Behavioral Health Services (OBH) Program must be certified by the Division of Behavioral Health Services (DBHS), unless expressly exempted from this requirement.

An Outpatient Behavioral Health Services agency must establish a site specific emergency response plan that complies with Section III., C., 1., i. under Agency Requirements: Behavioral Health Agency of the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual. Each agency site must have 24-hour emergency response capability to meet the emergency treatment needs of the Behavioral Health Services beneficiaries served by the site. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. An answering machine message to call 911 or report to the nearest emergency room in and of itself is not sufficient to meet the requirement.

Licensed performing providers as certified by DBHS must also maintain an Emergency Service Plan that complies with Section I., a. under Licensed Performing Provider of the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual.

All Outpatient Behavioral Health Services providers must demonstrate the capacity to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

211.100 Quality Assurance 7-1-15

Each Outpatient Behavioral Health Services agency must establish and maintain a quality assurance committee that will meet quarterly and examine the clinical records for completeness, adequacy and appropriateness of care, quality of care and efficient utilization of provider resources. The committee must also comply with Section III., C., 1., l. under Agency Requirements: Behavioral Health Agency of the DBHS Certification Rules for Providers of Outpatient Behavioral Health Services manual. Documentation of quality assurance committee meetings and quality improvement programs must be filed separately from the clinical records.

211.200 Staff Requirements 7-1-15

Each Outpatient Behavioral Health Services provider must ensure that they employ staff which is able and available to provide appropriate and adequate services offered by the provider. Behavioral Health staff members must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification and supervision that are required for each performing provider type.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Certified Peer Support Specialist	N/A	Yes, to provide services within a certified behavioral health agency	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Certified Youth Support Specialist	N/A	Yes, to provide services within a certified behavioral health agency	Required
Certified Family Support Partner	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider - non-degreed	N/A	Yes, to provide services within a certified behavioral health agency	Required
Qualified Behavioral Health Provider – Bachelors	N/A	Yes, to provide services within a certified behavioral health agency	Required
Independently Licensed Clinicians - Master's/Doctoral	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Independently Licensed Clinicians - Substance Abuse Certified Clinicians	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be certified to provide services	Not Required
Non-independently Licensed Clinicians - Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be supervised by appropriate Independently Licensed Clinician	Required
Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be a part of a certified agency and must be certified to provide services	Required
Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Licensed Master Social Worker (LMSW) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP)	Yes, must be supervised by appropriate Independently Licensed Clinician and must be certified to provide services	Required
Registered Nurse	Registered Nurse (RN)	No, must be a part of a certified agency	Required
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	No, must be part of a certified agency or have a Collaborative Agreement with a Physician	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	No, must provide proof of licensure	Not Required
Care Coordinator - Bachelor's	N/A	Yes	Required
Care Manager/Director - Master's	Licensed Clinical Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes	Not Required

A. The services of a medical records librarian are required. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved; that required indexes and registries are maintained and that statistical reports are prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable, establishing a central records index, and maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

When an Outpatient Behavioral Health Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the performing provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

211.300 Certification of Performing Providers 7-1-15

As illustrated in the chart in § 211.200, certain Outpatient Behavioral Health performing providers are required to be certified by the Division of Behavioral Health Services (DBHS). The certification requirements for performing providers are located on the DBHS website at <url>. The certification requirements for Care Coordinator and Care Director for the Behavioral Health Home are located on the DBHS website at <url>.

211.400 Facility Requirements 7-1-15

The Outpatient Behavioral Health Services provider shall be responsible for providing physical facilities that are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation and health. These standards apply to buildings in which care, treatment or services are provided. In situations where Outpatient Behavioral Health Services are not provided in buildings, a safe and appropriate setting must be provided.

211.500 Non-Refusal Requirement 7-1-15

The Outpatient Behavioral Health Services provider may not refuse services to a Medicaid-eligible beneficiary who meets the requirements for Outpatient Behavioral Health Services as outlined in this manual. If a provider does not possess the services or program to adequately treat the beneficiary's behavioral health needs, the provider must communicate this with the Behavioral Health Home for Tier 2 or Tier 3 beneficiaries or the Patient-Centered Medical Home for Tier 1 beneficiaries so that appropriate provisions can be made.

212.000 Scope 7-1-15

Care, treatment and services provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries that have a Behavioral Health diagnosis as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

Eligibility for services depends on the needs of the beneficiary. Tier 1 and crisis services can be provided to any beneficiary as long as the services are medically necessary. Beneficiaries will be deemed eligible for Tier 2 and Tier 3 services based upon the results of the interRAI Community Mental Health (CMH) assessment instrument performed by a contracted entity. The instrument is designed to incorporate the client's needs, strengths, and preferences when assessing the key domains of function, mental and physical health, social support, and appropriate services. The goal of the assessment is to determine the care, treatment, or services that will best meet the needs of the individual services initially and over time.

TIER 1 Time-limited behavioral health services provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Tier 1 outpatient based setting shall mean a behavioral health clinic/ office, healthcare center, physician office, and/or school.

TIER 2 Intensive home and community based behavioral health services coordinated by a certified behavioral health home for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent Assessment and Integrated Care Plan required. Tier 2 home and community based settings shall include services rendered in a beneficiary's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school.

TIER 3 Most intensive behavioral health services coordinated by a certified behavioral health home for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent assessment and Integrated Care Plan required. Tier 3 behavioral health services shall include services rendered in a beneficiary's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school. Residential treatment services are available—if deemed medically necessary.

213.000 Outpatient Behavioral Health Services Program Entry 7-1-15

Prior to continuing provision of Tier 1 treatment services, the provider must provide documentation of the medical necessity of Outpatient Behavioral Health Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate. If a beneficiary is determined to be in Tier 2 or Tier 3, the documentation of medical necessity of services will be met by the Independent Assessment.

The documentation of medical necessity of Outpatient Behavioral Health Services must be completed by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health.

Each beneficiary that receives only Tier 1 Outpatient Behavioral Health Services can receive a limited amount of Tier 1 services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record. The requirements for this are located in § 217.100 of this manual.

A standardized intake must be conducted prior to service provision in the Outpatient Behavioral Health Services program. This standardized assessment will assist providers in determining services needed and desired outcomes for the beneficiary. The assessment must be placed in the medical record of the beneficiary and must be signed by appropriately licensed providers.

For all beneficiaries under the age of 21, the Arkansas Indicators will be included as part of the standardized intake.

213.100 Independent Assessment for Beneficiaries 7-1-15

The Independent Assessment will utilize the interRAI Community Mental Health (CMH) assessment instrument performed by a contracted entity. The instrument is designed to incorporate the client's needs, strengths, and preferences when assessing the key domains of function, mental and physical health, social support, and appropriate services. The Independent Assessment is administered by an independent assessor to determine beneficiary eligibility for services. The Independent Assessment will evaluate beneficiaries across five different areas: safety, autonomy, health promotion, social life and economic issues.

An independent assessment of the beneficiary is required to determine need for Tier 2 services, Tier 3 services, and BHH services. Any beneficiary may refuse to participate in the independent

assessment when contacted, and refusal will be noted. If the beneficiary chooses not to participate in the Independent Assessment and the integrated care plan development, he or she will not be able to access Tier 2 services, Tier 3 services, or BHH services.

The Independent Assessment must be conducted at least every 12 months by the Independent Assessor in consultation with the beneficiary, anyone the beneficiary requests to participate in the Independent Assessment, and taking into consideration information obtained from behavioral health service providers.

The independent assessment will produce the independent assessment report which will indicate the areas of need of the beneficiary.

A beneficiary may be referred to the Independent Assessment entity to evaluate whether the beneficiary meets the needs-based State plan HCBS eligibility criteria. The following are allowable methods of referral to receive an independent assessment for determination of need for Tier 2 services, Tier 3 services and attribution to a BHH:

A. Trigger from claims data / MMIS claims data

B. Referral from Tier 1 Behavioral Health Provider

C. Referral from physician (including those in acute settings, mobile crisis units)

D. An individual determined to be Medically Fragile due to Behavioral Health needs

E. Referral from the Division of Children and Family Services (DCFS) / the Division of Youth Services (DYS) when they are the legal guardian of the beneficiary

F. Referral/Court Order from the Court System/Justice System

A re-assessment can be requested by the direct service provider if the direct service provider determines the individual's needs are not being met or the individual is not benefitting from the Tier 2 services or Tier 3 services being provided.

The independent assessor will contact the beneficiary to be assessed within 48 hours of referral and will complete the face-to-face assessment within 14 calendar days. For identified priority populations, the independent assessor will contact the beneficiary to be assessed within 24 hours of notification from the beneficiary's provider and will complete the assessment within 7 days of the notification. Examples of priority population include, but is not to be limited to:

A. Youth involved in the juvenile justice system

B. Individuals involved in the foster care system

C. Individuals discharged from acute hospital stays

D. Individuals discharged from crisis residential stays

E. Adults involved in the criminal justice system

F. Clients identified and referred by DBHS

213.200 Needs-based Tier 2/Tier 3 Eligibility Criteria 7-1-15

Eligibility for a Behavioral Health Home (BHH) and Tier 2 services and Tier 3 services will be determined by the Independent Assessment.

An integrated care plan will be developed by the BHH based on the independent assessment report. The beneficiary will be supported in integrated care plan development by the BHH and allowed the ability to choose who they want to participate in the integrated care plan development. In the case of children (Under Age18, the parents participation (or legal guardian, DCFS, DYS, caretaker) must be included in the development of the integrated care plan.

If the beneficiary (or the person chosen by the beneficiary to participate in the integrated care plan development) does not participate in the integrated care plan development, they will not be eligible to receive Tier 2 services, Tier 3 services or BHH services.

Individuals that do not qualify for a BHH and Tier 2 services/Tier 3 services can continue to be provided Tier 1 behavioral health services.

213.300 Opt-Out Process 7-1-15

Any time while receiving services, the beneficiary may opt out of the Behavioral Health Home (BHH), Tier 2 services, or Tier 3 services. When determined to meet the needs based criteria to receive Tier 2 services or Tier 3 services, the beneficiary will have the option to choose a BHH provider. DMS will send notification to the beneficiary and the BHH that the beneficiary has chosen the BHH. This notification will also include information on other BHH providers in the State, how the beneficiary can change BHH providers and how the beneficiary can opt-out of the BHH.

214.000 Role of Providers of Tier 1 Services 7-1-15

Outpatient Behavioral Health Providers provide Tier 1 services by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating behavioral health conditions. Tier 1 outpatient based setting shall mean services rendered in a behavioral health clinic/ office, healthcare center, physician office, and/or school. The performing provider must provide services only within the scope of their individual licensure. Services available to be provided by Tier 1 providers are listed in Section 252.110 of the Outpatient Behavioral Health Services manual.

214.100 Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) 7-1-15

Outpatient Behavioral Health Providers may provide dyadic treatment of beneficiary's age 0-47 months and the parent/caregiver of the eligible beneficiary. A prior authorization will be required for all dyadic treatment services (the Mental Health Diagnosis and Interpretation of Diagnosis DO NOT require a prior authorization). All performing providers of parent/caregiver and child Outpatient Behavioral Health Services MUST be certified to provide those services by DBHS.

Providers will diagnose children through the age of 47 months based on the DC: 0-3R. Providers will then crosswalk the DC: 0-3R diagnosis to a DMS diagnosis. Specified V codes will be allowable for this population.

215.000 Role of Behavioral Health Home 7-1-15

The Behavioral Health Home (BHH) is a transformative health care delivery model that holistically coordinates all care management for high needs behavioral health beneficiaries and supports their families in order to facilitate improved patient quality of care and positive population-based health outcomes.

The functions of a BHH are carried out by an Integrated Care Team comprised of, at a minimum, two roles: Care Director and Care Coordinator ordered by level of direct interaction with the beneficiary. The Care Coordinator directly interacts with a beneficiary, the beneficiary's family and his/her other treatment providers. The Care Director oversees BHH Care Coordinators, facilitates problem-solving with Care Coordinator's case issues and is responsible for reviewing and updating the integrated care plan. Care Directors/Managers may also help establish a relationship between the BHH and other treatment providers. The Care Director/Managers is responsible for managing budgetary and other administrative duties of a BHH. The Behavioral Health Home must meet the staffing requirements as outlined in the Division of Behavioral Health Services Behavioral Health Home Certification and Standards manual located at <url>.

The BHH is responsible for maintaining and updating the Integrated Care Plan. The Integrated Care Plan is a master document comprised of all treatment plans associated with the beneficiary. Information necessary to create the Integrated Care Plan will be obtained from the beneficiary, behavioral health service providers, the Independent Assessment, and anyone the beneficiary deems necessary to assist in the creation of the Individualized Care Plan. The Integrated Care Plan is actively managed and maintained by the BHH and the Integrated Care Team on an ongoing basis.

The Behavioral Health Home will be reimbursed with a Per Member Per Month payment based upon the number of beneficiaries enrolled in that Behavioral Health Home. The PMPM payments are as follows:

A. Tier 2 Beneficiaries = $100 PMPM

B. Tier 3 Beneficiaries = $200 PMPM

215.100 Behavioral Health Home Process Metrics 7-1-15

Using the provider portal, Behavioral Health Homes must complete and document the activities as described in the table below and meet the targets in order to continue participating in the Outpatient Behavioral Health Program as a Behavioral Health Home. Year 3 is July 1, 2017 to June 30, 2018. Year 4 is July 1, 2018 to June 30, 2019. Year 5 is July 1, 2019 to June 30, 2020. After year 5, the year 5 target will remain in effect unless changed via promulgation under the Arkansas Administrative Procedures Act.

All of the following must be met:

Activity		Target
Percentage of beneficiaries that have an integrated care plan		Year 3: 70% Year 4: 80% Year 5: 90%
A.	Percentage of beneficiaries with crisis intervention plan in place	Year 3: 90% Year 4: 90% Year 5: 90%
B.	Percentage of beneficiaries with whom the Behavioral Health Home is involved with Behavioral Health Inpatient discharge planning 1. Portal must reflect documented Behavioral Health Home contact with hospital discharge planner prior to discharge and notification of discharge to BH providers, PCMH, and/or PCP	Year 3: 50% Year 4: 65% Year 5 75%
At least one (1) of following must be met:		
C.	Percentage of beneficiaries who received appropriate number of client check-ins 1. Portal must reflect check-ins; frequency of check-ins required will vary based on intensity of report required	Year 3: 70% Year 4: 80% Year 5: 90%
D.	Percentage of beneficiaries with Behavioral Health Inpatient flag in portal for those requiring Inpatient care 1. Portal must reflect Behavioral Health Inpatient occurrences from claims data	Year 3: 50% Year 4: 65% Year 5: 75%

Activity		Target
E.	Percentage of clients who received follow-up from Behavioral Health Home within 3 days post-IP encounter	Year 3: 50% Year 4: 65% Year 5: 75%
	1. Portal must reflect Behavioral Health Home has followed up with client (face-to-face or by telephone) within 3 days of discharge.	
	2. These metric applies only to existing beneficiaries attributed to the Behavioral Health Home.	

DMS may add, remove, or adjust these metrics or targets, including additions beyond 3 years based on new research, empirical evidence or experience from initial metrics. DMS will publish such extension, addition, removal or adjustment at www.paymentinitiative.org.

215.200 Behavioral Health Home Outcome Metrics 7-1-15

Year 3 is July 1, 2017 to June 30, 2018. Year 4 is July 1, 2018 to June 30, 2019. Year 5 is July 1, 2019 to June 30, 2020. In Year 1 and Year 2, the Behavioral Health Home will qualify for 100% of the Per Member Per Month (PMPM) reimbursement for all attributed beneficiaries. Beginning in year 3, an increasing portion of the PMPM reimbursement will be placed at-risk based upon the metrics specified below.

Year 3: 90% of Base PMPM will be reimbursed to the Behavioral Health Home.

10% of PMPM is at risk.

Year 4: 80% of Base PMPM will be reimbursed to the Behavioral Health Home.

20% of PMPM is at risk.

Year 5: 70% of Base PMPM will be reimbursed to the Behavioral Health Home.

30% of PMPM is at risk.

Each metric will account for a percentage of the PMPM at risk. For instance, if there are 2 metrics that impact the at-risk portion of the PMPM, each would count for 50% of the PMPM at risk. If there are 3 metrics to be met to qualify to receive the at-risk portion of the PMPM, each metric would count for 33% of the PMPM at risk. The Behavioral Health Home must meet specific thresholds (as outlined below):

Metric		Threshold
A.	Follow-Up after hospitalization for mental illness (For adults and children)	Year 3: Metric will be set after analysis of data tracked from the first two years Year 4: Metric will be set after analysis of data tracked from the first two years Year 5: Metric will be set after analysis of data tracked from the first two years
	1. Percent of beneficiaries who were hospitalized for mental health disorders that visited mental health practitioners within 7 days of discharge	

Metric		Threshold
B.	Behavioral Health acute Inpatient readmission rate (For adults and children) 1. Rate of Behavioral Health related readmission within 30 day discharge from acute IP facility	Year 3: Metric will be set after analysis of data tracked from the first two years Year 4: Metric will be set after analysis of data tracked from the first two years Year 5: Metric will be set after analysis of data tracked from the first two years
C.	Utilization of Patient Centered Medical Home (PCMH) (For adults only) 1. Percent of beneficiaries who have received at least one documented healthcare visit with their PCMH (or physician or other healthcare providers if individual does not have a PCMH) that included a review of the medical plan	Year 4: Metric will be set after analysis of data tracked from the first two years Year 5: Metric will be set after analysis of data tracked from the first two years Year 6: Metric will be set after analysis of data tracked from the first two years
D.	Utilization of residential services (days Per Member Per Month) (Children only)	Year 4: Metric will be set after analysis of data tracked from the first two years Year 5: Metric will be set after analysis of data tracked from the first two years Year 6: Metric will be set after analysis of data tracked from the first two years

DMS will publish targets for subsequent years, calibrated based on experience from targets initially set, at **www.paymentinitiative.org**. Such targets will escalate over time.

DMS may add, remove, or adjust these metrics based on new research, empirical evidence or experience from initial metrics.

215.300 Behavioral Health Home Attribution 7-1-15

Upon choosing a BHH, beneficiaries will receive additional notification of their BHH assignment from the Division of Medical Services via U.S. Mail and other methods as necessary.

The BHH will also contact the beneficiary assigned to them either by phone or in person to answer any additional questions the beneficiary might have.

The beneficiary's letter of attribution will outline his or her right to initiate contact with DMS to (1) change providers and/or (2) opt out of the BHH. State notification will describe BHH services generally, outline the individual's choice in selecting a health home and provide a listing of all available health homes throughout the state. The beneficiary must participate and sign off on the creation of the Integrated Care Plan. The BHH will be responsible for the creation, maintenance and updating of the Integrated Care Plan. If a beneficiary (or the person chosen by the beneficiary to participate in the integrated care plan development) does not participate in the activities of creating or updating the Integrated Care Plan, the beneficiary will not be eligible to receive Tier 2 or Tier 3 services.

BHHs to which beneficiaries have chosen will receive communication from the State regarding a beneficiary's entry into the BHH. The BHH will notify other treatment providers (e.g. PCPs,

specialists acting as primary accountable providers such as OB/GYNs) about the goals for the beneficiary and the types of BHH services they are eligible for, as well as encourage their input in the creation of the Integrated Care Plan, development of two way communication regarding the patient and participation in care coordination efforts.

216.000 Role of Providers of Tier 2 Services and Tier 3 Services 7-1-15

Certified Tier 2 services and Tier 3 services providers make available Tier 2 services and Tier 3 services to qualified beneficiaries based upon the Independent Assessment Report and Integrated Care Plan produced by the Behavioral Health Home. A Behavioral Health Agency is not required to offer all services in all tiers.

217.100 Primary Care Physician (PCP) Referral 7-1-15

Each beneficiary that receives only Tier 1 Outpatient Behavioral Health Services can receive a limited amount of Tier 1 services. Once those limits are reached, a Primary Care Physician (PCP) referral or PCMH approval will be necessary to continue treatment. This referral or approval must be retained in the beneficiary's medical record.

A Tier 1 beneficiary can receive three Tier 1 Outpatient Behavioral Health Services before a PCP/PCMH referral is necessary in the medical record.

The Primary Care Medical Home (PCMH) will be responsible for coordinating care with a beneficiary's PCP or physician for Tier 1 services. Medical responsibility for beneficiaries in Tier 1 shall be vested in a physician licensed in Arkansas, preferably one specializing in psychiatry.

Beneficiaries receiving Tier 2 Services/Tier 3 Services will have care coordinated by the BHH.

The PCP referral or PCMH authorization for Tier 1 services will serve as the prescription for those services.

Verbal referrals from PCP's or PCMH's are acceptable to Medicaid as long as they are documented in the beneficiary's chart as described in Section 171.410.

See Section I of this manual for an explanation of the process to obtain a PCP referral.

218.000 Treatment Plan 7-1-15

A Treatment Plan is required for beneficiaries who are assessed to be qualified for Tier 2 or Tier 3 services. The Treatment Plan should build upon the information contained in the Integrated Care Plan created by the Behavioral Health Home and the Independent Assessment report generated by the Independent Assessment. Beneficiaries in Tier 1 do NOT require a Treatment Plan and providers will not be reimbursed for completion of a Treatment Plan for Tier 1 beneficiaries. However, the provider must provide documentation of the medical necessity of Outpatient Behavioral Health Services for beneficiaries in Tier 1. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate.

A Treatment Plan for Tier 2 and Tier 3 beneficiaries is required. The Treatment Plan must reflect services to address areas of need identified in the Independent Assessment Report. The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives

B. A projected schedule for service delivery—this includes the expected frequency and duration of each type of planned therapeutic session or encounter

C. The type of personnel that will be furnishing the services

D. A projected schedule for completing reevaluations of the patient's condition and updating the master treatment plan

The Treatment Plan for a Tier 2 or Tier 3 beneficiary must be completed by a mental health professional within 14 calendar days of the individual' entering care (first billable service). Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional and must occur at least every 90 days.

218.100 Participation of Families and Children in the Development of the Treatment Plan for Children Under Age 21 7-1-15

The Treatment Plans should be based on the beneficiary's (or the parents' or guardians' if the beneficiary is under the age of 18) articulation of the problems or needs to be addressed in treatment and the areas of need identified in the Independent Assessment Report. Each problem or need must have one or more clearly defined behavioral goals or objectives that will allow the beneficiary, family members, provider and others to assess progress toward achievement of the goal or objective. For each goal or objective, the Treatment Plan must specify the treatment intervention(s) determined to be medically necessary to address the problem or need and to achieve the goal(s) or objective(s).

218.200 Periodic Treatment Plan Review 7-1-15

For all beneficiaries assessed to be qualified for and are receiving Tier 2 or Tier 3 services, the Treatment Plan must be periodically reviewed in order to determine the beneficiary's progress toward the treatment and care objectives, the need for the services provided and the enrolled beneficiary's continued participation. The reviews must be performed on a regular basis (at least every 90 calendar days), documented in detail in the enrolled beneficiary's record, kept on file and made available as requested for state and federal purposes. If provided more frequently, there must be documentation of significant acuity or change in clinical status requiring an update in the beneficiary's treatment plan.

The Independent Assessment must occur annually, which means that the Independent Assessment Report will be updated annually for all beneficiaries assessed to be qualified for and receiving Tier 2 or Tier 3 services.

218.300 Participation of Families and Children in the Periodic Review of the Treatment Plan for Children Under Age 21 7-1-15

The review of the Treatment Plan must reflect the beneficiary's, or in the case of a beneficiary under the age of 18, the parent's or guardian's, assessment of progress toward meeting treatment goals or objectives and their level of satisfaction with the treatment services provided. Problems, needs, goals, objectives, strengths and supports should be revised based on the progress made, barriers encountered, changes in clinical status and any other new information. The beneficiary, the parent or the guardian must be provided an opportunity to express comments about the Treatment Plan and a space on the treatment plan form to record these comments and their level of satisfaction with the services provided. The review of the Treatment Plan must also reflect addressing additional areas of need identified in the required annual update of the Independent Assessment Report.

219.100 Covered Outpatient Services 7-1-15

Covered outpatient services include a broad range of services to Medicaid-eligible beneficiaries. Tier 2 and Tier 3 beneficiaries shall be served with an array of treatment services outlined on their Treatment Plan in an amount and duration designed to meet their medical needs.

219.110 Daily Limit of Beneficiary Services 7-1-15

For services that are not reimbursed on a per diem or per encounter rate, Medicaid has established daily benefit limits for all services. Beneficiaries will be limited to a maximum of eight

hours per 24 hour day of Outpatient Behavioral Health Services. Beneficiaries will be eligible for an extension of the daily maximum amount of services based on a medical necessity review by the contracted utilization management entity (See Section 231.100 for details regarding extension of benefits).

219.200 Telemedicine (Interactive Electronic Transactions) Services 7-1-15

Outpatient Behavioral Health telemedicine services are interactive electronic transactions performed "face-to-face" in real time, via two-way electronic video and audio data exchange.

Reimbursement for telemedicine services is only available when, at a minimum, the Arkansas Telehealth Network (ATN) recommended audio video standards for real-time, two-way interactive audiovisual transmissions are met. Those standards are:

A. Minimum bandwidth of fractional T1 (728 kilobytes)

B. Screen size of no less than 20 inch diagonal

C. Transmitted picture frame rate capable of 30 frames per second at 384Kbps and the transmitted picture frame rate is suitable for the intended application

D. All applicable equipment is UL and FCC Class A approved

Providers who provide telemedicine services for Medicaid-eligible beneficiaries **must be able to link or connect** to the Arkansas Telehealth Network to ensure HIPAA compliance. Sites providing reimbursable telemedicine services to Medicaid-eligible beneficiaries are required to demonstrate the ability to meet the ATN standards listed above. A site **must** be certified by ATN before telemedicine services can be conducted. ATN will conduct site visits at initial start-up to ensure that all standards are met and to certify each telemedicine site. ATN will view connectivity statistics in order to ensure that appropriate bandwidth is being utilized by sites and will conduct random site visits to ensure that providers continue to meet all recommended standards and guidelines.

The Arkansas licensed mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary who is located in a mental health clinic setting. There must be an employee of the clinic immediately available to the beneficiary when the beneficiary is receiving services provided via telemedicine. Refer to Section 256.200 for billing instructions.

The performing provider of telemedicine services practicing within the scope of their licensure MUST:

1. Possess a current license to practice in the state of Arkansas
2. Meet DMS telemedicine qualifications
3. Be located in Arkansas or the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas)

Only a psychiatrist is allowed to perform services via telemedicine from the six bordering states. To provide services via telemedicine in the six bordering states, the psychiatrist must meet all of the above requirements in additional to the following:

1. Provider shall have an Arkansas medical license in good standing
2. Provider shall be employed/be on contract with an Arkansas behavioral health provider organization
3. The psychiatrist, in conjunction with his/her hiring agency, shall annually develop a business plan outlining the scope of services for the psychiatrist which shall include:
    a. Hours and location of work
    b. Availability during non-work hours
    c. A crisis plan for cross-coverage and crisis situations must be developed that addresses the mental health needs of the beneficiary to address medical coverage.

d. The psychiatrist calling from the remote site must have available the phone numbers to the local authorities for the host site, IE: police, first responders in event of emergency.

4. There must be an employee of the clinic immediately available to the beneficiary when the beneficiary is receiving services provided via telemedicine.

5. The beneficiary must receive an in-person, face to face, service at the mental health facility prior to the allowance of services via telemedicine.

All providers participating in the provision of services via telemedicine must meet all applicable standards and rules enacted by the appropriate licensing authority. The above does not supersede any of the licensing board's authority.

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries under age 21 and Medicaid-eligible beneficiaries age 21 and over:

A. Individual Behavioral Health Counseling – (CPT Code 90832, 90834, 90837)

B. Psychoeducation – (CPT Code H2027)

C. Psychiatric Assessment – (CPT Code 90792)

D. Pharmacologic Management – (CPT Code 99212, 99213, 99214)

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries age 21 and over:

A. Mental Health Diagnosis – (CPT Code 90791)

B. Interpretation of Diagnosis – (CPT Code 90887)

219.300 Services Available to Residents of Long Term Care Facilities 7-1-15

The following services may be provided to residents of nursing homes and ICF/MR facilities who are Medicaid eligible when the services are prescribed according to policy guidelines detailed in this manual:

A. Mental Health Diagnosis – (CPT Code 90791)

B. Psychological Evaluation – (CPT Code 96101)

C. Pharmacologic Management by Physician - (CPT Code 99212, 99213, 99214)

D. Interpretation of Diagnosis – (CPT Code 90887)

E. Individual Behavioral Health Counseling – (CPT Code 90832, 90834, 90837)

Services provided to nursing home and ICF/MR residents may be provided on- or off-site from the provider if allowable per the service definition. Some services may be provided in the long-term care (LTC) facility, if necessary.

220.000 Inpatient Hospital Services 7-1-15

"Inpatient" means a patient who has been admitted to a medical institution on recommendation of a licensed practitioner authorized to admit patients; and who is receiving room, board and professional services in the institution on a continuous 24-hour-a-day basis; or who is expected by the institution to receive room, board and professional services for 24 hours or longer.

220.100 Hospital Visits 7-1-15

Inpatient hospital visits are Medicaid covered only for board certified or board eligible psychiatrists when the visit is necessary to evaluate, treat, or stabilize a psychiatric diagnosis which is secondary to the actual hospital admission. Each attending physician is limited to billing one day of care for an inpatient hospital Medicaid covered day, regardless of the number of

hospital visits made by the physician. Tier 2 Services/Tier 3 Services are not allowed to be billed for a beneficiary in an inpatient setting.

A "Medicaid covered day" is defined as a day for which the patient is Medicaid eligible, the patient's inpatient benefit limit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure and the claim is filed on time. (See Section III of this manual for information regarding "Timely Filing.")

220.200 Inpatient Hospital Services Benefit Limit 7-1-15

There is no inpatient benefit limit for Medicaid-eligible individuals under age 21. The benefit limit for general and rehabilitative hospital inpatient services is 24 paid inpatient days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries aged 21 and older. Extension of this benefit is not available.

221.000 Medicaid Utilization Management Program (MUMP) 7-1-15

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, both in state and out of state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Lengths-of-stay determinations are made by the Quality Improvement Organization (QIO), Arkansas Foundation for Medical Care, Inc., (AFMC) under contract to the Arkansas Medicaid Program.

221.100 MUMP Applicability 7-1-15

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see subpart B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by AFMC.

B. When a patient is transferred from one hospital to another, the stay in the receiving hospital must be certified from the first day.

221.110 MUMP Exemptions 7-1-15

A. Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under age one (1), are subject to this policy. Medicaid beneficiaries under age one (1) at the time of admission are exempt from the MUMP policy for dates of service before their first birthday.

B. MUMP policy does not apply to inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures.

221.200 MUMP Procedures 7-1-15

MUMP procedures are detailed in the following sections of this manual:

A. Direct (non-transfer) admissions – Section 221.210

B. Transfer admissions – Section 221.220

C. Certifications of inpatient stays involving retroactive eligibility – Section 221.230

D. Inpatients with third party or Medicare coverage – Section 221.240

E. Reconsideration reviews of denied extensions – Section 221.250

221.210 Direct Admissions 7-1-15

A. When the attending physician determines the patient should not be discharged by the fifth day of hospitalization, a hospital medical staff member may contact AFMC and request an extension of inpatient days. **View or print AFMC contact information.** The following information is required:

1. Patient name and address (including ZIP code)
2. Patient birth date
3. Patient Medicaid number
4. Admission date
5. Hospital name
6. Hospital Medicaid provider number
7. Attending physician Medicaid provider number
8. Principal diagnosis and other diagnosis influencing this stay
9. Surgical procedures performed or planned
10. The number of days being requested for continued inpatient stay
11. All available medical information justifying or supporting the necessity of continued stay in the hospital

B. Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital–refer to Section 221.220).

1. Providers initiating their request after the fourth day must accept the financial liability should the stay not meet necessary medical criteria for inpatient services.
2. When the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.
3. If the fifth day of admission falls on a Saturday, Sunday or holiday, it is recommended that the hospital provider call for an extension prior to the fifth day, if the physician has recommended a continued stay.

C. When a Medicaid beneficiary reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification for the additional days.

D. AFMC utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

E. AFMC assigns an authorization number to an approved extension request and sends written notification to the hospital.

F. Additional extensions may be requested as needed.

G. **The certification process under the MUMP is separate from prior authorization requirements.** Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

H. **Claims submitted without calling for an extension request will result in automatic denials of any days billed beyond the fourth day. There will be no exceptions granted except for claims reflecting third party liability.**

221.220 Transfer Admissions 7-1-15

If a patient is transferred from one hospital to another, the receiving facility must contact AFMC within 24 hours of admitting the patient to certify the inpatient stay. If admission falls on a weekend or holiday, the provider may contact AFMC on the first working day following the weekend or holiday.

221.230 Retroactive Eligibility 7-1-15

A. If eligibility is determined while the patient is still an inpatient, the hospital may call to request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge, the hospital may call AFMC for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than 30 days, the provider must submit the entire medical record to AFMC for review.

221.240 Third Party and Medicare Primary Claims 7-1-15

A. If a provider has not requested MUMP certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained as follows:

1. Send a copy of the third party payer's denial notice to AFMC, attention Pre-Certification Supervisor. **View or print AFMC contact information.**
2. Include a written request for post-certification.
3. Include complete provider contact information: full name and title, telephone number and extension.
4. An AFMC coordinator will call the provider contact for the certification information.

B. If a third party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

221.250 Request for Reconsideration 7-1-15

Reconsideration reviews of denied extensions may be expedited by faxing the medical record to AFMC. AFMC will advise the hospital of its decision by the next working day. **View or print AFMC contact information.**

221.260 Post-Payment Review 7-1-15

A post payment review of a random sample is conducted on all admissions, including inpatient stays of four days or less, to ensure that medical necessity for the services is substantiated.

222.000 Approved Service Locations 7-1-15

Outpatient behavioral health services are covered by Medicaid only in the outpatient setting, except for inpatient hospital visits by board-certified psychiatrists.

The services and procedure codes available for billing are listed in Section 250.000 of this manual.

223.000 Exclusions 7-1-15

Services not covered under the Outpatient Behavioral Health Program include, but are not limited to:

A. Room and board residential costs;

B. Educational services;

C. Telephone contacts with patient;

D. Transportation services, including time spent transporting a beneficiary for services **(reimbursement for other Outpatient Behavioral Health services is not allowed for the period of time the Medicaid beneficiary is in transport)**;

E. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes;

F. Services which are found not to be medically necessary and

G. Services provided to nursing home and ICF/MR residents other than those specified in Section 252.150.

224.000 Physician's Role 7-1-15

Certified Behavioral Health Agencies are required to have relationships with a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services. A physician will supervise and coordinate all psychiatric and medical functions as indicated in treatment plans. Medical responsibility shall be vested in a physician licensed in Arkansas, preferably one specializing in psychiatry. If medical responsibility is not vested in a psychiatrist, then psychiatric consultation must be available. Medical supervision responsibility shall include, but is not limited to, the following:

A. Beneficiaries receiving Tier 1 services must have a PCP referral or PCMH approval to receive Tier 1 services after three visits (See Section 217.100). Medical responsibility will be vested in a physician licensed in Arkansas who signs the PCP referral or PCMH approval. If medical responsibility is not vested in a psychiatrist, then psychiatric consultation must be available.

B. Beneficiaries receiving Tier 2 or Tier 3 services will receive those services in a Behavioral Health Agency, which will be required to employ a Medical Director. A physician must review and approve the beneficiary's Treatment Plan, including any subsequent revisions. Medical responsibility will be vested in a physician licensed in Arkansas who signs the Treatment Plan. If medical responsibility is not vested in a psychiatrist, then psychiatric consultation must be available.

C. Approval of all updated or revised treatment plans must be documented by the physician's dated signature on the revised document. The new 90-day period begins on the date the revised treatment plan is completed.

224.100 Psychiatric Assessment 7-1-15

The Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for Tier 1 beneficiaries to receive services. This service is required for beneficiaries in Tier 2 and Tier 3. This service can be provided to new patients and existing patients with differing requirements for each. This face-to-face psycho diagnostic assessment must be conducted by one of the following:

1. an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18)
2. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)

The PMHNP-BC must meet all of the following requirements:

1. Licensed by the Arkansas State Board of Nursing
2. Practicing with licensure through the American Nurses Credentialing Center
3. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC must be discussed with the supervising psychiatrist within 45 days of the beneficiary entering care. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat.

4. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act

Practicing within a PMHNP-BC's experience and competency level

A Psychiatric Assessment for a new patient must include:

A. An interview with the beneficiary, which covers the areas outlined below. The initial Psychiatric Assessment may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

1. The beneficiary's understanding of the factors leading to the referral
2. The presenting problem (including symptoms and functional impairments)
3. Relevant life circumstances and psychological factors
4. History of problems
5. Treatment history
6. Response to prior treatment interventions
7. Medical history (and examination as indicated)

B. The Psychiatric Assessment must include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete diagnosis

C. For beneficiaries under the age of 18, the Psychiatric Assessment must also include an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the reason for referral
2. Clarify the nature of the current symptoms and functional impairments
3. To obtain a detailed medical, family and developmental history

A Psychiatric Assessment for an existing client must include:

D. An interview with the beneficiary, which covers the areas outlined below. The Psychiatric Assessment for existing clients may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

1. Psychiatric assessment (including current symptoms and functional impairments)
2. Medications and responses
3. Response to current treatment interventions
4. Medical history (and examination, as indicated)

E. The Psychiatric Assessment must also include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete DSM diagnosis

F. For beneficiaries under the age of 18, the continuing care Psychiatric Assessment must include an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the nature of the current symptoms and functional impairments
2. Obtain a detailed, updated medical, family and developmental history

The Psychiatric Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the Treatment Plan (Treatment Plan is required for Tier 2 and Tier 3 beneficiaries and all problems or needs to be addressed on the Treatment Plan. The Psychiatric

Assessment for existing patients must be performed, at a minimum, every 12 months. Only one (1) Psychiatric Assessment is allowed per State Fiscal Year.

225.000 Diagnosis and Clinical Impression 7-1-15

Diagnosis and clinical impression is required in the terminology of ICD.

226.000 Documentation/Record Keeping Requirements

226.100 Documentation 7-1-15

All Outpatient Behavioral Health Services providers must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

A. Must be individualized to the beneficiary and specific to the services provided, duplicated notes are not allowed.

B. The date and actual time the services were provided.

C. Original signature, name and credentials of the person, who authorized the services.

D. Original signature, name and credentials of the person, who provided the services, if different from authorizing professional.

E. The setting in which the services were provided. For all settings other than the provider's enrolled sites, the name and physical address of the place of service must be included.

F. The relationship of the services to the treatment regimen described in the Treatment Plan.

G. Updates describing the patient's progress and

H. For services that require contact with anyone other than the beneficiary, evidence of conformance with HIPAA regulations, including presence in documentation of Specific Authorizations, is required.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in Section 211.200.

All documentation must be available to representatives of the Division of Medical Services or Office of Medicaid Inspector General at the time of an audit. All documentation must be available at the provider's place of business. A provider will have 30 (thirty) days to submit additional documentation in response to a request from DMS or OMIG. Additional documentation will not be accepted after this 30 day period.

227.001 Prescription for Outpatient Behavioral Health Services 7-1-15

Each beneficiary that receives only Tier 1 Outpatient Behavioral Health Services can receive a limited amount of Tier 1 services without a Primary Care Physician (PCP) referral or Patient-Centered Medical Home (PCMH) approval. Once those limits are reached, a PCP referral or PCMH approval will be necessary which will serve as the prescription for Outpatient Behavioral Health Services. Please see Section 217.100 for limits. Medicaid will not cover any service outside of the established limits without a current prescription signed by a psychiatrist or physician.

Tier 2 and Tier 3 beneficiaries must have a signed prescription for services by a psychiatrist or physician. Medicaid will not cover any Tier 2 or Tier 3 service without a current prescription signed by a psychiatrist or physician. The signed Treatment Plan will serve as the prescription for beneficiaries that are eligible for Tier 2 and Tier 3 services.

Prescriptions shall be based on consideration of an evaluation of the enrolled beneficiary, the Independent Assessment Report, Integrated Care Plan and Treatment Plan. The prescription of the services and subsequent renewals must be documented in the beneficiary's record.

228.000 Provider Reviews 7-1-15

The Utilization Review Section of the Arkansas Division of Medical Services has the responsibility for assuring quality medical care for its beneficiaries, along with protecting the integrity of both state and federal funds supporting the Medical Assistance Program.

228.100 Record Reviews 7-1-15

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with ValueOptions® to perform on-site inspections of care (IOC) and retrospective reviews of outpatient mental health services provided by Outpatient Behavioral Health Services providers. **View or print ValueOptions contact information.** The reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

228.110 On-Site Inspections of Care (IOC)

228.111 Purpose of the Review 7-1-15

The on-site inspections of care of Outpatient Behavioral Health Services providers are intended to:

A. Promote Outpatient Behavioral Health services being provided in compliance with federal and state laws, rules and professionally recognized standards of care

B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care

C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified

D. Provide accountability that corrective action plans are implemented

E. Determine the effectiveness of implemented corrective action plans

The review tool, process and procedures are available on the contractor's website at http://arkansas.valueoptions.com/provider/prv_forms.htm. Any amendments to the review tool will be adopted under the Arkansas Administrative Procedures Act.

228.112 Provider Notification of IOC 7-1-15

The provider will be notified no more than 48 hours before the scheduled arrival of the inspection team. It is the responsibility of the provider to provide a reasonably comfortable place for the team to work. When possible, this location will provide reasonable access to the patient care areas and the medical records.

228.113 Information Available Upon Arrival of the IOC Team 7-1-15

The provider shall make the following available upon the IOC Team's arrival at the site:

A. Medical records of Arkansas Medicaid beneficiaries who are identified by the reviewer

B. One or more knowledgeable administrative staff member(s) to assist the team

C. The opportunity to assess direct patient care in a manner least disruptive to the actual provision of care

D. Staff personnel records, complete with hire dates, dates of credentialing and copies of current licenses, credentials, criminal background checks and similar or related records

E. Written policies, procedures and quality assurance committee minutes;

F. Clinical Administration, Clinical Services, Quality Assurance, Quality improvement, Utilization Review and Credentialing

G. Program descriptions, manuals, schedules, staffing plans and evaluation studies

H. If identified as necessary and as requested, additional documents required by a provider's individual licensing board, child maltreatment checks and adult maltreatment checks

228.114 Cases Chosen for Review 7-1-15

The contractor will review twenty (20) randomly selected cases during the IOC review. If a provider has fewer than 20 open cases, all cases shall be reviewed.

The review period shall be specified in the provider notification letter. The list of cases to be reviewed shall be given to the provider upon arrival or chosen by the IOC Team from a list for the provider site. The components of the records required for review include:

1. All required assessments, including SED/SMI Certifications where applicable
2. Master treatment plan and periodic reviews of master treatment plan
3. Progress notes, including physician notes
4. Physician orders and lab results
5. Copies of records. The reviewer shall retain a copy of any record reviewed.

228.115 Program Activity Observation 7-1-15

The reviewer will observe at least one program activity.

228.116 Beneficiary/Family Interviews 7-1-15

The provider is required to arrange interviews of Medicaid beneficiaries and family members as requested by the IOC team, preferably with the beneficiaries whose records are selected for review. If a beneficiary whose records are chosen for review is not available, then the interviews shall be conducted with a beneficiary on-site whose records are not scheduled for review. Beneficiaries and family members may be interviewed on-site, by telephone conference or both.

228.117 Exit Conference 7-1-15

The Inspection of Care Team will conduct an exit conference summarizing their findings and recommendations. Providers are free to involve staff in the exit conference.

228.118 Written Reports and Follow-Up Procedures 7-1-15

The contractor shall provide a written report of the IOC team's findings to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days from the last day of on-site inspection. The written report shall clearly identify any area of deficiency and required submission of a corrective action plan.

The contractor shall provide a notification of either acceptance or requirement of directed correction to the provider, DMS Behavioral Health Unit and Arkansas Office of Medicaid Inspector General within 14 calendar days of receiving a proposed corrective action plan and shall monitor corrective actions to ensure the plan is implemented and results in compliance.

All IOC reviews are subject to policy regarding Administrative Remedies and Sanctions (Section 150.000), Administrative Reconsideration and Appeals (Section 160.000) and Provider Due Process (Section 190.000). DMS will not voluntarily publish the results of the IOC review until the provider has exhausted all administrative remedies. Administrative remedies are exhausted if the provider does not seek a review or appeal within the time period permitted by law or rule.

228.120 DMS/DBHS Work Group Reports and Recommendations 7-1-15

The DMS/DBHS Work Group (comprised of representatives from the Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General, the Division of Behavioral Health Services, the Office of Quality Assurance, the utilization review agency, as well as other units or divisions as required) will meet monthly to discuss IOC reports. When warranted by IOC results, the DMS/DBHS Work Group shall recommend to the DHS Review Team one or more actions in Section 228.322. Recommendations shall be in writing and shall include supporting documentation.

If a deficiency related to safety or potential risk to the beneficiary or others is found, then the utilization review agency shall immediately report this to the DMS Director (or the Director's designee).

228.121 Corrective Action Plans 7-1-15

The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC. The provider must submit the Corrective Action Plan to the contracted utilization review agency within 30 calendar days of the date of the written report. The contractor shall review the Corrective Action Plan and forward it, with recommendations, to the DMS Behavioral Health Unit, the Arkansas Office of Medicaid Inspector General and Division of Behavioral Health Services.

After acceptance of the Corrective Action Plan, the utilization review agency will monitor the implementation and effectiveness of the Corrective Action Plan via on-site review. DMS, its contractor(s) or both may conduct a desk review of beneficiary records. The desk review will be site-specific and not by organization. If it is determined that the provider has failed to meet the conditions of participation, DMS will determine if sanctions are warranted.

228.122 Actions 7-1-15

Actions that may be taken following an inspection of care review include, but are not limited to:

A. Decertification of any beneficiary determined to not meet medical necessity criteria for outpatient mental health services

B. Decertification of any provider determined to be noncompliant with the Division of Behavioral Health Services provider certification rules

C. On-site monitoring by the utilization review agency to verify the implementation and effectiveness of corrective actions

D. The contractor may recommend, and DMS may require, follow-up inspections of care and/or desk reviews. Follow-up inspections may review the issues addressed by the Corrective Action Plans or may be a complete re-inspection of care, at the sole discretion of the Division of Medical Services

E. Review and revision of the Corrective Action Plan

F. Review by the Arkansas Office of Medicaid Inspector General

G. Formulation of an emergency transition plan for beneficiaries including those in custody of DCFS and DYS

H. Suspension of provider referrals

I. Placement in high priority monitoring

J. Mandatory monthly staff training by the utilization review agency

K. Provider requirement for one of the following staff members to attend a DMS/DBHS monthly work group meeting: Clinical Director/Designee (at least a master's level mental health professional) or Executive Officer

L. Recoupment for services that are not medically necessary or that fail to meet professionally recognized standards for health care

M. Any sanction identified in Section 152.000

228.130 Retrospective Reviews 7-1-15

The Division of Medical Services (DMS) of the Arkansas Department of Human Services has contracted with a Quality Improvement Organization (QIO) or QIO-like organization to perform retrospective (post payment) reviews of outpatient mental health services provided by Outpatient Behavioral Health providers. **View or print ValueOptions contact information.**

The reviews will be conducted by licensed mental health professionals who will examine the medical record for compliance with federal and state laws and regulations.

228.131 Purpose of the Review 7-1-15

The purpose of the review is to:

A. Ensure that services are delivered in accordance with the Treatment plan and conform to generally accepted professional standards.

B. Evaluate the medical necessity of services provided to Medicaid beneficiaries.

C. Evaluate the clinical documentation to determine if it is sufficient to support the services billed during the requested period of authorized services.

D. Safeguard the Arkansas Medicaid program against unnecessary or inappropriate use of services and excess payments in compliance with 42 CFR § 456.3(a).

228.132 Review Sample and the Record Request 7-1-15

On a calendar quarterly basis, the contractor will select a statistically valid random sample from an electronic data set of all Outpatient Behavioral Health beneficiaries whose dates of service occurred during the three-month selection period. If a beneficiary was selected in any of the three calendar quarters prior to the current selection period, then they will be excluded from the sample and an alternate beneficiary will be substituted. The utilization review process will be conducted in accordance with 42 CFR § 456.23.

A written request for medical record copies will be mailed to each provider who provided services to the beneficiaries selected for the random sample along with instructions for submitting the medical record. The request will include the beneficiary's name, date of birth, Medicaid identification number and dates of service. The request will also include a list of the medical record components that must be submitted for review. The time limit for a provider to request reconsideration of an adverse action/decision stated in § 1 of the Medicaid Manual shall be the time limit to furnish requested records. If the requested information is not received by the deadline, a medical necessity denial will be issued.

All medical records must be submitted to the contractor via fax, mail or ProviderConnect. **View or print ValueOptions contact information.** When faxing or mailing records, send them to the attention of "Retrospective Review Process." Records will not be accepted via email.

228.133 Review Process 7-1-15

The record will be reviewed using a review tool based upon the promulgated Medicaid Outpatient Behavioral Health Services manual. The review tool is designed to facilitate review of regulatory compliance, incomplete documentation and medical necessity. All reviewers must have a professional license in nursing or therapy (LCSW, LMSW, LPE, LPC, RN, etc.). The reviewer will screen the record to determine whether complete information was submitted for review. If it is determined that all requested information was submitted, then the reviewer will review the documentation in more detail to determine whether it meets medical necessity criteria based upon the reviewer's professional judgment.

If a reviewer cannot determine that the services were medically necessary, then the record will be given to a psychiatrist for review. If the psychiatrist denies some or all of the services, then a denial letter will be sent to the provider and the beneficiary. Each denial letter contains a

rationale for the denial that is record specific and each party is provided information about requesting reconsideration review or a fair hearing.

The reviewer will also compare the paid claims data to the progress notes submitted for review. When documentation submitted does not support the billed services, the reviewer will deny the services which are not supported by documentation. If the reviewer sees a deficiency during a retrospective review, then the provider will be informed that it has the opportunity to submit information that supports the paid claim. If the information submitted does not support the paid claim, the reviewer will send a denial letter to the provider and the beneficiary. Each denial letter contains a rationale for the denial that is record-specific and each party is provided information about requesting reconsideration review or a fair hearing.

Each retrospective review, and any adverse action resulting from a retrospective review, shall comply with the Medicaid Fairness Act. DMS will ensure that its contractor(s) is/are furnished a copy of the Act.

229.000 Medicaid Beneficiary Appeal Process 7-1-15

When an adverse decision is received, the beneficiary may request a fair hearing of the denial decision.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty days of the date on the letter explaining the denial of services.

229.100 Electronic Signatures 7-1-15

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code 25-31-103.

230.000 PRIOR AUTHORIZATION (PA) AND EXTENSION OF BENEFITS

231.000 Introduction to Extension of Benefits 7-1-15

The Division of Medical Services contracts with ValueOptions to complete the prior authorization and extension of benefit processes.

231.100 Prior Authorization 7-1-15

Prior Authorization is required for certain Outpatient Behavioral Health Services provided to Medicaid-eligible individuals.

Prior Authorization requests must be sent to ValueOptions for beneficiaries under the age of 21 and for beneficiaries age 21 and over for services that require a Prior Authorization. **View or print ValueOptions contact information.** Information related to clinical management guidelines and authorization request processes is available at **www.valueoptions.com**.

Procedure codes requiring prior authorization:

National Codes	Required Modifier	Service Title

National Codes	Required Modifier	Service Title
90832	UK	Individual Behavioral Health Counseling – Age 3
90834	UK	Individual Behavioral Health Counseling – Age 3
90837	UK	Individual Behavioral Health Counseling – Age 3
90847	UK	Marital/Family Behavioral Health Counseling with Beneficiary Present – Dyadic Treatment
H2027	UK	Psychoeducation – Dyadic Treatment
H0015	--	Intensive Outpatient Substance Abuse Treatment
H0019	HQ	Therapeutic Communities – Level 1
H0019	HQ, HK	Therapeutic Communities – Level 2

231.200 Extension of Benefits 7-1-15

Extension of benefits is required for all services when the maximum benefit for the service is exhausted. Yearly service benefits are based on the state fiscal year running from July 1 to June 30. Extension of Benefits is also required whenever a beneficiary exceeds eight hours of outpatient services in one 24-hour day, with the exception of any service that is paid on a per diem basis.

Extension of benefit requests must be sent to ValueOptions for beneficiaries. **View or print ValueOptions contact information.** Information related to clinical management guidelines and authorization request processes is available at **www.valueoptions.com**.

240.000 REIMBURSEMENT 10-4-09

240.100 Reimbursement 7-1-15

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Outpatient Behavioral Health Services must be billed on a per unit basis, as reflected in a daily total, per beneficiary, per service.

One (1) unit =	8 - 24 minutes
Two (2) units =	25 - 39 minutes
Three (3) units =	40 - 49 minutes

Four (4) units =	50 - 60 minutes

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per Outpatient Behavioral Health service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Outpatient Behavioral Health service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

One (1) unit =	8 - 24 minutes
Two (2) units =	25 - 39 minutes
Three (3) units =	40 - 49 minutes
Four (4) units =	50 - 60 minutes

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

NOTE: For services provided by a Qualified Behavioral Health Provider (QBHP), the accumulated time for the Outpatient Behavioral Health service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provide Behavioral Assistance (CPT Code 2019). The first QBHP spends a total of 10 minutes. Later in the day, another QBHP provides Behavioral Assistance (CPT Code 2019) to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance (CPT Code 2019) was provided, which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

Encounter is defined as a direct provider/practitioner vested with the responsibility for and treating the beneficiary. The interaction (face-to-face including telemedicine technology) between the beneficiary and practitioner who is has primary responsibility for diagnosing, evaluating, and treating the beneficiary at a given contact. An encounter may also be provided to one or more family members outside of the presence of a beneficiary if allowable by service definition and the service provided directly pertains to the beneficiary's Mental Health and/or Substance Abuse condition. Encounters are not activities incidental to an encounter for a provider visit. The direct provider/practitioner must be certified and practicing within their scope of licensure to provide the specified reimbursable service.

B. Inpatient Services

The length of time and number of units that may be billed for inpatient hospital visits are determined by the description of the service in *Current Procedural Terminology (CPT).*

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://www.medicaid.state.ar.us** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

242.000 Rate Appeal Process 7-1-15

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

250.000 BILLING PROCEDURES

251.000 Introduction to Billing 7-1-15

Outpatient Behavioral Health Services providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary. **View a CMS-1500 sample form.**

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures

252.100 Procedure Codes for Types of Covered Services 7-1-15

Covered Behavioral Health Services are outpatient services. Specific Behavioral Health Services are available to inpatient hospital patients (as outlined in Sections 240.000 and 220.100), through telemedicine, and to nursing home and ICF/MR residents. Outpatient Behavioral Health Services are billed on a per unit basis as listed. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service.

252.110 Tier 1 Services 7-1-15

252.111 Individual Behavioral Health Counseling 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832 90834 90837 90832, U7 - Telemedicine 90834, U7 – Telemedicine 90837, U7 – Telemedicine 90832, HF – Substance Abuse 90834, HF – Substance Abuse 90837, HF – Substance Abuse 90832, UK – Under Age 4 90834, UK – Under Age 4 90837, UK – Under Age 4	90832: psychotherapy, 30 min 90834: psychotherapy, 45 min 90837: psychotherapy, 60 min

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in DSM-IV or subsequent revisions. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face to face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	90832: 30 minutes 90834: 45 minutes 90837: 60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 90832: 1 90834: 1 90837: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12 units between all 3 codes

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS

Children, Youth, and Adults	A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual Counseling / Psychotherapy Code on the same date of service for the same beneficiary. There are 12 total individual counseling visits allowed per year regardless of code billed for Tier 1 beneficiaries.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	1
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency) • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72

252.112 Group Behavioral Health Counseling 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90853 90853, HF – Substance Abuse	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with master treatment plan • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e.: 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities,	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. There are 12 total Group Behavioral Health Counseling visits allowed per year for Tier 1 beneficiaries.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral	03, 11, 49, 50, 53, 57, 71, 72	

Health Services ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	

252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90847 90847, HF – Substance Abuse 90847, UK – Dyadic Treatment *	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. – ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized and is only available for beneficiaries in Tier 1. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Child-Parent Psychotherapy (CPP) and Parent Child Interaction**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

Therapy (PCIT).		
NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient Present / Home and Community Marital / Family Psychotherapy with (or without) Patient Present encounter per day. There are 12 total Marital/Family Behavioral Health Counseling with Beneficiary Present visits allowed per year for Tier 1 beneficiaries. **The following codes cannot be billed on the Same Date of Service:** 90849 - Multi-Family Behavioral Health Counseling	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

• Independently Licensed Clinicians - Master's / Doctoral
• Non-independently Licensed Clinicians – Master's / Doctoral
• Advanced Practice Nurse
• Physician
• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services
  ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians
  ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)
• Providers of dyadic services must be trained and certified in specific evidence based practices to be		

reimbursed for those services ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.114 Marital/Family Behavioral Health Counseling without Beneficiary Present 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
90846 90846, HF – Substance Abuse	Family psychotherapy (without the patient present)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Marital/Family Behavioral Health Counseling without Beneficiary Present is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated	
NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	

Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Beneficiary Present / Home and Community Marital / Family Psychotherapy with (or without) Beneficiary Present encounter per day. **The following codes cannot be billed on the Same Date of Service:** 90849 - Multi-Family Behavioral Health Counseling
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	1
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	03, 11, 49, 50, 53, 57, 71, 72

252.115 Psychoeducation 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027 H2027, U7 – Telemedicine H2027, UK – Dyadic Treatment *	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. – ***Dyadic treatment is available for**	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes

parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.	current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 90847, - Home and Community Marital/Family Psychotherapy with Beneficiary Present 90846 - Marital/Family Behavioral Health Counseling without Beneficiary Present 90846, - Home and Community Marital/Family Psychotherapy without Beneficiary Present	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults and Children)	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be	03, 11, 49, 50, 53, 57, 71, 72	

trained and certified by the Division of Behavioral Health Services ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency) • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.116 Multi-Family Behavioral Health Counseling 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849 90849, HF – Substance Abuse	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	There are 12 total Multi-Family Behavioral Health Counseling visits allowed per year. **The following codes cannot be billed on the Same Date of Service:** 90887 – Interpretation of Diagnosis 90887, - Interpretation of Diagnosis, Telemedicine	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	03, 11, 49, 50, 53, 57, 71, 72	

252.117 Mental Health Diagnosis 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791 90791, U7 – Telemedicine 90791, UK – Dyadic Treatment *	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation

revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service can be provided via telemedicine to beneficiaries only ages 21 and above. – ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:** – **Presenting symptoms and behaviors;** – **Developmental and medical history;** – **Family psychosocial and medical history;** – **Family functioning, cultural and communication patterns, and current environmental conditions and stressors;** – **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** – **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment

	H0001 – Substance Abuse Assessment
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults Only)	1
ELIGIBLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency) • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 11, 49, 50, 53, 57, 71, 72

252.118 Interpretation of Diagnosis 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887 90887, U7 – Telemedicine 90887, UK – Dyadic Treatment	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide

by the beneficiary and provided with cultural competence.	with the master treatment plan or proposed master treatment plan or recommendations. • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This service can be provided via telemedicine to beneficiaries only ages 21 and above. – ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1 for a Tier 1 beneficiary 2 for a Tier 2 / Tier 3 beneficiary
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** H2027 – Psychoeducation H2027, - Home and Community Psychoeducation 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults Only)	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse	03, 11, 49, 50, 53, 57, 71, 72	

• Physician
• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services
  ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians
  ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.119 Substance Abuse Assessment 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0001	Alcohol and / or drug assessment	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified. The assessment should include a multi-panel test to assist in the beneficiary's self-report of his/her alcohol and drug use and to develop an accurate diagnosis, and referral.	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
The assessment process results in the assignment of a diagnostic impression, beneficiary recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary, initial plan (provisional) of care and referral to a service appropriate to effectively treat the condition(s) identified.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

If indicated, the assessment process must refer the beneficiary for a psychiatric consultation		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment 90887 – Interpretation of Diagnosis 90791 – Mental Health Diagnosis	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

• Independently Licensed Clinicians - Master's / Doctoral
• Non-independently Licensed Clinicians – Master's / Doctoral
• Advanced Practice Nurse
• Physician
• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services
  ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians
  ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)
	03, 11, 49, 50, 53, 57, 71, 72	

252.120 Psychological Evaluation 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, eg. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation,	• Date of Service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral

emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions; • history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility.	• Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Psychologist (LP) • Licensed Psychological Examiner (LPE) • Licensed Psychological Examiner – Independent (LPEI)	03, 11, 49, 50, 53, 57, 71, 72	

252.121 Pharmacologic Management 7-1-15

	PROCEDURE CODE DESCRIPTION
99212, UB - Physician 99213, UB – Physician 99214, UB - Physician 99212, U7, UB – Physician, Telemedicine 99213 U7, UB – Physician, Telemedicine 99214 U7, UB – Physician, Telemedicine 99212, SA - APN 99213, SA - APN 99214, SA – APN 99212, U7, SA – APN, Telemedicine 99213, U7, SA – APN, Telemedicine 99214, U7, SA – APN, Telemedicine	99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication	• Date of Service • Start and stop times of actual encounter with beneficiary

prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.	• Place of service (When 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Applies only to medications prescribed to address targeted symptoms as identified in the treatment plan.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults and Children)	1

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72

252.122 Psychiatric Assessment 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792 90792, U7 - Telemedicine	Psychiatric diagnostic evaluation with medical services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for Tier 1 beneficiaries to receive services.	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history

	and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults Telemedicine (Adults and Children)	**The following codes cannot be billed on the Same Date of Service:** H0001 – Substance Abuse Assessment 90791 – Mental Health Diagnosis	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	1	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

252.123 Intensive Outpatient Substance Abuse Treatment 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based upon an individualized treatment plan), including assessment, counseling, crisis intervention, activity therapies or education
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Intensive Outpatient services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal oriented interactions with the individual or in group/family settings. This community based service allows the individual to apply skills in “real world” environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The services follow a defined set of policies and procedures or clinical protocols. The service also provides a coordinated set of individualized treatment services to persons who are able to function	• Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Rationale for service and service used that must coincide with master treatment plan • Beneficiary's response to service that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan,

in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide 9 or more hours per week of skilled treatment, 3 – 5 times per week in groups of no fewer than three and no more than 12 clients. This service is available to beneficiaries in all Tiers.	diagnosis, or medication(s) • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
A prior authorization is required for this service.	Per diem	Beneficiary can receive no more than 19 hours of Intensive Outpatient Substance Abuse Treatment Services per week YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 24
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider cannot bill any other services on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Intensive Outpatient Substance Abuse Treatment must be provided in a facility that is certified by the Division of Behavioral Health Services as an Intensive Outpatient Substance Abuse Treatment provider.	11, 14, ,22, 49, 50, 53, 57, 71	

253.000 Tier 2 Services 7-1-15

253.001 Treatment Plan 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220	S0220: Medical conference by a physician with interdisciplinary team of health professionals representative of community agencies to coordinate activities of patient care (patient is present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives

prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity /date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed when the beneficiary enters care and must be reviewed every ninety (90) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	Must be reviewed every ninety (90) calendar days	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Substance Abuse Licensed Clinicians – Master's (must be employed by Behavioral Health Agency) • Non-independently Licensed Clinicians – Master's / Doctoral • Substance Abuse Certified Clinicians – Master's (must be employed by Behavioral Health Agency) • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

253.002 Home and Community Individual Psychotherapy 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832, HK 90834, HK 9083, HK	90832: psychotherapy, 30 minutes 90834: psychotherapy, 45 minutes 90837: psychotherapy, 60 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Home and Community Individual Psychotherapy is a face-to-face service provided on an individual basis.	• Date of Service • Start and stop times of face to face encounter with

<table>
<tr><td>Services consist of structured sessions that work toward achieving mutually defined goals as documented in the Master Treatment Plan. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to conditions listed in DSM-IV or subsequent revisions, and maintain, or improve level of functioning, and/or prevent deterioration.</td><td colspan="2">beneficiary
• Place of service
• Diagnosis and pertinent interval history
• Brief mental status and observations
• Rationale and description of the treatment used that must coincide with objectives on the master treatment plan
• Beneficiary's response to treatment that includes current progress or regression and prognosis
• Any revisions indicated for the master treatment plan, diagnosis, or medication(s)
• Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.</td><td>90832: 30 minutes

90834: 45 minutes

90837: 60 minutes</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:
90832: 1
90834: 1
90837: 1
YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested):

26</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual Counseling / Psychotherapy Code on the same date of service for the same beneficiary. There are 26 total individual counseling / psychotherapy visits allowed per year regardless of code billed for Tier 2 / Tier 3 beneficiaries.</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">2</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>• Independently Licensed Clinicians - Master's / Doctoral

• Non-independently Licensed Clinicians – Master's / Doctoral

• Advanced Practice Nurse

• Physician

• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services

o Independently Licensed Clinicians - Substance Abuse Certified Clinicians</td><td colspan="2">03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72</td></tr>
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○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	

253.003 Home and Community Family Psychoeducation 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2027, HK	Psychoeducational service; per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Home and Community Family Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illnesses and substance abuse, and teaches problem-solving, communication, and coping skills to support recovery. Home and Community Family Psychoeducation can be implemented in two formats: multifamily group and single family group. Due to the group format, beneficiaries and their families are also able to benefit from peer support and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 90847, - Home and Community Marital/Family Psychotherapy with Beneficiary Present	

	90846 - Marital/Family Behavioral Health Counseling without Beneficiary Present 90846, - Home and Community Marital/Family Psychotherapy without Beneficiary Present
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	2
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72

253.004 Home and Community Marital/Family Psychotherapy with Beneficiary Present 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90847, HK	Family psychotherapy (conjoint psychotherapy)(with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Home and Community Marital/Family Psychotherapy with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans

<table>
<tr><td></td><td colspan="2">• Staff signature/credentials/date of signature
• HIPAA compliant release of Information, completed, signed and dated</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.</td><td>Encounter</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 30 (combined with Home and Community Marital/Family Psychotherapy without Beneficiary Present)</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient Present / Home and Community Marital / Family Psychotherapy with (or without) Patient Present encounter per day. There are 30 total Marital/Family Behavioral Health Counseling with Beneficiary Present visits allowed per year for Tier 2 / Tier 3 beneficiaries.

The following codes cannot be billed on the Same Date of Service:

90849 - Multi-Family Behavioral Health Counseling</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">2</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>• Independently Licensed Clinicians - Master's / Doctoral

• Non-independently Licensed Clinicians – Master's / Doctoral

• Advanced Practice Nurse

• Physician

• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services

o Independently Licensed Clinicians - Substance Abuse Certified Clinicians

o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)</td><td colspan="2">03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72</td></tr>
</table>

253.005 Home and Community Based Marital/Family Psychotherapy without Beneficiary Present 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
90846, HK	Family psychotherapy (without the patient present)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Home and Community Marital/Family Psychotherapy without Beneficiary present is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated	
NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 30 (combined with Home and Community Marital/Family Psychotherapy with Patient Present)
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient Present / Home and Community Marital / Family Psychotherapy with (or without) Patient Present encounter per day. There are 30 total Marital/Family Behavioral Health Counseling with Beneficiary Present visits allowed per year for Tier 2 / Tier 3 beneficiaries. **The following codes cannot be billed on the Same**	

	Date of Service: 90849 - Multi-Family Behavioral Health Counseling
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	2
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

• Independently Licensed Clinicians - Master's / Doctoral
• Non-independently Licensed Clinicians – Master's / Doctoral
• Advanced Practice Nurse
• Physician
• Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services
  ○ Independently Licensed Clinicians - Substance Abuse Certified Clinicians
  ○ Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)
	03, 11, 49, 50, 53, 57, 71, 72

253.006 Community Group Psychotherapy 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
90853, HK	Group psychotherapy (other than of a multiple-family group)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Community Group Psychotherapy is a face-to-face intervention provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate symptoms of a mental illness. A practitioner uses the emotional interactions of the group's members to assist them in implementing each beneficiary's Master Treatment Plan. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group psychotherapy must coincide with master treatment plan • Beneficiary's response to the group psychotherapy that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e.: 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities,		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 104 for a Tier 2 beneficiary 208 for a Tier 3 beneficiary
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. There are 104 total Group Behavioral Health Counseling visits allowed per year for Tier 2 beneficiaries and 208 total Group Behavioral Health Counseling visits allowed per year for Tier 3 beneficiaries.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's / Doctoral • Non-independently Licensed Clinicians – Master's / Doctoral • Advanced Practice Nurse • Physician • Providers of substance abuse services must be trained and certified by the Division of Behavioral Health Services o Independently Licensed Clinicians - Substance Abuse Certified Clinicians o Non-independently Licensed Clinicians - Substance Abuse Certified Clinicians (must be employed by Behavioral Health Agency)	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

253.007 Partial Hospitalization 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0035	Mental health partial hospitalization treatment, less than 24 hours
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program	• Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations

provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.	• Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals • Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services • All services provided must be clearly documented din the medical record • Staff signature/credentials

NOTES	UNIT	BENEFIT LIMITS
Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual. The medical record must indicate the services provided during Partial Hospitalization.	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 40

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider may not bill for any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	2
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11 , 22, 49, 52, 53

EXAMPLE ACTIVITIES

Care provided to a client who is not ill enough to need admission to facility but who has need of more intensive care in the therapeutic setting than can be provided in the community. This service shall include at a minimum intake, individual and group therapy, and psychosocial education. Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.

253.008 Behavioral Assistance 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2019, HK, HN – QBHP Bachelors or RN H2019, HK, HM – QBHP Non-Degreed	H2019: Therapeutic behavioral services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating treatment • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the

	beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	A provider can only bill 292 units of H2019, HK, HN or H2019, HK, HM combined per SFY.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2019 with HK, HN modifiers)	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	
EXAMPLE ACTIVITIES		
Behavioral Assistance is designed to support youth and their families in meeting behavioral goals identified goals in various community settings. The service is targeted for children and adolescents who are at risk of out-of-home placement or who have returned home from residential placement and need flexible wrap-around supports to ensure safety and support community integration. The service is tied to specific treatment goals and is developed in coordination with the youth and their family. Behavioral Assistance aid the family in implementing safety plans and behavioral management plans when youth are at risk for offending behaviors, aggressions, and oppositional defiance. Staff provides supports to youth and their families during periods when behaviors have been typically problematic - such as during morning preparation for school, at bedtime, after school, or other times when there is evidence of a pattern of an escalation of problem difficult behaviors. The service may be provided in school classrooms or on school busses for short periods of time to help a youth's transition from hospitals or residential settings but is not intended as a permanent solution to problem difficult behaviors at school.		

253.009 Aftercare Recovery Services 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2017, HK, HN – QBHP Bachelors or RN H2017, HK, HM – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the

	supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults	**The following codes cannot be billed on the Same Date of Service:** H2015 – Individual Recovery Support, Bachelors H2015 – Individual Recovery Support, Non-Degreed H2015 – Group Recovery Support, Bachelors H2015 – Group Recovery Support, Non-Degreed	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2019 with HK, HN modifiers)	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99	

253.010 Peer Support 7-1-15

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
H0038 H0038, U8 - Telephonic	Self-help/peer services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of

		benefits can be requested): 120
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Youth and Adults	Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Certified Peer Support Specialist • Certified Youth Support Specialist	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	
EXAMPLE ACTIVITIES		
Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.		

253.011 Family Support Partners 7-1-15

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
H2014 H2014, U8 - Telephonic	Skills training and development, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral health care needs. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach, and model appropriate child-rearing strategies, techniques, and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the family in securing community resources and developing natural supports.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how services used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	Provider can only bill for 120 units (combined between H2014 and H2014, U8) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Certified Family Support Partner	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	
EXAMPLE ACTIVITIES		
Family Support Partners serve as a resource for families with a child, youth, or adolescent receiving behavioral health services. Family Support Partners help families identify natural supports and community resources, provide		

leadership and guidance for support groups, and work with families on: individual and family advocacy, social support for assigned families, educational support, systems advocacy, lagging skills development, problem solving technics and self-help skills.

253.012 Individual Pharmacologic Counseling by RN 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0034, TD	Medication training and support	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
A specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers, related to their psychopharmological treatment. Individual Pharmaceutical counseling involves providing medication information orally or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	Encounter	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	Provider can only bill for 12 units (combined between H0034, TD and H0034, HQ, TD) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Registered Nurse	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	

253.013 Group Pharmacologic Counseling by RN 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0034, HQ, TD	Medication training and support
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A specific, time limited intervention provided to a group of beneficiaries and/or caregivers by a nurse, related to their psychopharmological treatment. Group Pharmaceutical counseling involves providing medication information orally or in written form to the beneficiary and/or caregivers. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
	Encounter	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	Provider can only bill for 12 units (combined between H0034, TD and H0034, HQ, TD) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	2	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Registered Nurse	03, 04, 11, 12, 13, 14, 15, 16 , 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	

254.000 Tier 3 Services 7-1-15

254.001 Individual Life Skills Development 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2017, HA, HN – QBHP Bachelors or RN H2017, HA, HM – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Individual Life Skills Development is a service that provides support and training for transitional aged youth (ages 14 to 21) on a one-on-one basis. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how services address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Youth (Age 16-20)	A provider cannot bill any other H2017 code (regardless of service) on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	3	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2017 with HA, HN modifiers)	03, 04, 11, 12, 14, 16, 22 , 49, 50, 53, 57, 71, 72
EXAMPLE ACTIVITIES	
General skills training, family and relationship supports and skill development, parenting support, anger management, basic life skill training, self-help, drug and alcohol management, lifestyle programs, filling out job applications, developing positive interview skills, assisting with passing permit test and obtaining a license and/or learning the mass transit transportation system.	

254.002 Group Life Skills Development 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2017, HQ, HN – QBHP Bachelors or RN H2017, HQ, HM – QBHP Non-Degreed	Psychosocial rehabilitation services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Group Life Skills Development is a service that provides support and training for transitional aged youth (ages 14 to 21) in a group setting of up to six (6) beneficiaries with one staff member or up to ten (10) beneficiaries with two staff members. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. This service is designed to assist youth in acquiring the skills needed to support an independent lifestyle and promote a strong sense of self-worth. In addition, it aims to assist youth in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness, and nutrition.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how services address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Youth (Age 16-20)	A provider cannot bill any other H2017 code (regardless of service) on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	3	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2017 with HA, HN modifiers)	03, 04, 11, 14, 16, 22 , 49, 50, 53, 57, 71, 72	
EXAMPLE ACTIVITIES		

General skills training, family and relationship supports and skill development, parenting support, parenting classes, anger management, basic life skill training, self-help, drug and alcohol management, lifestyle programs,. filling out job applications, developing positive interview skills, assisting with passing permit test and obtaining a driver's license and/or learning the mass transit transportation system . Referrals to Vocational Rehabilitation Services, supportive housing or supportive employment.

254.003 Child and Youth Support Services 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H2015, HA, HN – QBHP Bachelors or RN H2015, HA, HM – QBHP Non-Degreed	Comprehensive community support services	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Child and Youth Support Services are clinical, time-limited services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools. Services might include an In-Home Case Aide. An In-Home Case Aide is an intensive, time-limited therapy for youth in the beneficiary's home or, in rare instances, a community based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	**QUARTERLY** MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any other H2015 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	3	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HA, HN modifiers)	03, 04, 12, 16	

254.004 Individual Recovery Support 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2015, HK, HN – QBHP Bachelors or RN H2015, HK, HM – QBHP Non-degreed	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Recovery Support services are delivered face-to-face and designed to train and assist participants in acquiring, retaining, and improving the ADLs, self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings. The services must seek to restore or develop the abilities to perform these tasks and foster independence rather than simply performing the task for the beneficiary. Documentation must identify the habilitation and rehabilitation goals addressed and demonstrate the benefit to the beneficiary. Services are beneficiary focused and may include: – **Supported Employment** is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. – **Supported Housing** is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chem free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. – **Life Skills Development** services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

management, budgeting, following a medication regimen, and interacting with the criminal justice system.		
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	**QUARTERLY** MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any other H2015 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	3	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HK, HN modifiers)	04, 11, 12 , 16, 49, 53, 57, 99	

254.005 Group Recovery Support 7-1-15

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
H2015, HQ, HN – QBHP Bachelors or RN H2015, HQ, HM – QBHP Non-Degreed	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Recovery Support services are delivered by one provider to a group (2 to 8) and are designed to assist participants in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings. The services must seek to restore the abilities to perform these tasks and foster independence rather than simply performing the task for the beneficiary. Documentation must identify the habilitation goals addressed and demonstrate the benefit to the beneficiary. Services are beneficiary focused and may include: – **Supported Employment** is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

from mainstream society. – **Supported Housing** is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chem free living; provides opportunities for involvement in community life; and facilitates the individuals recovery journey**.** – **Life Skills Development** services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration. Services delivered are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping, laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.		
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 624
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults	A provider cannot bill any other H2015 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	3	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse (Use Code H2015 with HQ, HN modifiers)	04, 11, 12 , 16, 49, 53, 57, 99	

254.006 Therapeutic Communities 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0019, HQ – Level 1 H0019, HQ, HK – Level 2	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service • Document how interventions used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Therapeutic Communities Level will be determined by the following: • Functionality based upon the InterRAI Score • Outpatient Treatment History and Response • Medication • Compliance with Medication/Treatment **A prior authorization is required for this service.**	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): H0019, HQ – 180 H0019, HQ, HK - 185
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults	A provider cannot bill any other services on the same date of service.	
	PROGRAM SERVICE CATEGORY	
	Tier 3 - Residential Service	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider	14, 21, 51, 55	

254.004 Planned Respite 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0045	Respite care services, per diem
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Planned Respite provides temporary direct care and supervision for a beneficiary in the beneficiary's community that is not facility-based. The primary	

purpose is relief to the principal caregiver of an individual with a behavioral health need. Respite services de-escalate stressful situations and provide a therapeutic outlet. Services should be scheduled and reflected in the wraparound or treatment plan. Planned Respite can only be provided by a provider who is certified by the Division of Behavioral Health Services as a Planned Respite provider.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Children and Youth	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
	PROGRAM SERVICE CATEGORY	
	Tier 3	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Planned Respite must be provided in a facility that is certified by the Division of Behavioral Health Services as a Planned Respite provider.	04 , 12, 16, 49, 53, 57, 99	

255.000 Crisis Services 7-1-15

255.001 Acute Psychiatric Hospitalization 7-1-15

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
N/A	N/A	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Psychiatric Hospitalization is indicated when a lesser restrictive environment is not adequate to ensure the safety of the beneficiary and others.	Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21	
NOTES	**EXAMPLE ACTIVITIES**	
Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21		
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Children, Youth, and Adults	Per Diem	Refer to Hospital/Critical Access Hospital/End-Stage Renal Disease Manual for adults and Inpatient Psychiatric Services for Under Age 21 Manual for Under Age 21
	PROGRAM SERVICE CATEGORY	
	Crisis Service	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	N/A
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
N/A	21, 51

255.003 Acute Crisis Units 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
H0018	Behavioral Health; short-term residential	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	Per Diem	- 96 hours or less per encounter - 1 encounter per month - 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
N/A	21, 51, 55, 56	

255.004 Substance Abuse Detoxification 7-1-15

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H0014	Alcohol and/or drug services; detoxification
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing	•

treatment.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	- 1 encounter per month - 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
N/A	21, 55	

256.110 Inpatient Hospital Procedure Codes 7-1-15

RSPMI providers may be reimbursed for the following visits made to patients of acute care inpatient hospitals by board-certified or board eligible psychiatrists.

99218	99219	99220	99221	99222
99223	99231	99232	99233	99234
99235	99236	99238	99251	99252
99253	99254	99255		

256.200 Telemedicine Services Billing Information 7-1-15

The Arkansas licensed mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary who is located in a mental health clinic setting. See Section 252.410 for billing instructions.

The following services may be provided via telemedicine by an Arkansas licensed mental health professional to Medicaid-eligible beneficiaries under age 21 and Medicaid-eligible beneficiaries age 21 and over; bill with POS 99:

National Code	Required Modifier	Service Title
90832 90834 90837	U7 U7 U7	Individual Behavioral Health Counseling - Telemedicine
H2027	U7	Psychoeducation - Telemedicine
90792	U7	Psychiatric Assessment
99212 99213 99214	U7, UB U7, UB U7, UB	Pharmacologic Management – Physician, Telemedicine
99212 99213 99214	U7, SA U7, SA U7, SA	Pharmacologic Management – APN, Telemedicine

The following services may be provided via telemedicine by a mental health professional to Medicaid-eligible beneficiaries age 21 and over; bill with POS 99:

National Code	Required Modifier	Service Title
90791	U7	Mental Health Diagnosis
90887	U7	Interpretation of Diagnosis

256.300 Services Available to Residents of Long Term Care Facilities Billing Information

7-1-15

The following Outpatient Behavioral Health Services procedure codes are payable to an Outpatient Behavioral Health provider for services provided to residents of nursing homes who are Medicaid eligible when prescribed according to policy guidelines detailed in this manual:

National Code	Required Modifier	Procedure Code Description
90791		Mental Health Diagnosis
S0220		Treatment Plan (payable only for beneficiaries in Tier 2 and Tier 3)
90887		Interpretation of Diagnosis
90832 90834 90837		Individual Behavioral Health Counseling

Services provided to nursing home residents may be provided on or off site from the Outpatient Behavioral Health Services provider. The services may be provided in the long-term care (LTC) facility, if necessary.

256.400 Place of Service Codes

7-1-15

Electronic and paper claims now require the same national place of service codes.

Place of Service	POS Codes
Outpatient Hospital	22
Office (RSPMI Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/MR	54

Place of Service	POS Codes
Other Locations	99
Outpatient Behavioral Health Services Clinic (Telemedicine)	99
Emergency Services in ER	23

256.500 Billing Instructions - Paper Only 7-1-15

HP Enterprise Services offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for Outpatient Behavioral Health services, use the CMS-1500 form The numbered items correspond to numbered fields on the claim form. **View a CMS-1500 sample form.**

When completing the CMS-1500, accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to HP Enterprise Services. **View or print HP Enterprise Services Claims contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

256.510 Completion of the CMS-1500 Claim Form 7-1-15

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.

Field Name and Number		Instructions for Completion
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	PATIENT STATUS	Not required.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. OTHER INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a-d are required. Name of the insured individual's employer and/or school.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	10d. RESERVED FOR LOCAL USE	Not used.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.

Field Name and Number	Instructions for Completion
b. EMPLOYER'S NAME OR SCHOOL NAME	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral or PCMH sign-off is required for Outpatient Behavioral Health Services for all beneficiaries after 3 Tier 1 visits. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not applicable to Outpatient Behavioral Health Services.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 252.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No”. EMG identifies if the services was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure codes from Sections 252.100 through 252.150.
MODIFIER	Use applicable modifier.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

Field Name and Number	Instructions for Completion
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. .
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	Enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. Service Site Medicaid ID number	Enter the 9-digit Arkansas Medicaid provider ID number of the service site.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.

Field Name and Number	Instructions for Completion
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

257.000 Special Billing Procedures

257.100 Outpatient Behavioral Health Services Billing Instructions 7-1-15

Outpatient Behavioral Health Services Medicaid providers who provide covered telemedicine services must comply with the definitions and coding requirements outlined below when billing Medicaid.

1. Telemedicine transactions involve interaction between an Arkansas licensed mental health professional and a beneficiary who are in different locations. The beneficiary must be in a mental health clinic setting.

   Telemedicine Site Definitions

   Local Site: The local site is the patient's location.

   Remote Site: The remote site is the location of the Arkansas licensed mental health professional performing a telemedicine service for the beneficiary at the local site.

2. The place of service code is determined by the patient's location (the local site). The remote site is *never* the place of service.

   Telemedicine Place of Service Codes

   Paper Claims Code = H, Electronic Claims Code = 99 RSPMI Clinic (Telemedicine)

257.200 Substance Abuse Covered Diagnosis Codes 7-1-15

Certain Outpatient Behavioral Health Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Those services are listed below:

National Code	Required Modifier	Procedure Code Description
90832	HF	Individual Behavioral Health Counseling – Substance Abuse
90834	HF	
90837	HF	
90853	HF	Group Behavioral Health Counseling – Substance Abuse
90847	HF	Marital/Family Behavioral Health Counseling with Beneficiary Present – Substance Abuse
90846	HF	Marital/Family Behavioral Health Counseling without Beneficiary Present – Substance Abuse
90849	HF	Multi-Family Behavioral Health Counseling – Substance Abuse
90791		Mental Health Diagnosis
90791	U7	
90887		Interpretation of Diagnosis
90887	U7	

National Code	Required Modifier	Procedure Code Description
H0001		Substance Abuse Assessment
H0015		Intensive Outpatient Substance Abuse Treatment

For an Outpatient Behavioral Health Services provider delivering an Outpatient Behavioral Health Services service, the primary diagnosis is the DSM mental health disorder that is the primary focus of the mental health treatment service being delivered.

For persons being treated by an Outpatient Behavioral Health Services provider for a mental health disorder who also have a co-occurring substance use disorder(s), this (these) substance use disorder(s) is (are) listed as a secondary diagnosis. Outpatient Behavioral Health Services providers that are certified to provider Substance Abuse services may also provide substance abuse treatment services to their behavioral health clients. In the provision of Outpatient Behavioral Health Services mental health services, the substance use disorder is appropriately focused on with the client in terms of its impact on and relationship to the primary mental health disorder. All Outpatient Behavioral Health Services must be focused toward and address the behavioral health needs of the client.