EXHIBIT K

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES (1897)

SUBJECT: Rehabilitative Services for Persons with Mental Illness (RSPMI) 6-11

DESCRIPTION: Effective January 15, 2012, the Rehabilitative Services for Persons with Mental Illness (RSPMI) manual will be updated to add a modifier to the current procedure code for a Psychiatric Diagnostic Assessment to indicate a Psychiatric Diagnostic Assessment – Continuing Care. This update requires that a Psychiatric Diagnostic Assessment – Continuing Care be performed every 12 months during an episode of care. This update also changes the name of the current Psychiatric Diagnostic Assessment to Psychiatric Diagnostic Assessment – Initial. The Psychiatric Diagnostic Assessment – Initial can only be provided to a beneficiary at the start of an episode of care.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on October 25, 2011. Public comments were as follows:

Joel Landreneau, Trinity Behavioral Health Care System, Inc.

Comment: The first concern is the requirement for a face-to-face interview with the parent or guardian, without making allowance for the possibility that such a contact may be difficult or impossible to achieve, at least on a face-to-face basis. This could be mitigated by allowing for contact that is other than face-to-face, least for the purpose of the annual renewal of the PDA, once it is established through documentation that attempts for a face-to-face contact were attempted, and the reasons why other contact had to be used.

A major reason why this is a concern is the question of what the consequences of a citation would be if any one of the mandatory elements of what constitutes a completed PDA would have for our ability to continue to provide services to the client. For example, if a client record is compliant in every other respect besides this issue, will the deficiency in the PDA lead to a conclusion that because there is not a valid PDA, there is therefore no medical necessity established for the client, leading to a disallowance of all billing from the date of the expiration of the prior PDA forward?

Response: This language was taken directly from the currently promulgated Section 224.201 (Psychiatric Diagnostic Assessment) in the Rehabilitative Services for Persons with Mental Illness (RSPMI) manual. The process and requirements for a face-to-face interview with the parent or guardian for the Psychiatric Diagnostic Assessment – Continuing Care will be the exact same as how it currently is with the Psychiatric Diagnostic Assessment. This will also be the same for the Psychiatric Diagnostic Assessment – Initial. This regulation does not change anything in the requirements in Section 224.201, C and this same language is used in Section 224.202, C.

The continuing care PDA was created for the determination of the patient status as a new or established patient. Professional services are those face to face services rendered by a physician and reported by specific codes. The new definition will not change the current practices of physicians.

Comment: This concern also has bearing on the second issue I see in the proposed revision. In the last paragraph of Section 224.202(C), PDA's "must contain sufficient information to substantiate all diagnoses . . . functional impairments . . . and all problems and needs to be addressed in the treatment plan." What constitutes "sufficient detailed information to substantiate" is inherently a judgment call, and thus, subjective. Besides the question of interpretation of what will be sufficient, there is also the matter of the mandatory nature of "all."

This could be interpreted to require a new PDA any time there is a new or newly-discovered issue that would require an amendment to the treatment plan, because if the treatment plan is changed to add a new "problem," the previous PDA will not address it. Will this lead to a determination of no medical necessity if the services to address the new "problem" are not "substantiated" in the PDA? The treatment plan, approved by the physician, is the order for medical services. If the physician conducting the PDA overlooks including in the PDA an issue contained in the treatment plan simply by error, will treatment aimed at that missing issue be deemed not medically necessary? The proposal to require the inclusion of "all" diagnoses, impairments and needs in the PDA holds open the possibility that the purpose is to create a point of potential technical error that can be used to deny coverage, rather than a more generalized effort to ensure completeness of medical records.

Response: This language was taken directly from the currently promulgated Section 224.201 (Psychiatric Diagnostic Assessment). DMS expects providers to be able to substantiate any diagnosis specified in the Psychiatric Diagnostic Assessment (PDA) and treatment plan. Since the PDA requires that the provider must include "A complete multi-axial (5) diagnosis", they should have no problems with providing the documentation to substantiate the diagnosis specified.

If the beneficiaries' condition changes enough to warrant a new diagnosis/new problem discovered, extension of benefits are available for the PDA. The purpose of this regulation is not to create a point of potential technical error that can be used to deny coverage, but rather to remove barriers that providers have identified to conduct a yearly PDA and thus maintain completeness of medical records.

Donna Reed and Robert Gershon, Ozark Guidance

Comment: We greatly appreciate the opportunity to provider telemedicine services to Medicaid RSPMI recipients, aged 21 and over. This provision will allow providers to treat severely mentally ill patients, in remote and rural settings, with greater efficiency. We would urge the Division of Medical Services, to include SED U-21 Medicaid recipients in the provision of telemedicine services, comparable to what is currently available to beneficiaries, age 21 and older. Given the national shortage of children and adolescent psychiatrists, the increasing challenges providers are experiencing in recruiting and retaining Mental Health Professionals and with the largely rural population in our state, opportunities to provide telemedicine services to the U-21 population would offer a significant economic, logistical, and medical benefits to Medicaid recipients and providers alike.

Response: DMS is currently in the process of promulgating regulations which will allow telemedicine to be provided to beneficiaries under the age of 21 for procedure codes T1023 (Psychiatric Diagnostic Assessment) and 90862 (Pharmacologic Management by a Physician) based upon recommendations from the Arkansas Children's Behavioral Healthcare Commission.

Comment: We would respectfully request than an extension of benefits be considered, as part of an extended authorization, for Psychiatric Diagnostic Assessment – Continuing care for Medicaid recipients. Beneficiaries who are certified as SED/SMI during the first 45 days of service and who receive a Psychiatric Diagnostic Assessment, often require an additional Psychiatric Assessment, prior to the 12 month annual requirement. Changes in a patient's medical/psychiatric status, situational factors, acute stressors, or additional medical/clinical information disclosed in the case of treating a Medicaid beneficiary, may inexorably lead to the need for a PDA, prior to the 12 month annual requirement. In this circumstance, the ability of a provider to request authorization for an extension of benefits for a PDA, would assist providers and recipients to be served in a least restrictive, clinically effective and cost effective manner, therefore minimizing the need for an alternate placement or the need for hospitalization.

Response: The Psychiatric Diagnostic Assessment – Continuing Care will have the same extension of benefits requirements that other services currently have. If, as a provider, you feel it necessary to provide another Psychiatric Diagnostic Assessment prior to the 12 month annual requirement, extension of benefits is available for this service.

Summary of Changes Due to Public Comment Period

Rehabilitative Services for Persons with Mental Illness (RSPMI) 6-11 had to be changed to delete the telemedicine codes in Section 217.111 (Procedure Codes Not Requiring PCP Referral for Beneficiaries Under Age 21) as it was expected that RSPMI 2-11, which will add the option for telemedicine for procedure code T1023 for U21 beneficiaries, would be promulgated. RSPMI 2-11, which will add the option for telemedicine for this procedure code for U21 beneficiaries, has begun promulgation process and is expected to be effective March 1, 2012.

The proposed effective date is January 15, 2012.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs. Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

JCS 1-5-12

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Eugene I. Gessow
CONTACT PERSON Robert Nix
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8362 **FAX NO.** 682-2480 **E-MAIL** robert.nix@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Jeffrey Wood
PRESENTER E-MAIL jeffrey.wood@arkansas.gov

INSTRUCTIONS

A. **Please make copies of this form for future use.**
B. **Please answer each question completely using layman terms. You may use additional sheets, if necessary.**
C. **If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.**
D. **Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

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1. What is the short title of this rule?

   Rehabilitative Services for Persons with Mental Illness (RSPMI) 6-11

2. What is the subject of the proposed rule?

   Adding a modifier to the current Psychiatric Diagnostic Assessment to indicate a Psychiatric Diagnostic Assessment – Continuing Care.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ___ No __X__.
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes___ No__X__.

   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes____ No__

5. Is this a new rule? Yes___ No __X__ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No__X__ If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

   Is this an amendment to an existing rule? Yes__X__ No ___If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed rule is to add a modifier to the current procedure code for a Psychiatric Diagnostic Assessment to indicate a Psychiatric Diagnostic Assessment – Continuing Care.

   The proposed rule is necessary so providers are able to correctly bill for the required yearly Psychiatric Diagnostic Assessment for beneficiaries in care. This update will also simplify the required yearly update for providers so that services to beneficiaries can be continued.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

   https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ____ No __X__.
   If yes, please complete the following:
   Date:_____
   Time:_____
   Place:_____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    October 25, 2011

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    January 15, 2012

12. Do you expect this rule to be controversial? Yes_____ No __X__ If yes, please explain.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Randy Helms
TELEPHONE NO. 682-1857 **FAX NO.** 682-2480 **EMAIL:** randy.helms@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – RSPMI-6-11

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ____ No __X__.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes ____ No __X__.

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____
Other (Identify)_____	Other (Identify)_____
Total_____	Total_____

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

Current Fiscal Year	**Next Fiscal Year**
NONE	NONE

Summary for
Rehabilitative Services for Persons with Mental Illness-6-11

Effective January 15, 2012, the Rehabilitative Services for Persons with Mental Illness (RSPMI) manual will be updated to add a modifier to the current procedure code for a Psychiatric Diagnostic Assessment to indicate a Psychiatric Diagnostic Assessment - Continuing Care. This update requires that a Psychiatric Diagnostic Assessment – Continuing Care be performed every 12 months during an episode of care. This update also changes the name of the current Psychiatric Diagnostic Assessment to Psychiatric Diagnostic Assessment – Initial. The Psychiatric Diagnostic Assessment - Initial can only be provided to a beneficiary at the start of an episode of care.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE: **January 15, 2012**

PROPOSED

SUBJECT: **Provider Manual Update Transmittal RSPMI-6-11**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
217.111	11-1-10	217.111	1-15-12
224.100	07-1-08	224.100	1-15-12
224.200	07-1-08	224.200	1-15-12
224.201	05-1-08	224.201	1-15-12
—	—	224.202	1-15-12
231.100	07-1-10	231.100	1-15-12
252.110	10-5-09	252.110	1-15-12
252.140	10-5-09	252.140	1-15-12
252.430	10-4-09	252.430	1-15-12

Explanation of Updates

Section 217.111 is updated to include the following procedure codes and modifiers: T1023, HA, U1 for Psychiatric Diagnostic Assessment – Initial; T1023, U7 for Psychiatric Diagnostic Assessment – Initial (telemedicine); T1023, HA, U2 for Psychiatric Diagnostic Assessment – Continuing Care; and T1023, U7, U1 for Psychiatric Diagnostic Assessment – Continuing Care (telemedicine).

Sections 224.100 and 224.200 are updated to include requirements for initial and continuing care Psychiatric Diagnostic Assessments.

Section 224.201 is updated to include requirements for initial Psychiatric Diagnostic Assessments.

Section 224.202 is inserted to include requirements for continuing care Psychiatric Diagnostic Assessments.

Sections 231.100, 252.110, 252.140 and 252.430 are updated to include billing information for initial and continuing care Psychiatric Diagnostic Assessments.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

PROPOSED

Eugene I. Gessow, Director

Toc required

217.111 Procedure Codes Not Requiring PCP Referral for Beneficiaries Under Age 21 1-15-12

Services designated by the following procedure codes and modifiers **do not** require PCP referral:

A. 90801, HA, U1 – Mental Health Evaluation/Diagnosis
B. 90885, HA, U2 – Master Treatment Plan
C. 90887, HA, U2 – Interpretation of Diagnosis
D. H2011, HA – Crisis Intervention
E. T1023, HA, U1 – Psychiatric Diagnostic Assessment – Initial
F. T1023, U7 – Psychiatric Diagnostic Assessment – Initial (telemedicine)
G. T1023, HA, U2 – Psychiatric Diagnostic Assessment – Continuing Care
H. T1023, U7, U1 – Psychiatric Diagnostic Assessment – Continuing Care (telemedicine)

PROPOSED

224.100 Physician's Role for Adults Age 21 and Over 1-15-12

RSPMI providers are required to have a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services provided by the agency. 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. For RSPMI enrolled adults age 21 and over, medical supervision responsibility shall include, but is not limited to, the following:

A. For any beneficiary certified as being Seriously Mentally Ill (SMI), the physician will perform an initial Psychiatric Diagnostic Assessment during the earlier of 45 days of the beneficiary entering care or 45 days from the effective date of certification of serious mental illness. This initial evaluation is not required if the beneficiary discontinues services prior to calendar day 45. The SMI beneficiary must receive a continuing care Psychiatric Diagnostic Assessment within one year after the date of the initial Psychiatric Diagnostic Assessment and at least every year thereafter.

B. For beneficiaries not certified as having a Serious Mental Illness, the physician may determine through review of beneficiary records and consultation with the treatment staff that it is not medically necessary to directly see the enrolled beneficiary. By calendar day 45 after entering care, the physician must document in the beneficiary's record that it is not medically necessary to see the beneficiary. If the beneficiary continues to be in care for more than six months after program entry, the psychiatrist/physician must conduct an initial Psychiatric Diagnostic Assessment of the beneficiary by the end of six months and perform a continuing care Psychiatric Diagnostic Assessment at least every 12 months thereafter.

C. The physician will review and approve the enrolled beneficiary's RSPMI treatment plan and document approval in the enrolled beneficiary's record. If the treatment plan is revised prior to each 90 day interval, the physician must approve the changes within 14 calendar days, as indicated by a dated signature on the revised plan.

D. 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.

PROPOSED

224.200 Physician's Role for Children Under Age 21 1-15-12

RSPMI providers are required to have a board certified or board eligible psychiatrist who provides supervision and oversight for all medical and treatment services provided by the agency. 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 on a regular basis. For RSPMI enrolled children, under age 21, medical supervision responsibility shall include, but is not limited to, the following:

A. For any beneficiary under age 18, certified as being Seriously Emotionally Disturbed (SED) or individuals age 18 through age 20 certified as Seriously Mentally Ill (SMI), the physician will conduct an initial Psychiatric Diagnostic Assessment of the beneficiary the earlier of 45 days of the individual's entering care or 45 days from the effective date of certification of serious mental illness/serious emotional disturbance. This initial evaluation is not required if the beneficiary discontinues services prior to calendar day 45. The SMI/SED beneficiary must be evaluated again directly by the physician through the Psychiatric Diagnostic Assessment – Continuing Care within 12 months after the date of the initial examination and every 12 months after (at a minimum) during an episode of care.

B. For beneficiaries not certified as having a Serious Mental Illness or Serious Emotional Disturbance, the psychiatrist or physician may determine through review of beneficiary records and consultation with the treatment staff that it is not medically necessary to directly assess and interview the enrolled beneficiary. By calendar day 45 after entering care, the physician must document in the beneficiary's record that it is not medically necessary to provide the beneficiary a physician assessment. If the beneficiary continues to be in care for more than six months after program entry, the psychiatrist/physician must conduct an initial Psychiatric Diagnostic Assessment of the beneficiary by the end of six months and perform a continuing care Psychiatric Diagnostic Assessment at least every 12 months thereafter.

C. The physician will review and approve the enrolled beneficiary's RSPMI treatment plan and document the approval in the enrolled beneficiary's record. If the treatment plan is revised prior to each 90 day interval, the physician must approve the changes within 14 calendar days, as indicated by a dated signature on the revised plan.

D. 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.

224.201 Psychiatric Diagnostic Assessment – Initial 1-15-12

The purpose of this service is to determine the existence, type, nature, and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9. This face-to-face psychodiagnostic assessment must be conducted by an Arkansas licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). The initial Psychiatric Diagnostic Assessment must include:

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

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 and
7. Medical history (and examination as indicated).

PROPOSED

B. The initial Psychiatric Diagnostic Assessment must include:
   1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18) and
   2. A complete multi-axial (5) diagnosis.
C. For beneficiaries under the age of 18, the initial Psychiatric Diagnostic 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 and
   3. To obtain a detailed medical, family and developmental history.

The initial Psychiatric Diagnostic Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the assessment and treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The initial Psychiatric Diagnostic Assessment can only be provided at the start of an episode of care.

224.202 Psychiatric Diagnostic Assessment – Continuing Care **1-15-12**

The purpose of this service is to determine the continuing existence, type, nature and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9CM. This face-to-face psychodiagnostic reassessment must be conducted by an Arkansas licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). The continuing care Psychiatric Diagnostic Assessment must include:

A. An interview with the beneficiary, which covers the areas outlined below. The continuing care Psychiatric Diagnostic Assessment may build on information obtained through other assessments reviewed by the physician and verified through the physician's interview. The interview should obtain or verify:
   1. Psychiatric assessment (including current symptoms and functional impairments),
   2. Medications and responses,
   3. Response to current treatment interventions and
   4. Medical history (and examination, as indicated).
B. The continuing care Psychiatric Diagnostic Assessment must also include:
   1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18) and
   2. A complete multi-axial (5) diagnosis.
C. For beneficiaries under the age of 18, the continuing care Psychiatric Diagnostic 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:

PROPOSED

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

The continuing care Psychiatric Diagnostic Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the continuing care assessment and updated treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The continuing care Psychiatric Diagnostic Assessment must be performed every 12 months during an episode of care.

231.100 Prior Authorization and Extension of Benefits 1-15-12

Prior Authorization is required for certain services provided to Medicaid-eligible individuals. Extension of benefits is required for all other 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 crisis intervention, crisis stabilization intervention by a mental health professional, and crisis stabilization intervention by paraprofessional.

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

Prior authorization and extension requests must be sent to ValueOptions for beneficiaries age 21 and over. **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
90846 90846 90846	HA, U3, — U7 (telemedicine)	Marital/Family Therapy without patient present
90853 90853	HA, U1 —	Group Outpatient – Group Psychotherapy
90862	HA, HQ	Group Outpatient – Pharmacologic Management by Physician
H2012 H2012	HA UA	Therapeutic Day/Acute Day Treatment
90887 90887	HA U7 (telemedicine)	Collateral Intervention, MHP
90887	HA, UB	Collateral Intervention, MHPP

National Codes	Required Modifier	Service Title
H2015 H2015 H2015	HA, U5 U6 U7 (telemedicine)	Intervention, MHP
H2015 H2015	HA, U1 U2	Intervention, MHPP
H2017 H2017	HA, U1 —	Rehabilitative Day Service

Procedure codes requiring Extension of Benefits: PROPOSED

National Codes	Required Modifier	Service Title	Yearly Maximum
90801 90801	HA, U1 U7 (telemedicine)	Mental Health Evaluation/Diagnosis	16
96101	HA, UA	Psychological Evaluation	32
90885	HA, U2	Master Treatment Plan	8
90887 90887	HA, U2 U3, U7 (telemedicine)	Interpretation of Diagnosis	16
H0004 H0004 H0004	 HA U7 (telemedicine)	Individual Psychotherapy	48
90847 90847 90847	HA, U3 — U7 (telemedicine)	Marital/Family Therapy with patient present	48
H2011 H2011	HA U7 (telemedicine)	Crisis Intervention	72
T1023 T1023	HA, U1 U7 (telemedicine)	Psychiatric Diagnostic Assessment (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care)	1
T1023 T1023	HA, U2 U7, U1 (telemedicine)	Psychiatric Diagnostic Assessment – Continuing Care	1

National Codes	Required Modifier	Service Title	Yearly Maximum
99201	HA, UB	Physical Examination	12
99202	HA, UB		
99203	HA, UB		
99204	HA, UB		
99212	HA, UB		
99213	HA, UB		
99214	HA, UB		
AND			
99201	HA, SA		
99202	HA, SA		
99203	HA, SA		
99204	HA, SA		
99212	HA, SA		
99213	HA, SA		
99214	HA, SA		
90862	HA	Pharmacologic Management	24
90862	—		
90862	HA, UB		
90862	U7 (telemedicine)		
90885	HA	Periodic Review of Master treatment plan	10
90885	HA, U1		
36415	HA	Routine Venipuncture for Collection of Specimen	12
H2011	HA, U6	Crisis Stabilization, MHP	72
H2011	U2		
H2011	U2, U7 (telemedicine)		
H2011	HA, U5	Crisis Stabilization, MHPP	72
H2011	U1		

PROPOSED

252.110 **Outpatient Procedure Codes** 1-15-12

National Code	Required Modifier	Definition
92506	HA	***Diagnosis: Speech Evaluation*** 1 unit = 30 minutes Maximum units per day: 4 Maximum units per state fiscal year (SFY) = 4 units
90801	HA, U1	**SERVICE: Mental Health Evaluation/Diagnosis (Formerly known only as Diagnosis)** **DEFINITION:** The cultural, developmental, age and disability - relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic formulation for the purpose of developing a plan

National Code	Required Modifier	Definition
		of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8, **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • 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 five axes • Treatment recommendations • Staff signature/credentials/date of signature **NOTES and COMMENTS:** 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. Prior Authorization requests, master treatment plans, etc.).
90801	U7	**Mental Health Evaluation/Diagnosis:** Use the above definition and requirements. Additional information: Use code 90801 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
96101	HA, UA	**SERVICE:** Psychological Evaluation (Formerly Diagnosis –

National Code	Required Modifier	Definition
		Psychological Test/Evaluation and Diagnosis – Psychological Testing Battery) **DEFINITION:** A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 16 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 32 **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 • 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 • Axis Five DSM diagnostic impressions • Treatment recommendations and findings related to rationale for service and guided by the master treatment plan and test results • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Medical necessity for this service is met when the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions, when the history and symptomatology are not readily attributable to a particular psychiatric diagnosis and the 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, ***Or***

National Code	Required Modifier	Definition
		Medical necessity is met when the beneficiary has demonstrated a complexity of issues related to cognitive functioning or the impact of a disability on a condition or behavior and the service is necessary to develop treatment recommendations after the beneficiary has received various treatment services and modalities, has not progressed in treatment, and continues to be symptomatic. Medicaid WILL NOT reimburse evaluations or testing that is considered primarily educational. Such services are those used to identify specific learning disabilities and developmental disabilities in beneficiaries who have no presenting behavioral or psychiatric symptoms which meet the need for mental health treatment evaluation. This type of evaluation and testing is provided by local school systems under applicable state and federal laws and rules. Psychological Evaluation services that are ordered strictly as a result of court-ordered services are not covered unless medical necessity criteria are met. Psychological Evaluation services for employment, disability qualification, or legal/court related purposes are not reimbursable by Medicaid as they are not considered treatment of illness. A Psychological Evaluation report must be completed within fourteen (14) calendar days of the examination; documented; clearly identified as such; and signed/dated by the staff completing the evaluation. This service constitutes both face to face time administering tests to the beneficiary and time interpreting these test results and preparing the report.
T1023	HA, U1	**SERVICE: Psychiatric Diagnostic Assessment – Initial (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care)** **DEFINITION:** A direct face-to-face service contact occurring between the physician and the beneficiary for the purpose of evaluation. The initial Psychiatric Diagnostic Assessment includes a history, mental status and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for requirements.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as 1 per episode. **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS:** • Date of Service • Start and stop times • Place of service

PROPOSED

National Code	Required Modifier	Definition
		• Diagnosis (all 5 Axes) • Diagnostic Impression • Psychiatric (re)assessment • Functional (re)assessment • Discharge criteria • Physician's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** The initial Psychiatric Diagnostic Assessment can only be provided to a beneficiary at the start of an episode of care.
T1023	U7	**SERVICE: Psychiatric Diagnostic Assessment – Initial (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care):** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
T1023	HA, U2	**SERVICE: Psychiatric Diagnostic Assessment - Continuing Care** **DEFINITION:** A direct face-to-face service contact occurring between the physician and the beneficiary during an episode of care for the purpose of evaluation. The continuing care Psychiatric Diagnostic Assessment includes a Psychiatric assessment, mental status examination, functional assessment, medications, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for requirements.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as 1 per episode. **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over;U21; **DOCUMENTATION REQUIREMENTS:** • Date of Service • Start and stop times • Place of service • Diagnosis (all 5 Axes) • Psychiatric assessment • Functional assessment • Mental Status Examination

National Code	Required Modifier	Definition
		• Medications • Discharge criteria • Physician's signature indicating medical necessity/credentials/date of signature PROPOSED **NOTES and COMMENTS:** The continuing care Psychiatric Diagnostic Assessment must be performed, at a minimum, at least every 12 months during an episode of care.
T1023	U7, U1	**SERVICE: Psychiatric Diagnostic Assessment – Continuing Care:** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7, U1" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
90885	HA, U2	**SERVICE: Master Treatment Plan** **DEFINITION:** A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. 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 prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 8 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • 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

National Code	Required Modifier	Definition
		• Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • 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 and COMMENTS:** The service formerly coded as T1023 and titled "Assessment and Treatment Plan/Plan of Care" is now incorporated into this service. This service may be billed one (1) time upon entering care and once yearly thereafter. The master treatment plan 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 paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA	**SERVICE: Periodic Review of Master Treatment Plan** **DEFINITION:** The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 10 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's

National Code	Required Modifier	Definition
		Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): Completed by the primary MHP (If not, then must have a rationale for another MHP completing the documentation and only with input from the primary MHP) • Date of service • Start and stop times for review and revision of plan • Place of service • Diagnosis and pertinent interval history • Beneficiary's updated strengths and needs • Progress/Regression with regard to treatment goal(s) as documented in the master. • Progress/Regression of the measurable objectives as documented in the master treatment plan • Individualized rationale to support the medical necessity of continued services • Updated schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Modifications to 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(s) • Physician's signature indicating continued medical necessity/date of signature **NOTES and COMMENTS:** This service must be provided every ninety (90) days or more frequently if there is documentation of significant change in acuity or change in clinical status requiring an update/change in the beneficiary's master treatment plan. If progress is not documented, then modifications should be made in the master treatment plan or rationale why continuing to provide the same type and amount of services is expected to achieve progress/outcome. It is the responsibility of the primary mental health professional to insure that all paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA, U1	**Periodic Review of Master Treatment Plan**

National Code	Required Modifier	Definition
		Apply the above description. Additional information: Use code 90885 with modifier "U1" to claim for this service when provided by a non-physician.
90887	HA, U2	**SERVICE: Interpretation of Diagnosis** **DEFINITION:** A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention used that must coincide with the master treatment plan or proposed master treatment plan or recommendations. • Participant response and feedback • Any changes or revision to the master treatment plan, diagnosis, or medication(s) • Staff signature/credentials/date of signature(s) **NOTES AND COMMENTS:** 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.
90887	U3, U7	**Interpretation of Diagnosis** Use above definition and requirements Additional information: Use code 90887 with modifier "U3, U7" to claim for services provided via telemedicine only. Note:

PROPOSED

National Code	Required Modifier	Definition
		Telemedicine POS 99
H0004	HA	**SERVICE: Individual Psychotherapy** **DEFINITION**: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31) School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** U21, but not for beneficiaries under the age of 3 except in documented exceptional cases **REQUIRED DOCUMENTATION** (See Section 226.200 for additional requirements): • 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 intervention used that must coincide with the master • Beneficiary's response to intervention 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 and COMMENTS:** 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.

National Code	Required Modifier	Definition
H0004	—	**Individual Psychotherapy** Use above definition and requirements. Additional information: Use code H0004 with no modifier to claim for services provided to beneficiaries ages 21 and over.
H0004	U7	**Individual Psychotherapy** Use above definition and requirements. Additional information: Use code H0004 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90846	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is not present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **REQUIRES PRIOR AUTHORIZATION** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention 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.

National Code	Required Modifier	Definition
		• Spouse/Family response to intervention 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 • HIPPA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature **NOTES and COMMENTS:** 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.
90846	—	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above definition and requirements. Additional information: Use code 90846 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90846	U7	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above definition and requirements. Additional information: Use code 90846 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90847	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living

National Code	Required Modifier	Definition
		Facility (13); Group Home (14) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention 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 intervention 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 and COMMENTS:** 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. Additional information: Use code 90847 with modifiers "HA, U3" to claim for services provided to beneficiaries under age 21.
90847	—	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90847	U7	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with modifier "U7" to claim for services provided via telemedicine only. Telemedicine POS 99
92507	HA	**Individual Outpatient – Speech Therapy, Speech Language Pathologist**

National Code	Required Modifier	Definition
		Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92507	HA, UB	**Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92508	HA	**Group Outpatient – Speech Therapy, Speech Language Pathologist** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
92508	HA, UB	**Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
90853	HA, U1	**SERVICE: Group Outpatient – Group Psychotherapy** **DEFINITION:** Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness. The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); **AGE GROUP(S):** Ages 4 – 20; Under age 4 by prior authorized medically needy exception **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for

National Code	Required Modifier	Definition
		additional requirements): • 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 intervention and intervention used that must coincide with master treatment plan • Beneficiary's response to the group intervention 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 and COMMENTS:** 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,
90853	—	**Group Outpatient – Group Psychotherapy** Apply the above definition and requirements. Additional information: Use code 90853 with no modifier to claim for services provided to beneficiaries ages 21 and over.
H2012	HA	**SERVICE: Therapeutic Day/Acute Day Treatment** **DEFINITION:** Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization

National Code	Required Modifier	Definition
		and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services must include constant staff supervision of beneficiaries and physician oversight. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 32 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11) **STAFF to CLIENT RATIO:** 1:5 for ages 18 and over; 1:4 for U18 **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and interventions used that must coincide with the master treatment plan • Beneficiary's response to the intervention 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 • Staff signature/credentials **NOTES and COMMENTS:** Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.

National Code	Required Modifier	Definition
		See Section 219.110 for additional information.
H2012	UA	**Therapeutic Day/Acute Day Treatment** Apply the above definition and requirements. Additional Information: Use code H2012 with modifier "UA" to claim for services provided to beneficiaries ages 21 and over. See Section 219.110 for additional information.
H2011	HA	**SERVICE: Crisis Intervention** **DEFINITION:** Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service (If 99 is used, specific location and rationale for location must be included) • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for

National Code	Required Modifier	Definition
		further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U7	**Crisis Intervention** Apply the above definition and requirements. Additional information: Use code H2011 plus modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
Physician: 99201 99202 99203 99204 99212 99213 99214 PCNS & PANP: 99201 99202 99203 99204 99212 99213 99214	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA	**SERVICE: Physical Examination – Psychiatrist or Physician** **Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12 **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual encounter with beneficiary • Date of service • Place of service • Identifying information • Referral reason and rationale for examination • Presenting problem(s) • Health history • Physical examination • Laboratory and diagnostic procedures ordered • Health education/counseling • Identification of risk factors • Mental status/clinical observations and impressions • ICD-9 diagnoses

National Code	Required Modifier	Definition
		• DSM diagnostic impressions to include all five axes • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Treatment recommendations for findings, medications prescribed, and indicated informed consents Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be billed only by the RSPMI provider. The physician, Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner may not bill for an office visit, nursing home visit, or any other outpatient medical services procedure for the beneficiary for the same date of service. Pharmacologic Management may not be billed on the same date of service as Physical Examination, as pharmacologic management would be considered one component of the full physical examination (office visit).
90862	HA	**SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)** **Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication 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, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 24 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Nursing Facility (32); Skilled Nursing Facility (31); ICF/MR (54) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (If 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included)

National Code	Required Modifier	Definition
		• Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and intervention used that must coincide with the master treatment plan • Beneficiary's response to intervention 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 and COMMENTS:** Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan.
90862	—	**Pharmacologic Management by Physician** Apply the above definition and requirements. Additional information: Use code 90862 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90862	U7	**Pharmacologic Management by Physician** Apply the above definition and requirements. Additional information: Use code 90862 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90862	HA, UB	**Pharmacologic Management by Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** Apply the above definition and requirements.
T1502	—	**SERVICE: Medication Administration by a Licensed Nurse** **DEFINITION:** Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for

National Code	Required Modifier	Definition
		additional requirements): • Date of Service • Time of the specific procedure • Place of service • Physician's order must be included in medication log • Staff signature/credentials/date of signature **NOTES and COMMENTS:** Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan. Drugs and biologicals that can be self-administered shall not be in this group unless there is a documented reason the patient cannot self administer. Non-prescriptions and biologicals purchased by or dispensed to a patient are not covered.
90862	HA, HQ	**SERVICE: Group Outpatient – Pharmacologic Management by a Physician** **DEFINITION:** Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 18 and over **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group • Brief mental status and observations • Rationale for group intervention and intervention used that must coincide with master treatment plan • Beneficiary's response to the group intervention that includes current progress or regression and prognosis

National Code	Required Modifier	Definition
		• Any changes indicated for the master treatment plan, diagnosis, or medication(s) • If provided by physician that is not a psychiatrist, then any off label uses of medications must include documented consultation with the overseeing psychiatrist • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan. This does NOT include *psychosocial groups* in rehabilitative day programs or educational groups. The maximum that may be served in a specified group is ten (10). Providers may bill for services only at times during which beneficiaries participate in this program activity.
36415	HA	**SERVICE: Routine Venipuncture for Collection of Specimen** **DEFINITION:** The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1, Per routine **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12 **ALLOWABLE PLACES OF SERVICE:** Office (11); Assisted Living Facility (13); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Time of the specific procedure • Place of service (If 99 is used, specific location and rationale for location must be included) • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be provided only to beneficiaries taking prescribed psychotropic medication or who have a substance abuse diagnosis.
90887	HA	**SERVICE: Collateral Intervention, Mental Health Professional** **DEFINITION:** A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled

PROPOSED

National Code	Required Modifier	Definition
		beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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, diagnosis, or medication(s) • Plan for next contact, if any • Staff signature/credentials/Date of signature **NOTES and COMMENTS:** The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Billing for interventions performed by a mental health professional must warrant the need for the higher level of staff licensure. Professional interventions of a type which could be provided by a paraprofessional will require documentation of the reason it was needed. Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.

National Code	Required Modifier	Definition
90887	U7	**Collateral Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code 90887 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90887	HA, UB	**SERVICE: Collateral Intervention, Mental Health Paraprofessional** **DEFINITION:** A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements: • 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

National Code	Required Modifier	Definition
		NOTES and COMMENTS: Supervision by a Mental Health Professional must be documented in personnel files and addressed in accordance of agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision. The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.
H2011	HA, U6	**SERVICE: Crisis Stabilization Intervention, Mental Health Professional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop time of actual encounter with beneficiary • Place of service, (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s)

National Code	Required Modifier	Definition
		• Plan for next session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U2	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over.
H2011	U2, U7	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U2, U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H2011	HA, U5	**SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop time of actual encounter with beneficiary • Place of service If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Behavioral observations • Consult with MHP or physician regarding events that necessitated this service and the review of the outcome of

National Code	Required Modifier	Definition
		the intervention • Intervention used must coincide with the master treatment plan, psychiatric advance directive or crisis plan which must be documented and communicated to the supervising MHP • Beneficiary's response to intervention that includes current progress or regression • Plan for next session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2011	U1	**Crisis Stabilization Intervention, Mental Health Paraprofessional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U1" to claim for services provided to beneficiaries ages 21 and over
H2015	HA, U5	**SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)** **DEFINITION:** Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements):

National Code	Required Modifier	Definition
		• Start and stop times of actual encounter with beneficiary • Date of service • Place of service, (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Brief mental status and observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Interventions of a type that could be performed by a paraprofessional may not be billed at a mental health professional rate unless the medical necessity for higher level staff is clearly documented.
H2015	U6	**Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U6" to claim for services provided to beneficiaries ages 21 and over.
H2015	U7	**Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H2015	HA, U1	**SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)** **DEFINITION:** Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living

National Code	Required Modifier	Definition
		Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop times of actual encounter with beneficiary • 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 • Beneficiary's response to intervention that includes current progress or regression and prognosis • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Billing for this service does not include time spent transporting the beneficiary to a required service, nor does it include time spent waiting while a beneficiary attends a scheduled or unscheduled appointment. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2015	U2	**Intervention, Mental Health Paraprofessional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over
H2017	HA, U1	**SERVICE: Rehabilitative Day Service for Persons under Age 18** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with

National Code	Required Modifier	Definition
		stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** 16 for ages 0-17 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 80 for ages 0-17 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Assisted Living Facility (13); Group Home (14); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the beneficiary's treatment plan). **MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS:** 1:10 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. **AGE GROUP(S):** U18 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual program participation by beneficiary • Date of service • Place of service • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's participation and response to the intervention • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • a weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished **NOTES and COMMENTS:** Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies.

National Code	Required Modifier	Definition
		However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.
H2017	—	**Rehabilitative Day Service for Persons Ages 18-20** Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below). Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20. DAILY MAXIMUM UNITS THAT MAY BE BILLED: 24 WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED: 120 MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS: 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.
H2017	—	**SERVICE: Adult Rehabilitative Day Service** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** 24 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 120 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Assisted Living Facility (13); Group Home (14); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the

National Code	Required Modifier	Definition
		beneficiary's treatment plan). **MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS:** 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. AGE GROUP(S): Ages 21 and over **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop times of actual program participation by beneficiary • Place of service • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's participation and response to the intervention • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • A weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished through participation in rehabilitative day service. **NOTES and COMMENTS:** Rehabilitative Day services do NOT include vocational services and training, academic education, personal care or home health services, purely recreational activities and may NOT be used to supplant services which may be obtained or are required to be provided by other means. Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.

252.140 Telemedicine RSPMI Services Billing Information 1-15-12

The mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary age 21 or over 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 a mental health professional, bill with POS 99:

National Code	Required Modifier	Local Code	Local Code Description
90801	U7	Z0560	Mental Health Evaluation/Diagnosis
90887	U3, U7	Z0564	Interpretation of Diagnosis
H0004	U7	Z0568	Individual Psychotherapy
90846	U7	Z0571	Marital/Family Psychotherapy – Beneficiary is not present
90847	U7		Marital/Family Psychotherapy – Beneficiary is present
H2011	U7	Z1536	Crisis Intervention
T1023	U7	Z1537	Psychiatric Diagnostic Assessment
T1023	U7, U1		Psychiatric Diagnostic Assessment – Continuing Care
H2011	U2, U7		Crisis Stabilization Intervention, Mental Health Professional
H2015	U7	Z1540	Intervention, Mental Health Professional
90862	U7	Z1545	Pharmacologic Management by a Physician
90887	U7	Z1547	Collateral Intervention, Mental Health Professional

252.430 Daily Service Billing Exclusions PROPOSED 1-15-12

RSPMI providers may not bill for the following services together on the same date of service:

National Codes and Modifiers	Service Titles
90885 -HA, U2 AND 90885 – HA or 90885 – HA, U1	Master treatment plan and Periodic Review of Master treatment plan
H2017-HA, U1 AND H2017	Adult Rehabilitative Day Service AND U21 Rehabilitative Day Service
90801 or 90801-HA, U1 AND 90885-HA, or 90885 HA, U1	Mental Health Evaluation/Diagnosis AND Periodic Review of Master treatment plan
90862 or 90862-HA or 90862-HA,UB AND 90862-HA, HQ	Pharmacologic Management AND Group Outpatient – Pharmacologic Management by a Physician

National Codes and Modifiers	Service Titles
H2012 – HA or H2012 – UA AND H2017	Therapeutic Day/Acute Day AND Adult Rehabilitative Day Service
H2012 – HA or H2012 – UA AND H2017 – HA, U1	Therapeutic Day/Acute Day AND U21 Rehabilitative Day Service
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA; AND 90862 or 90862-HA or 90862-HA,UB	Physical Examination PROPOSED AND Pharmacologic Management
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA; AND 90862-HA, HQ AND 90862 – HA	Physical Examination AND Group Outpatient – Pharmacologic Management by a Physician AND Pharmacologic Management by Physician
T1023 – HA, U1 AND T1023 – HA, U2	Psychiatric Diagnostic Assessment – Initial and Psychiatric AND Psychiatric Diagnostic Assessment – Continuing Care

Mark Up

Toc required

217.111 Procedure Codes Not Requiring PCP Referral for Beneficiaries Under Age 21 ~~11-1-101-~~ 15-12

Services designated by the following procedure codes and modifiers **do not** require PCP referral:

A. 90801, HA, U1 – Mental Health Evaluation/Diagnosis

B. 90885, HA, U2 – Master Treatment Plan

C. 90887, HA, U2 – Interpretation of Diagnosis

D. H2011, HA – Crisis Intervention

E. T1023, HA, U1 – Psychiatric Diagnostic Assessment – Initial

F. T1023, U7 – Psychiatric Diagnostic Assessment – Initial (telemedicine)

G. T1023, HA, U2 – Psychiatric Diagnostic Assessment – Continuing Care

H. T1023, U7, U1 – Psychiatric Diagnostic Assessment – Continuing Care (telemedicine)

224.100 Physician's Role for Adults Age 21 and Over ~~7-1-081-~~15-12

RSPMI providers are required to have a board certified or board eligible psychiatrist who provides appropriate supervision and oversight for all medical and treatment services provided by the agency. 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. For RSPMI enrolled adults age 21 and over, medical supervision responsibility shall include, but is not limited to, the following:

A. For any ~~individuals~~beneficiary certified as being Seriously Mentally Ill (SMI), the physician will ~~see and evaluate the individual~~perform an initial Psychiatric Diagnostic Assessment during the earlier of 45 days of the ~~individual's~~ beneficiary entering care or 45 days from the effective date of certification of serious mental illness. This initial evaluation is not required if the beneficiary discontinues services prior to calendar day 45. The SMI beneficiary must ~~be re-evaluated directly by a physician~~receive a continuing care Psychiatric Diagnostic Assessment within one year after the date of the ~~examination~~ initial Psychiatric Diagnostic Assessment and at least every year thereafter.

B. For ~~individuals~~beneficiaries not certified as having a Serious Mental Illness ~~or Serious Emotional Disturbance~~, the physician may determine through review of beneficiary records and consultation with the treatment staff that it is not medically necessary to directly see the enrolled beneficiary. By calendar day 45 after entering care, the physician must document in the beneficiary's record that it is not medically necessary to see the beneficiary. If the beneficiary continues to be in care for more than six months after program entry, the psychiatrist/physician must conduct an initial Psychiatric Diagnostic Assessment of the beneficiary by the end of six months and perform a continuing care Psychiatric Diagnostic Assessment at least every 12 months thereafter ~~shall see and evaluate the individual directly by the end of six months, initially, then at least every year, thereafter~~

C. The physician will review and approve the enrolled beneficiary's RSPMI treatment plan and document approval in the enrolled beneficiary's record. If the treatment plan is revised

prior to each 90 day interval, the physician must approve the changes within 14 calendar days, as indicated by a dated signature on the revised plan.

D. 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.

224.200 Physician's Role for Children Under Age 21 ~~7-1-08~~1-15-12

RSPMI providers are required to have a board certified or board eligible psychiatrist who provides supervision and oversight for all medical and treatment services provided by the agency. 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 on a regular basis. For RSPMI enrolled children, under age 21, medical supervision responsibility shall include, but is not limited to, the following:

A. For any ~~individuals~~ beneficiary under age 18, certified as being Seriously Emotionally Disturbed (SED) or individuals age 18 through age 20 certified as Seriously Mentally Ill (SMI), the physician will conduct an initial ~~p~~Psychiatric Diagnostic Assessment of the ~~individual~~ beneficiary the earlier of 45 days of the individual's entering care or 45 days from the effective date of certification of serious mental illness/serious emotional disturbance. This initial evaluation is not required if the beneficiary discontinues services prior to calendar day 45. The SMI/SED beneficiary must be evaluated again directly by the physician through the Psychiatric Diagnostic Assessment – Continuing Care within 12 months after the date of the initial examination and every 12 months after (at a minimum) during an episode of care. ~~within one year after the date of the examination and at least every year thereafter.~~

B. For ~~individuals~~ beneficiaries not certified as having a Serious Mental Illness or Serious Emotional Disturbance, the psychiatrist or physician may determine through review of beneficiary records and consultation with the treatment staff that it is not medically necessary to directly assess and interview the enrolled beneficiary. By calendar day 45 after entering care, the physician must document in the beneficiary's record that it is not medically necessary to provide the beneficiary a physician assessment. If the beneficiary continues to be in care for more than six months after program entry, the psychiatrist/physician must conduct an initial Psychiatric Diagnostic Assessment of the ~~individual directly~~beneficiary by the end of six months, ~~initially, and then perform a~~ continuing care Psychiatric Diagnostic Assessment at least every ~~year~~,12 months thereafter.

C. The physician will review and approve the enrolled beneficiary's RSPMI treatment plan and document the approval in the enrolled beneficiary's record. If the treatment plan is revised prior to each 90 day interval, the physician must approve the changes within 14 calendar days, as indicated by a dated signature on the revised plan.

D. 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.

224.201 Psychiatric Diagnostic Assessment – Initial 1-15-12~~5-1-08~~

The purpose of this service is to determine the existence, type, nature, and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9. This face-to-face psychodiagnostic assessment~~process~~ must be conducted by an Arkansas licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). The initial Psychiatric Diagnostic Assessment ~~process~~ must include:

A. An interview with the beneficiary, which covers the areas outlined below. The initial ~~p~~Psychiatric ~~d~~Diagnostic ~~A~~assessment may build on information obtained through other assessments reviewed by the physician and verified through the physician's interview. The interview should obtain or verify:

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 and
7. Medical history (and examination as indicated).

B. The initial Psychiatric Diagnostic ~~a~~Assessment must include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18) and
2. A complete multi-axial (5) diagnosis.

C. For beneficiaries under the age of 18, the initial ~~p~~Psychiatric ~~d~~Diagnostic ~~a~~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 and
3. To obtain a detailed medical, family and developmental history.

The initial Psychiatric ~~d~~Diagnostic ~~a~~Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the assessment and treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The initial Psychiatric Diagnostic Assessment ~~must be updated every 12 months at a minimum~~can only be provided at the start of an episode of care.

224.202 Psychiatric Diagnostic Assessment – Continuing Care **1-15-12**

The purpose of this service is to determine the continuing existence, type, nature and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9CM. This face-to-face psychodiagnostic reassessment must be conducted by an Arkansas licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). The continuing care Psychiatric Diagnostic Assessment must include:

A. An interview with the beneficiary, which covers the areas outlined below. The continuing care Psychiatric Diagnostic Assessment may build on information obtained through other assessments reviewed by the physician and verified through the physician's interview. The interview should obtain or verify:

1. Psychiatric assessment (including current symptoms and functional impairments),

2. Medications and responses,
3. Response to current treatment interventions and
4. Medical history (and examination, as indicated).

B. The continuing care Psychiatric Diagnostic Assessment must also include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18) and
2. A complete multi-axial (5) diagnosis.

C. For beneficiaries under the age of 18, the continuing care Psychiatric Diagnostic 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 reason for referral,
2. Clarify the nature of the current symptoms and functional impairments and
3. Obtain a detailed, updated medical, family and developmental history.

The continuing care Psychiatric Diagnostic Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the continuing care assessment and updated treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The continuing care Psychiatric Diagnostic Assessment must be performed every 12 months during an episode of care.

231.100 Prior Authorization and Extension of Benefits ~~7-1-10~~1-15-12

Prior Authorization is required for certain services provided to Medicaid-eligible individuals. Extension of benefits is required for all other 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 crisis intervention, crisis stabilization intervention by a mental health professional, and crisis stabilization intervention by paraprofessional.

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

Prior authorization and extension requests must be sent to ValueOptions for beneficiaries age 21 and over. **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
90846 90846 90846	HA, U3, — U7 (telemedicine)	Marital/Family Therapy without patient present
90853 90853	HA, U1 —	Group Outpatient – Group Psychotherapy

National Codes	Required Modifier	Service Title
90862	HA, HQ	Group Outpatient – Pharmacologic Management by Physician
H2012 H2012	HA UA	Therapeutic Day/Acute Day Treatment
90887 90887	HA U7 (telemedicine)	Collateral Intervention, MHP
90887	HA, UB	Collateral Intervention, MHPP
H2015 H2015 H2015	HA, U5 U6 U7 (telemedicine)	Intervention, MHP
H2015 H2015	HA, U1 U2	Intervention, MHPP
H2017 H2017	HA, U1 —	Rehabilitative Day Service

Procedure codes requiring Extension of Benefits:

National Codes	Required Modifier	Service Title	Yearly Maximum
90801 90801	HA, U1 U7 (telemedicine)	Mental Health Evaluation/Diagnosis	16
96101	HA, UA	Psychological Evaluation	32
90885	HA, U2	Master Treatment Plan	8
90887 90887	HA, U2 U3, U7 (telemedicine)	Interpretation of Diagnosis	16
H0004 H0004 H0004	 HA U7 (telemedicine)	Individual Psychotherapy	48
90847 90847 90847	HA, U3 — U7 (telemedicine)	Marital/Family Therapy with patient present	48
H2011 H2011	HA U7 (telemedicine)	Crisis Intervention	72
T1023 T1023	HA, U1 U7 (telemedicine)	Psychiatric Diagnostic Assessment (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care)	1

National Codes	Required Modifier	Service Title	Yearly Maximum
T1023 T1023	HA, U2 U7, U1 (telemedicine)	Psychiatric Diagnostic Assessment – Continuing Care	1
99201 99202 99203 99204 99212 99213 99214	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB	Physical Examination	12
AND			
99201 99202 99203 99204 99212 99213 99214	HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA		
90862 90862 90862 90862	HA — HA, UB U7 (telemedicine)	Pharmacologic Management	24
90885 90885	HA HA, U1	Periodic Review of Master treatment plan	10
36415	HA	Routine Venipuncture for Collection of Specimen	12
H2011 H2011 H2011	HA, U6 U2 U2, U7 (telemedicine)	Crisis Stabilization, MHP	72
H2011 H2011	HA, U5 U1	Crisis Stabilization, MHPP	72

252.110 Outpatient Procedure Codes ~~10-5-091~~-15-12

National Code	Required Modifier	Definition
92506	HA	***Diagnosis: Speech Evaluation*** 1 unit = 30 minutes Maximum units per day: 4 Maximum units per state fiscal year (SFY) = 4 units
90801	HA, U1	**SERVICE: Mental Health Evaluation/Diagnosis (Formerly known only as Diagnosis)**

National Code	Required Modifier	Definition
		DEFINITION: The cultural, developmental, age and disability - relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8, **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • 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 five axes • Treatment recommendations • Staff signature/credentials/date of signature **NOTES and COMMENTS:** 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. Prior Authorization requests, master treatment plans, etc.).
90801	U7	**Mental Health Evaluation/Diagnosis**: Use the above definition and requirements. Additional information: Use code 90801 with modifier "U7" to claim

National Code	Required Modifier	Definition
		for services provided via telemedicine only. Note: Telemedicine POS 99
96101	HA, UA	**SERVICE:** Psychological Evaluation (Formerly Diagnosis – Psychological Test/Evaluation and Diagnosis – Psychological Testing Battery) **DEFINITION:** A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 16 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 32 **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 • 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 • Axis Five DSM diagnostic impressions • Treatment recommendations and findings related to rationale for service and guided by the master treatment plan and test results • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Medical necessity for this service is met when the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions, when the history and symptomatology are not readily attributable to a particular psychiatric diagnosis and the questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic

National Code	Required Modifier	Definition
		interview, observation in therapy, or an assessment for level of care at a mental health facility, ***Or*** Medical necessity is met when the beneficiary has demonstrated a complexity of issues related to cognitive functioning or the impact of a disability on a condition or behavior and the service is necessary to develop treatment recommendations after the beneficiary has received various treatment services and modalities, has not progressed in treatment, and continues to be symptomatic. Medicaid WILL NOT reimburse evaluations or testing that is considered primarily educational. Such services are those used to identify specific learning disabilities and developmental disabilities in beneficiaries who have no presenting behavioral or psychiatric symptoms which meet the need for mental health treatment evaluation. This type of evaluation and testing is provided by local school systems under applicable state and federal laws and rules. Psychological Evaluation services that are ordered strictly as a result of court-ordered services are not covered unless medical necessity criteria are met. Psychological Evaluation services for employment, disability qualification, or legal/court related purposes are not reimbursable by Medicaid as they are not considered treatment of illness. A Psychological Evaluation report must be completed within fourteen (14) calendar days of the examination; documented; clearly identified as such; and signed/dated by the staff completing the evaluation. This service constitutes both face to face time administering tests to the beneficiary and time interpreting these test results and preparing the report.
T1023	HA, U1	**SERVICE: Psychiatric Diagnostic Assessment – Initial (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care)** **DEFINITION:** A direct face-to-face service contact occurring between the physician and the beneficiary for the purpose of evaluation. The initial Psychiatric Diagnostic Assessment includes a history, mental status and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for requirements.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as 1 per episode. **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS:**

National Code	Required Modifier	Definition
		• Date of Service • Start and stop times • Place of service • Diagnosis (all 5 Axes) • Diagnostic Impression • Psychiatric (re)assessment • Functional (re)assessment • Discharge criteria • Physician's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** ~~The beneficiary must be reassessed, reviewed, and recertified at least every year~~The initial Psychiatric Diagnostic Assessment can only be provided to a beneficiary at the start of an episode of care.
T1023	U7	**SERVICE: Psychiatric Diagnostic Assessment – Initial (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care):** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
T1023	HA, U2	**SERVICE: Psychiatric Diagnostic Assessment - Continuing Care** **DEFINITION:** A direct face-to-face service contact occurring between the physician and the beneficiary during an episode of care for the purpose of evaluation. The continuing care Psychiatric Diagnostic Assessment includes a Psychiatric assessment, mental status examination, functional assessment, medications, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for requirements.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as 1 per episode. **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over;U21; **DOCUMENTATION REQUIREMENTS:** • Date of Service • Start and stop times • Place of service

National Code	Required Modifier	Definition
		• Diagnosis (all 5 Axes) • Psychiatric assessment • Functional assessment • Mental Status Examination • Medications • Discharge criteria • Physician's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** The continuing care Psychiatric Diagnostic Assessment must be performed, at a minimum, at least every 12 months during an episode of care.
T1023	U7, U1	**SERVICE: Psychiatric Diagnostic Assessment – Continuing Care:** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7, U1" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
90885	HA, U2	**SERVICE: Master Treatment Plan** **DEFINITION:** A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. 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 prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 8 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis

National Code	Required Modifier	Definition
		• 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 • 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 and COMMENTS:** The service formerly coded as T1023 and titled "Assessment and Treatment Plan/Plan of Care" is now incorporated into this service. This service may be billed one (1) time upon entering care and once yearly thereafter. The master treatment plan 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 paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA	**SERVICE: Periodic Review of Master Treatment Plan** **DEFINITION:** The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and

National Code	Required Modifier	Definition
		his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 10 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): Completed by the primary MHP (If not, then must have a rationale for another MHP completing the documentation and only with input from the primary MHP) • Date of service • Start and stop times for review and revision of plan • Place of service • Diagnosis and pertinent interval history • Beneficiary's updated strengths and needs • Progress/Regression with regard to treatment goal(s) as documented in the master. • Progress/Regression of the measurable objectives as documented in the master treatment plan • Individualized rationale to support the medical necessity of continued services • Updated schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Modifications to 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(s) • Physician's signature indicating continued medical necessity/date of signature **NOTES and COMMENTS:** This service must be provided every ninety (90) days or more frequently if there is documentation of significant change in acuity or change in clinical status requiring an update/change in the beneficiary's master treatment plan. If progress is not documented, then modifications should be made in the master treatment plan or rationale why continuing to provide the same type and amount of services is expected to achieve progress/outcome. It is the responsibility of the primary mental

National Code	Required Modifier	Definition
		health professional to insure that all paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA, U1	**Periodic Review of Master Treatment Plan** Apply the above description. Additional information: Use code 90885 with modifier "U1" to claim for this service when provided by a non-physician.
90887	HA, U2	**SERVICE: Interpretation of Diagnosis** **DEFINITION:** A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention used that must coincide with the master treatment plan or proposed master treatment plan or recommendations. • Participant response and feedback • Any changes or revision to the master treatment plan, diagnosis, or medication(s) • Staff signature/credentials/date of signature(s) **NOTES AND COMMENTS:** 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.

National Code	Required Modifier	Definition
90887	U3, U7	**Interpretation of Diagnosis** Use above definition and requirements Additional information: Use code 90887 with modifier "U3, U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H0004	HA	**SERVICE: Individual Psychotherapy** **DEFINITION**: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 48 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31) School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** U21, but not for beneficiaries under the age of 3 except in documented exceptional cases **REQUIRED DOCUMENTATION** (See Section 226.200 for additional requirements): • 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 intervention used that must coincide with the master • Beneficiary's response to intervention 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 and COMMENTS:** Services provided must be congruent with the objectives and interventions articulated on the most

National Code	Required Modifier	Definition
		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.
H0004	—	**Individual Psychotherapy** Use above definition and requirements. Additional information: Use code H0004 with no modifier to claim for services provided to beneficiaries ages 21 and over.
H0004	U7	**Individual Psychotherapy** Use above definition and requirements. Additional information: Use code H0004 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90846	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is not present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **REQUIRES PRIOR AUTHORIZATION** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention used that must coincide with

National Code	Required Modifier	Definition
		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 intervention 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 • HIPPA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature **NOTES and COMMENTS:** 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.
90846	—	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above definition and requirements. Additional information: Use code 90846 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90846	U7	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above definition and requirements. Additional information: Use code 90846 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90847	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6

National Code	Required Modifier	Definition
		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 48 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention 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 intervention 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 and COMMENTS:** 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. Additional information: Use code 90847 with modifiers "HA, U3" to claim for services provided to beneficiaries under age 21.
90847	—	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90847	U7	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with modifier "U7" to claim for services provided via telemedicine only. Telemedicine

National Code	Required Modifier	Definition
		POS 99
92507	HA	**Individual Outpatient – Speech Therapy, Speech Language Pathologist** Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92507	HA, UB	**Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92508	HA	**Group Outpatient – Speech Therapy, Speech Language Pathologist** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
92508	HA, UB	**Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
90853	HA, U1	**SERVICE: Group Outpatient – Group Psychotherapy** **DEFINITION:** Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness. The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14);

National Code	Required Modifier	Definition
		AGE GROUP(S): Ages 4 – 20; Under age 4 by prior authorized medically needy exception **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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 intervention and intervention used that must coincide with master treatment plan • Beneficiary's response to the group intervention 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 and COMMENTS:** 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,
90853	—	**Group Outpatient – Group Psychotherapy** Apply the above definition and requirements. Additional information: Use code 90853 with no modifier to claim for services provided to beneficiaries ages 21 and over.
H2012	HA	**SERVICE: Therapeutic Day/Acute Day Treatment** **DEFINITION:** Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental

National Code	Required Modifier	Definition
		health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services must include constant staff supervision of beneficiaries and physician oversight. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 32 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11) **STAFF to CLIENT RATIO:** 1:5 for ages 18 and over; 1:4 for U18 **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and interventions used that must coincide with the master treatment plan • Beneficiary's response to the intervention 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 • Staff signature/credentials **NOTES and COMMENTS:** Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must

National Code	Required Modifier	Definition
		be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting. See Section 219.110 for additional information.
H2012	UA	**Therapeutic Day/Acute Day Treatment** Apply the above definition and requirements. Additional Information: Use code H2012 with modifier "UA" to claim for services provided to beneficiaries ages 21 and over. See Section 219.110 for additional information.
H2011	HA	**SERVICE: Crisis Intervention** **DEFINITION:** Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service (If 99 is used, specific location and rationale for location must be included) • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes

National Code	Required Modifier	Definition
		current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U7	**Crisis Intervention** Apply the above definition and requirements. Additional information: Use code H2011 plus modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
Physician: 99201 99202 99203 99204 99212 99213 99214	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB	**SERVICE: Physical Examination – Psychiatrist or Physician** **Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12 **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual encounter with beneficiary • Date of service • Place of service • Identifying information • Referral reason and rationale for examination • Presenting problem(s) • Health history • Physical examination • Laboratory and diagnostic procedures ordered • Health education/counseling • Identification of risk factors
PCNS & PANP: 99201 99202 99203 99204 99212 99213 99214	HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA	

National Code	Required Modifier	Definition
		• Mental status/clinical observations and impressions • ICD-9 diagnoses • DSM diagnostic impressions to include all five axes • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Treatment recommendations for findings, medications prescribed, and indicated informed consents Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be billed only by the RSPMI provider. The physician, Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner may not bill for an office visit, nursing home visit, or any other outpatient medical services procedure for the beneficiary for the same date of service. Pharmacologic Management may not be billed on the same date of service as Physical Examination, as pharmacologic management would be considered one component of the full physical examination (office visit).
90862	HA	**SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)** **Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication 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, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 24 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Nursing Facility (32); Skilled Nursing Facility (31); ICF/MR (54) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (If 99 is used for telemedicine, specific

National Code	Required Modifier	Definition
		locations of the beneficiary and the physician must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and intervention used that must coincide with the master treatment plan • Beneficiary's response to intervention 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 and COMMENTS:** Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan.
90862	—	**Pharmacologic Management by Physician** Apply the above definition and requirements. Additional information: Use code 90862 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90862	U7	**Pharmacologic Management by Physician** Apply the above definition and requirements. Additional information: Use code 90862 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90862	HA, UB	**Pharmacologic Management by Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** Apply the above definition and requirements.
T1502	—	**SERVICE: Medication Administration by a Licensed Nurse** **DEFINITION:** Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99)

National Code	Required Modifier	Definition
		AGE GROUP(S): Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Time of the specific procedure • Place of service • Physician's order must be included in medication log • Staff signature/credentials/date of signature **NOTES and COMMENTS:** Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan. Drugs and biologicals that can be self-administered shall not be in this group unless there is a documented reason the patient cannot self administer. Non-prescriptions and biologicals purchased by or dispensed to a patient are not covered.
90862	HA, HQ	**SERVICE: Group Outpatient – Pharmacologic Management by a Physician** **DEFINITION:** Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 18 and over **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group • Brief mental status and observations • Rationale for group intervention and intervention used that must coincide with master treatment plan

National Code	Required Modifier	Definition
		• Beneficiary's response to the group intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • If provided by physician that is not a psychiatrist, then any off label uses of medications must include documented consultation with the overseeing psychiatrist • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan. This does NOT include *psychosocial groups* in rehabilitative day programs or educational groups. The maximum that may be served in a specified group is ten (10). Providers may bill for services only at times during which beneficiaries participate in this program activity.
36415	HA	**SERVICE: Routine Venipuncture for Collection of Specimen** **DEFINITION:** The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1, Per routine **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12 **ALLOWABLE PLACES OF SERVICE:** Office (11); Assisted Living Facility (13); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service • Time of the specific procedure • Place of service (If 99 is used, specific location and rationale for location must be included) • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be provided only to beneficiaries taking prescribed psychotropic medication or who have a substance abuse diagnosis.
90887	HA	**SERVICE: Collateral Intervention, Mental Health Professional** **DEFINITION:** A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with

National Code	Required Modifier	Definition
		the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • 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, diagnosis, or medication(s) • Plan for next contact, if any • Staff signature/credentials/Date of signature **NOTES and COMMENTS:** The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Billing for interventions performed by a mental health professional must warrant the need for the higher level of staff licensure. Professional interventions of a type which could be provided by a paraprofessional will require documentation of the reason it was needed.

National Code	Required Modifier	Definition
		Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.
90887	U7	**Collateral Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code 90887 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90887	HA, UB	**SERVICE: Collateral Intervention, Mental Health Paraprofessional** **DEFINITION:** A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements: • 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

National Code	Required Modifier	Definition
		• Plan for next contact, if any • Staff signature/credentials/Date of signature **NOTES and COMMENTS:** Supervision by a Mental Health Professional must be documented in personnel files and addressed in accordance of agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision. The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.
H2011	HA, U6	**SERVICE: Crisis Stabilization Intervention, Mental Health Professional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop time of actual encounter with beneficiary • Place of service, (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to intervention that includes current

National Code	Required Modifier	Definition
		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 • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U2	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over.
H2011	U2, U7	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U2, U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H2011	HA, U5	**SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop time of actual encounter with beneficiary • Place of service If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history

National Code	Required Modifier	Definition
		• Behavioral observations • Consult with MHP or physician regarding events that necessitated this service and the review of the outcome of the intervention • Intervention used must coincide with the master treatment plan, psychiatric advance directive or crisis plan which must be documented and communicated to the supervising MHP • Beneficiary's response to intervention that includes current progress or regression • Plan for next session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2011	U1	**Crisis Stabilization Intervention, Mental Health Paraprofessional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U1" to claim for services provided to beneficiaries ages 21 and over
H2015	HA, U5	**SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)** **DEFINITION:** Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99)

National Code	Required Modifier	Definition
		AGE GROUP(S): U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual encounter with beneficiary • Date of service • Place of service, (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Brief mental status and observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Interventions of a type that could be performed by a paraprofessional may not be billed at a mental health professional rate unless the medical necessity for higher level staff is clearly documented.
H2015	U6	**Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U6" to claim for services provided to beneficiaries ages 21 and over.
H2015	U7	**Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H2015	HA, U1	**SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)** **DEFINITION:** Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8

National Code	Required Modifier	Definition
		PRIOR AUTHORIZATION REQUIRED **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop times of actual encounter with beneficiary • 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 • Beneficiary's response to intervention that includes current progress or regression and prognosis • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Billing for this service does not include time spent transporting the beneficiary to a required service, nor does it include time spent waiting while a beneficiary attends a scheduled or unscheduled appointment. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2015	U2	**Intervention, Mental Health Paraprofessional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over
H2017	HA, U1	**SERVICE: Rehabilitative Day Service for Persons under Age 18** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their

National Code	Required Modifier	Definition
		mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** 16 for ages 0-17 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 80 for ages 0-17 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Assisted Living Facility (13); Group Home (14); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the beneficiary's treatment plan). **MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS:** 1:10 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. **AGE GROUP(S):** U18 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Start and stop times of actual program participation by beneficiary • Date of service • Place of service • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's participation and response to the intervention • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • a weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished

National Code	Required Modifier	Definition
		NOTES and COMMENTS: Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.
H2017	—	**Rehabilitative Day Service for Persons Ages 18-20** Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below). Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20. DAILY MAXIMUM UNITS THAT MAY BE BILLED: 24 WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED: 120 MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS: 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.
H2017	—	**SERVICE: Adult Rehabilitative Day Service** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** 24 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 120 **PRIOR AUTHORIZATION REQUIRED**

National Code	Required Modifier	Definition
		ALLOWABLE PLACES OF SERVICE: Office (11); Assisted Living Facility (13); Group Home (14); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the beneficiary's treatment plan). **MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS:** 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. AGE GROUP(S): Ages 21 and over **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of service • Start and stop times of actual program participation by beneficiary • Place of service • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's participation and response to the intervention • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • A weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished through participation in rehabilitative day service. **NOTES and COMMENTS:** Rehabilitative Day services do NOT include vocational services and training, academic education, personal care or home health services, purely recreational activities and may NOT be used to supplant services which may be obtained or are required to be provided by other means. Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.

The mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary age 21 or over 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 a mental health professional, bill with POS 99:

National Code	Required Modifier	Local Code	Local Code Description
90801	U7	Z0560	Mental Health Evaluation/Diagnosis
90887	U3, U7	Z0564	Interpretation of Diagnosis
H0004	U7	Z0568	Individual Psychotherapy
90846	U7	Z0571	Marital/Family Psychotherapy – Beneficiary is not present
90847	U7		Marital/Family Psychotherapy – Beneficiary is present
H2011	U7	Z1536	Crisis Intervention
T1023	U7	Z1537	Psychiatric Diagnostic Assessment
T1023	U7, U1		Psychiatric Diagnostic Assessment – Continuing Care
H2011	U2, U7		Crisis Stabilization Intervention, Mental Health Professional
H2015	U7	Z1540	Intervention, Mental Health Professional
90862	U7	Z1545	Pharmacologic Management by a Physician
90887	U7	Z1547	Collateral Intervention, Mental Health Professional

252.430 Daily Service Billing Exclusions

~~10-4-091-~~ 15-12

RSPMI providers may not bill for the following services together on the same date of service:

National Codes and Modifiers	Service Titles
90885 -HA, U2 AND 90885 – HA or 90885 – HA, U1	Master treatment plan and Periodic Review of Master treatment plan
H2017-HA, U1 AND H2017	Adult Rehabilitative Day Service AND U21 Rehabilitative Day Service

National Codes and Modifiers	Service Titles
90801 or 90801-HA, U1 AND 90885-HA, or 90885 HA, U1	Mental Health Evaluation/Diagnosis AND Periodic Review of Master treatment plan
90862 or 90862-HA or 90862-HA,UB AND 90862-HA, HQ	Pharmacologic Management AND Group Outpatient – Pharmacologic Management by a Physician
H2012 – HA or H2012 – UA AND H2017	Therapeutic Day/Acute Day AND Adult Rehabilitative Day Service
H2012 – HA or H2012 – UA AND H2017 – HA, U1	Therapeutic Day/Acute Day AND U21 Rehabilitative Day Service
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA; AND 90862 or 90862-HA or 90862-HA,UB	Physical Examination AND Pharmacologic Management
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA; AND 90862-HA, HQ AND 90862 – HA	Physical Examination AND Group Outpatient – Pharmacologic Management by a Physician AND Pharmacologic Management by Physician

National Codes and Modifiers	Service Titles
T1023 – HA, U1 AND T1023 – HA, U2	Psychiatric Diagnostic Assessment – Initial and Psychiatric AND Psychiatric Diagnostic Assessment – Continuing Care