Summary Telemedicine:

In accordance with Act 203 of the 91st General Assembly of 2017; effective for dates of service on or after April 10, 2018, the originating site for Telemedicine services will be covered for Arkansas Medicaid beneficiaries. This will not affect current benefit limits.

Telemedicine was pulled from the public health agenda and dates were changed effective 8/1/2018; with a retroactive date for claims to 4/10/2018.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Policy Coordination & Promulgation

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: August 1, 2018

SUBJECT: Provider Manual Update Transmittal Secl-1-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
105.190	9-1-15	105.190	8-1-18

Explanation of Updates

Section 105.190, Reserved, has been changed to include Telemedicine general policy.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the 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 the Office of Policy Coordination and Promulgation at (501) 320-6429.

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Thank you for your participation in the Arkansas Medicaid Program.

Rose Naff
Director

SECTION I - GENERAL POLICY
CONTENTS

TOC required

105.190 ~~Reserved~~Telemedicine ~~9-1-15~~8-1-18

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.

Store-and-forward technology is the transmission of a patient's medical information from a healthcare provider at an originating site to a healthcare provider at a distant site. Remote patient monitoring means the use of electronic information and communication technology to collect personal health information and medical data from a patient at an originating site that is transmitted to a healthcare provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring.

Arkansas Medicaid shall provide payment to a licensed or certified healthcare professional or a licensed or certified entity for services provided through telemedicine if the service provided through telemedicine is comparable to the same service provided in person. Payment will include a reasonable facility fee to the originating site operated by a licensed or certified healthcare professional or licensed or certified healthcare entity if the professional or entity is authorized to bill Arkansas Medicaid directly for healthcare services. There is no facility fee for the distant site. The professional or entity at the distant site must be an enrolled Arkansas Medicaid Provider.

Coverage and reimbursement for services provided through telemedicine will be on the same basis as for services provided in person. While a distant site facility fee is not authorized under the Telemedicine Act, if reimbursement includes payment to an originating site (as outlined in the above paragraph), the combined amount of reimbursement to the originating and distant sites may not be less than the total amount allowed for healthcare services provided in person.

Professional Relationship

The distant site healthcare provider will not utilize telemedicine services with a patient unless a professional relationship exists between the provider and the patient. A professional relationship exists when:

1. The healthcare provider has previously conducted an in-person examination of the patient and is available to provide appropriate follow-up care;
2. The healthcare provider personally knows the patient and the patient's health status through an ongoing relationship and is available to provide follow-up care;
3. The treatment is provided by a healthcare provider in consultation with, or upon referral by, another healthcare provider who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment including follow-up care;
4. An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare provider or another healthcare provider who has established a professional relationship with the patient; or
5. A relationship exists in other circumstances as defined by the Arkansas State Medical Board (ASMB) or a licensing or certification board for other healthcare

providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.

a. A professional relationship is established if the physician provider performs a face to face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination. (See ASMB Regulation 2.8); or

b. If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board (See ASMB Regulation 38 for these safeguards including the standards of care).

A professional relationship does not include a relationship between a healthcare provider and a patient established only by the following:

1. An internet questionnaire;
2. An email message;
3. A patient-generated medical history;
4. Audio only communication, including without limitation interactive audio;
5. Text messaging;
6. A facsimile machine (Fax) and EFax; or
7. Any combination of the above;
8. Any future technology that does not meet the criteria outlined in this section.

The existence of a professional relationship is not required when:

1. An emergency situation exists; or
2. The transaction involves providing information of a generic nature not meant to be specific to an individual patient.

Once a professional relationship is established, the healthcare provider may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare provider is licensed or certified and in accordance with the safeguards established by the healthcare professionals licensing board. The use of interactive audio is not reimbursable under Arkansas Medicaid.

Telemedicine with a Minor

Regardless of whether the individual is compensated for healthcare services, if a healthcare provider seeks to provide telemedicine services to a minor in a school setting and the minor is enrolled in Arkansas Medicaid, the healthcare provider shall:

1. Be the designated Primary Care Provider (PCP) for the minor;
2. Have a cross-coverage arrangement with the designated PCP of the minor; or
3. Have a referral from the designated PCP of the minor.

If the minor does not have a designated PCP, this section does not apply. Only the parent or legal guardian of the minor may designate a PCP for a minor.

Telemedicine Standard of Care

Healthcare services provided by telemedicine, including without limitation a prescription through telemedicine, shall be held to the same standard of care as healthcare services provided in

person. A healthcare provider providing telemedicine services within Arkansas shall follow applicable state and federal laws, rules and regulations regarding:

1. Informed consent;
2. Privacy of individually identifiable health information;
3. Medical record keeping and confidentiality, and
4. Fraud and abuse.

A healthcare provider treating patients in Arkansas through telemedicine shall be fully licensed or certified to practice in Arkansas and is subject to the rules of the appropriate state licensing or certification board. This requirement does not apply to the acts of a healthcare provider located in another jurisdiction who provides only episodic consultation services.

SECTION I - GENERAL POLICY
CONTENTS

TOC required

105.190 Telemedicine

8-1-18

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3. The treatment is provided by a healthcare provider in consultation with, or upon referral by, another healthcare provider who has an ongoing relationship with the patient and who has agreed to supervise the patient's treatment including follow-up care;
4. An on-call or cross-coverage arrangement exists with the patient's regular treating healthcare provider or another healthcare provider who has established a professional relationship with the patient; or
5. A relationship exists in other circumstances as defined by the Arkansas State Medical Board (ASMB) or a licensing or certification board for other healthcare providers under the jurisdiction of the appropriate board if the rules are no less restrictive than the rules of the ASMB.

a. A professional relationship is established if the provider performs a face to face examination using real time audio and visual telemedicine technology that provides information at least equal to such information as would have been obtained by an in-person examination. (See ASMB Regulation 2.8); or

b. If the establishment of a professional relationship is permitted via telemedicine under the guidelines outlined in ASMB regulations, telemedicine may be used to establish the professional relationship only for situations in which the standard of care does not require an in-person encounter and only under the safeguards established by the healthcare professional's licensing board (See ASMB Regulation 38 for these safeguards including the standards of care).

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Telemedicine Standard of Care

Healthcare services provided by telemedicine, including without limitation a prescription through telemedicine, shall be held to the same standard of care as healthcare services provided in person. A healthcare provider providing telemedicine services within Arkansas shall follow applicable state and federal laws, rules and regulations regarding:

1. Informed consent;

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TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – All Providers

EFFECTIVE DATE: August 1, 2018

SUBJECT: Provider Manual Update Transmittal SecIII-1-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	305.000	8-1-18

Explanation of Updates

Section 305.000 is updated to add Telemedicine Billing Guidelines.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

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Rose Naff
Director

TOC required

305.000 Telemedicine Billing Guidelines 8-1-18

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring. (See policy section I.)

Arkansas Medicaid shall provide payment for telemedicine healthcare services to licensed or certified healthcare professionals or entities that are authorized to bill Arkansas Medicaid directly for healthcare services. Coverage and reimbursement for healthcare services provided through telemedicine shall be reimbursed on the same basis as healthcare services provided in person.

Payment will include a reasonable facility fee to the originating site, the site at which the patient is located at the time telemedicine healthcare services are provided. In order to receive reimbursement, ~~T~~the originating site must be operated by a healthcare professional or licensed healthcare entity authorized to bill Medicaid directly for healthcare services. The distant site is the location of the healthcare provider delivering telemedicine services. Services at the distant site must be provided by an enrolled Arkansas Medicaid Provider who is authorized by Arkansas law to administer healthcare.

Coding Guidelines:

1. The originating site shall submit a telemedicine claim under the billing providers "pay to" information using HCPCS code Q3014. The code must be submitted for the same date of service as the professional code and must indicate the place of service where the member was at the time of the telemedicine encounter. Except in the case of hospital facility claims, the provider who is responsible for the care of the member at the originating site shall be entered as the performing provider in the appropriate field of the claim. For outpatient claims that occur in a hospital setting, the provider must also use Place of Service code 22 with the originating site billing Q3014. In the case of in-patient services, HCPCS code Q3014 is not separately reimbursable because it is included in the hospital per diem.
2. The provider of the distant site must submit claims for telemedicine services using the appropriate CPT or HCPCS code for the professional service delivered, along with the telemedicine modifier GT. The GT modifier should appear in one of the four modifier fields on the claim. The provider must also use Place of Service 02 (telemedicine distant site) when billing CPT or HCPCS codes with a GT modifier.

TOC required

305.000 Telemedicine Billing Guidelines 8-1-18

Telemedicine is defined as the use of electronic information and communication technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring. (See policy section I.)

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501-320-6428 · Fax: 501-404-4619
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TO: **Arkansas Medicaid Health Care Providers – Outpatient Behavioral Health Services**

EFFECTIVE DATE: **August 1, 2018**

SUBJECT: **Provider Manual Update Transmittal OBHS-2-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
218.000	7-1-17	218.000	8-1-18
219.200	7-1-17	219.200	8-1-18
252.111	2-1-18	252.111	8-1-18
252.115	2-1-18	252.115	8-1-18
252.116	2-1-18	252.116	8-1-18
252.117	2-1-18	252.117	8-1-18
252.118	2-1-18	252.118	8-1-18
252.121	2-1-18	252.121	8-1-18
252.122	2-1-18	252.122	8-1-18
253.001	2-1-18	253.001	8-1-18
256.200	2-1-18	256.200	8-1-18
256.400	7-1-17	256.400	8-1-18
257.100	7-1-17	257.100	8-1-18

Explanation of Updates

The above sections have been updated effective 8-1-18 for dates of services on or after 4-10-18.

Sections 218.000 and 253.001 have been updated to allow revisions to the treatment plan every 180 days.

Section 219.200 has been updated by removing the section contents and directing providers to Section I and Section III for Telemedicine information.

Sections 256.200 and 257.100 have been removed and sections reserved.

Sections 252.111, 252.115, 252.116, 252.117, 252.121, and 252.122 have been updated to remove telemedicine procedure codes, modifiers, and mode of delivery.

Section 252.118 has been updated to remove Telemedicine from Interpretation of Diagnosis.

Section 256.400 has been updated to remove Telemedicine place of service and corresponding code.

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.

TOC required

218.000 Treatment Plan 87-1-187

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment. Beneficiaries receiving only Counseling Level Services do NOT require a Treatment Plan and providers will not be reimbursed for completion of a Treatment Plan for beneficiaries receiving only Counseling Level Services. However, the provider must provide documentation of the medical necessity of Counseling Level Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate.

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services. The Treatment Plan must reflect services to address areas of need identified during the standardized Independent Assessment. The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

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

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

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

D. A projected schedule for completing reevaluations of the patient's condition and updating the Treatment Plan

The Treatment Plan for a beneficiary that is eligible for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) at a Rehabilitative Level Services or Therapeutic Communities certified Behavioral Health Agency. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional and must occur at least every ~~90~~ 180 days.

219.200 Telemedicine (Interactive Electronic Transactions) Services 87-1-187

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

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

~~A. Minimum bandwidth of fractional T1 (728 kilobytes);~~

~~B. Screen size of no less than 20 inch diagonal;~~

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

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

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

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

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

A. Possess a current license to practice in the state of Arkansas

B. Meet DMS telemedicine qualifications

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

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

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

B. Psychoeducation – (HCPCS Code H2027)

C. Psychiatric Assessment – (CPT Code 90792)

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

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

A. Mental Health Diagnosis – (CPT Code 90791)

B. Interpretation of Diagnosis – (CPT Code 90887) See Section I for Telemedicine policy and Section III for Telemedicine billing protocol.

252.111 Individual Behavioral Health Counseling

~~8~~7~~2~~-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832, U4	90832: psychotherapy, 30 min
90834, U4	90834: psychotherapy, 45 min
90837, U4	90837: psychotherapy, 60 min
~~90832, U4, U7 – Telemedicine~~	
~~90834, U4, U7 – Telemedicine~~	
~~90837, U4, U7 – Telemedicine~~	

90832, U4, U5 – Substance Abuse 90834, U4, U5 – Substance Abuse 90837, U4, U5 – Substance Abuse 90832, UC, UK, U4 – Under Age 4 90834, UC, UK, U4 – Under Age 4 90837, UC, UK, U4 – Under Age 4	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	90832: 30 minutes 90834: 45 minutes 90837: 60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 90832: 1 90834: 1 90837: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units between all 3 codes Rehabilitative/Intensive Level Beneficiary: 26 units between all 3 codes
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	

Children, Youth, and Adults	A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual Counseling / Psychotherapy Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 26 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**

• Independently Licensed Clinicians – Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.115 Psychoeducation

8~~7~~2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027, U4 ~~H2027, U4, U7 – Telemedicine~~ H2027, UK, U4 – Dyadic Treatment*	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present

	90847 – Home and Community Marital/Family Psychotherapy with Beneficiary Present 90846 – Marital/Family Behavioral Health Counseling without Beneficiary Present 90846 – Home and Community Marital/Family Psychotherapy without Beneficiary Present
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.116 Multi-Family Behavioral Health Counseling 8?2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849, U4 90849, U4, U5 – Substance Abuse	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	There are 12 total Multi-Family Behavioral Health	

	Counseling visits allowed per year. **The following codes cannot be billed on the Same Date of Service:** 90887 – Interpretation of Diagnosis ~~90887 – Interpretation of Diagnosis, Telemedicine~~
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72

252.117 Mental Health Diagnosis

~~8~~7~~2~~-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791, U4 ~~90791, U4, U7 – Telemedicine~~ 90791, UC, UK, U4 – Dyadic Treatment *	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• 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 plus strengths and needs in specified life domains • DSM diagnostic impressions to include all

	axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). ~~This service can be provided via telemedicine to beneficiaries only ages 21 and above.~~ ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors;** ○ **Developmental and medical history;** ○ **Family psychosocial and medical history;** ○ **Family functioning, cultural and communication patterns, and current environmental conditions and stressors;** ○ **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine (Adults Only)	Counseling
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.118 Interpretation of Diagnosis

8~~7~~2-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887, U4 ~~90887, U4, U7 – Telemedicine~~ 90887, UC, UK, U4 – Dyadic Treatment	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face-to-face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the master treatment plan or proposed master treatment plan or recommendations • Participant(s) response and feedback • Staff signature/credentials/date of

	signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. ~~This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service.~~ This documentation must be included in the medical record. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1 Rehabilitative/Intensive Level Beneficiary: 2
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** H2027 – Psychoeducation 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment ~~This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service.~~ This	

	documentation must be included in the medical record.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine Adults and Children	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.121 Pharmacologic Management 827-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
99212, UB, U4 – Physician 99213, UB, U4 – Physician 99214, UB, U4 – Physician ~~99212, UB, U4, U7 – Physician, Telemedicine~~ ~~99213, UB, U4, U7 – Physician, Telemedicine~~ ~~99214, UB, U4, U7 – Physician, Telemedicine~~ 99212, SA, U4 – APN 99213, SA, U4 – APN 99214, SA, U4 – APN ~~99212, SA, U4, U7 – APN, Telemedicine~~ ~~99213, SA, U4, U7 – APN, Telemedicine~~ ~~99214, SA, U4, U7 – APN, Telemedicine~~	99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination;

	Medical decision making of moderate complexity
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service ~~(When 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included)~~ • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
Applies only to medications prescribed to address targeted symptoms as identified in the treatment plan.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults and Children)	Counseling	

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.122 Psychiatric Assessment 872-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792, U4 ~~90792, U4, U7 – Telemedicine~~	Psychiatric diagnostic evaluation with medical services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service is not required for beneficiaries receiving only Counseling Level Services in the	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

Outpatient Behavioral Health Services program. The Psychiatric Assessment is required for beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities in Intensive Level Services.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults Telemedicine (Adults and Children)	**The following codes cannot be billed on the Same Date of Service:** 90791 – Mental Health Diagnosis	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72	

253.001 Treatment Plan 82-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220, U4	S0220: Treatment Plan
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the

	document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed when the beneficiary enters care and must be reviewed every ninety one-hundred eighty (90180) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	Must be reviewed every 180 calendar days
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72

256.200 Reserved~~Telemedicine Services Billing Information~~ ~~8~~72-1-18

~~The Arkansas licensed mental health professional may provide certain treatment services from a remote site to the Medicaid-eligible beneficiary who is located in a mental health clinic setting. See Section 257.100 for billing instructions.~~

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

~~National Code~~	~~Required Modifier~~	~~Service Title~~

National Code	Required Modifier	Service Title
90832	U4, U7	Individual Behavioral Health Counseling - Telemedicine
90834	U4, U7	
90837	U4, U7	
H2027	U4, U7	Psychoeducation – Telemedicine
90792	U4, U7	Psychiatric Assessment – Physician, APN – Telemedicine
99212	UB, U4, U7	Pharmacologic Management – Physician, Telemedicine
99213	UB, U4, U7	
99214	UB, U4, U7	
99212	SA, U4, U7	Pharmacologic Management – APN, Telemedicine
99213	SA, U4, U7	
99214	SA, U4, U7	
90887	U4, U7	Interpretation of Diagnosis

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

National Code	Required Modifier	Service Title
90791	U4, U7	Mental Health Diagnosis

256.400 Place of Service Codes

87-1-4718

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

Place of Service	POS Codes
Outpatient Hospital	22
Office (Outpatient Behavioral Health Provider Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/IDD	54
Other Locations	99
Outpatient Behavioral Health Services Clinic (Telemedicine)	99
Emergency Services in ER	23

257.100 ~~Outpatient Behavioral Health Services Billing Instructions~~Reserved ~~8~~7-1-18~~7~~

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

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

~~**Telemedicine Site Definitions**~~

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

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

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

~~**Telemedicine Place of Service Codes**~~

~~**Paper Claims Code = H, Electronic Claims Code = 99 Outpatient Behavioral Health Providers Clinic (Telemedicine)**~~

TOC required

218.000 Treatment Plan 8-1-18

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment. Beneficiaries receiving only Counseling Level Services do NOT require a Treatment Plan and providers will not be reimbursed for completion of a Treatment Plan for beneficiaries receiving only Counseling Level Services. However, the provider must provide documentation of the medical necessity of Counseling Level Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate.

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services. The Treatment Plan must reflect services to address areas of need identified during the standardized Independent Assessment. The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

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

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

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

D. A projected schedule for completing reevaluations of the patient's condition and updating the Treatment Plan

The Treatment Plan for a beneficiary that is eligible for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) at a Rehabilitative Level Services or Therapeutic Communities certified Behavioral Health Agency. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional and must occur at least every 180 days.

219.200 Telemedicine (Interactive Electronic Transactions) Services 8-1-18

See Section I for Telemedicine policy and Section III for Telemedicine billing protocol.

252.111 Individual Behavioral Health Counseling 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832, U4	90832: psychotherapy, 30 min
90834, U4	90834: psychotherapy, 45 min
90837, U4	90837: psychotherapy, 60 min
90832, U4, U5 – Substance Abuse	
90834, U4, U5 – Substance Abuse	

90837, U4, U5 – Substance Abuse 90832, UC, UK, U4 – Under Age 4 90834, UC, UK, U4 – Under Age 4 90837, UC, UK, U4 – Under Age 4	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	90832: 30 minutes 90834: 45 minutes 90837: 60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 90832: 1 90834: 1 90837: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units between all 3 codes Rehabilitative/Intensive Level Beneficiary: 26 units between all 3 codes

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual

	Counseling / Psychotherapy Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 26 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.115 Psychoeducation 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027, U4 H2027, UK, U4 – Dyadic Treatment*	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to	• Date of Service • Start and stop times of actual encounter with spouse/family

support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**	• Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 90847 – Home and Community Marital/Family Psychotherapy with Beneficiary Present 90846 – Marital/Family Behavioral Health

	Counseling without Beneficiary Present 90846 – Home and Community Marital/Family Psychotherapy without Beneficiary Present
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.116 Multi-Family Behavioral Health Counseling 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849, U4 90849, U4, U5 – Substance Abuse	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	There are 12 total Multi-Family Behavioral Health	

	Counseling visits allowed per year. **The following codes cannot be billed on the Same Date of Service:** 90887 – Interpretation of Diagnosis
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72

252.117 Mental Health Diagnosis 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791, U4 90791, UC, UK, U4 – Dyadic Treatment *	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• 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 plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes

	• Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors;** ○ **Developmental and medical history;** ○ **Family psychosocial and medical history;** ○ **Family functioning, cultural and communication patterns, and current environmental conditions and stressors;** ○ **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment	
ALLOWED MODE(S) OF DELIVERY	**TIER**	

Face-to-face Telemedicine (Adults Only)	Counseling
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.118 Interpretation of Diagnosis 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887, U4 90887, UC, UK, U4 – Dyadic Treatment	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face-to-face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the master treatment plan or proposed master treatment plan or recommendations • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This documentation must be included in the medical record. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1 Rehabilitative/Intensive Level Beneficiary: 2

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** H2027 – Psychoeducation 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment This documentation must be included in the medical record.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine Adults and Children	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.121 Pharmacologic Management 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
99212, UB, U4 – Physician 99213, UB, U4 – Physician 99214, UB, U4 – Physician 99212, SA, U4 – APN 99213, SA, U4 – APN 99214, SA, U4 – APN	99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history

to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.	• Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

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

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.122 Psychiatric Assessment 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792, U4	Psychiatric diagnostic evaluation with medical services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service is not required for beneficiaries receiving only Counseling Level Services in the Outpatient Behavioral Health Services program. The Psychiatric Assessment is required for beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities in Intensive Level Services.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults Telemedicine (Adults and Children)	**The following codes cannot be billed on the Same Date of Service:** 90791 – Mental Health Diagnosis
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

253.001 Treatment Plan 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220, U4	S0220: Treatment Plan

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature

NOTES	UNIT	BENEFIT LIMITS

This service may be billed when the beneficiary enters care and must be reviewed every one-hundred eighty (180) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	Must be reviewed every 180 calendar days	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

256.200 Reserved 8-1-18

256.400 Place of Service Codes 8-1-18

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

Place of Service	POS Codes
Outpatient Hospital	22
Office (Outpatient Behavioral Health Provider Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/IDD	54
Other Locations	99
Emergency Services in ER	23

257.100	Reserved	8-1-18

TOC required

218.000 Treatment Plan 8-1-18

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services through the standardized Independent Assessment. The Treatment Plan should build upon the information from any Behavioral Health provider and information obtained during the standardized Independent Assessment. Beneficiaries receiving only Counseling Level Services do NOT require a Treatment Plan and providers will not be reimbursed for completion of a Treatment Plan for beneficiaries receiving only Counseling Level Services. However, the provider must provide documentation of the medical necessity of Counseling Level Services. This documentation must be made part of the beneficiary's medical record. The documentation of medical necessity is a written assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate.

A Treatment Plan is required for beneficiaries who are determined to be qualified for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services. The Treatment Plan must reflect services to address areas of need identified during the standardized Independent Assessment. The Treatment Plan must be included in the beneficiary's medical record and contain a written description of the treatment objectives for that beneficiary. It also must describe:

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

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

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

D. A projected schedule for completing reevaluations of the patient's condition and updating the Treatment Plan

The Treatment Plan for a beneficiary that is eligible for Rehabilitative Level Services or Therapeutic Communities/Planned Respite in Intensive Level Services must be completed by a mental health professional within 14 calendar days of the beneficiary entering care (first billable service) at a Rehabilitative Level Services or Therapeutic Communities certified Behavioral Health Agency. Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the mental health professional and must occur at least every 180 days.

219.200 Telemedicine (Interactive Electronic Transactions) Services 8-1-18

See Section I for Telemedicine policy and Section III for Telemedicine billing protocol.

252.111 Individual Behavioral Health Counseling 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90832, U4 90834, U4 90837, U4 90832, U4, U5 – Substance Abuse 90834, U4, U5 – Substance Abuse	90832: psychotherapy, 30 min 90834: psychotherapy, 45 min 90837: psychotherapy, 60 min

90837, U4, U5 – Substance Abuse 90832, UC, UK, U4 – Under Age 4 90834, UC, UK, U4 – Under Age 4 90837, UC, UK, U4 – Under Age 4	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature

NOTES	**UNIT**	**BENEFIT LIMITS**
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	90832: 30 minutes 90834: 45 minutes 90837: 60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 90832: 1 90834: 1 90837: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units between all 3 codes Rehabilitative/Intensive Level Beneficiary: 26 units between all 3 codes

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	A provider may only bill one Individual Counseling / Psychotherapy Code per day per beneficiary. A provider cannot bill any other Individual

	Counseling / Psychotherapy Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 26 total individual counseling visits allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.115 Psychoeducation 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
H2027, U4 H2027, UK, U4 – Dyadic Treatment*	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to	• Date of Service • Start and stop times of actual encounter with spouse/family

support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**	• Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation / Home and Community Family Psychoeducation per SFY combined, regardless of code billed. **The following codes cannot be billed on the Same Date of Service:** 90847 – Marital/Family Behavioral Health Counseling with Beneficiary Present 90847 – Home and Community Marital/Family Psychotherapy with Beneficiary Present 90846 – Marital/Family Behavioral Health

	Counseling without Beneficiary Present 90846 – Home and Community Marital/Family Psychotherapy without Beneficiary Present
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.116 Multi-Family Behavioral Health Counseling 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90849, U4 90849, U4, U5 – Substance Abuse	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	There are 12 total Multi-Family Behavioral Health	

	Counseling visits allowed per year. **The following codes cannot be billed on the Same Date of Service:** 90887 – Interpretation of Diagnosis
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72

252.117 Mental Health Diagnosis 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90791, U4 90791, UC, UK, U4 – Dyadic Treatment *	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• 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 plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes

	• Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors;** ○ **Developmental and medical history;** ○ **Family psychosocial and medical history;** ○ **Family functioning, cultural and communication patterns, and current environmental conditions and stressors;** ○ **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment	
ALLOWED MODE(S) OF DELIVERY	**TIER**	

Face-to-face Telemedicine (Adults Only)	Counseling
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.118 Interpretation of Diagnosis 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90887, U4 90887, UC, UK, U4 – Dyadic Treatment	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face-to-face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the master treatment plan or proposed master treatment plan or recommendations • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This documentation must be included in the medical record. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.**	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1 Rehabilitative/Intensive Level Beneficiary: 2

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** H2027 – Psychoeducation 90792 – Psychiatric Assessment H0001 – Substance Abuse Assessment This documentation must be included in the medical record.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine Adults and Children	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.121 Pharmacologic Management 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
99212, UB, U4 – Physician 99213, UB, U4 – Physician 99214, UB, U4 – Physician 99212, SA, U4 – APN 99213, SA, U4 – APN 99214, SA, U4 – APN	99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service • Diagnosis and pertinent interval history

to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.	• Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

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

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

252.122 Psychiatric Assessment 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
90792, U4	Psychiatric diagnostic evaluation with medical services

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.). This service is not required for beneficiaries receiving only Counseling Level Services in the Outpatient Behavioral Health Services program. The Psychiatric Assessment is required for beneficiaries receiving Rehabilitative Level Services or Therapeutic Communities in Intensive Level Services.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults Telemedicine (Adults and Children)	**The following codes cannot be billed on the Same Date of Service:** 90791 – Mental Health Diagnosis
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Advanced Practice Nurse • Physician	03, 04, 11, 12, 49, 50, 53, 57, 71, 72

253.001 Treatment Plan 8-1-18

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
S0220, U4	S0220: Treatment Plan

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature

NOTES	UNIT	BENEFIT LIMITS

This service may be billed when the beneficiary enters care and must be reviewed every one-hundred eighty (180) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	Must be reviewed every 180 calendar days	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

256.200 Reserved 8-1-18

256.400 Place of Service Codes 8-1-18

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

Place of Service	POS Codes
Outpatient Hospital	22
Office (Outpatient Behavioral Health Provider Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/IDD	54
Other Locations	99
Emergency Services in ER	23

257.100	Reserved	8-1-18