

# Medicaid Behavioral Health Clinic/Rehabilitation Services Manual

WV DHHR Bureau for Medical Services  
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# Clinic/Rehab Collaboration



Over the past year, BMS, BHHF, behavioral health providers from across the state, and contractors for DHHR held collaborative workgroups in an effort to revise and update the Behavioral Health Clinic and Behavioral Health Rehabilitation Services, Chapters 502 and 503.

This collaboration was vital in the development of the manuals. Meetings were held weekly to biweekly on average and are credited for the successful revisions. A statewide training and multiple webinars will be conducted over the next few weeks along with agency-specific trainings over the next year as needed to assist providers to learn and implement the new policy. This presentation will be placed on both the BMS and APS Healthcare websites.

# Clinic/Rehab Manuals



Any provider of Medicaid and/or BHHF services will be expected to have working knowledge of Chapters 502 and 503 as well as other chapters relevant to the services provided (please see Chapters 100 through 900).

[www.dhhr.wv.gov/bms/pages/providermanuals.aspx](http://www.dhhr.wv.gov/bms/pages/providermanuals.aspx)

For further clarifications, you may access the BMS and APS Healthcare websites where FAQs will be posted following these trainings. APS Healthcare trainer-consultants are also available for assistance.

[www.dhhr.wv.gov/bms/hcbs/pages/default.aspx](http://www.dhhr.wv.gov/bms/hcbs/pages/default.aspx)

[www.apshealthcare.com/publicprograms/west\\_virginia/West\\_Virginia1.htm](http://www.apshealthcare.com/publicprograms/west_virginia/West_Virginia1.htm)

## **PART 2**

### **FOCUSED AND COORDINATED CARE SERVICES, TELEHEALTH SERVICES, TRANSPORTATION SERVICES, AND ALL ASSESSMENT SERVICES**

**CHAPTERS 503.12-503.13, 503.25.1-503.25.2, 503.15-503.15.6**

# Definition of Focused Service

- ▶ Members determined to have a behavioral health disorder which may be addressed through the low frequency of professional treatment services
- ▶ Treatment team consists of the professional and the member and/or member's designated legal representative who establish a treatment strategy

# Focused Care Requirements

- ▶ The provider must develop a treatment strategy that must relate directly to the behavioral health condition(s) identified as being medically necessary to treat. Documentation of on-going therapeutic and/or medication management contacts must relate directly to the treatment strategy.
- ▶ A physician/physician extender or licensed or supervised psychologist must approve the diagnosis and services (See Medical Necessity).

- ▶ Minimum of a Master's Degree in a behavioral health service field
  - Except Mental Health Assessment by Non-Physician (H0031)
  - Except current Bachelor's degree ADCs who are addressing only substance use disorders

# Focused Services

- ▶ Medical office services (billed as E/M codes)
  - Medication Management services
- ▶ Professional Individual Therapy
- ▶ Professional Group Therapy
- ▶ Assessment and Screening codes

# Definition of Coordinated Care

- ▶ Members who have severe and/or chronic behavioral health conditions that necessitate a team approach to provide medically necessary services
- ▶ Treatment is usually provided on a more intensive basis (i.e. several times per week, if not daily)
- ▶ Team consists of personnel ranging from paraprofessionals through psychiatrists in providing care
- ▶ Member is likely to have a case manager who is responsible for coordinating and facilitating care

# Coordinated Care Requirements

- ▶ **Comprehensive Service Plan**
  - Initial Plan developed when Member enters service(s) that dictates care until interdisciplinary team can meet
    - Developed within 7 days
    - Developed by the primary clinician
  - Master Service Plan developed within 30 days
    - Addresses integration and coordination of various entities and programs providing services to the member
    - On-going documentation reflects team's ability to communicate issues of concern, member progress and barriers to treatment
    - Recommendations consistent with findings of assessments/evaluations
    - Services that are of high intensity and/or shorter duration (i.e. IS, Crisis Support, Residential) may develop Master Plan at admission instead of an Initial Plan
      - Especially for those services of 30 days or shorter length

- ▶ The West Virginia Bureau for Medical Services encourages providers that have the capability to render services via Telehealth to allow easier access to services for WV Medicaid members. To utilize Telehealth providers will need to document that the service was rendered under that modality. When filing a claim the provider will bill the service code with a GT Modifier. Each service in this manual is identified as “Available” or “Not Available” for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate.

# Telehealth Equipment Requirements

- ▶ Minimum equipment standards are:
  - transmission speeds of 256kbps or higher over ISDN (Integrated Services Digital Network)
  - OR proprietary network connections including VPNs (Virtual Private Networks), fractional T1, or T1 comparable cable bandwidths.
  - Software that has been developed for the specific use of Telehealth may be used as long as it is HIPAA Compliant & abides by a federal code pertaining to Telehealth.
- ▶ The audio, video, and/or computer telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine.
- ▶ The equipment must be of a quality to complete adequately all necessary components to document the level of service for the CPT or HCPCS codes that are available to be billed.
- ▶ If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.

# Telehealth Guidelines



- ▶ The provider at the distant site is responsible to maintain standards of care within the identified scope of practice.
- ▶ All Medicaid conditions and regulations apply to Telehealth services unless otherwise specified in this manual.
- ▶ The provider must have an appropriately trained employee of the facility available in the building at all Telehealth contacts with a member. Appropriately trained is defined as trained in systematic de-escalation.
- ▶ The health care agency or entity that has the ultimate responsibility for the care of the patient must be licensed in the State of West Virginia and enrolled as a WV Medicaid provider. The practitioner performing services via telemedicine, whether from West Virginia or out of state, must meet the credentialing requirements contained within this manual.
- ▶ Telehealth providers must have in place a systematic quality assurance and improvement program relative to Telehealth services that is documented and monitored.

# Telehealth Guidelines

- ▶ All providers are required to develop and maintain written documentation of the services provided in the form of progress notes. The notes must meet the same guidelines as those required of an in-person visit or consultation, with the exception that the mode of communication (i.e., Telehealth) must be noted.
- ▶ The operator of the Telehealth equipment must be an enrolled provider or an employee or contract employee of the enrolled provider for compliance with confidentiality and quality assurance.
- ▶ The practitioner who delivers the service to a participant shall ensure that any written information is provided to the participant in a form and manner which the participant can understand using reasonable accommodations when necessary.
- ▶ Participant's consent to receive treatment via telehealth shall be obtained, and may be included in the participant's initial general consent for treatment.
- ▶ If the participant (or legal guardian) indicates at any point that he or she wishes to stop using the technology, the service should cease immediately and an alternative method of service provision should be arranged.

# Telehealth Guidelines

- ▶ The health care practitioner who has the ultimate responsibility for the care of the patient must first obtain verbal and written consent from the recipient, including as listed below:
  - The right to withdraw at any time
  - A description of the risks, benefits and consequences of telemedicine
  - Application of all existing confidentiality protections
  - Right of the patient to documentation regarding all transmitted medical information
  - Prohibition of dissemination of any patient images or information to other entities without further written consent
- ▶ BMS Manual standards apply to all services available through Telehealth unless otherwise described. Medicaid will reimburse according to the fee schedule for services provided.
- ▶ Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a Provider and a participant.

# Transportation Services

- ▶ Behavioral Health Transportation Services are the services used to physically transport a Medicaid member to/from a therapeutic or diagnostic Medicaid service that is designated in the member's service plan.

## 503.25.1 NON-EMERGENCY TRANSPORTATION BY VEHICLE OTHER AMBULANCE

### AMBULANCE

- ▶ Procedure Code: A0120HE Service Unit: Trip
- ▶ Service Limits: Six trips daily Prior Authorization: None
- ▶ **Definition: Non-emergency Transportation by minibus is a service in which a one-way transport of a member by a vehicle other than an ambulance is provided. If more than one member is being transported, each member's transport to the Medicaid service is billable. However, if multiple stops must be made for multiple members, the service provider must only bill for each member's transport to his/her Medicaid reimbursable service. (e.g., a vehicle, carrying two members from their group home, transports the first member to a physician's office and the second to a Day Treatment Program. Only two separate transports must be billed; one for each member. The provider cannot unbundle the second member's trip as two trips; one from the group home to the physician's office, since he received no service there, and the second to the Day Treatment Program).**
- ▶ **Documentation:** Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times.

## 503.25.2 NON-EMERGENCY TRANSPORTATION: PER MILE

- ▶ Procedure Code: A0160HE
- ▶ Service Unit: One mile
- ▶ Service Limits: 500 miles per month
- ▶ Prior Authorization: None
- ▶ Definition: Non-emergency Transportation: Per Mile is a service in which the member's transportation by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members. Mileage can only be calculated using the shortest, most direct route between the member's place of departure and destination. This code cannot be billed by provider staff unless a member is present in the vehicle.
- ▶ Documentation: Documentation must contain an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, actual billable mileage, and date of service.

# Mental Health Assessment by Non-Physician

- ▶ Service Unit: Event
- ▶ Telehealth: Available
- ▶ Service Limits:
  - Coordinated Care: Maximum of 4 units per year
  - Focused Care: Maximum of 2 units per year
  - After all authorizations are expired/utilized, more can be requested.
  - One global assessment may be requested per year to reaffirm medical necessity and the need for continued care/services.
  - Change of payer source does not justify H0031.

# Staff Credentials

- ▶ Minimum of a master's degree in a field of human services OR
- ▶ Registered Nurse with supervision and oversight by an individual with a minimum of a master's degree. (See Clinical Supervision)
- ▶ Bachelor's degree in a field of human services with supervision and oversight by an individual with a minimum of a master's degree. (See Clinical Supervision)
- ▶ Staff must be properly credentialed by the agency's internal credentialing committee.

# H0031 Service Definition

- ▶ Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

# H0031 Approved Causes For Utilization



- ▶ 1. Intake/Initial evaluation;
- ▶ 2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral health condition to a lesser level of care.
- ▶ 3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services;
- ▶ 4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment;

The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.

- ▶ 5. No one under the age of three (3) will have a H0031 conducted on them. The Medicaid member under the age of the 3 should be referred to the Birth to Three Program.

# Documentation Requirements for H0031 Assessment



- A. Purpose for the assessment
- B. Demographic data (name, age, date of birth, etc.);
- C. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
- D. Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
- E. History of behavioral health and health treatment (recent and remote);
- F. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
- G. Medical problems and medications currently prescribed;

## Documentation Requirements For H0031 Assessment Cont'd



- ▶ H. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
- ▶ I. Analysis of available social support system at present;
- ▶ J. Mental status examination;
- ▶ K. Recommended treatment (initial);
- ▶ L. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
- ▶ M. Place of evaluation, date of evaluation, start/stop times, signature and credentials of evaluator.
- ▶ N. Efficacy of and compliance with past treatment (If past treatment is reported)
- ▶ O. Past treatment history and medication compliance (If past treatment is reported)

# Documentation for H0031 Re-Assessment

- ▶ A. Date of last comprehensive assessment;
- ▶ B. Current demographic data;
- ▶ C. Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such).
- ▶ D. Changes in situation, behavior, functioning since prior evaluation;
- ▶ E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
- ▶ F. Mental status examination;
- ▶ G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
- ▶ H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and
- ▶ I. Place of evaluation, date of evaluation, start/stop times, signature and credentials of evaluator.

- ▶ Note: H0031, T1023HE and 90791 or 90792 are not to be billed at the same initial intake or re-assessment unless the H0031 is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment.
- ▶ Documentation must justify need for further evaluation using 90791 or 90792.

# Psychological Testing 96101 Service Limits

- ▶ Service Unit: 60 Minutes
- ▶ Telehealth: Not Available
- ▶ Service Limits: All Units must be prior authorized
- ▶ Prior Authorization: Refer to Utilization Management Guidelines

- ▶ Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology or a Supervised Psychologist under supervision of a Board approved Supervisor.

# 96101 Service Definition

Evaluation by a psychologist including psychological testing with interpretation and report (Report must be completed within 15 calendar days from the date of service)

- ▶ Psychological testing includes, but is not limited to standard psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests. This service should not be utilized for interpretation and report of technician or computer administered tests.

# 96101 Service Exclusions

- ▶ 1. Psychometrician/Technician Work
- ▶ 2. Computer-Scoring
- ▶ 3. Self-Administered Assessments
- ▶ 4. Computer-Interpretation

# 96101 Documentation Requirements

- ▶ Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:
  - Date of Service
  - Location of Service
  - Time Spent (Start/Stop Times)
  - Signature with Credentials
  - Purpose of the Evaluation
  - Documentation that Medicaid Member was present for the evaluation
  - Report must contain results (score and category) of the administered tests/evaluations
  - Report must contain interpretation of the administered tests/evaluations
  - Report must contain documentation of mental status exam
  - Report must contain a rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology
  - Report must contain recommendations consistent with the findings of administered test/evaluation

# Psychiatric Diagnostic Eval Service Limits

- ▶ 90791
- ▶ Service Unit: Event (completed evaluation)
- ▶ Service Limits: Two events per year
- ▶ Telehealth: Available
- ▶ Prior Authorization: Refer to Utilization Management Guidelines

- ▶ Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by Board approved Supervisor, a Physician, or a Physician Extender.

## 90791 Service Definition

An integrated bio-psychosocial assessment, including history, mental status, and recommendations.

- ▶ The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

# 90791 Documentation Requirements

- ▶ Documentation must contain the following and **be completed in 15 calendar days** from the date of service.
  - Purpose for the Assessment
  - Date of Service
  - Location of Service
  - Psychiatrist's/Psychologist's signature with credentials
  - Presenting Problem
  - History of Medicaid Member's presenting illness
  - Duration and Frequency of Symptoms
  - Current and Past Medication efficacy and compliance
  - Psychiatric History up to Present Day
  - Medical History related to Behavioral Health Condition
  - Mental Status Exam
  - Members diagnosis per current DSM or ICD methodology
  - Medicaid Member's prognosis with rationale
  - Rationale for Diagnosis
  - Appropriate Recommendations consistent with the findings of the evaluation

# 90792 Service Limits and Staff Credentials

- ▶ Psychiatric Diagnostic Evaluation with Medical Services
- ▶ Service Unit: Event (completed evaluation)
- ▶ Service Limits: Two events per year
- ▶ Telehealth: Available
- ▶ Prior Authorization: Refer to Utilization Management Guidelines
- ▶ Must be completed by a Physician or a Physician Extender

## 90792 Service Definition

An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

# 90792 Documentation Requirements

Documentation must contain the following and **be completed 15 calendar days** from the date of service:

- Purpose for the Assessment
- Date of Service
- Location of Service
- Psychiatrist's signature with credentials
- Purpose of the evaluation
- Documentation that Medicaid Member was present for the evaluation
- Documentation that Medical Evaluation was completed
- Presenting Problem
- History of the Medicaid Member's presenting illness
- Duration and Frequency of symptoms
- Current and Past Medication including efficacy and compliance
- Psychiatric history up to present day
- Medical History related to behavioral health condition
- Documentation of Mental Status Exam
- Medicaid Member's diagnosis per current DSM and ICD Methodology
- Medicaid Member's prognosis with rationale
- Appropriate recommendations consistent with the findings of the evaluation

# T1023HE Service Limits and Staff Credentials



## Screening by Licensed Psychologist

- ▶ Service Unit: Event (completed evaluation)
- ▶ Telehealth: Available
- ▶ Service Limits: One event every six months
- ▶ Prior Authorization: Refer to Utilization Management Guidelines
- ▶ Must be performed by a West Virginia licensed psychologist or supervised psychologist in good standing with WV Board of Examiners of Psychology

# T1023HE Service Definition

This is a screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol. Procedure codes 96101 or 90791 must be used when a more in-depth assessment is indicated.

# T1023HE Documentation Requirements

Documentation must contain the following:

- Purpose for the Assessment
- Date of Service
- Location of Service
- Start/Stop Times
- Practitioner signature and credentials
- Appropriate recommendations based on clinical data gathered in the evaluation

# 96110 Service Limits

## Developmental Testing

- ▶ Service Unit: Event (completed interpretation and report)
- ▶ Telehealth: Not Available
- ▶ Service Limits: All units must be prior authorized
- ▶ Payment Limits: This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months.
- ▶ Prior Authorization: Refer to Utilization Management Guidelines

# 96110 Staff Credentials

Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology, a psychologist who is under the supervision of a Board approved supervisor, a physician or physician extender.

## 96110 Service Definition

This is limited to developmental testing (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.

# Documentation Requirements

## Documentation must contain the following:

- Purpose for the Assessment
- Date of Service
- Location of Service
- Time Spent (start/stop times)
- Signature with credentials
- Documentation that the member was present for the evaluation
- Documentation must contain the results (scores and category) of the administered tests/evaluations
- Documentation must contain the documentation of the mental status exam
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD Methodology
- Recommendations consistent with the findings of the administered tests/evaluations.

# Follow Up Training

As follow up to the webinars being offered on the Medicaid manual, APS trainer consultants will be available for onsite trainings, simulated reviews, and phone and email consultation regarding site specific questions.

## APS Trainer Consultant Staff Available for Trainings/Simulated Reviews



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