TABLE OF CONTENTS

SECTION **PAGE NUMBER**

Background 4

Policy 5

503.1 Member Eligibility 5

503.2 Medical Necessity 5

503.3 Provider Enrollment 5

503.3.1 Enrollment Requirements: Agency Administration 6

503.3.2 Enrollment Requirements: Staff Qualifications 6

503.4 Fingerprint-Based Background Checks 7

503.5 Clinical Supervision 8

503.6 Service Certification Requirements 9

503.7 Methods of Verifying Bureau for Medical Services' Requirements 9

503.8 Rehabilitation Provider Reviews 9

503.9 Training and Technical Assistance 11

503.10 Other Administrative Requirements 11

503.11 Focused and Coordinated Care Services 12

503.12 Telehealth Services 13

503.13 Documentation 14

503.14 Assessment Services 14

503.14.1 Mental Health Assessment by Non-Physician 14

503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services) 16

503.14.3 Psychiatric Diagnostic Evaluation with Medical Services (this includes prescribing

DRAFT

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of medications) 17
503.14.4 Screening by Licensed Psychologist 18
503.15 Testing Services 19
503.15.1 Psychological Testing with Interpretation and Report 19
503.15.2 Developmental Testing: Limited 20
503.16 Service Planning Requirements 21
503.16.1 Mental Health Service Plan Development 23
503.16.2 Mental Health Service Plan Development by Psychologist 25
503.16.3 Physician Coordinated Care Oversight Services 25
503.16.4 Case Consultation 25
503.17 Supportive Services 26
503.17.1 Behavioral Health Counseling, Professional, Individual 26
503.17.2 Behavioral Health Counseling, Professional, Group 27
503.17.3 Behavioral Health Counseling, Supportive, Individual 28
503.17.4 Behavioral Health Counseling, Supportive, Group 29
503.18 Skills Training and Development 30
503.19 General Medication Services 31
503.19.1 Comprehensive Medication Services: Mental Health 32
503.19.2 Non-Methadone Medication Assisted Treatment 32
503.20 Comprehensive Programs of Services 35
503.20.1 Day Treatment 35
503.20.2 Comprehensive Community Support Services 38
503.21 Crisis Services 40
503.21.1 Crisis Intervention 40

DRAFT

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503.21.2 Community Psychiatric Supportive Treatment 41

503.22 Assertive Community Treatment (ACT) 47

503.23 Behavior Management Services 54

503.23.1 Therapeutic Behavioral Services - Development 54

503.23.2 Therapeutic Behavioral Services – Implementation 59

503.24 Transportation Services 59

503.24.1 Transportation by Minibus 59

503.24.2 Transportation: Per Mile 60

503.25 Service Limitations 60

503.26 Service Exclusions 60

503.27 Rounding Units of Service 61

503.28 Prior Authorization 61

503.28.1 Prior Authorization Procedures 61

503.28.2 Prior Authorization Requirements 61

503.29 Documentation and Record Retention Requirements 62

503.30 Billing Procedures 62

503.31 Program of Service Requirements 62

Glossary 63

Change Log 65

DRAFT

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BACKGROUND

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary behavioral health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal regulations. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the West Virginia Bureau for Medical Services (BMS).

This chapter sets forth BMS's requirements for payment of Behavioral Health Rehabilitation Services provided by Behavioral Health providers to eligible West Virginia (WV) Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of Behavioral Health Rehabilitation Services in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (WVDHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

The Bureau of Medical Services has a joint goal with Medicaid Enrolled Providers to ensure effective services are provided to Medicaid Members.

Medicaid Enrolled Providers should give priority to children that have been identified as being in the foster care system. To uphold our responsibility to children in foster care, addressing children's needs must begin at entry and by making these foster children a priority especially with the assessment services stated in *Section 503.14* and *Section 503.15* of this manual. Medicaid Enrolled Providers should make a good faith effort to complete assessments in a timely manner as well as work with Bureau for Children and Families (BCF) to ensure that information is shared in a timely manner with BCF, court systems, as well as other entities involved in the care and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid Members have the right to freedom of choice when choosing a provider for treatment. A Medicaid Member may receive one type of service from one provider and another type of service from a different provider. Providers that are found to be inhibiting freedom of choice to Medicaid Members are in violation of their provider agreement.

All Medicaid Enrolled Providers should coordinate care if a Medicaid Member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is the forefront of the Member's treatment. Appropriate Releases of Information should be signed in order that Health Insurance Portability and Accountability Act (HIPAA) Compliant Coordination of Care takes place.

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POLICY

503.1 MEMBER ELIGIBILITY

Behavioral Health Rehabilitation Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when prior authorization for Behavioral Health Rehabilitation Services is requested through the utilization management contractor (UMC) authorized by BMS to perform administrative review. The Prior Authorization process is explained in *Section 503.28* of this manual.

503.2 MEDICAL NECESSITY

All Behavioral Health Rehabilitation Services covered in this chapter are subject to a determination of medical necessity defined as follows in the managed care position paper published in 1999 by the State of WV:

Services and Supplies that are:

1. appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
2. provided for the diagnosis or direct care of an illness;
3. within the standards of good practice;
4. not primarily for the convenience of the plan member or provider; and
5. the most appropriate level of care that can be safely provided.

Medical Necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination.

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system
- Service is the appropriate level of care

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. As stated in *Section 503.14.1*, the provider may perform one assessment per calendar year in order to update medical necessity (See Service Code H0031 for more details). Diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

Providers rendering services that require prior authorization must register with BMS's UMC and receive authorization before rendering such services. Prior Authorization does not guarantee payment for services rendered. See *Section 503.28.1, Prior Authorization Procedures* and *Section 503.28.2, Prior Authorization Requirements*.

503.3 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of Behavioral Health

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Rehabilitation Services must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*.

503.3.1 Enrollment Requirements: Agency Administration

Each participating provider must develop and maintain a Credentialing Committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring the following activities:

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff has demonstrated competency to provide the services rendered.
- Review all documented evidence of credentials such as university transcripts, copies of professional licenses, certificates or documents relating to the completion of training, letters of reference and supervision, etc. must be reviewed by the committee. Based on this review, the committee must determine which services staff are qualified to provide.
- These reviews and determinations must be completed at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts/copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records.

Participating providers must develop standards for staff training, supervision, and compliance monitoring in accordance with existing state policy and federal regulations.

503.3.2 Enrollment Requirements: Staff Qualifications

Services may be rendered to Medicaid members by physician's assistants under the supervision of a psychiatrist. Services may also be rendered to Medicaid members by an Advanced Practice Registered Nurse (APRN) as defined below. An APRN without a psychiatric certification must function under the direct supervision of a WV Board of Medicine approved supervising physician. An APRN with a psychiatric certification may practice without direct supervision by a psychiatrist.

An APRN must have a signed collaborative agreement for prescriptive authority with a psychiatrist/physician. The collaborative agreement must document the professional relationship between the APRN and the psychiatrist/physician. Regulations set forth in WV Code, Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed. Physician's Assistants and/or APRNs will be referred to as physician extenders throughout the manual.

Board Approved Supervisors may only bill for the four (4) psychologists they are supervising. Board Approved Supervisors may not "trade" supervisees for billing Medicaid services.

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Documentation including required licenses, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between physician assistants/APRNs and physicians, proof of psychiatric certification as applicable, and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the Behavioral Health Facility.

All further Staff Qualifications will be indicated under the service codes. All documentation for staff including college transcripts, certifications, credentials, background checks, and trainings should be kept in the staff's personnel file and may be reviewed at any time by BMS or the Bureau's contractors or state and federal auditors.

503.4 FINGERPRINT-BASED BACKGROUND CHECKS

All Rehabilitation provider staff, having direct contact with members must, at a minimum, have results from a state level fingerprint-based background check. This check must be conducted initially and again every 3 years. If the current or prospective employee, within the past 5 years, has lived or worked out of state or currently lives or works out of state, an additional federal background check must be conducted by the Agency through the West Virginia State Police also upon hire and every 3 years of employment thereafter. Providers may do an on-line preliminary check and use these results for a period of 3 months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies that check counties in which the applicant has lived and worked within the last 5 years. An individual who is providing services or is employed by a provider cannot be considered to provide services, nor can be employed or continue to be employed if ever convicted of the following:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
  Felony drug related offenses within the last 10 years;
- Felony Driving Under the Influence (DUI) within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

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Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in conviction status of an agency staff member providing Rehabilitation services, the Rehabilitation provider must take appropriate action, including notification to the BMS Program Manager for Behavioral Health Services.

The Federal Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) must be checked by the Behavioral Health Rehabilitation Service provider for every agency staff who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services.

It is the responsibility of the employer to check the list of excluded individuals/entities monthly at:

- (LEIE) at: http://exclusions.oig.hhs.gov/;
- (Formerly EPLS) https://www.sam.gov/;

A form may be printed from this website to verify that the check occurred. Any document that has multiple staff names may be kept in a separate file and made available to staff as needed and during agency audits.

The following web addresses are provided to assist the governing body or designee to check applicants against the sex offender registries for West Virginia and the National sex offender registry, on a monthly basis. Results of this check must be present in the employee/volunteer personnel file and available for review upon request:

- West Virginia's state police offender registry is at http://www.wvsp.gov
- National sex offender registry is at http://www.nsopw.gov/

503.5 CLINICAL SUPERVISION

The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to WV Medicaid policy, therefore the provider must have a policy for Clinical Supervision including guidelines for the following:

- the responsibilities of the supervisor,
- credentialing requirements of the supervisor, and
- the minimum frequency for which supervision should occur.

Each agency shall have a chart demonstrating clinical chain of command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of their clinical and administrative supervision structure.

The clinical supervisor should have an equal or higher degree, credential, or clinical experience than those they supervise. If a clinical supervisor is responsible for a Medicaid funded program, the supervisor should be able to demonstrate familiarity with Medicaid requirements and relevant manuals. This applies to all rehabilitation services rendered.

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503.6 SERVICE CERTIFICATION REQUIREMENTS

A physician, physician extender, or psychologist must certify the need for Behavioral Health Rehabilitation Coordinated Services by:

- Signing the "Behavior Health Clinic/Rehabilitation Services, Authorization for Services" form within 72 hours of the member's admission to the program for services and prior to the start of treatment. **If an Initial Service Plan is created on day of intake then a 72-hour authorization form is not required. Upon initiation of the Initial Service Plan, the "Behavior Health Clinic/Rehabilitation Services, and Authorization for Services" form is no longer in effect since it is no longer necessary.** This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Rehabilitation Services until the development and initiation of the Initial Service Plan. The initial service plan must include all information that is required on the 72-hour authorization form.
- If a Medicaid Member is considered to be in *Focused Care* then a provider cannot bill for a Service Plan and/or Treatment Plan. No 72 hour Authorization is required for individuals receiving only Focused Treatment Services.

  For members receiving *Coordinated Care (Refer to Section 503.11)*, the following is required:

  - Development of the Initial Service Plan within seven days of the initial admission and intake
  - Development of the Master Service Plan within 30 days of the initial admission and intake
  - Review and re-evaluation of the service plan at a minimum every 90 days, or sooner if dictated by the member's needs

If any Behavioral Health Rehabilitation Services occur outside the time frames of these forms which authorize services, the services provided are not billable.

503.7 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contracted agents. BMS' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information,* of the Provider Manual and are subject to review by state and federal auditors.

503.8 REHABILITATION PROVIDER REVIEWS

The primary means of monitoring the quality of Rehabilitation services is through provider reviews conducted by the Office of Health Facility Licensure and Certification (OHFLAC) and the Contracted Agent as determined by BMS by a defined cycle.

The Contracted Agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Rehabilitation provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to receipt of Incident Management Reports, complaint data, Plan of Corrections (POC), etc.

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Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Rehabilitation provider. If potential disallowances are identified, the Rehabilitation provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Rehabilitation provider and issue a final report to the Rehabilitation Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Rehabilitation Services. A cover letter to the Rehabilitation provider's Executive Director will outline the following options to effectuate repayment:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments.

If the Rehabilitation provider disagrees with the final report, the Rehabilitation provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The Rehabilitation provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the Contracted Agent review, then the Rehabilitation Provider will receive a final letter and a final report from BMS.

For information relating to additional audits that may be conducted for services contained in this chapter please see *Chapter 800, Program Integrity* of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

Plan of Correction (POC)

In addition to the draft exit report sent to the Rehabilitation providers, the Contracted Agent will also send a draft POC electronically. Rehabilitation providers are required to complete the POC and electronically submit a POC to the Contracted Agent for approval within 30 calendar days of receipt of the draft POC from the Contracted Agent. BMS may place a pay hold on claims if an approved POC is not received by the Contracted Agent within the specified time frame. The POC must include the following:

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1. How the deficient practice for the services cited in the report will be corrected;
2. What system will be put into place to prevent recurrence of the deficient practice;
3. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
4. The date the Plan of Correction will be completed; and
5. Any provider-specific training requests related to the deficiencies.

503.9 TRAINING AND TECHNICAL ASSISTANCE

The Contracted Agent develops and conducts training for Rehabilitation providers and other interested parties as approved by BMS as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

503.10 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of BMS' policies and procedures pertaining to service planning, documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Records must be legible.
- Prior to the retrospective review all records requested must be presented to the reviewers completing the retrospective review.
- If requested the providers must provide copies of Medicaid Members records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- A point of contact must be provided by the provider throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, Behavioral Health Rehabilitation Service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information*, and *Chapter 300, Provider Participation Requirements* of the Provider Manual.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Reimbursement is not available for a telephone conversation, electronic mail message (e-mail), or facsimile transmission (fax) between a Provider and a member.
- Behavioral Health Rehabilitation services provided via Telehealth must align with *Section 503.12, Telehealth Services* of this Chapter. Medicaid will reimburse according to the fee schedule for services provided.

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503.11 FOCUSED AND COORDINATED CARE SERVICES

The Bureau of Medical Services expects that each member will receive the type and amount of behavioral health service(s) necessary to ameliorate and stabilize the behavioral health disorder(s) defining medical necessity for services. The BMS has established two levels of behavioral health treatment, with similar but somewhat differing credentialing and documentation requirements. Assessment services are not included within either category but are considered necessary to establish medical necessity for a particular service or level of care.

Focused Care: Members receiving focused services have been determined to have a behavioral health disorder which may be addressed through the provision of low frequency (generally a maximum of once per week, ranging as rarely as once each six months) professional treatment services. Services are provided by a behavioral health professional with at minimum a master's degree in a behavioral health service field, excluding Mental Health Assessment by a Non-Physician. The treatment team consists of the professional and the member and/or member's designated legal representative who together establish a treatment strategy which is documented in the member's record. The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services:

- Medical office services (billed as E/M codes);
- Professional Individual therapy
- Professional Group therapy
- Assessment and Screening codes

The treatment strategy 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.

Coordinated Care: Members requiring coordinated care are those with severe and/or chronic behavioral health conditions that necessitate a team approach to providing medically necessary care. The treatment is usually provided on a more intensive basis, several times a week if not daily. A full range of individuals may be employed in providing care, ranging from paraprofessionals through psychiatrists. The treatment team consists of the personnel involved in providing the care and includes the member and the member's guardian if any. The member is likely to have a case manager, who is responsible for coordinating and facilitating care.

Documentation consists of a comprehensive service plan. When the member enters the service, an initial plan is developed which dictates care until the interdisciplinary team can meet. An initial plan must be completed within seven days. Those services that are time-limited and of high intensity may require an initial plan immediately upon admission that is then adapted as the member moves through levels of care. Services that are projected to be of unlimited or extended duration are expected to include development of a master service plan within 30 days that describes specific objectives to be achieved during the course of treatment, stated in observable and/or measureable terms. The master service plan must address integration and coordination of various entities and programs providing services to the member. On-going documentation must reflect the team's ability to communicate issues of concern, member progress and barriers to treatment.

Services falling under Coordinated Care may include but are not limited to the following:

- Assertive Community Treatment
- Professional Individual Therapy

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- Professional Group Therapy
- Crisis Stabilization and detoxification services
- Targeted Case Management
- Comprehensive Community Support Services
- Basic Living Skills
- Intensive Service Programs
- Supportive Counseling
- Professional therapy and medication management provided in the context of the Coordinated Care services
- Residential Care for Children and Youth
- Emergency Shelter Care
- Day Treatment

503.12 TELEHEALTH SERVICES

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.

- 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 the software is HIPAA Compliant and 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 telecommunication 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.
- 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 that involves patient management.
- 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.

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- 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, a contracted employee, or an employee of the enrolled provider for compliance with confidentiality and quality assurance.
- The practitioner who delivers the service to a member shall ensure that any written information is provided to the member in a form and manner which the member can understand using reasonable accommodations when necessary. Member's consent to receive treatment via Telehealth shall be obtained, and may be included in the member's initial general consent for treatment.
- If the member (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.
- 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.

503.13 DOCUMENTATION

The WV Bureau for Medical Services recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy based system. When services require documentation the Bureau will accept both types of documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice.

503.14 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by suitably trained staff credentialed by the internal credentialing policies and procedures of the agency. Assessment services are designed to make determinations concerning the mental, physical and functional status of the member. Those identified as being in the Foster Care system should receive assessment as rapidly as possible.

503.14.1 Mental Health Assessment By Non-Physician

Procedure Code: H0031
Service Unit: Event
Telehealth: Available
Service Limits: Maximum of (four) 4 per year for members with complex behavioral healthcare needs (Coordinated Care) and (two) 2 per year per member with relatively simple behavioral healthcare needs (Focused Care). The provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Change of payer source does not justify H0031.

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Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required (See Clinical Supervision). Staff must be properly credentialed by the agency's internal credentialing committee.

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.

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. If the child is aging out of the Birth to Three Program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted.

Documentation:

1. Initial/intake (may include use of standardized screening tools):

   A. Demographic data (name, age, date of birth, etc.);
   B. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
   C. 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;
   D. History of behavioral health and health treatment (recent and remote);
   E. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
   F. Medical problems and medications currently prescribed;
   G. 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;
   H. Analysis of available social support system at present;

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I. Mental status examination;
J. Recommended treatment (initial);
K. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and
L. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.
M. Efficacy of and compliance with past treatment. (If past treatment is reported)
N. Past treatment history and medication compliance (If past treatment is reported)

2. 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**.

503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: Two events per year

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, a Physician, a Physician Extender, or a Supervised Psychologist who is supervised by a Board Approved Supervisor.

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.

Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date

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of service.

- Date of Service
- Location of Service
- Purpose of Evaluation
- 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 - The Mental Status Exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of Consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought Process/Form and Thought Content
    - Suicidality and Homicidality
    - Insight and Judgment
- Members diagnosis per current DSM or ICD methodology
- Rationale for Diagnosis
- Medicaid Member's prognosis for treatment
- Rationale for Prognosis
- Appropriate Recommendations consistent with the findings of the evaluation

503.14.3 Psychiatric Diagnostic Evaluation With Medical Services *(This Includes Prescribing of Medications)

Procedure Code: 90792
Service Unit: Event (completed evaluation)
Service Limits: Two events per year
Telehealth: Available

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Must be completed by a physician or a physician extender

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.

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Documentation: Documentation/Report must contain the following and be completed in 15 calendar days from the date of service.

- Date of Service
- Location of Service
- Purpose of the evaluation
- Psychiatrist's signature with credentials
- 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
- Mental Status Exam - The Mental Status Exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of Consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought Process/Form and Thought Content
    - Suicidality and Homicidality
    - Insight and Judgment
- Medicaid Member's diagnosis per current DSM and ICD Methodology
- Rationale for Diagnosis
- Medicaid Member's prognosis for treatment
- Rationale for Prognosis
- Appropriate recommendations consistent with the findings of the evaluation

503.14.4 Screening By Licensed Psychologist

Procedure Code: T1023 HE
Service Unit: Event (completed evaluation)
Telehealth: Available
Service Limits: One event every six months

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia Licensed psychologist or Supervised Psychologist in good standing with WV Board of Examiners of Psychology

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

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in-depth assessment is indicated.

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

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

503.15 TESTING SERVICES

The following services are used for the testing of cognitive function of the central nervous system. The testing of cognitive processes, visual motor responses, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. The service report times include the face-to-face time with the patient and the time spent interpreting and preparing the report.

503.15.1 Psychological Testing With Interpretation and Report

Procedure Code: 96101
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology or a Supervised Psychologist who is supervised by a Board Approved Supervisor.

Definition: Evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to standard psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status and/or social history of an individual are also included. 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 interpreted, completed and reported technician-and computer-administered tests.

Note: Interpretation and report of technician and computer-based tests may not be completed using this service. It is intended for the integration of previously interpreted and reported technician and computer-based tests.

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

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- 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
- Mental Status Exam - The Mental Status Exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of Consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought Process/Form and Thought Content
    - Suicidality and Homicidality
    - Insight and Judgment
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology.
- Recommendations consistent with the findings of administered tests/evaluations

Service Exclusions:

- Psychometrician/Technician Work
- Computer - Scoring
- Self-Administered Assessments
- Computer – Interpretation

503.15.2 Developmental Testing: Limited

Procedure Code: 96110
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

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the WV Board of Examiners of Psychology, a Physician, a Physician Extender, or a Psychologist who is supervised by a Board Approved Supervisor.

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

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

- Date of Service
- Location of Service
- Purpose of Evaluation
- 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 interpretation, diagnosis, and recommendations.
- Mental Status Exam - The Mental Status Exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of Consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought Process/Form and Thought Content
    - Suicidality and Homicidality
    - Insight and Judgment
- Rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology
- Recommendations consistent with the findings of the administered tests/evaluations.

Service Exclusions:

- Psychometrician/Technician Work
- Computer - Scoring
- Self-Administered Assessments
- Computer – Interpretation

503.16 SERVICE PLANNING REQUIREMENTS

Coordinated Care Services:

Service planning and consultation is available only in the Coordinated Care model of service provision. Service planning codes cannot be billed when the development of a service plan is an integral aspect of the service being provided (for example, Community Psychiatric Supportive Treatment). Service planning is to be conducted when multiple programs and services need to be coordinated by a team representative of the differing agencies and provider groups providing care to the member.

All members receiving coordinated care must have a master service plan. The Agency may choose to create one plan that is modified as the individual moves through a service, or may choose to create an initial service plan

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followed by a master service plan. Agencies with services with shorter lengths of stay may choose the first option if the length of stay is predicted to be less than thirty days.

The initial service plan must be completed within 7 days of admission to a service. The plan must be completed by the primary clinician and the member and/or member's guardian.

Development of the initial plan without the entire interdisciplinary team is not a billable service (see Service Plan Development for clarification and description of exceptions). The initial plan of service describes the services and/or supports the member is to receive until the assessment process is complete and the master plan of service is developed. This initial plan shall consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed;
- A listing of immediate interventions to be provided along with objectives for the interventions;
- A date for development of a master plan of services. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 days from the date of the signing of the initial plan. If a program is an intensive service the master plan must be completed within 7 days; and
- The signature of the member and/or DLR, intake worker, physician and other persons participating in the development of the initial plan.

The Master Service Plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessment(s) during the treatment process.

The Master Plan is developed within 30 days of admission and must include:

- Date of development of the plan;
- Participants in the development of the plan;
- A statement or statements of the goal(s) of services in general terms;
- A listing of specific objectives that the service providers and the member hope to achieve or complete;
- The measures to be used in tracking progress toward achievement of an objective;
- The technique(s) and/or services (intervention) to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives; and
- Discharge Criteria
- A date for review of the plan, timed in consideration of the expected duration of the program or service.
- Start and Stop Times
- Credentials

It is expected that objectives be specific, measureable, realistic and capable of being achieved in the time available in the projected duration of the program or service.

Service plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service plans must be revisited at critical treatment junctures including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective the service plan must reflect consideration by the team of changes in the intervention strategy.

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503.16.1 Mental Health Service Plan Development

Procedure Code: H0032
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 16 units per 90 day period. If Medicaid Member is in *Focused Care* H0032 cannot be billed.

Prior Authorization: Refer Utilization Management Guidelines.

Definition: An individual service plan is required for all members receiving services through *Coordinated Care.* The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session. All members of the team must receive adequate notice of the treatment team meeting. If a member of the team does not come, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A physician extender may serve on the committee in place of the physician.

An Initial Service Plan is developed based on intake information within seven days of intake; a Master Service Plan is developed within 30 days of intake and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's needs.

All service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours of the service plan meeting and prior to implementing services.

The physician, designated physician extender, or licensed or supervised psychologist must be present physically or by Telehealth and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician or physician extender has been specifically requested by the case manager or the member.

The case manager is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictate. Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the inclusion of the member. The agency providing services to the member may bill for participation by any of their staff necessary for the service planning process. Participation by staff from other agencies is not billable by the agency coordinating the service planning session. Participation by family members is not billable. It is important to

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remember that, although coordination of the service planning process is the responsibility of the case manager, development of the service plan is the responsibility of the treatment team.

Providers must make the proper distinction between service planning and other activities related to case management for the member. The case manager may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plans, educational plans, etc. as called for by the member's Master Service Plan. These types of activities may constitute billable time for case management services; ***however, when the case manager participates in a treatment team meeting he/she must bill Mental Health Service Plan Development rather than Targeted Case Management.***

Individual program plans for Day Treatment, Children's Residential Services (Please refer to *Chapter 531, Policy 531.2 Residential Children Services*), and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services.

Mental Health Service Plan Development reimburses for team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.

Documentation: The following documentation is required for substantiation of Mental Health Service Plan Development:

- A service plan signature page is required. This document is to be placed in the member's clinical record along with the completed service plan or service plan update.
  - There must be signatures of all participating members of the treatment team (including the member, their guardian, or the member's requested representative).
  - All signatures must be original, must include the title and credentials of the individual, must be dated by the treatment team member, and must include the actual time spent providing the service by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process.
- If a staff person from another agency participates in the service planning session, he/she must:
  - Meet the previously listed requirements of the service plan signature page. This includes signing the signature page along with listing the agency they are representing.
  - Write an activity note (which must be included in **their** agency's clinical record) that states their purpose for participating in the meeting, their signature and credentials, the location of the session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.

Documentation must contain the physician's signature or that of the psychologist or physician extender on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within 7 calendar days by the member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.

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503.16.2 Mental Health Service Plan Development By Psychologist

Procedure Code: H0032 AH
Service Unit: 15 Minutes
Telehealth: Available
Service Limits: One unit per month

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: These are activities performed by a licensed psychologist directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Mental Health Service Plan Development.

Documentation: Documentation must contain the licensed psychologist's signature, **in ink or in an electronic documentation system**, on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and stop times of his/her participation. A psychologist under supervision of a Licensed Psychologist may perform this service with oversight of their Supervising Licensed Psychologist. The Supervising Licensed Psychologist must indicate their oversight by their signature and the date.

503.16.3 Physician Coordinated Care Oversight Services

Procedure Code: G9008
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 2 units per 90 days

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by physician or physician extender.

Definition: These are activities performed by a physician or physician extender directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to Mental Health Service Plan Development.

Documentation: Documentation must contain the physician or physician extender's signature, date of signature, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

503.16.4 Case Consultation

Procedure Code: 90887
Service Unit: Event
Telehealth: Available
Service Limits: 1 unit per 90 days

Prior Authorization: Refer to Utilization Management Guidelines

Definition: A Case Consultation Service is an interpretation or explanation of results of psychiatric, and other

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medical examinations and procedures through the requesting clinician to family or other responsible persons.

These are services provided at the request of a professional requiring the opinion, recommendation, suggestion and/or expertise of another professional for a specific purpose regarding services and/or activities of a member relevant to the particular area of expertise of the consulting professional. The consulting professional must be licensed or certified in the needed area of expertise. Case Consultation may not be used during service planning. The member's case manager cannot be a case consultant. Professional staff persons who participated in the current member's service plan within the current 90 day period, or were directed to provide treatment, cannot bill for case consultation.

Only the consulting professional's time may be billed for this service. Any other professional(s) involved in the case consultation may not bill case consultation for their time. The consulting professional whose services are being billed must currently be an enrolled Medicaid provider if he/she is not an employee (either directly or under contract) of the agency seeking consultation.

Documentation: The consulting professional must document a summary of the consultation that includes: purpose, activities/services discussed, recommendations with desired outcomes, the relationship of the consultation to a specific objective(s) in the service plan, date of service, location, signature and credentials of the consulting professional, and the actual time spent providing the service by listing the start-and-stop times of the consultation.

503.17 SUPPORTIVE SERVICES

503.17.1 Behavioral Health Counseling, Professional, Individual

Procedure Code: H0004 HO
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 60 units per year

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Individual, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions

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and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service.

Often by necessity, Behavioral Health Counseling of children will involve work with parents as the agent of change in maladaptive behavior of children. Structured behavior therapies designed to provide parents with therapeutic tools to control and modify inappropriate behavior and promote adaptive coping behaviors are considered to be appropriate use of this service.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

503.17.2 Behavioral Health Counseling, Professional, Group

Procedure Code: H0004 HO HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: 50 units per year

Payment Limits: Behavioral Health Counseling, Professional, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Professional, Group, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Definition: Behavioral Health Counseling, Professional, Group, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions.

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Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member in a group setting.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Group so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

Documentation: Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal on the Plan. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

503.17.3 Behavioral Health Counseling, Supportive, Individual

Procedure Code: H0004
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another Behavioral Health service to meet service definition and medical necessity The supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Individual, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

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Supportive counseling should:

1. Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
2. The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

503.17.4 Behavioral Health Counseling, Supportive, Group

Procedure Code: H0004 HQ
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

Definition: Behavioral Health Counseling, Supportive, Group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Group, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Service Description:

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Supportive counseling should:

1. Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
2. The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Documentation: There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the member's response to the supportive intervention including any improvement or exacerbation of symptoms.

503.18 SKILLS TRAINING AND DEVELOPMENT

Procedure Code:	H2014 U4	Skills Training 1:1 by Paraprofessional
	H2014 U1	Skills Training 1:2-4 by Paraprofessional
	H2014 HN U4	Skills Training 1:1 by Professional
	H2014 HN U1	Skills Training 1:2-4 by Professional
Service Unit:	15 minutes	
Telehealth:	Not Available	
Service Limits:	All units must be prior authorized	

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Skills Training and Development is a combination of structured individual and group activities offered to members who have basic skill deficits. These skill deficits may be due to several factors such as history of abuse or neglect, or years spent in institutional settings or supervised living arrangements that did not allow normal development in the areas of daily living skills.

The purpose of this service is to provide therapeutic activities focused on Skills Training and Development Services which are elementary, basic, and fundamental to higher-level skills and are designed to improve or preserve a member's level of functioning. Therapeutic activities may be provided to a member in his/her natural environment through a structured program as identified in the goals and objectives described in the service plan. Therapeutic activities include, but are not limited to:

- Learning and demonstrating personal hygiene skills
- Managing living space
- Manners
- Sexuality
- Social appropriateness

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- Daily living skills

Where these services are provided in a group context, the group must be limited to four members to each staff person. In any setting, these services target members who require direct prompting or direct intervention by a provider.

Recreational trips, visits to the mall, recreational/leisure time activities, activities which are reinforcements for behavioral management programs, and social events are not therapeutic services and cannot be billed as Skills Training and Development Services.

The following guidelines apply to Skills Training and Development Services provided to young children:

- The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual children.
- The service must not be utilized to provide therapeutic activities for children under the age of five in a group setting for more than four hours per day or more than four days per week.
- Therapeutic activities for young children must promote skill acquisition, include necessary adaptations and modifications, and be based upon developmentally appropriate practice. These services must also be provided in a way that supports the daily activities and interactions within the family's routine.

Skill acquisitions for Skills Training and Development Services for young children include, but are not limited to:

- Adaptive, self-help, safety, and nutritional skills
- Parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
- Interpersonal and communication skills
- Mobility, problem solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

Documentation: Documentation must contain an activity note describing the service/activity provided and the relationship of the service/activity to objectives in the member's service plan. Documentation must include: the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

Additionally, if the service is provided in a ratio of 1:2-4, there must be an attendance roster listing those members and staff who participate in each ratio. The roster must be signed (with credential initials) and dated by staff that provided the service. It must not be stored in the main clinical record, but must be maintained and be available for review.

503.19 GENERAL MEDICATION SERVICES

General medication services assist a Medicaid member in accessing behavioral medication or medication services. (Methadone administration or case management is not covered.)

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503.19.1 Comprehensive Medication Services: Mental Health

Procedure Code: H2010
Service Unit: 15 minutes
Telehealth: Available
Service Limits: All units must be prior authorized

Payment Limits: This service includes all physician and nurse oversight; therefore, neither Community Psychiatric Support Treatment (procedure code H0036), Pharmacologic Management (E&M Codes), nor any other physician code can be billed on the same day as Comprehensive Medication Services; Mental Health.

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: Physician or Physician Extender

Definition: Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy. These services include obtaining the sample for necessary blood work and the laboratory results for a member by a registered nurse and subsequent evaluation of the results by the physician and/or physician extender as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. This is a physician directed service, a physician or physician extender must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. Methadone is **not** a covered medication.

Members receiving this service are not precluded from receiving other Behavioral Health Rehabilitation Services on the same day (except for those indicated in this service's definition or "Payment Limits") as long as the actual time frames do not overlap.

Documentation: Documentation must contain a written note of the assessment results as completed by the registered nurse, and other laboratory results, and current psychotropic medication dosage with authorized pharmacy name. The documentation must include: place of service, start/stop time and date of service, and signature of qualified staff providing the service.

503.19.2 Non-Methadone Medication Assisted Treatment

Non-Methadone Medication Assisted Treatment Guidelines:

West Virginia Medicaid covers non-Methadone Medication Assisted Treatment Services under the following circumstances:

- Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician as specified below, before beginning medication assisted treatment.
- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.

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- All physicians agree to adhere to the Coordination of Care Agreement (*See Appendix 503B*) which will be signed by the member, the treating physician and the treating therapist.
- Each member receiving non-methadone medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.
- The agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

Physician Requirements: The physician responsible for prescribing and monitoring the member's treatment must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider.

Therapy Services: Therapy for Non-Methadone Assisted Treatment Patients is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service **(See Program Guidelines for Professional Therapy Requirements).**

Any therapeutic intervention applied must be performed by a minimum of a Master's Level Therapist using the generally accepted practice of therapies recognized by national accrediting bodies of:

- Psychology plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Psychiatry plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Counseling plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Social work plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions

Physician and Professional Therapy services will be provided for individuals utilizing Buprenorphine, Suboxone® strips, or Vivitrol®.

Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic interventions. The plan must also include a schedule detailing the frequency for which therapy services are to be provided.

A member receiving focused care (Physician and Professional Therapy only) will require a treatment strategy in lieu of a Master Service Plan. The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the objectives utilizing individual therapeutic interventions. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic

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intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Physicians and/or agencies may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of professional therapeutic services per month. The four hours must contain a **minimum** of one (1) hour individual professional therapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of professional therapeutic services per month individual, family, or group. Frequency of therapeutic services may increase based upon medical necessity.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens must be maintained in the member's record. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment:
Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as: two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's discretion. The physician and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

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Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol® will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. The Physician must work with another physician that has a DEA-X. The physician taking responsibility for prescribing and monitoring the member's treatment while the primary physician is unavailable must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed, board certified and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider so that treatment is not interrupted for any reason for Medicaid Members participating in this service. If a physician fails to have a plan in place **a hold will be placed on all Rx authorizations**. At no time is an APRN or a Physician's Assistant to prescribe Suboxone®.

503.20 COMPREHENSIVE PROGRAMS OF SERVICES

Comprehensive services are all-inclusive and may have only a few services which can be billed separately.

503.20.1 Day Treatment

Procedure Code: H2012
Service Unit: 60 minutes
Telehealth: Not Available
Service Limits: All units must be prior authorized

Payment Limits: Day Treatment services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Behavioral Health Rehabilitation Day Treatment is a structured program of on-going, regularly scheduled therapeutic activities to increase a member's skill level, produce behavioral change which improves adaptive functioning, and/or which facilitates progress toward more independent living in accordance with member's potential and interest as reflected in the Service Plan.

Day Treatment Services for adults have a maximum staff-to-member ratio of one staff person per five members. They must be available for five days a week for a minimum of four hours each day.

For children under age five, the maximum ratio is one staff per four children. Day Treatment Services for children under the age of five must not be utilized to provide therapeutic activities for more than four hours per day and no more than four days per week.

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Day Treatment Services must only be provided at a site listed on the provider's behavioral health provider license. **Activities provided for the purpose of leisure or recreations are not billable services.**

Day Treatment Services include activities occurring in a therapeutic environment designed to increase the members' skills in specific areas. These activities may consist of small group activities using training modules or structured developmental exercises which present the opportunities for members to practice and use developing skills, or participate in member meetings designed to develop social skills. The intensity, frequency, and type of Day Treatment activities must be appropriate to the age and functional level of the member.

Progress on all objectives must be reviewed at 90 day intervals. Any objective that results in no progress after two consecutive 90 day intervals must be discontinued or modified. Areas of intervention may include but are not limited to the following:

- Self-care skills
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction
- Carryover of physical and/or occupational therapy
- Interpersonal skills instruction
- Functional community skills (such as recognizing emergency and other public signs, money management skills, travel training, etc.)
- Volunteering in community service settings
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other services necessary for a member to participate in the community settings of his/her choice

Program Staff Requirements:

- The Day Treatment program supervisor must meet one of the educational criteria along with the training and experience criteria listed below:
  - Education Criteria (one of the educational criteria must be met):
    - Licensed Psychologist (or Masters level psychologist under supervision for licensure)
    - Licensed Professional Counselor
    - Licensed Certified Social Worker
    - Licensed Social Worker with a minimum of a Bachelor's degree
    - Registered Nurse
    - Masters or Bachelor's level in education with a specialization to a disability group and teaching certification
    - Occupational/recreational or physical therapist with appropriate state certification and licensure
    - Certified Addiction Counselor with minimum of a bachelor degree
    - Master's degree in a human services field with 20 hours verified of training specific to the target population served
    - Bachelor's level degree in a human services field with at least one year of specific experience providing services to the target population served.
  - Training Criteria

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        - Each qualified staff person must have verified training, experience, and skills specific to the targeted population served by the Day Treatment Program
    - Experience Criteria
        - All Bachelor level staff are required to obtain 15 hours every two years of continued education relevant to the targeted population served or the provision of Day Treatment Services
- Staff with a Bachelor's degree in a human service field that does not specifically provide training in developmental disabilities services must meet one of the three following criteria:
    - Completion of specific courses relating to developmental disabilities
    - Completion of staff development in-service or classes relating to developmental disabilities
    - Completion of 15 hours every two years of continuing education relating to developmental disabilities.
- Paraprofessional staff must have, at a minimum, the following qualifications:
    - Be at least 18 years old
    - A high school diploma or Graduate Equivalent Degree
    - Be currently certified in Standard First Aid and Adult/Child Cardiopulmonary Resuscitation
    - Successfully completed Behavioral Health agency training in all of the following criteria:
        - Various aspects of developmental disabilities
        - Instructional techniques necessary to achieve objectives of individual's program plans
        - Health related issues
        - Recognition of abuse and neglect
        - Individuals' rights and confidentiality
        - Awareness of, and sensitivity to, family and individual's needs
        - Non-aversive behavior intervention techniques for those providers who are implementing behavior support and intervention plans

The Behavioral Health Rehabilitation Provider must maintain documentation of training and qualifications.

Documentation:

- Documentation must contain a daily summary of Day Treatment Services that includes the total time in attendance at the Day Treatment Program by listing the start and stop times of each member's attendance, the place of service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary. This documentation is not required to be stored in the main clinical record, but must be maintained and be available for review.
- Documentation must also include an activity note that describes each separate service/activity provided and the relationship of the service to objectives in the service plan. This includes the signature of staff providing the service along with their credentials, place of service, date of service, and actual time spent providing the service by listing the start and stop times. **Note: All treatment objectives provided in the Day Treatment Program must be included on the member's Master Service Plan (or 90 day update).**
- There must be a daily attendance roster listing those members and staff who participate in each ratio. The roster must be signed (with credential initials) and dated by staff that provided the service. This daily attendance roster must not be stored in the main clinical record, but must be maintained and be available for review.
- There must be monthly notes that summarize progress on the objectives specified in the individual member's service plan or Day Treatment Plan. This documentation must be reviewed at 90 day intervals. The review summaries must be placed in the member's master clinical record. Any objective that results in no progress or desired changes after two consecutive 90 day periods must be discontinued or modified.

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Day Treatment Program Certification Process:

Behavioral Health Rehabilitation providers must obtain approval from BMS to provide Day Treatment Services and to bill the West Virginia Medicaid Program for such services. Providers must complete and send the Day Treatment Program Certification form to BMS.

Any changes from an approved original certification must be submitted with corresponding rationale for the changes. A Day Treatment Program must recertify every 2 years. This submission must include a summary of utilization information for the 2 years. Specific content is listed on the Application for Day Treatment Program Certification (*See Appendix 503C*) used by BMS.

503.20.2 Comprehensive Community Support Services

Procedure Code: H2015
Telehealth: Unavailable
Service Unit: 15 minutes
Service Limits: All units must be prior authorized

Payment Limits: Comprehensive Community Support services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Comprehensive Community Support is a long-term, preventive, and rehabilitative service designed to serve members with severe and persistent mental illness whose quality of life and level of functioning would be negatively impacted without structured, ongoing skill maintenance and/or enhancement activities. This is a structured program of ongoing, regularly scheduled activities designed to maintain a member's level of functioning, prevent deterioration which could result in the need for institutionalization, and/or facilitate a member's return to their previously demonstrated level of functioning. This may be accomplished through skill maintenance and/or development and behavioral programming designed to maintain or improve adaptive functioning. This service emphasizes community-based activities.

Comprehensive Community Support Services are to be provided in accordance with the member's potential and interests as reflected in the Master Service Plan. The intensity, frequency and type of Comprehensive Community Support activities must be appropriate to the age and functional level of the member, and individualized to meet their own specific needs and future plans. Critical skills identified as essential to maintain placement in the community and preventing hospitalization will also be targeted for skill maintenance/enhancement.

Examples of skill areas (if the member has the specific need) include:

- Health Education - first aid, pedestrian and passenger safety, home safety
- Meal Preparation - nutrition, menu planning, cooking
- Personal Hygiene - grooming, oral and general body care
- Utilization of Community Resources - church groups, clubs, volunteer work, getting and keeping entitlements, learning to access recreational opportunities, Internet and computer skills, etc. [Note: Recreational activities themselves (including trips to a mall, activities which may be reinforcement for a behavioral program, and social events) are not billable under this code.]

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- Interpersonal Skills
- Problem Solving
- Communications - assertiveness, correspondence, initiating conversation, giving and taking compliments and criticism, body language, active listening, etc.
- Stress Reduction - relaxation techniques, biofeedback, etc.
- Interpersonal relationships with peers, caregivers, family, etc.
- Interaction with strangers
- Social Skill Development and Coping Skills
- Social Competence - social skill training, presenting opportunities for social interaction
- Understanding Mental Illness - medication usage, course of the illness, symptom management, coping mechanisms, normalization, etc.

This service has a maximum staff-to-member ratio of one staff person per 12 members when provided at a licensed site; and a maximum staff-to-member ratio of one staff person to eight members when provided in a community setting. The amount of Comprehensive Community Support provided is individually determined and should not automatically reflect the program's operating hours. Members eligible for Comprehensive Community Support do not meet medical necessity for Day Treatment services. Comprehensive Community Support services must be based at a site listed on the agency's behavioral health license. Training may occur onsite or in community settings.

DOCUMENTATION:

- All treatment objectives addressed in a Comprehensive Community Support Program must be included on the member's Individual Master Service Plan.
- A daily attendance roster reflecting all participants (with start-and-stop times of participation specific to each member) must be maintained and available for review at the community treatment site. The roster must be signed and dated by all staff that have been providing Comprehensive Community Support Services, and must list staff start-and-stop times. The daily attendance roster must note the location of the services/activities and actual staff/member ratios. It is not required to be maintained in the master clinical record, but must be maintained in accordance with Medicaid records retention policy. After one year, daily attendance rosters may be stored at the provider's record retention facility.
- Documentation for each daily episode of Comprehensive Community Support must include a description of the service/activity provided and the relationship of the service/activity to objectives in the service plan. Progress on each objective in the service plan being addressed must be noted. Documentation must include the date of service, start-and-stop time spent for each specified activity, and the location of the service/activity. Daily documentation must become part of the master clinical file.
- When services are reviewed by the treatment team as part of the service planning process, each objective being implemented in the Comprehensive Community Support Program must be addressed. Documentation must include progress toward objectives, problems that impeded progress, and provide a decision to continue the same plan, or adjust the plan to meet the changing needs of the member. Additionally, all documentation requirements for Mental Health Service Plan Development (procedure code H0032) must be satisfied.

Staff Qualifications:

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- The Comprehensive Community Support program site must be supervised by a Qualified Mental Health Professional (QMHP) with a minimum of a Bachelor's degree and experience working with individuals with serious and persistent mental illness. The full-time-equivalent hours in the agency's job description for the supervisor must reflect the number of hours expected supervising the program If the supervisor is included as part of the direct care ratio, the hours spent supervising must be outside of the direct care hours provided by the supervisor.
- Paraprofessional staff must possess at a minimum a high school diploma and have verified training, experience and skills specific to working with individuals with serious and persistent mental illness.

Comprehensive Community Support Program Certification Process:

- All Comprehensive Community Support programs require approval through the completion of the Comprehensive Community Support Certification Form. The application is reviewed and subject to approval by the Bureau for Medical Services.
- New Comprehensive Community Support Programs must submit the Comprehensive Community Support Certification Form to BMS for approval. All programs must be based at a site listed on the provider Behavioral Health License. Billing may commence after receiving initial Bureau approval.
- After initial approval, a desk review and/or an onsite review will be conducted to validate the approval. BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per policy contained in *Chapter 100, General Administration and Information*,, Medicaid regulations.
- Any changes from an original certification must be submitted with corresponding rationale for the changes. (*See Appendix 503D*).

503.21 CRISIS SERVICES

503.21.1 Crisis Intervention

Procedure Code: H2011
Service Unit: 15 minutes- 16 units per 30 days
Telehealth: Not Available
Service Limits: Refer to Utilization Management Guidelines.

Prior Authorization: Refer to Utilization Management Guidelines

Staff Credentials: Bachelor's degree in Human Services with specific documented training on crisis intervention

Definition: Crisis Intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions in order to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize and create a plan as quickly as possible. This service is not intended for use as an emergency response to situations such as members running out of medication or housing problems. Any such activities will be considered inappropriate for billing of this service by the provider.

Documentation: Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the

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signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

A physician, physician extender, supervised psychologist or licensed psychologist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow up and whether the treatment plan is to be modified or maintained, the signature and credentials of the physician, physician extender, supervised psychologist or licensed psychologist and the date of service. The signature will serve as the order to perform the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.

Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations.

Exclusions

Listed below are activities that are excluded from being performed through the Crisis Intervention Service Code

- Response to a Domestic Violence Situation
- Admission to a Hospital
- Admission to a Crisis Stabilization Unit
- Time awaiting for Transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

503.21.2 Community Psychiatric Supportive Treatment

Procedure Code: H0036
Service Unit: 15 minutes
Telehealth: Available – for medical services provided by a physician or physician extender only. Daily face to face meeting with physician must be in person
Service Limits: 288 units per six months

Payment Limits: No payment will be made for any other Behavioral Health Rehabilitation Services, except for Targeted Case Management (procedure code T1017). Billing for Community Psychiatric Supportive Treatment cannot exceed 48 units in a 24 hour period (midnight to midnight) and must be utilized on consecutive days.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Community Psychiatric Supportive Treatment is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate crisis episode). This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

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Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-going. These services are not intended for use as an emergency response to situations such as members running out of medication, or loss of housing. Any such activities will be considered as non-reimbursable activities. Since this service is intended to address an episode, it must be rendered on consecutive days of service. Community Psychiatric Supportive Treatment cannot be rendered on alternate days such as Tuesday and Thursday or only on Mondays, Wednesdays, and Fridays; with other days of non-service (such as holidays or weekends) or other intervening services interrupting the episode. Community Psychiatric Supportive Treatment is an acute and short-term service.

Community Psychiatric Supportive Treatment Programs must be available seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e. substance abuse, mental health). The other staff must have an LPN or higher degree in the medical field (See Glossary for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.

The program must have access to a psychiatrist/physician/physician extender to provide psychiatric evaluations and medication orders at all times.

Much of the structured, staff-directed activity or face-to-face activity which has been documented in an activity note can be considered billable time. Some examples of billable versus non-billable time are as follows:

- Billable activities:
  - Structured, staff-directed activities such as therapies and counseling
  - Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
  - Time spent in treatment team meetings or staff consultation
  - Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
  - Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day. The physician must document the need for the observation as related to the Medicaid Member's qualifying behavioral health condition/crisis episode.
- Non-billable activities:
  - Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television and or videos
  - Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
  - Time in which the member is sleeping, eating, grooming (except as outlined above).

The following elements are required components of Community Psychiatric Supportive Treatment:

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- Comprehensive Psychiatric Evaluation at intake to contain documentation of:
  A. Reason for admission/presenting problems: Purpose of evaluation is to assess symptoms in order to determine need for crisis stabilization services, determine need for changes to medication regimen, and develops an initial plan of care as appropriate.
  B. Presenting problems/reason for the evaluation including list of any collateral interviews conducted
  C. History and description of present illness
  D. Past psychiatric history including description of any past suicidal or homicidal behavior or threats
  E. History of alcohol and other substance use including longest period of sobriety, history of prior treatment attempts, and medical risks associated with detoxification as appropriate
  F. General medical history including list of current medications, current medical providers, and past treatment attempts (may be completed by ancillary staff person)
  G. Developmental, psychosocial and sociocultural history (may be completed by ancillary staff person)
  H. Occupational and military history (may be completed by ancillary staff person)
  I. Legal history (may be completed by ancillary staff person)
  J. Family history (may be completed by ancillary staff person)
  K. Review of systems (sleep, appetite, pain levels, other systems directly linked to the patient's psychiatric symptoms)
  L. Focused Physical examination including appearance and vital signs, musculoskeletal review of gait and station and description of any specific physical anomalies and allergies
  M. Mental status examination including assessment of insight, judgment, and general cognitive functioning
  N. Assessment of daily functionality and ADLs (may be completed by ancillary staff person)
  O. Diagnostic conclusions and prognosis
  P. Treatment recommendations including clear statement of justification for recommendation for admission to CSU and reasoning for elimination of lesser level of care.
- Daily psychiatric review and examination
- Ongoing psychotropic medication evaluation and administration
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan
- Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to Community Psychiatric Supportive Treatment.
- Psychological/functional evaluations specific to the disability population where appropriate and;
- Family intervention must be made available to the families of members as appropriate Community Psychiatric Supportive Treatment must be provided at a site licensed by WVDHHR for the delivery of Behavioral Health Rehabilitation Services.

ADMISSION AND CONTINUED STAY CRITERIA:

The criteria for prior authorization to exceed service limits for Community Psychiatric Supportive Treatment Services are organized around three primary areas that determine the need for this service:

- Acute Psychiatric signs and symptoms
- Danger to self/others
- Medication management/active drug or alcohol withdrawal

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Additionally, criteria for continued stay have been devised so that those members who still require Community Psychiatric Supportive Treatment Services can be authorized to continue services.

To receive or continue to receive Community Psychiatric Supportive Treatment Services, the following corresponding criteria must be satisfied.

PSYCHIATRIC SIGNS AND SYMPTOMS

- **Admission Criteria (Both criterions must be met)**
  - The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms. The member may be displaying behaviors and/or impairments ranging from impaired abilities in the daily living skills domains to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability that may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed placement, or other current living situation;
  - The member is in need of a structured, intensive intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the member's needs based on the documented response to prior treatment and/or interventions.

- **Continued Stay Criteria (One of the three criterions must be met)**
  - The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharge date based on the change in the care plan.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new acute psychiatric symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.
  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.

DANGER TO SELF/OTHERS

- **Admission Criteria**
  - The member is in need of an intensive treatment intervention to prevent hospitalization (e.g. the member engages in self-injurious behavior but not at a level of severity that would require inpatient care, the member is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).

- **Continued Care Criteria (One of the three criterions must be met)**
  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.
  - It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other

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appropriate interventions and treatment options.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting and, a less intensive level of care would not adequately meet the member's needs.

MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL

- **Admission Criteria (Either criterion must be met)**
  - The member is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect.
  - There is evidence that the member is using drugs that have produced a physical dependency as evidenced by clinically significant withdrawal symptoms which require medical supervision.

- **Continued Stay Criteria (One of the three criterion must be met)**
  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but treatment goals have not been reached.
  - It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.

DOCUMENTATION

There must be a permanent clinical record consistent with licensing regulations and agency records/policies for each member-provided Psychiatric Supportive Treatment Service. Items to be included in the clinical record are written orders (for each crisis episode) from the physician/psychiatrist for the Community Psychiatric Supportive Treatment Program, medication orders for each member as indicated, medication administration records when medications are administered, and the member's individualized service plan. See below for Documentation Requirement.

Daily Documentation criteria:

- Number of treatment hours per day
- Summary of the member's status – need for continued CSU
- Member's Service participation
- Symptoms related to the crisis that are being addressed
- If admitted for detox; vitals and use of nationally recognized withdrawal protocol
- Services Provided:

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Individual Therapy – notes at a minimum need to contain:
- Addressed specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention
- Relate back to treatment plan
- Member's response

Group Therapy – notes at a minimum need to contain:
- Addresses specifics of admission criteria to substantiate appropriate level of care
- Substantiation of daily/appropriate treatment services
- Intervention
- Relate back to treatment plan
- Member's response

Family Therapy – notes at a minimum need to contain:
- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

Individual Supportive Counseling: notes at a minimum need to contain:
- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response

Group Supportive Counseling: notes at a minimum need to contain:
- Addresses specifics of admission criteria to substantiate appropriate level of care.
- Substantiation of daily/appropriate treatment services.
- Intervention
- Relate back to treatment plan.
- Member's response.

503.22 ASSERTIVE COMMUNITY TREATMENT (ACT)

Procedure Code:	H0040
Service Unit:	24 hours
Telehealth:	Available for the following services Behavioral Health, Supportive, Individual and Group; Behavioral Health Counseling, Professional, Individual and Group; Mental Health Assessment by Non-Physician; Psychiatric Diagnostic Evaluation (No Medical Services); Psychiatric Diagnostic Evaluation with Medical Services; medication management via E/M codes; and Screening by a Licensed Psychologist.
Service Limits:	One per day - All units must be prior authorized

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Payment Limits: Payment for ACT services is all-inclusive. GT Modifier does not need to billed when Telehealth is utilized. Documentation should reflect that Telehealth was utilized.

No payment will be made for ACT services when the member is hospitalized for a psychiatric condition, or receiving Community Psychiatric Supportive Services (except for 84 hours per year). However, the ACT Team must maintain contact and be part of the hospital discharge efforts. No Psychiatric services other than 90887, Personal Care Services (procedure codes T1001, T1002, or T1019) or H0036 Community Psychiatric Supportive Services up to 84 hours per year may be billed for members receiving ACT services; however ACT cannot be billed concurrently with Community Psychiatric Supportive Services.

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: ACT is an inclusive array of community-based rehabilitative mental health services for members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, in order to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions including mental health and substance use or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment.

ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

Only qualified teams, certified by the Bureau of Behavioral Health and Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification of the team must be renewed, following initial approval, at Bureau-designated intervals, or with any changes in personnel. All currently certified ACT Teams must submit for recertification by January 1, 2015.

Purpose: ACT is a service designed to achieve the following treatment goals:

- To reduce psychiatric hospitalization for members with serious and persistent mental illnesses;
- To provide an established clinical relationship with the member and his or her natural support system in order to promote continuity of care;
- To compose and implement a mutually agreed service plan promoting success and satisfaction in the community;
- To increase the cognizance of the member to the need for medication compliance, the nature of his or her disease, and early warning signs of psychiatric difficulty so as to maximize his or her functioning and independence in the community;
- To improve successful integration into the larger community through non-traditional approaches to broadening a member's social support base;
- To ensure that the member's basic needs for sustaining community living are addressed, promoting acquisition of independent levels of adult living skills whenever possible; and
- To maintain member engagement in treatment by providing supportive behavioral health and skill development services in a community environment so as to maximize generalization of learning.

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Member Participation Criteria: Members eligible to become a recipient of ACT services must meet one of the following criteria:

- Three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months;
- Five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; or
- 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months.

The Bureau for Medical Services may authorize ACT services for members within other specific target populations who exhibit medical necessity for the service (e.g., persons who are homeless and who have a severe and persistent mental illness, members with a mental illness who have frequent contact with law enforcement or the criminal justice system, or members with co-occurring mental illness and chemical addiction who require consistent monitoring).

A member must have an eligible diagnosis as determined by BMS' contracted authorization agent and be in an eligible disability group of Serious and Persistent Mental Health Disorders or co-occurring Mental Health and Substance Abuse Disorders or co-occurring Mental Health Disorders and Mild Intellectual Disability.

An ACT Team may serve members on an on-going basis following authorization/re-authorization of eligibility based upon continuing need and clinical appropriateness of ACT services.

ACT Team Composition and Staff Qualifications: The ACT Team must include a multidisciplinary staff mix, including mental health professionals and substance abuse treatment professionals. The team is composed at a minimum of a psychiatrist or board certified physician with behavioral health experience and five other staff persons. The additional five (minimum) staff composing the ACT Team must include:

1. One full time Team Leader/Supervisor with three (3) years' experience in behavioral health services, two (2) of which must be in a supervisory capacity, and a master's degree and valid West Virginia license in Counseling, Social Work, Psychology, a Supervised Psychologist. A registered nurse may serve as a team leader if the team has an additional full time registered nurse.
2. One full time Registered nurse with one year of psychiatric experience;
3. Two (2) full time staff at the Master's level in Counseling, Social Work, or Psychology and two (2) years' experience in behavioral health services. At least one of these individuals must have experience in substance abuse assessment/treatment and/or vocational rehabilitation; and
4. One full time staff with a Bachelor's degree in Social Work or an alternative Behavioral Science, with one year of behavioral health experience.

ACT Weekend and Holiday Requirements: Staff working as weekend and holiday coverage may be on a rotating basis. Staff must be sufficient to meet ACT Members' needs including, but not limited to, medication delivery, crisis response – via phone or face to face, therapeutic services to promote stability. The ACT staff individual on call must review each member with the ACT Team Leader or the team leader's designee, which must be a master's level staff or RN on the certified ACT Team each weekend day and holiday. The physician or physician extender must be accessible for medication adjustments or any issues that arise that would indicate the need for a physician or physician extender to be involved.

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Role of The Physician: The physician must be actively involved with members and the team. He/she must participate in the daily ACT Team meetings, though he or she may do so by means of tele-video conferencing when unable to be physically present. A suitably trained and experienced physician extender (Advanced Practice Registered Nurse or Physician's Assistant) under the direct supervision of the team physician may participate on the team in lieu of the physician; however the substitution on team meetings must be documented. The physician and/or physician extender must physically attend at least one team meeting per week.

The physician must physically participate in the annual service planning session, and must demonstrate direct and on-going involvement with the ACT team and ACT members.
The physician or physician extender must be actively involved with the team and the members for a minimum of 16 hours per week.

Caseload Mix and Ratios: The certified ACT Team must always have the required minimum staffing unless temporary approval is obtained from the Bureau for Medical Services to operate the team in the absence of a member.

The maximum number of members served by an approved ACT Team is 120.

The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the Physician or physician extender) when the number of ACT members served by the team exceeds 50.

With the exception of the team physician and physician extender, if any, the ACT Team cannot serve non-ACT members.

ACT Service Elements: ACT is a Recovery oriented program**. "**"Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential " (SAMHSA, 2012).

The ACT Team is required to directly provide the following combination of case management and rehabilitation services:

- Assertive outreach designed to identify and engage individuals that meet clinical guidelines and could benefit from the program;
- Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities in order to facilitate more integrated and successful community living;
- Comprehensive and appropriate assessment of medical, environmental and social needs;
- Maintenance of on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation centers in order to assist in transition back to a community placement;
- Member-specific advocacy;
- Assistance with securing basic necessities (e.g., food, income, safe and stable housing, medical and dental care, other social, educational, vocational, and recreational services);
- Facilitation of maintenance of living arrangements during periods of institutional care. The member and his/her support system remains responsible for these expenses;
- Counseling, problem solving, and personal support;
- Psychiatric services and medication management;

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- Assistance in obtaining necessary primary care services;
- Facilitation and improvement of daily living/community living skills;
- Behavior management as necessary and appropriate;
- 24-hour crisis response for ACT members;
- Transportation or facilitation of transportation to necessary community and Medicaid services as specified on the treatment plan;
- Representative payee-ship or facilitation of representative payee-ship when needed;
- Collaboration with family/personal support network; and
- Assistance with preparation of advanced psychiatric directives.

Because ACT is a community focused treatment modality, a minimum of 75 percent of service must be delivered outside of program offices.

ACT Fidelity Indicators:

- The team works with a small caseload (10 to one preferred when caseloads exceed 50);
- The team is cooperative and collaborative. Team members are familiar with and work with all clients;
- Program meeting occurs daily other than federally recognized holidays;
- The team leader is a practicing clinician providing services at least 50% of the time;
- Program staff remain consistent over time; turnover is low;
- The program operates at 95% or more of full staffing on average over a 12 month period;
- The physician/physician extender works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;
- Each team has one full time registered nurse in a program of 50 clients;
- At least one staff member has training or certification in working with members with substance abuse issues;
- The program is of sufficient size to provide consistently the necessary staffing, diversity, and coverage (minimum 6 members);
- The program has explicitly defined admission criteria that address a clearly defined population;
- No more than 6 new members are admitted per month on average;
- The program is required to have available the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services;
- The program provides 24 hour services for crisis intervention;
- The team is actively involved in admission in 95% or more of hospital admissions. Admission involvement must become active as soon as the team becomes aware that the member is at risk of being admitted or has been admitted without the team's prior knowledge to an institutional environment, including Crisis Stabilization Units. Active involvement is demonstrated by regular contact with the institutional treatment team, exchange of information as necessary, contact with the member as possible and appropriate, and interaction with family members as necessary and desired by the member;
- The team participates in discharge planning for 95% of members, providing assistance to the institutional team with housing, benefits, medication appointments, etc.;
- All members are served on a time-unlimited basis with fewer than 5% of the population expected to graduate annually;
- 75% of member contacts occur outside the clinic setting;

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- The team actively pursues engagement of treatment resistant members as described in the policy described below under "Discharge Criteria";
- The program is aggressive in assuring engagement and uses outreach and contacts with corrections and homeless programs to engage members;
- Each member receives an average of two face to face contacts with a team member per week;
- Each member receives at least four contacts per week of any type;
- With or without the member present, the team provides support and skills for the member's support network: family, landlords, employers, etc.;
- One or more team members provides direct treatment and substance abuse treatment for members with substance use disorders;
- The program uses group modalities as a treatment strategy for people with substance use disorders;
- The program uses a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations of abstinence; and
- Stable recovering members may be involved as members of the team providing direct services.

Medication Delivery and Monitoring: If a provider delivers medications to a member on a regular basis, the provider must have a policy that ensures that:

Delivery date, time, person receiving and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location);

If there are children or other incapacitated adults in the home, medications are at least initially stored properly in a secure location;

If medications are delivered to a member at a location other than the home, the medications must be delivered in a manner that ensures the confidentiality of the member and shields the nature of the items delivered; and

A system of monitoring the member's compliance with consumption of medications is created with the agreement and participation of the member. The nature of the monitoring system will be individualized and designed by the clinical team in conjunction with the member. This system may consist of the member logging consumption of his or her own medications. The member has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the member's residence and/or make alternative arrangements for the provision of medications if clinically appropriate.

Documentation: The program must have a valid authorization for service from the Bureau for Medical Services to bill for ACT services.

At entry into the program, there must be documentation of a comprehensive assessment and a recommendation by a qualified professional that ACT services are necessary and appropriate.
The team must develop an initial service plan for the ACT member within seven days of admission into the program. The initial plan must authorize the services to be provided to the member until the comprehensive plan for the member is complete.

The ACT Team, including the member, must amend or develop a comprehensive service plan for the member within 30 days. The plan must describe goals and specific objectives the member hopes to achieve with the

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assistance of ACT. The comprehensive plan must identify the services to be provided under ACT and must be approved by the member, as signified by his or her signature.

The team may elect to create a comprehensive plan upon admission into the program without completing an initial and subsequent comprehensive plan, however the on-going plan must reflect amendments made in services, goals, and/or objectives as the team moves forward. The service plan is a fluid document which must be amended as the needs of the member change or are newly recognized.

The record must sufficiently document assessments, service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT Team can identify the member's treatment needs and services rendered.

The comprehensive plan must identify the Qualified Team that is providing ACT to the member. The certification of the team and a roster of members assigned to an ACT Team must be available for review.

All staff contacts with members of the ACT team must be documented. Each entry needs to include date and place of the contact, the purpose, content and outcome of the contact, the start and stop times of the contact, and the signature, credentials, and title of the individual providing the service.

At minimum the documentation must include the following:

1. A log documenting the discussion of each member in the daily team meeting (except weekends and federal holidays);
2. A weekly summary of member status;
3. 90 day reviews of the comprehensive plan and/or documentation of team meetings and revisions of comprehensive plans at the time of critical treatment junctures; and
4. Documentation of each member contact as described above.

Each member enrolled in ACT must receive a minimum of two face-to-face contacts with one or more ACT team members per week. Documentation must provide evidence of the delivery of at least four separate ACT services per week (e.g., four days of medication delivery is inappropriate and insufficient to meet this standard), but so long as the two contacts required for face to face is met, the service may be indirect, telephonic, collateral, etc. It is permissible for a member to receive more than one service during one member contact, however the documentation must clearly describe the two or more services provided.

The 90 day review required for each ACT member must summarize progress towards achieving the service objectives and describe problems that impeded progress towards meeting objectives. If a member is clearly not making progress toward achieving an objective after 90 days, the team must either amend the objective or describe why the objective was not amended. An objective on an ACT plan may include activities designed to preserve stability in the community, rather than requiring active progress towards meeting an objective.

A team may maintain an "inactive roster" as described below. The roster must include a list of each ACT recipient who has not received services in the past 30 to 60 days and describe why the member is included on the roster. Members must be discharged from ACT if they have been on the "inactive roster" more than 60 days.

Discharge Criteria:

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A provider may discharge an ACT recipient of services for the following reasons:

1. The member no longer meets eligibility criteria;
2. The member has met all program goals and is at maximum level of functioning;
3. The member has moved outside of the ACT team's geographic area;
4. The member is no longer participating or refuses services regardless of the ACT team's efforts at engagement; and/or
5. By virtue of diagnosis or intensity of service needs, the member would be better served by an alternative program of care.

The team must document at least weekly attempts to locate the member for 30 days before a discharge should be considered. Attempts should not consist solely of telephone calls but should include at least weekly visits to the location the member was last known to live and telephone calls or visits to significant others for the member.

If a member consistently refuses to participate or cannot be located, the provider has the option to place the member on an "inactive roster" after 30 days of no contact, preserving the authorization for service. Providers must not bill ACT services for members on an inactive roster. This option should be utilized primarily when the member is familiar to the team and has a history of being unavailable or noncompliant for periods of time, but returning to service regularly. At 30 days of lack of contact or refusal to participate, the provider must make a decision as to whether to place the individual on the inactive roster, or discharge him or her. If the member is on the inactive roster for 60 days with no contact and/or continued refusal of services, the agency must discharge the member from ACT.

The provider is required to notify the Contracted Agent within 72 hours of discharge of an ACT member in order to terminate the authorization for services.

Billing for ACT services is permissible only when active treatment is occurring based on a current service plan. No billing may be submitted for a member enrolled in ACT who has not received services from ACT Team staff for a period of seven days or more. When services resume, billing may resume.

ACT Team Certification Process:

- All ACT Teams require initial approval through the completion of the ACT Team Certification form. The certification form is reviewed and subject to approval by the Bureau for Medical Services (BMS) and the Bureau of Behavioral Health and Health Facilities (BHHF). Certification is specific to the individuals in a team, the team composition, and qualifications submitted. Specific certification elements are described in the BMS application form for the ACT Certification.
- Certification packet may be requested from BMS and will be sent electronically or through postal service at the request of the provider **(***See Appendix 503E***)**
- Certification is valid for 2 years from the approval date stated on the certification letter issued by BMS.
- BMS will issue a denial or acceptance of a certification team within 30 days of receipt of completed certification packet
- A provider must apply for certification of each ACT Team.
- No ACT services may be billed for a member without written certification of the ACT Team by BMS.
- Re-certification shall occur each two years through a process developed by BMS in conjunction with BHHF.
- All teams must be based at a site listed on the provider's Behavioral Health License. Administrative support must be provided by the parent agency sufficient to meet scheduling and support needs of the ACT Team.

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- Billing may commence after receiving approval from BMS. After initial approval, a site review will be conducted to validate the approval.
- BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in *Chapter 100, General Administration and Information*,, Medicaid regulations.
- Variations from the original certification must be submitted with corresponding rationale for changes.
- When a team member resigns or is no longer associated with the Certified ACT Team, the ACT Team must replace the team member within 30 days of the team member's last day. The provider is responsible for notification of the BMS in writing within two working days of the resignation of the team member. A team is considered then to be provisionally certified until the team member is replaced. The provisional is in place until the team member is replaced. The provider may apply for extended provisional certification if an appropriately credentialed individual cannot be found within the original 30 day period. The BMS will notify the provider in writing of the acceptability of the proposed replacement team member after review of the individual's credentials as submitted by the provider. If more than one team member resigns or is terminated, the 30 day provisional status will be reinitiated at the loss of the subsequent team member.

503.23 BEHAVIOR MANAGEMENT SERVICES

Behavior Management Services are to address the symptoms of the diagnosed behavioral health condition that are negatively impacting the members functioning. These services arise in relation to areas of need identified on the member's service plan. Behavior Management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

503.23.1 Therapeutic Behavioral Services – Development

Procedure Code: H2019 HO
Service Unit: 15 minutes
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Staff Credentials: The Behavior Management Specialist must be an individual with a minimum education at the Master's level in psychology, psychiatry, education, social work or counseling This individual's training must have include successful completion of course work and documented training in behavioral theory. The Behavior Management Specialist is responsible for all aspects of Behavior Management Services provided by Behavior Management Assistants and must sign all documentation of those services.

The Behavior Management Assistant must be an individual with a minimum education of a bachelor's degree in a human services field **(See Glossary for complete listing)** who has been certified by the agency as having training specific to behavior management which is consistent with documented training in behavioral theory. Behavior Management Services provided by Behavior Management Assistants are subject to review and approval by the Behavior Management Specialist. A copy of the provider's training program for its Behavioral Health Assistant staff must be retained and filed by the provider. (The Behavior Management Assistant must use the HO modifier when providing Therapeutic Behavioral Services – Development, procedure code H2019HO, since their documentation must be reviewed and signed by the Behavior Management Specialist. Otherwise, the wrong service, Therapeutic Behavioral Services – Implementation, procedure code H2019, would be billed).

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Definition: Therapeutic Behavioral Services - Development includes four major components:

- Behavior Assessment
- Plan Development
- Implementation Training
- Data Analysis and Review of the Behavior Management Plan once implementation has begun.

Therapeutic Behavioral Services - Implementation is an integral component of Behavior Management services (detailed under procedure code H2019).

Behavior Assessment Component

Behavior Assessment is a process of data collection, behavior and skill assessments, and functional analysis that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms beyond the developmental and they must be stated in terms of an objective, quantifiable measurement. The target behaviors must address symptoms of the diagnosed behavioral health condition that negatively impacts the member's overall functioning. The target behavior(s) is causing a functional deficit and is related to the behavioral health condition. Baseline data (quantified measurements which describe the intensity, frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan.

Following implementation of the Behavior Management Plan, behavior assessment must occur to determine objectively whether to continue, modify, or terminate the plan.

Plan Development Component

Plan Development refers to those activities required for the formal development of a Behavior Management Plan. It should be noted that a formal plan is developed only if objective baseline data supports and demonstrates the need for such a plan. A Behavior Management Plan for which there is no documentation of behavior management implementation activity must be considered invalid for billing purposes except for those activities related to assessment where a decision was made based on assessment data that it was not appropriate to proceed.

In those instances when baseline data indicate an occurrence of the target behavior(s) at a frequency or duration not sufficient to warrant the development of a complete Behavior Management Plan and its implementation training and on-going data analysis and review, the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Protocol**. A Behavior Protocol is a document that describes a consistent response(s) upon the occurrence/reoccurrence of the target behavior(s) as a means to maintain the rate of behavior(s) at a low rate. No more than two units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Protocol**.** Following the development of a Behavior Protocol, no further Therapeutic Behavioral Services billing must occur unless a new problem behavior is discovered. If this occurs, behavior assessment on the new behavior must follow, and the process should start anew.

When a Behavior Management Plan has achieved the criteria for success (the objective, quantified amount of behavior change has been maintained for the time period specified in the plan), the Behavior Management

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Specialist or the Behavior Management Assistant may develop a **Behavior Management Maintenance Plan**. A Behavior Management Maintenance Plan is a document that describes a consistent response(s) to the target behavior(s) as a means to maintain target level performance. No more than four units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Management Maintenance Plan. Following the implementation of the Behavior Management Maintenance Plan (which is not to exceed 90 days), the Behavior Management Specialist or the Behavior Management Assistant may conduct data analysis and review on no more than three occasions (a maximum of one unit each occasion) to assure that behavior levels are maintained.

Implementation Training Component

Implementation training is the process by which the Behavior Management Specialist or the Behavior Management Assistant provides the rationale for the plan, defines the behavior(s) that are targeted for change and instructs the individual(s) responsible in the specific steps necessary for implementation of the plan. All individuals who will be involved in providing Therapeutic Behavioral Services – Implementation (procedure code H2019) must receive implementation training prior to implementation of the plan. This includes agency employees and/or significant others (e.g., parents, teachers, foster care providers, etc.).

Data Analysis and Review Component

Data Analysis and Review is the process by which the Behavior Management Specialist or the Behavior Management Assistant evaluates plan effectiveness. Plan effectiveness is determined through a comparison of the baseline data for the target behavior(s) with objective, quantified implementation data to determine whether the plan is leading to achievement of the criteria for success. Any necessary direct observation of member ***behavior*** is included in this category. This analysis and review result in the determination of continuation, modification, or termination of the Behavior Management Plan.

Documentation Requirements:

There are four types of Therapeutic Behavioral Services - Development documentation:

- Activity notes
- Behavior Management Plan
- Behavior Protocol
- Behavior Management Maintenance Plan.

Standard Activity Notes Documentation Requirements

Activity Notes identify the specific component of Therapeutic Behavioral Services - Development (i.e., Behavior Assessment, Plan Development, Implementation Training, Data Analysis and Review) that was performed, place of service, date of service, the amount of time spent by listing the start-and-stop times, and the signature (with credential initials) of the staff person who provided the service.

Behavior Assessment documentation must be present prior to the development of the Behavior Management Plan In addition to the standard activity notes documentation requirements, behavior assessment documentation must reflect that the following activities have occurred in this order:

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- Identification of the target behavior(s).
- Specific description of each target behavior in terms capable of objective, quantified measurement.
- Collection of baseline data on each target behavior to obtain an objective, quantifiable determination of its occurrence/nonoccurrence.
- Review and analysis of baseline data to determine objectively if a need for further Behavior Management Services exists.

Following implementation of the Behavior Management Plan, **Behavior Assessment** documentation must include (in addition to the standard activity notes documentation requirements) rationale for such assessment, which may take one of two forms. These are:

- Identification of a new target behavior. Should this occur, behavior assessment must meet the requirements identified in the above listed additional requirements for behavior assessment documentation to provide objective documentation of the need to modify the plan.
- Objective determination through data analysis and review that the plan is not effective. If this occurs, behavior assessment must be conducted to determine if the plan is being implemented correctly. If implementation is not occurring correctly, implementation training must reoccur. If the plan is being implemented correctly, further data-based assessment to determine whether to modify the plan will occur. Documentation for the latter must reflect the specific components of the plan addressed and modified to obtain the desired behavior change.

Activity notes documenting **Plan Development** must include the specific components of the plan itself that were developed in addition to the standard activity notes documentation requirements.

Activity notes for **Implementation Training** must document the training of implementation staff (and/or unpaid support staff) as defined by the plan, the definitions of the behavior(s) targeted for change, and the specific steps necessary for implementation of the plan. It must also include the standard activity notes documentation requirements.

Activity notes for **Data Analysis and Review** must document a measured amount of each target behavior, a comparison of that amount to a previously documented amount and, based on that measured amount, a determination of continuation, modification, or termination of the plan. It must also include the standard activity notes documentation requirements.

Behavior Management Plan Documentation Requirements

The second type of documentation is a separate, freestanding document labeled **Behavior Management Plan.** The Behavior Management Plan must contain, at a minimum, the following components within the body of the plan itself, regardless of their presence anywhere else in the member's record.

- The Name and Agency Identification Number of the member for whom the plan has been developed
- Implementation Date - the date the plan is implemented
- Target Behaviors/Specific Descriptions.
- Baseline data including the actual dates the baseline data was collected.
- The criteria for success – (A generic statement such as "The member will obey the rules more frequently" is not acceptable, as it does not state a quantified amount that can be compared to baseline data).

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- Methods of Behavioral Intervention includes the following:
  - Method - A description of the behavioral intervention that implementation staff (and/or unpaid support staff) will employ given the occurrence/nonoccurrence of the target behavior(s).
  - Method and Schedule of Reinforcement - The method statement must specify and describe the method of reinforcement, the type of reinforcers to be used, when the reinforcers will be provided (i.e., the schedule of reinforcement), by whom, and whether reinforcers are delivered upon occurrence/reoccurrence of the target behavior(s), or upon the occurrence of behavior(s) incompatible with the target behavior(s).
  - Data Collection - A description of the quantified information that will be collected during the implementation of the Behavior Management Plan. This must include who collects the information and what type of quantified information is recorded, such as frequency or duration of behavior. This information must be of the same type as that collected during baseline so that comparisons can occur.
- Responsible person - a designated Behavior Management Specialist is responsible for the Behavior Management Plan in terms of its appropriateness in clinical practice and for financial reimbursement, and for identifying staff and/or others and their respective responsibility relative to the plan. It should be noted that implementation staff do not have to be named individually, but they must have received the required implementation training prior to implementing the plan. The Behavior Management Specialist must sign and date all plans prior to their implementation (or review and co-sign plans signed and dated by a Behavior Management Assistant). The signature of any individual(s) who participated in the development of the written plan must also be included in the plan (and the date of their participation), along with the degree, and other credentials (license type and number) of each individual.

Behavior Protocol Documentation Requirements

The third type of documentation is the completed Behavior Protocol. The Behavior Protocol consists of:

- A summary of objective, quantified baseline data
- A rationale for the development of the protocol
- Recommendations for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s)
- Date the protocol was developed, the amount of time spent developing the protocol by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the protocol.

Behavior Management Maintenance Plan Documentation Requirements

The fourth type of documentation is the Behavior Management Maintenance Plan. The Behavior Management Maintenance Plan consists of:

- A summary of objectives
- Quantified implementation data (collected during the implementation of the plan)
- A rationale for the development of a maintenance plan (i.e., the criteria for success has been achieved)
- Recommendation for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s)
- Date the maintenance plan was developed, the amount of time spent developing the plan by listing the start and stop times, and the signature (with credential initials) of the staff person who developed the plan.

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503.23.2 Therapeutic Behavioral Services – Implementation

Procedure Code: H2019
Service Unit: 15 minutes
Service Limits: All units must be prior authorized

Prior Authorization: Refer to Utilization Management Guidelines.

Definition: Behavior Management Implementation services means a face-to-face, hands-on encounter where the actual time is spent in the delivery of a behavioral health service to a specific member (i.e., any delivery of the service must be on a strictly one staff to one member basis). Such encounters are interventions, or reinforcements that have been previously described in the Behavior Management Plan and are measured and recorded. Any and all Therapeutic Behavioral Services - Implementation activities under this procedure will be considered non-reimbursable if the activities are not supported by a Behavior Management Plan that meets the documentation requirements detailed under Therapeutic Behavioral Services – Development (procedure code H2019HO).

General observation and/or monitoring are not considered billable implementation activities.

Documentation: Documentation must contain the intervention used (which is individualized to meet the needs of the member), methods, measurements, delivery of service, outcome of the implementation, place of service, date of service, signature of implementing staff (with credential initials), and the actual time spent by listing the start-and-stop times.

Only trained, qualified staff can provide **billable** Therapeutic Behavioral Services - Implementation Services. Activities provided by a non-staff person may be considered as a valid part of the service if there is documentation of the role and specific activities by such individuals in both the description of the methods of intervention in the Behavior Management Plan and in the data which describes the encounters by non-staff persons as they implement the plan. Activity by non-staff persons as described above, however, will not be considered billable under neither Therapeutic Behavioral Services – Development (procedure code H2019HO), nor Therapeutic Behavioral Services – Implementation (procedure code H2019).

503.24 TRANSPORTATION SERVICES

Transportation Services for Community Integration Transportation are the services used to physically transport a Medicaid member to and/or from a community activity within the Assertive Community Treatment (ACT) program and/or Community Focused Treatment (CFT) programs.

For transportation services provided to/from medical services please refer to *Chapter 524, Transportation Services*.

503.24.1 Transportation by Minibus

Procedure Code: A0120 DD HE
Service Unit: Trip
Service Limits: Six trips daily

Prior Authorization: None

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Definition: Community Integration Transportation by minibus is a service in which a one-way transport of a member by a vehicle is provided. If more than one member is being transported, each member's transport to the community activity 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 community activity service.

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.

503.24.2 Transportation: Per Mile

Procedure Code: A0160 DD HE
Service Unit: One mile
Service Limits: 500 miles per month

Prior Authorization: None

Definition: Community Integration Transportation: Per Mile is a service in which the member's transportation to his/her community activity 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.

Documentation: Documentation must consist 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.

503.25 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* of the Provider Manual.

503.26 SERVICE EXCLUSIONS

In addition to the exclusions listed in *Chapter 100, General Administration and Information*, BMS will not pay for the following services:

- Telephone consultations
- Meeting with the Medicaid Member or Medicaid Member's family for the sole purpose of reviewing evaluation and/or results.
- Missed appointments, including but not limited to, canceled appointments and appointments not kept.
- Services not meeting the definition of Medical Necessity
- Time spent in preparation of reports
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Methadone administration or management

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- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider's license

503.27 ROUNDING UNITS OF SERVICE

- Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. **Units of service based on an episode or event cannot be rounded**.
- Many services are described as being "planned", "structured", or "scheduled". If a service is planned, structured, or scheduled, this would assure that the service is billed in whole units; therefore, rounding is not appropriate.
- The following services are eligible for rounding:
    - Mental Health Service Plan Development (H0032)
    - Mental Health Service Plan Development by Psychologist (H0032AH)
    - Physician Coordinated Care Oversight Services (G9008)
    - Case Consultation (90887)
    - Comprehensive Medication Services; Mental Health (H2010)
    - Crisis Intervention (H2011)
    - Therapeutic Behavioral Services – Development (H2019HO)
    - Therapeutic Behavioral Services – Implementation (H2019)

In filing claims for Medicaid reimbursement for a service eligible for rounding, the amount of time documented in minutes must be totaled and divided by the number of minutes in a unit. The result of the division must be rounded to the nearest whole number in order to arrive at the number of billable units. After arriving at the number of billable units, the last date of service provision must be billed as the date of service. **The billing period cannot overlap calendar months. Only whole units of service may be billed.**

503.28 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. In addition, the following limitations also apply to the requirements for payment of Behavioral Health Rehabilitation Services described in this chapter.

503.28.1 Prior Authorization Procedures

- The Bureau for Medical Services requires that providers register and prior authorize **all** Behavioral Health Rehabilitation Services described in this manual with exception of Transportation Services, (procedure codes A0120 DD HE and A0160 DD HE)
- Prior authorization must be obtained from BMS' UMC.
- General information on prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' UMC.

503.28.2 Prior Authorization Requirements

- Prior authorization requests for Behavioral Health Rehabilitation Services must be submitted within the timelines required by BMS' UMC

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- Prior authorization requests must be submitted in a manner specified by BMS' UMC.

503.29 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

Providers of Behavioral Health Rehabilitation Services must comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Providers of Behavioral Health Rehabilitation Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

503.30 BILLING PROCEDURES

- Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by BMS to process the claim for payment.
- The amount billed to BMS must represent the provider's usual and customary charge for the services delivered.
- Claims must be accurately completed with required information.
- By signing the BMS Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures.
- Claim must be filed on a timely basis, i.e., filed within 12 months from date of service, and a separate claim must be completed for each individual member.

503.31 PROGRAM OF SERVICE REQUIREMENTS

Program approval from BMS is required for the following Behavioral Health Rehabilitation Services Program:

- Day Treatment
- Assertive Community Treatment
- Comprehensive Community Supportive Services

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GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Abuse and Neglect: As defined in **West Virginia Code §49-1-3**

Assertive Community Treatment (ACT): An intensive and highly integrated approach for community mental health service delivery. ACT teams serve outpatients whose symptoms of mental illness result in serious functioning difficulties in several major areas of life.

Advanced Alcohol & Drug Counselor (AADC): Professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Advanced Practice Registered Nurse (APRN): As defined in **West Virginia Code §30-7-1:** A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Alcohol & Drug Counselor (ADC): Professional certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements.

Alcohol & Drug Clinical Supervisor (ADC-S): Certification as defined by the West Virginia Certification Board of Addiction Prevention Professionals requirements

Behavioral Health Rehabilitation Services: Services that are medical or remedial that recommended by a physician, physician extender, licensed psychologist, or supervised psychologist for the purpose of reducing a physical or mental disability and restoration of a member to his/her best function level. These services are designed for all members with conditions associated with mental illness, substance abuse and/or dependence. Behavioral Health Rehabilitation Services may be provided to members in a variety of settings, including in the home, community, or a residential program, but do not include services provided in an inpatient setting.

Behavioral Health Condition: A mental illness, behavioral disorder and/or substance use disorder which necessitates therapeutic and/or supportive treatment.

Coordination of Care: Sharing information between relevant parties to plan, arrange, implement, and monitor provision of services to Medicaid Members.

Critical Juncture: Any time there is a significant event or change in the member's life that requires a treatment team meeting. The occurrence constitutes a change in the member's needs that require services, treatment, or interventions to be decreased, increased or changed. The member's needs affected would be related to their behavioral health, physical health, change in setting or crisis.

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Designated Legal Representative (DLR): Parent of a minor child, conservator, legal guardian (full or limited), health care surrogate, medical power of attorney, power of attorney, representative payee, or other individual authorized to make certain decisions on behalf of a member and operating within the scope of his/her authority.

External Credentialing: A process by which an individual's external credential is verified to provide Medicaid Rehabilitation Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

Freedom of Choice: The guaranteed right of a beneficiary to select a participating provider of their choice.

Homeless: An individual meeting the current federal definition of homelessness as defined in **42 USC § 11302.**

Foster Child: The West Virginia Department of Health and Human Resources defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

Human Services Degree: A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:

- Psychology
- Criminal Justice
- Nursing
- Sociology
- Social Work
- Counseling/Therapy
- Teacher Education
- Behavioral Health
- Other Degrees approved by the West Virginia Board of Social Work.

(Note: Some services require specific degrees as listed in the manual see specific services for detailed information on staff qualification.)

Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Intensive Services (IS): A combination of specific services for a targeted population to be used on a frequent basis for a limited period of time. Approval for an IS program and prior authorization for members admitted to an IS program must be obtained by contacting the UMC.

Internal Credentialing: An individual approved to provide Rehabilitation Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

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Licensed Practical Nurse (LPN): An individual who has completed the licensed practical nurse program from an accredited school and who is licensed by the WV State Board of Examiners for Licensed Practical Nurses.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the WV Board of Examiners of Psychologist and is in current good standing with the board.

Office of Health Facility Licensure and Certification (OHFLAC): The office designated by the West Virginia Department of Health and Human Resources to determine whether facilities comply with Federal and State licensure and State certification standards.

Physician: As defined in West Virginia Code Annotated §30-3-10, an individual who has been issued a license to practice medicine in the state of WV by the WV Board of Medicine and is in good standing with the board; or an individual licensed by the WV Board of Osteopathy in accordance with West Virginia Code Annotated 30-14-6.

Physician's Assistant: An individual who meets the credentials described in West Virginia Code Annotated, §30-3-13 and §30-3-5. A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master's degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Physician Extender: A medical professional including an advanced practice registered nurse or a physician's assistant functioning within his or her legal scope of practice.

Registered Nurse (RN): A person who is professionally licensed by the State of West Virginia as a Registered Nurse and in good standing with the West Virginia Board of Examiners for Registered Professional Nurses.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Utilization Management Contractor (UMC): The contracted agent of BMS.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.