



CHAPTER 500–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH CLINIC SERVICES

Replace	Title	Change Date	Effective Date
Section 503	Medical Necessity	10-17-05	11-01-05
Section 504.2	Enrollment Requirements; Staff Qualifications	10-17-05	11-01-05
Section 505	Index of Services	10-17-05	11-01-05
Section 506.3	Psychiatric Diagnostic Interview Examination	10-17-05	11-01-05
Section 506.4	Screening by Licensed Psychologist	10-17-05	11-01-05
Section 506.5	Developmental Testing; Limited	10-17-05	11-01-05
Section 507	Service Planning	10-17-05	11-01-05
Section 509.1	Pharmacologic Management	10-17-05	11-01-05
Section 509.6.1	Injection, Risperidone	10-17-05	01-01-05
Section 505	Index of Services	7-01-04	7-01-04
Section 506.1	Mental Health Assessment by Non-Physician	7-01-04	7-01-04
Section 506.2	Psychological Testing with Interpretation and Report	7-01-04	7-01-04



Section 506.4	Screening by Licensed Psychologist	7-01-04	7-01-04
Section 506.5	Developmental Testing; Limited	7-01-04	7-01-04
Section 507.1	Mental Health Service Plan Development	7-01-04	7-01-04
Section 507.2	Physician Coordinated Care Oversight Services	7-01-04	7-01-04
Section 507.3	Case Coordination	7-01-04	7-01-04
Section 508.1	Behavioral Health Counseling, Professional, Individual	7-01-04	7-01-04
Section 508.2	Behavioral Health Counseling, Professional, Group	7-01-04	7-01-04
Section 508.3	Behavioral Health Counseling, Supportive, Individual	7-01-04	7-01-04
Section 508.4	Behavioral Health Counseling, Supportive, Group	7-01-04	7-01-04
Section 509.1	Pharmacologic Management	7-01-04	7-01-04
Section 509.7	Comprehensive Medication Services; Mental Health	7-01-04	7-01-04
Section 506.3	Psychiatric Diagnostic Interview Examination	7-01-04	7-01-04



Section 510	Day Treatment	7-01-04	7-01-04
Section 511.1	Crisis Intervention	7-01-04	7-01-04
Section 511.2	Community Psychiatric Supportive Treatment	7-01-04	7-01-04
Section 512.1	Therapeutic Behavioral Services – Development	7-01-04	7-01-04
Section 512.2	Therapeutic Behavioral Services – Implementation	7-01-04	7-01-04
Section 513.1	Non-Emergency Transportation by Minibus	7-01-04	7-01-04
Section 513.2	Non-Emergency Transportation: per Mile	7-01-04	7-01-04
Section 517	Registration/Prior Authorization Procedures	7-01-04	7-01-04

OCTOBER 17, 2005

SECTION 503

Introduction: Medical Necessity:

Old Policy: Did not contain statement that providers are required to register and/or prior authorize some of the services described in this manual – references Section 518.1 (Registration/Prior Authorization Procedures)

New Policy: Added language to include advice early in the manual that providers are required to register and/or prior authorize some of the services described in this manual – references Section 517.1 (Registration/Prior Authorization Procedures)



Change: Add language to state that services may require prior authorization

Directions: Please replace the above section

Section 504.2

Introduction: Enrollment Requirements: Staff Qualifications

Old Policy: Did not contain language to reflect the utilization of Nurse Practitioners:

New Policy: States Services may be rendered to Medicaid members by physician assistants who are under the supervision of a psychiatrist. Services may be rendered to Medicaid members by Advanced RN practitioners. An Advanced RN practitioner without a psychiatric specialty must be under the supervision of a psychiatrist. An Advanced RN practitioner with a psychiatric specialty may practice without direct supervision by a psychiatrist.

Prescriptive authority is not required. An Advanced RN practitioner must have a signed collaborative agreement for prescriptive authority with a psychiatrist. The collaborative agreement must document the professional relationship between the Advanced RN practitioner and the physician.

Documentation including required license, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, proof of psychiatric specialty 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 Rehabilitation Facility.

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.

Change: Add Advanced Nurse Practitioner, and Advanced Nurse Practitioner with Psychiatric Specialty, provide additional language to clarify Physician Assistant Services

Directions: Please replace the above section

Section 505

Introduction: Index of Services: Addition

Old Policy: Did not include Section for Injection, Risperidone, long acting (Risperdal Consta IM)

New Policy: added Section 509.6.1 Injection, Risperidone, long acting (Risperdal Consta IM)



Change: Addition of Section - 509.6.1

Directions: Please replace the above section

Section 506.3

Introduction: Psychiatric Diagnostic Interview (90801), Change in Documentation Requirements

Old Policy: Stated: documentation must include: place of evaluation, date of service, and actual time spent providing the service by listing the start and stop times.

New Policy: replaces with statement: documentation must include place of evaluation and date of service

Change: Psychiatric Diagnostic Interview Examination (90801) event code—remove duration, start- and stop times

Directions: Please replace the above section

Section 506.4

Introduction: Screening by Licensed Psychologist (T1023 HE) Change in Documentation Requirements

Old Policy: Stated: documentation must include: place of evaluation, date of service, and actual time spent providing the service by listing the start and stop times.

New Policy: replaces with statement: documentation must include place of evaluation and date of service

Change: event code, remove duration, start- and stop times

Directions: Please replace the above section

Section 506.5

Introduction: Developmental Testing - Limited (96110) Change in Documentation Requirements

Old Policy: Stated: documentation must include: place of evaluation, date of service, and actual time spent providing the service by listing the start and stop times.

New Policy: replaces with statement: documentation must include place of evaluation and date of service

Change: Event code, remove duration, start- and stop times

Directions: Please replace the above section



Section 507

Introduction: Service Planning and Consultation - Clarifying Low End Service Provision

Old Policy: did not contain specific language referring to a treatment strategy that is available for individuals receiving only low end services.

New Policy: added language a treatment strategy is sufficient to replace the service plan (SP) when offering low-end services. The strategy describes what the clinician and/or consumer will do/achieve, at a minimum, prior to the next session or at some time in the future related to the focus of treatment. This is typically found as an addendum to the intake, part of the clinical summary, or the concluding section of documentation of consumer contact [progress note]. The Bureau for Medical Services, the Office of Health Facility Licensure and Certification and APS has approved the utilization of a treatment strategy when offering low-end services. (September 2004) A treatment strategy is not billable.

Change: clarification on the availability of a treatment strategy for individuals **receiving only low end services**

Directions: Please replace the above section

Section 509.1

Introduction: Pharmacologic Management (90862) Change in Documentation Requirements

Old Policy: Stated: documentation must include: place of evaluation, date of service, and actual time spent providing the service by listing the start and stop times.

New Policy: replaces with statement: documentation must include place of evaluation and date of service

Change: 90862 event codes, remove duration, start- and stop times

Directions: Please replace the above section

Section 509.6.1

Introduction: Add J2794 Injection, Risperidone, long acting

Old Policy: did not include this code which has been effective since 01-01-2005

New Policy: update of manual to include this code with an effective date of 01-01-2005

Change: Add, J2794 – Injection, Risperidone, long acting

Directions: Please replace the above section



July 1, 2004

Section 505

Introduction: Index of Services, to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Modifier HE added to T1023, A0120, and A0160

Directions: Please replace the above section

Section 506.1

Introduction: Mental Health Assessment by Non-Physician: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 506.2

Introduction: Psychological Testing with Interpretation and Report: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 506.3

Introduction: Psychiatric diagnostic Interview Examination: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 506.4

Introduction: Screening by Licensed Psychologist: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS



Directions: Please replace the above section

Section 506.5

Introduction: Developmental Testing, Limited: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 507.1

Introduction: Mental Health Service Plan Development to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS; Documentation Language, last paragraph changed to 7 days instead of 72 hours.

Directions: Please replace the above section

Section 507.2

Introduction: Physician Coordinated Care oversight Services: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 507.3

Introduction: Case Consultation: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 508.1

Introduction: Behavioral Health Counseling, Professional, Individual: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services



Change: Service Limits Language 60 units per year with registration; Prior Authorization Language reference to APS; Documentation Language reference to crisis activity deleted.

Directions: Please replace the above section

Section 508.2

Introduction: Behavioral Health Counseling, Professional, Group: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Service Limits Language 50 units per year with registration, Prior Authorization Language reference to APS, Documentation Language reference to crisis activity deleted

Directions: Please replace the above section

Section 508.3

Introduction: Behavioral Health Counseling, Supportive, Individual: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Service Limits Language all units must be prior authorized, Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 508.4

Introduction: Behavioral Health Counseling, Supportive, Group, to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Service Limits Language all units must be prior authorized, Prior Authorization Language reference to APS; Documentation Language reference to crisis activity deleted

Directions: Please replace the above section

Section 509.1

Introduction: Pharmacologic Management: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Payment Limits Language, Prior Authorization Language

Directions: Please replace the above section



Section 509.7

Introduction: Comprehensive Medication Services; Mental Health: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Payment Limit Language, Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 510

Introduction: Day Treatment: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 511.1

Introduction: Crisis Intervention: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 511.2

Introduction: Community Psychiatric Supportive Treatment, formerly known as Crisis Stabilization: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 512.1

Introduction: Therapeutic Behavioral Services, Development: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section



Section 512.2

Introduction: Therapeutic Behavioral Services, Implementation: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 513.1

Introduction: Non-Emergency Transportation, by Minibus: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Add modifier HE to A0120

Directions: Please replace the above section

Section 513.2

Introduction: Non-Emergency Transportation per Mile: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Add modifier HE to A0160

Directions: Please replace the above section

Section 517

Introduction: Registration/Prior Authorization: to introduce revisions to Chapter 500 – Covered Services, Limitations, and Exclusions for Behavioral Health Clinic Services

Change: Add modifier HE to A0120 and A0160

Directions: Please replace the above section



CHAPTER 500–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH CLINIC SERVICES

500 INTRODUCTION

The West Virginia Medicaid Program offers a comprehensive scope of medically necessary medical and mental 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 requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

This chapter sets forth BMS' requirements for payment of Behavioral Health Clinic Services provided by Behavioral Health Clinic 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 Clinic 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.

501 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions of the Provider Manual. In addition, the following definition also applies to the requirements for payment of Behavioral Health Clinic Services described in this chapter.

“Behavioral Health Clinic Services” means the services Federally defined as those preventive, diagnostic, therapeutic, or palliative items or services provided to outpatients under the direction of a physician. These services must be provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. Clinic Services must be provided at the clinic, the only exception being services provided to the homeless.

“Under the Direction of a Physician” means that (1) a physician must sign the “Behavior Health Clinic/Rehabilitation Services, Authorization for Services” form; and (2) a physician has a face-to-face contact with the member before or at the Master Treatment Planning juncture to authorize services; and (3) the physician will periodically review the continued need for care. Other requirements for physician involvement are detailed in Section 507 on Service Planning.



502 MEMBER ELIGIBILITY

Behavioral Health Clinic 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 registration or prior authorization for Behavioral Health Clinic Services is requested of BMS' contracted agent. The Registration/Prior Authorization process is explained in Section 517 of this manual.

503 MEDICAL NECESSITY

All Behavioral Health Clinic Services covered in this chapter are subject to a determination of medical/clinical necessity. For these types of services, the following four factors will be included as part of this determination as appropriate:

- Diagnosis (as determined by a physician or licensed psychologist)
- Level of functioning
- Evidence of clinical stability
- Available support system

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. Diagnostic and standardized instruments (as approved by BMS) must be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record and as documentation of service need and justification for the level and type of service provided.

Refer to Section 517.1. The Bureau for Medical Services requires that providers register and/or prior authorize with APS Health Care, Inc. some of the services described in this manual.

504 PROVIDER ENROLLMENT

In order to participate in the WV Medicaid Program and receive payment from BMS, providers of Behavioral Health Clinic Services must meet all enrollment criteria as described in Chapter 300.

504.1 ENROLLMENT REQUIREMENTS: AGENCY ADMINISTRATION

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

- Written criteria must be developed 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.
- 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 annually. Documentation of the credentials review must be filed in each staff person's personnel file.

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.

504.2 ENROLLMENT REQUIREMENTS: STAFF QUALIFICATIONS

Providers of Behavior Health Clinic Services must apply the following minimum standards to their staff that provide the services listed below.

- The following medically and psychologically based services must be provided by professionally trained and licensed staff:
 - Mental Health Assessment by Non-Physician
 - Case Consultation
 - Crisis Intervention
- Professionally trained and licensed staff approved to provide the above listed services includes:
 - Physicians
 - Psychiatrists
 - Doctoral and Master's prepared staff in appropriate, related fields
 - Physician Assistants
 - Advanced RN Nurse Practitioners with Psychiatric Specialty
 - Registered Nurses with appropriate experience and training
 - Master's or Bachelor's level staff working under the supervision of fully trained and licensed staff operating within the scope of their professional practice and training
- The following remedial services may be provided by non-professional staff:
 - Behavioral Health Counseling, Supportive
 - Therapeutic Behavioral Services, Implementation
 - Transportation Services
- Staff approved to provide the above listed remedial services include:
 - Bachelor's level prepared staff in appropriate related human service fields with certified competencies in service specific areas
 - Paraprofessionally trained staff with either an Associate degree in a related field or a high school graduate/GED

Services provided by Bachelor's level staff with less than one year experience, paraprofessionally trained staff, or high school graduate/GED staff must be provided under



the supervision and training of licensed and certified staff.

- Certified Addiction Counselors may provide the professional and remedial services listed above that are within the scope of their professional practice as defined by their level of certification and training.
- All other Behavioral Health Clinic Services must be provided by staff designated in the description and definition of each service in this manual.

Services that may be provided by Physician Assistants or Advanced Nurse Practitioners include but are not limited to:

- Psychiatric Diagnostic Interview Evaluation
- Pharmacologic Management
- Comprehensive Medication Services: Mental Health
- Assertive Community Treatment
- Community Psychiatric Supportive Treatment

Services may be rendered to Medicaid members by physician assistants who are under the supervision of a psychiatrist. Services may be rendered to Medicaid members by Advanced RN practitioners. An Advanced RN practitioner without a psychiatric specialty must be under the direct supervision of a psychiatrist. An Advanced RN practitioner with a psychiatric specialty may practice without direct supervision by a psychiatrist.

Prescriptive authority is not required. An Advanced RN practitioner must have a signed collaborative agreement for prescriptive authority with a psychiatrist. The collaborative agreement must document the professional relationship between the Advanced RN practitioner and the physician.

Documentation including required license, certifications, proof of completion of training, contracts between physicians and physician assistants, collaborative agreements for prescriptive authority, if applicable, between certified nurse practitioners and physicians, proof of psychiatric specialty 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 Rehabilitation Facility.

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. Section 501 defines criteria for Behavioral Health Clinic Services and Under the Direction of a Physician which also must be followed.

504.3 SERVICE CERTIFICATION REQUIREMENTS

A physician must certify the need for Behavioral Health Clinic 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. This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Clinic Services until the development and initiation of the Initial Service Plan. Upon initiation of the Initial Service Plan, the "Behavior Health Clinic/Rehabilitation Services, Authorization for Services" form is no longer in effect since it is no longer necessary.

- 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 Clinic Services occur outside the time frames of these forms which authorize services, the services provided are not billable.

504.4 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. Termination reports must be filed upon case closure.
- In addition to the documentation requirements described in this chapter, Behavioral Health Clinic Service providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 700, General Administration 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.

504.5 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 700, General Administration, of the Provider Manual.



505 INDEX OF SERVICES

<u>Procedure Description</u>	<u>Procedure Code</u>	<u>Section</u>
• ASSESSMENT SERVICES		
– Mental Health Assessment by Non-Physician	H0031	506.1
– Psychological Testing with Interpretation and Report	96100	506.2
– Psychiatric Diagnostic Interview Evaluation	90801	506.3
– Screening by Licensed Psychologist	T1023HE	506.4
– Developmental Testing; Limited	96110	506.5
• SERVICE PLANNING AND CONSULTATION SERVICES		
– Mental Health Service Plan Development	H0032	507.1
– Physician Coordinated Care Oversight Services	G9008	507.2
– Case Consultation	90887	507.3
• SUPPORTIVE SERVICES		
– Behavioral Health Counseling, Professional, Individual	H0004HO	508.1
– Behavioral Health Counseling, Professional, Group	H0004HO HQ	508.2
– Behavioral Health Counseling, Supportive, Individual	H0004	508.3
– Behavioral Health Counseling, Supportive, Group	H0004HQ	508.4
• GENERAL MEDICATION SERVICES		
– Pharmacologic Management	90862	509.1
– Injection, Haloperidol (Haldol)	J1630	509.2
– Injection, Haloperidol Decanoate (Haldol Decanoate)	J1631	509.3
– Injection, Fluphenazine Decanoate (Prolixin Decanoate)	J2680	509.4
– Injection, Chlorpromazine HCl (Thorazine)	J3230	509.5
– Injection, Perphenazine Decanoate (Trilafon)	J3310	509.6
– Injection, Risperidone, long acting	J2741	509.61
– Comprehensive Medication Services; Mental Health	H2010	509.7
• DAY TREATMENT	H2012	510



- **CRISIS SERVICES**
 - **Crisis Intervention** **H2011** **511.1**
 - **Community Psychiatric Supportive Treatment** **H0036** **511.2**
- **BEHAVIOR MANAGEMENT SERVICES**
 - **Therapeutic Behavioral Services – Development** **H2019HO** **512.1**
 - **Therapeutic Behavioral Services – Implementation** **H2019** **512.2**
- **TRANSPORTATION SERVICES**
 - **Non-Emergency Transportation by Minibus** **A0120HE** **513.1**
 - **Non-Emergency Transportation: Per Mile** **A0160HE** **513.2**

506 ASSESSMENT SERVICES

Assessment services include evaluative services and standardized testing instruments applied by licensed professional staff necessary to make determinations concerning the mental, physical, and functional status of the member.

506.1 MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

PROCEDURE CODE: H0031
SERVICE UNIT: Event
SERVICE LIMITS: Six events per year with registration
PRIOR AUTHORIZATION: Yes, if units exceed six events per year. Refer to APS Health Care Utilization Management Guidelines.

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. Additional specialty evaluations such as occupational therapy, nutrition, or functional skills assessments may be addressed within the initial or reassessment evaluation.

This code may also be used for special requests of WVDHHR 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.

DOCUMENTATION:

Documentation must contain the completed evaluation, signed (with credential initials) by staff who provided the service. The documentation must include: place of evaluation, date of service, and actual time spent providing the service by listing the start and stop times.



506.2 PSYCHOLOGICAL TESTING WITH INTERPRETATION AND REPORT

PROCEDURE CODE: 96100
SERVICE UNIT: 60 minutes
SERVICE LIMITS: All units must be prior authorized
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Psychological Testing with Interpretation and Report is an all-inclusive evaluation (includes psycho diagnostic assessment of personality, psycho pathology; emotionality, intellectual abilities, e.g. WAIS-R, Rorschach, MMPI) that must be administered by a qualified, licensed psychologist.

DOCUMENTATION:

Documentation must contain the completed evaluation, signed by the qualified, licensed psychologist. The documentation must include: place of evaluation, date of service and actual time spent providing the service by listing the start-and-stop times.

506.3 PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION

PROCEDURE CODE: 90801
SERVICE UNIT: Event (completed evaluation)
SERVICE LIMITS: Two events per year with registration
PRIOR AUTHORIZATION: Yes, if units exceed two events per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Psychiatric Diagnostic Interview Examination is an all-inclusive initial or reassessment evaluation of a member's functional level(s), mental status, history, and a disposition performed by a psychiatrist or psychologist. It may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

DOCUMENTATION:

Documentation must contain the completed evaluation signed by the psychiatrist or psychologist. The documentation must include: place of evaluation and date of service.

506.4 SCREENING BY LICENSED PSYCHOLOGIST

PROCEDURE CODE: T1023 HE
SERVICE UNIT: Event (completed evaluation)
SERVICE LIMITS: One event every six months with registration
PRIOR AUTHORIZATION: Yes, if units exceed one event every six months. Refer to APS Health Care Utilization Management



Guidelines.

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 96100 or 90801 must be used when a more in-depth assessment is indicated.

DOCUMENTATION:

Documentation must contain the completed evaluation, signed by the qualified, licensed psychologist. The documentation must include: place of the evaluation and date of service.

506.5 DEVELOPMENTAL TESTING; LIMITED

- PROCEDURE CODE:** 96110
- SERVICE UNIT:** Event (completed interpretation and report)
- SERVICE LIMITS:** All units must be prior authorized
- PAYMENT LIMITS:** This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96100) has been billed in the last six months.
- PRIOR AUTHORIZATION:** Yes, Refer to APS Health Care Utilization Management Guidelines

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

DOCUMENTATION:

Documentation must contain the completed interpretation and report, signed by the licensed psychologist or qualified staff, along with their credentials. The documentation must include the place of the testing and date of service. If performed by staff other than a psychologist, a licensed psychologist must review, sign, and date the completed interpretation and report.

507 SERVICE PLANNING AND CONSULTATION SERVICES

Service planning is the process by which a team of behavioral health staff meet (along with the member, their guardian, and/or their representative) in order to review assessments and identify resources necessary to implement individual service plans. Service planning includes initial plan development as well as later review and revision.

A treatment strategy is sufficient to replace the service plan (SP) when offering low-end services. The strategy describes what the clinician and/or consumer will do/achieve, at a minimum, prior to the next session or at some time in the future related to the focus of treatment. This is typically found as an addendum to the intake, part of the clinical summary, or the concluding section of documentation of consumer contact [progress note]. The Bureau for Medical Services, the Office of Health Facility Licensure and Certification and APS has approved the utilization of a treatment strategy when offering low-end services. (September 2004) A treatment strategy is not billable.



507.1 MENTAL HEALTH SERVICE PLAN DEVELOPMENT

PROCEDURE CODE:	H0032
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	16 units per month with registration
PRIOR AUTHORIZATION:	Yes, if units exceed 16 units per month. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

An individual service plan is required for all members receiving services from licensed, enrolled providers of Behavioral Health Clinic Services.

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 have a representative participate in the service planning session.

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 significant 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 must be physically present and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications
- Have a diagnosis of major psychosis or major affective disorder
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician 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 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, Long Term Residential 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. Thus reimbursement is for participation in the process, not for the product. A process by which the case manager writes a service plan or takes a written plan and walks it to each team member separately to get it signed does not constitute service planning.

DOCUMENTATION:

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

- Required is a separate activity note by the case manager coordinating the service planning session.
 - It must justify each staff person's presence by stating their purpose for participating in the meeting.
 - Each note must include the signature and credentials of the case manager participating in the session, place of session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.
- Also required is a service plan signature page. 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, **in ink**, 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.

The second agency can send no more than one representative to the service planning session for each of the programs they are providing to the member.

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.

507.2 PHYSICIAN COORDINATED CARE OVERSIGHT SERVICES

PROCEDURE CODE:	G9008
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	One unit per month with registration
PRIOR AUTHORIZATION:	Yes, if units exceed one unit per month. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

These are activities performed by a physician directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to 507.2 Mental Health Service Plan Development.

DOCUMENTATION:

Documentation must contain the physician’s signature, **in ink**, 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.

507.3 CASE CONSULTATION

PROCEDURE CODE:	90887
SERVICE UNIT:	Event
SERVICE LIMITS:	All units must be prior authorized
PRIOR AUTHORIZATION:	Refer to APS Health Care Utilization Management Guidelines



DEFINITION:

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

508 SUPPORTIVE SERVICES

Supportive services are face-to-face interventions which are intended to provide support to the member in order to maintain or enhance levels of functioning and to assist in day-to-day management and problem solving. These services include counseling, individual and group therapy, specially designed behavior plans with scheduled direct intervention, and skills training and development.

508.1 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, INDIVIDUAL

PROCEDURE CODE:	H0004 HO
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	60 units per year with registration
PRIOR AUTHORIZATION:	Yes, if units exceed 60 per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

These are face-to-face, structured interventions (e.g., psychotherapy, specialty therapies, family preservation interventions, etc.) to improve a member's cognitive processing and/or



functional abilities. The intent of this type of intervention is to focus on the dynamics of a member's problems (i.e., the cause of the member's dysfunctions; resolution of intrapsychic/interpersonal conflicts; eliciting change in behavior patterns; and to produce change toward identifiable goals). Interventions are grounded in a specific and identifiable theoretical base that provides a framework for assessing change. This service must be provided on a scheduled basis by designated staff.

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. Certified Addiction Counselors (CACs) are considered to be credentialed to provide Individual and Family therapy, but only when directly addressing Substance Abuse Treatment issues. To provide therapy in other treatment areas, the CACs must be credentialed by the applicable accrediting bodies of their respective professional disciplines.

Under this procedure code, other individuals who have a significant relationship to the member (e.g., spouse, parent, child, sibling, etc.) may participate in therapy to the extent it is helpful to the progress of the member; however, such participation by others is not reimbursable as a separate activity.

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to a specific objective(s) in the therapy plan, and the outcome of the service. 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. Treatment strategies and objectives utilizing individual therapeutic interventions must be included in the member's Master Service Plan and in an individual therapeutic intervention plan which expands on the more generalized objectives in the Master Service Plan.

508.2 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, GROUP

PROCEDURE CODE:	H0004 HO HQ
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	50 units per year with registration
PAYMENT LIMITS:	Behavioral Health Counseling, Professional, Group sessions are limited in size to a maximum of 12 persons per group session.
PRIOR AUTHORIZATION:	Yes, if units exceed 50 per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

These sessions are face-to-face, structured interventions (e.g., psychotherapy, specialty therapies, etc.) in a group setting to improve an individual's cognitive processing and/or functional abilities. The intent of this type of intervention is to focus on the dynamics of a member's problems (i.e., the cause of the member's dysfunctions; resolution of



intrapyschic/interpersonal conflicts; eliciting a change in behavior patterns; and to otherwise produce change toward identifiable goals). These activities are carried out within a group context where the therapist engages the group dynamics in terms of peer relationships, common problems focus, and mutual support to promote progress for individual members. Interventions are grounded in a specific and identifiable theoretical base that provides a framework for assessing change. This service must be provided on a scheduled basis by designated staff.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted therapies recognized by national associations for psychology, psychiatry, counseling, and social work. Certified Addiction Counselors (CACs) are considered to be credentialed to provide Group Therapy, but only when directly addressing Substance Abuse Treatment issues. To provide therapy in other treatment areas, the CACs must be credentialed by the applicable accrediting bodies of their respective professional disciplines.

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided and the relationship of the service/activity to a specific objective(s) in the therapy plan, and the outcome of the service. 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. Treatment strategies and objectives utilized in therapeutic groups must be included in the member's Master Service Plan and in a therapeutic group intervention plan which expands on the more generalized objectives in the Master Service Plan.

508.3 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, INDIVIDUAL

PROCEDURE CODE:	H0004
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	All units must be prior authorized
PRIOR AUTHORIZATION:	Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention that is intended to provide support by using counseling techniques to maintain member progress toward identified goals, and to assist members in their day-to-day management and problem solving.

This service utilizes basic counseling techniques and must be included in the member's service plan. This service must be provided on a scheduled basis by designated staff with the exception of unscheduled crisis activities.

Staff other than licensed professional counselors must be qualified by their agencies with a training curriculum in counseling techniques.



DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided and the relationship of the service/activity to a specific objective(s) in the service plan, and the outcome of the service. 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. If provided due to an unscheduled crisis activity, the activity note must also include a summary of events leading up to the crisis.

508.4 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, GROUP

- PROCEDURE CODE:** H0004 HQ
- SERVICE UNIT:** 15 minutes
- 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 APS Health Care Utilization Management Guidelines.

DEFINITION:

This is a face-to-face intervention in a group setting that is intended to provide support to maintain member progress towards identified goals and to assist members in their day-to-day management and problem solving.

Behavioral Health Counseling, Supportive, Group utilizes basic counseling techniques and must be included in the member's service plan. This service must be provided on a scheduled basis by designated staff with the exception of unscheduled crisis activities.

Staff other than licensed professional counselors must be qualified by their agencies with a training class in counseling techniques.

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided and the relationship of the service/activity to a specific objective(s) in the service plan, and the outcome of the service. 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.

509 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)



509.1 PHARMACOLOGIC MANAGEMENT

PROCEDURE CODE: 90862
SERVICE UNIT: Event
SERVICE LIMITS: Two events per month with registration
PAYMENT LIMITS: Members may not receive Psychiatric Diagnostic Interview Evaluation (procedure code 90801) or Mental Health Comprehensive Medication Services (procedure code H2010) on the same day 90862 is provided.

PRIOR AUTHORIZATION: Yes, if units exceed two events per month. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Pharmacologic Management services include prescription, use, and review of medication by a psychiatrist/physician, with no more than minimal medical psychotherapy.

DOCUMENTATION:

The psychiatrist/physician must complete and sign an activity note describing the service provided. The documentation must include: place of service and date of service.

509.2 INJECTION, HALOPERIDOL (HALDOL)

PROCEDURE CODE: J1630
SERVICE UNIT: Treatment
SERVICE LIMITS: Two per month
PRIOR AUTHORIZATION: None

DEFINITION:

This is an injection of Haloperidol (Haldol), up to 5 mg, which includes the cost of the medication.

DOCUMENTATION:

Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.

509.3 INJECTION, HALOPERIDOL DECANOATE (HALDOL DECANOATE)

PROCEDURE CODE: J1631
SERVICE UNIT: Treatment
SERVICE LIMITS: Two per month
PRIOR AUTHORIZATION: None



DEFINITION:

This is an injection of Haloperidol Decanoate (Haldol Decanoate), per 50 mg, which includes the cost of the medication.

DOCUMENTATION:

Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.

509.4 INJECTION, FLUPHENAZINE DECANOATE (PROLIXIN DECANOATE)

PROCEDURE CODE: J2680
SERVICE UNIT: Treatment
SERVICE LIMITS: Two per month
PRIOR AUTHORIZATION: None

DEFINITION:

This is an injection of Fluphenazine Decanoate (Prolixin Decanoate), up to 25 mg, which includes the cost of the medication.

DOCUMENTATION:

Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.

509.5 INJECTION, CHLORPROMAZINE HCl (THORAZINE)

PROCEDURE CODE: J3230
SERVICE UNIT: Treatment
SERVICE LIMITS: Two per month
PRIOR AUTHORIZATION: None

DEFINITION:

This is an injection of Chlorpromazine HCl (Thorazine), up to 50 mg, which includes the cost of the medication.

DOCUMENTATION:

Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.



509.6 INJECTION, PERPHENAZINE (TRILAFON)

PROCEDURE CODE: J3310
SERVICE UNIT: Treatment
SERVICE LIMITS: Two per month
PRIOR AUTHORIZATION: None

DEFINITION:

This is an injection of Perphenazine Decanoate (Trilafon), up to 5 mg, which includes the cost of the medication.

DOCUMENTATION:

Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.

509.6.1 INJECTION, Risperidone, long acting (Resperdal Consta IM)

PROCEDURE CODE: J2794
SERVICE UNIT: Treatment
SERVICE LIMITS: Every 2 weeks
PRIOR AUTHORIZATION: None

DEFINITION: This is an injection of Risperidone long acting (Resperdal Consta), which includes the cost of medication. New code effective 1/1/05. Requires ICD-9-CM code 295XX on CMS 1500 claim form for payment consideration. Age limit 18>years.

DOCUMENTATION:

Medical necessity documentation of services provided must be maintained in the member's individual file. Documentation must include a signed activity note by the medical practitioner (physician, registered nurse, licensed practical nurse, etc., who is eligible to perform this injection) which documents the injection, dose, and route of administration. The documentation must include: place of service, time, and date of administration.

509.7 COMPREHENSIVE MEDICATION SERVICES; MENTAL HEALTH

PROCEDURE CODE: H2010
SERVICE UNIT: 15 minutes
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 (procedure code 90862), nor any other physician code can be billed on the same day as Comprehensive Medication Services; Mental Health.

PRIOR AUTHORIZATION:

Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy, along with the injection of medications as required (except psychotropic medications which require administration but no consistent and intensive monitoring. These incidents of medication administration are covered in section 509 of this manual). 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 as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. Because this is a physician directed service, a physician must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. (The status of psychotropic medications eligible for use in this service is available when seeking prior authorization from BMS' contracted agent).

Methadone is **not** a covered medication.

Members receiving this service are not precluded from receiving other Behavioral Health Clinic 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, white blood cell level, other laboratory results, and current Clozaril/Clozapine (or other psychotropic medication) dosage with authorized pharmacy name. The documentation must include: place of service, specific time and date of service, and signature of qualified staff providing the service.

510 DAY TREATMENT

PROCEDURE CODE: H2012
SERVICE UNIT: 60 minutes
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 Clinic Service.
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.



DEFINITION:

Behavioral Health Clinic Day Treatment is a program only for Medicaid members with Mentally Retarded/Developmentally Disabled (MR/DD) diagnoses. It is a structured program of skill building instruction and supervision designed to assist members in achieving greater independence (and/or employment) or to maintain their current abilities in activities of daily living. The programming must be in accordance with each member's needs and interests as reflected in his/her Master Service Plan.

Programs are to include positive behavior support interventions that assist members in reducing challenging behaviors and replacing them with socially valuable, adaptive behaviors and skills. If specific written programs for either skill building or behavior reduction are implemented that require one-to-one staff to member ratio, Therapeutic Behavioral Services – Implementation (procedure code H2019) would be utilized in lieu of Day Treatment.

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.

Day Treatment Services must only be provided at a site listed on the provider's behavioral health clinic provider license. **Activities provided for the purpose of leisure or recreation 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 (or desired change) after two consecutive 90 day intervals must be discontinued or modified.

Areas of intervention may include but are not limited to:

- 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 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
 - * Masters 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 individuals with mental retardation and/or developmental disabilities under the supervision of a qualified staff person
 - Training Criteria
 - * 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 Clinic 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.

DAY TREATMENT PROGRAM CERTIFICATION PROCESS:

Behavioral Health Clinic 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. This submission must include a summary of utilization information for the past year. Specific content is listed on the Application for Day Treatment Program Certification used by BMS.

511 CRISIS SERVICES

Crisis services must be provided at a clinic site.

511.1 CRISIS INTERVENTION

PROCEDURE CODE:	H2011
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	(All units must be registered)
PRIOR AUTHORIZATION:	Refer to APS Health Care Utilization Management Guidelines.

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, and stabilize 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 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/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/licensed psychologist (in ink), date of service, and the actual time spent reviewing the documentation by listing the start-and-stop times. The physician/licensed psychologist signature will serve as the order to perform the service.

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

511.2 COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

PROCEDURE CODE: H0036
SERVICE UNIT: 15 minutes
SERVICE LIMITS: 288 units per six months by registration
PAYMENT LIMITS: No payment will be made for any other Behavioral Health Clinic 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)

PRIOR AUTHORIZATION: Yes, if units exceed 288 per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Community Psychiatric Supportive Treatment is an organized program of services designed to ameliorate or 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). Any member who still requires additional treatment services at the end of the 288 unit external prior authorization service limit must be referred to either higher or lower service intensity as appropriate. This 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.

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 ongoing. 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 relatively short-term service; therefore,



there may be multiple episodes in a six-month period.

Community Psychiatric Supportive Treatment Programs must be available a minimum of three hours a day, 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 be a clinically qualified professional. 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 to provide psychiatric evaluations, medication orders, and/or treatment as needed.

Methadone administration or case management is **not** covered.

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.
- Non-billable activities:
 - Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television, etc.
 - 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:

- It must be authorized by a physician/psychiatrist and a written order provided
- Each member must have a psychiatric evaluation and an initial Community Psychiatric Supportive Treatment plan developed within 24 hours of service initiation for each separate crisis episode. The plan must define the objectives of the Community Psychiatric Supportive Treatment Program, supportive services needed to maintain the



member in the community while in the program, and criteria for discharge from the program.

Community Psychiatric Supportive Treatment Services must include, but are not limited to:

- Daily psychiatric review and examination (for each day the program operates)
- On going 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 an assessment of the antecedent conditions that caused the need for Community Psychiatric Supportive Treatment. Once identified, these conditions must be addressed to the agencies or agents who can modify them
- 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 Clinic Services.

ADMISSION AND CONTINUED STAY CRITERIA FOR EXCEEDING SERVICE LIMITS:

Criteria must be used for both registration and prior authorization determinations.

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:

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

Additionally, criteria for continued stay have been devised so that those members who exceed the service limit but 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 criteria must be met)

- The member is experiencing a crisis due to a mental 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 criteria must be met)

- The 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 symptoms and/or maladaptive behaviors may 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.
- Relevant 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.

- **DANGER TO SELF/OTHERS**

Admission Criterion

- 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 criteria must be met)

- Relevant 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 may 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 criteria must be met)

- Relevant 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 may 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.
- There must be a daily summary that describes milieu and each separate service provided to the member, member progress relative to objectives in the service plan, the member's status, and their participation in the service. Also included must be 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.
- The program must maintain a daily schedule of program services and attendance records



for the services.

- Registration must be documented and include the required registration form. Providers must include: the reason for admission or continued stay, the physician’s signature, and a clinical note documenting the specific need for the services. These are required in addition to the standard documentation for the service. Documentation of the criteria met must be in the physician’s orders, plan of care, and the documentation of the service. (The initial registration obtained from BMS’ contracted agent will fulfill most of this requirement).
- Prior Authorizations require that the prior authorization form and supporting documentation be sent to the entity designated to do the prior authorization reviews and approvals. Copies of these forms, plus the notification of approval or denial, must be placed in the member’s clinical record. Documentation of the criteria met must be in the physician’s orders, plan of care, and the documentation of the service.

512 BEHAVIOR MANAGEMENT SERVICES

Behavioral Management Services means specific activities that have been planned and tailored to eliminate inappropriate (maladaptive) behaviors and to increase or develop desired adaptive behaviors for an individual member. These services result from 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).

512.1 THERAPEUTIC BEHAVIORAL SERVICES - DEVELOPMENT

PROCEDURE CODE:	H2019HO
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	All units must be prior authorized
PRIOR AUTHORIZATION:	Refer to APS Health Care Utilization Management Guidelines.

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 observation, 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, and they must be stated in terms of an objective, quantifiable measurement. Baseline data (quantified measurements which describe the scope and/or 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 objectively determine 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 Specialist or the Behavior Management Assistant must 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.

STAFF QUALIFICATION REQUIREMENTS

- The Behavior Management Specialist must be an individual with a minimum education at the Master's level. This individual's graduate training must have included successful completion of course work and practical experience in the techniques of applied behavior analysis. 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 who has been certified by the agency as having training specific to behavior management which is consistent with techniques of applied behavior analysis. 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).

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:

- 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).
- 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 re-inforcers to be used, when the re-inforcers will be provided (i.e., the schedule of reinforcement), by whom, and whether re-inforcers 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.

512.2 THERAPEUTIC BEHAVIORAL SERVICES - IMPLEMENTATION

PROCEDURE CODE:	H2019
SERVICE UNIT:	15 minutes
SERVICE LIMITS:	All units must be prior authorized
PRIOR AUTHORIZATION:	Refer to APS Health Care 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).

513 TRANSPORTATION SERVICES

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

513.1 NON-EMERGENCY TRANSPORTATION BY MINIBUS

PROCEDURE CODE:	A0120HE
SERVICE UNIT:	Trip
SERVICE LIMITS:	Six trips daily
PRIOR AUTHORIZATION:	None
DEFINITION:	

Non-emergency Transportation by minibus is a service in which a one-way transport of a member by a minibus or van is provided. If more than one member is being transported, each member’s transport to the Medicaid service is billable. However, if multiple stops must be made for multiple members, the service provider must only bill for each member’s transport to his/her Medicaid reimbursable service. (e.g., a minibus, carrying two members from their group home, transports the first member to a physician’s office and the second to a Day Treatment Program. Only two separate transports must be billed; one for each member. The provider cannot unbundle the second member’s trip as two trips; one from the group home to the physician’s office, since he received no service there, and the second to the Day Treatment Program).

DOCUMENTATION:

Documentation must contain an activity note for each separate transport describing the



purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff (along with their credentials), and actual time spent providing the service by listing the start-and-stop times.

513.2 NON-EMERGENCY TRANSPORTATION: PER MILE

PROCEDURE CODE: A0160HE
SERVICE UNIT: One mile
SERVICE LIMITS: 500 miles per month
PRIOR AUTHORIZATION: None
DEFINITION:

Non-emergency Transportation: Per Mile is a service in which the member’s transportation by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members. Mileage can only be calculated using the shortest, most direct route between the member’s place of departure and destination. This code cannot be billed by provider staff unless a member is present in the vehicle.

DOCUMENTATION:

Documentation must 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, date of service, and actual time spent providing the service by listing the start-and-stop times.

514 SERVICE LIMITATIONS

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

515 SERVICE EXCLUSIONS

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

- Telephone consultations
- Missed appointments
- 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
- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider’s license

516 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)
 - 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.

517 REGISTRATION/PRIOR AUTHORIZATION

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

517.1 REGISTRATION/PRIOR AUTHORIZATION PROCEDURES

- The Bureau for Medical Services requires that providers register and/or prior authorize all Behavioral Health Clinic Services described in this manual (with the exception of General Medication “J” codes, procedure codes J1630, J1631, J2680, J3230, and J3310; and Transportation Services, procedure codes A0120HE and A0160HE) with BMS’ contracted agent.
- Registration and prior authorization must be obtained from BMS’ contracted agent.
- General information on registration requirements, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS’ contracted agent. Telephone numbers for this agent are located in Appendix M.

517.2 REGISTRATION/PRIOR AUTHORIZATION REQUIREMENTS

- Registration and prior authorization requests for Behavioral Health Clinic Services must



be submitted within the timelines required by BMS' contracted agent.

- Registration and prior authorization requests must be submitted in a manner specified by BMS' contracted agent.

518 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

- Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements and Chapter 700, General Administration of the Provider Manual.
- Providers of Behavioral Health Clinic 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.
 - 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 Clinic Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

519 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.



520 PROGRAM OF SERVICE REQUIREMENTS

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

- Day Treatment

521 MANAGED CARE AND ITS RELATIONSHIP TO BEHAVIORAL HEALTH CLINIC SERVICES

Behavioral Health Clinic Services are carved out of the Health Maintenance Organization's (HMO's) responsibility for coverage. They do not require Physician Assured Access System (PAAS) approval. Behavioral Health Clinic Services provided must follow the guidelines set forth in this manual and are reimbursable by Medicaid.

522 HOW TO OBTAIN INFORMATION

To obtain information concerning procedure codes and diagnosis codes, please refer to Chapter 100, General Information of the Provider Manual. In addition, please refer to the following attachments:

- Attachment A Application for Medicaid Day Treatment Certification
- Attachment B Behavior Health Clinic/Rehabilitation Services, Authorization for Services

Physician's Current Procedural Terminology (CPT), Health Care Financing Administration Common Procedures Going System (HCFA CPC), International Classification of Diseases, 9th Edition (ICD-IX), Fourth Edition Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-IV-TR), Healthcare Common Procedure Coding System Level II 15th Edition (HCPCS)