SECTION 2
Behavioral Health Services

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2 General Policy

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, note the specific link that is not working and the page number where the link is found.

For general information regarding Medicaid, refer to the *Section I: General Information* provider manual.

Behavioral health services are a covered benefit when the services meet the definition of medical necessity as defined in Utah Administrative Code R414-1-2. Behavioral health services are directed to the treatment of behavioral health disorders and provided directly to or directed exclusively toward the member or exclusively toward the treatment of the member.

2-1 Definitions

Accountable Care Organization (ACO) means a Utah managed care organization that contracts with the Department to provide medical services to its enrollees.

Behavioral Health Disorders: mental health disorders and substance use disorders (SUDs).

Behavioral Health Services: the services directed to the treatment of behavioral health disorders.

CPT manual: the Current Procedural Terminology CPT Professional Edition or CPT Professional Codebook published by the American Medical Association.

Fee-for-Service (FFS): Medicaid-covered services that are reported directly to and paid directly through FFS Medicaid based on an established fee schedule.

Habilitation Services: interventions for the purpose of helping individuals acquire new functional abilities. (See Rehabilitative Services definition below.)

Healthy Outcomes Medical Excellence (HOME): a voluntary managed care program for Medicaid members who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides its members with medical services, behavioral health services, and targeted case management services.

Institution for Mental Diseases (IMD): means the same as defined in 42 CFR 435.1010 "Institution for mental diseases".

Medically Necessary Services: means the same as defined in Utah Administrative Code R414-1-2(18).

Mental Health Therapist: means the same defined in the Mental Health Practice Act 58-60-102.

Prepaid Mental Health Plan (PMHP): the mental health and substance use disorder managed care plan operating under the authority of the Department of Health and Human Service's 1915(b) waiver that contracts with the Department to provide to its enrollee's mental health and substance use disorder services, or in one designated area of the State, mental health services only.

Rehabilitative Services: any medical or remedial services ordered by a physician or other licensed practitioner for maximum reduction of an individual's behavioral health disorder and restoration of the individual to their best possible functional level.

Utah Medicaid Integrated Care (UMIC) Plan: a Utah managed care organization that contracts with the Department to provide medical and behavioral health (i.e., mental health and substance use disorder services to its enrollees) HOME is not a UMIC Plan.

2-2 Early and Periodic Screening, Diagnostic, and Treatment

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a program for individuals under the age of 21 to receive preventive health care and all medically necessary services. The program's purpose is to find and treat health problems before they become more serious. Behavioral Health Services covered in this manual are available for the EPSDT population. To learn more, see the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services manual. To request reimbursement for a service that is not defined in this manual, providers may request the service be reviewed by the EPSDT Committee.

Providers must submit an authorization request at https://medicaid.utah.gov/prior-authorization/

Providers and members can also contact the member's managed care plan or a Health Program Representative at 1-866-608-9422 to get information about the EPSDT program.

3 Coding

As part of the Provider Agreement, enrolled providers agree to comply with and follow all guidelines of the National Correction Coding Initiative per *Section I: General Information,* Chapter 3 "Provider Participation and Requirements".

Utah Medicaid has some coding policies unique to Utah that are outlined in this manual. When specific guidance is not given Utah Medicaid follows the National Correction Coding Initiative. Providers are responsible for identifying and reporting the correct codes for all services rendered. Additional guidance on coding behavioral health services can be found in the Coverage and Reimbursement Code Lookup tool.

4 Provider Participation and Requirements

Refer to *Section I: General Information*, Chapter 3, "Provider Participation and Requirements."

4-1 Providers Qualified to Prescribe Behavioral Health Services

Behavioral health services must be prescribed by a mental health therapist as defined in Title 58-60-102, *Mental Health Professional Practice*.

4-2 Providers Qualified to Render Behavioral Health Services

All providers must only render services within their scope of practice and should consult with their licensing or certifying entities for their scope of practice. Qualified providers for some services are authorized through the Utah Medicaid State Plan, Utah's Medicaid Reform 1115 Demonstration and other Medicaid policies.

4-3 Other Trained Individuals

Other trained individuals may provide psychosocial rehabilitative services and supportive living, as defined in this manual, and other services as defined in the Managed Care Manual.

Before other trained individuals can report services, the hiring body must ensure the following minimum training requirements are met:

Individuals shall receive training on all administrative policies and procedures of the agency, and the program as applicable, including:

- Fraud, waste or abuse detection and reporting,
- HIPAA and confidentiality/privacy policy and procedures,

- Emergency/crisis procedures, and
- Other relevant administrative-level subjects.

Individuals shall also receive information and training in areas including:

- Philosophy, objectives, and purpose of the service(s) the individual will be delivering,
- Medicaid definition of the service(s) the individual will be delivering,
- Specific job duties,
- Treatment plans and development of treatment goals,
- Role and use of clinical supervision of the other trained individual,
- Population(s) served and the functional impacts of diagnoses that result in the need for the service,
- Healthy interactions with members to help them obtain goals,
- Management of difficult behaviors,
- Medications and their role in treatment,
- Any formal programming materials used in the delivery of the service (the individual shall understand their use and receive training on them as required), and
- Other relevant subjects as determined by the agency.

The hiring body shall maintain documentation of training including dates of training, agendas, and training/educational materials used. The supervising provider must ensure individuals complete all training within 60 calendar days of the hiring date, or for existing providers within 60 calendar days from the date of enrollment as a Medicaid provider.

5 Record Keeping

Providers must maintain records in accordance with relevant laws and statutes. Refer to Section I: General Information, Chapter 4, *Record Keeping.* Additionally, the provider must develop and maintain sufficient written documentation for each service or session to support the medical necessity and provision of the prescribed mental health service.

For services that are bundled, documentation must be completed for each service rendered and must meet the record keeping standards described in this manual.

Documentation must include:

- name of each service the member received,
- date, start and stop time, and duration of each service,
- setting in which each service was rendered. When services are provided via telehealth, the provider setting and a notation that the service was provided via telehealth must be made,
- record of what happened during the service including treatment goals addressed, and
- signature and licensure or credentials of the individual who rendered the service.

5-1 Time Rules

Utah Medicaid follows the time rules standards set by CMS. For services with 15-minute units follow the time rules below.

- Less than 8 minutes equals 0 units,
- 8 minutes through 22 minutes of service equals 1 unit,
- 23 minutes through 37 minutes of service equals 2 units,
- 38 minutes through 52 minutes of service equals 3 units,
- 53 minutes through 67 minutes of service equals 4 units, etc.…

6 Coding and Billing

Refer to *Section I: General Information*, Chapter 11 "Billing Medicaid" for detailed billing instructions. Utah Medicaid requires all enrolled providers to comply with all laws, rules, and regulations governing the Medicaid Program. As part of the Provider Agreement, all enrolled Medicaid providers agree to follow all guidelines of the National Uniform Billing Code when billing for Medicaid services. Refer to *Section I: General Information*, Chapter 3 "Provider Participation and Requirements" for Provider Agreement information.

For per diem bundled service codes, at least one behavioral health service must be rendered to the member to report the bundled code.

6-1 Telehealth Services

When reporting services delivered via telehealth refer to *Section I - General Information*, Chapter 8-4.2 "Telehealth" for additional information.

6-2 Third Party Liability

Requirements for billing third parties are described in *Section I: General Information*, Chapter 11-5 "Billing Third Parties."

6-3 Medicaid as Payment in Full, Member Billing Prohibited

A provider who accepts a member must accept Medicaid payment as reimbursement in full. Refer to *Section I: General Information Provider Manual*, Chapters 3-4 "Medicaid as Payment in Full, Client Billing Prohibited" and Chapter 3-5 "Exceptions to Prohibition on Billing Members" for exceptions to billing members.

7 Treatment Plan

Based on data from evaluation(s), when behavioral health services are deemed medically necessary, a mental health therapist is responsible for the development of an individualized treatment plan in collaboration with the member. A mental health therapist is also responsible to conduct reassessments/treatment plan reviews with the member, as clinically indicated, to ensure the member's treatment plan is current and accurately reflects the member's goals and needed behavioral health services. Initial treatment plans and any subsequent treatment plan review and updates must also be documented.

The treatment plan must include the following:

1. measurable treatment goals including the date each treatment goal is added to the treatment plan,
2. the specific treatment methods that will be used to meet the measurable treatment goals,
3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method,
4. the licensure or credentials of the individuals who will furnish the medically necessary services, and
5. the signature and licensure or credentials of the mental health therapist who developed the treatment plan.

8 Behavioral Health Services

8-1 General Information

Behavioral health services must be provided to or directed exclusively toward the treatment of the Medicaid member.

Behavioral health services may be provided to members with a dual diagnosis of a mental health disorder, substance use disorder, intellectual disability, developmental disorder, or related condition. Services should be directed toward the treatment or remediation of the diagnosis.

For applied behavioral analysis (ABA) policies for treating autism spectrum disorder (ASD), refer to the *Autism Spectrum Disorder Services* provider manual.

The following descriptions of services provide general information, provider requirements, limitations, and coding/billing guidelines for Medicaid covered services. Services with specific Utah regulations include pertinent information. For services without unique Utah rules, general information is included, and providers should refer to the CPT Manual or the National Correct Coding Initiative (NCCI) for information.

8-2 Psychiatric Diagnostic Evaluation

8-2.1 General

Psychiatric diagnostic evaluations are an integrated biopsychosocial assessment performed for the purpose of assessing and determining diagnoses. These evaluations include the assessment of the patient's psychosocial history, current mental status, review, and ordering of diagnostic studies followed by appropriate treatment recommendations. In certain circumstances information may be obtained from family members, guardians, or significant others in lieu of the patient.

Additional provider requirements apply when evaluations may be used to qualify a Medicaid member to receive Medicaid-covered autism spectrum disorder (ASD)-related services. For information on these requirements and on ASD-related services, refer to the *Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services* for EPSDT Eligible Individuals.

For information and requirements regarding psychiatric diagnostic evaluations for individuals with a chronic pain management service and evaluations required prior to certain medical and surgical procedures, refer to the Utah Medicaid Provider Manual for *Physician Services*, 8-15.1 “Evaluations and Psychological Testing”.

8-2.2 Provider Participation

Psychiatric diagnostic evaluations must be performed by a licensed mental health therapist. Psychiatric diagnostic evaluations with medical services must be performed by a licensed provider acting within their scope of practice.

Psychiatric diagnostic evaluations performed for physical health purposes (including prior to medical procedures), or for diagnosing intellectual or development disabilities, or organic disorders, the services are paid directly by FFS Medicaid and not by ACOs, PMHPs or UMIC Plans. To ensure correct adjudication of the claim use the UC modifier with the procedure code for these services.

8-2.3 Limitations

Psychiatric diagnostic evaluations are not reimbursable when requested by a court, the Department of Health and Human Services (DHHS), Division of Child and Family Services, solely for the purpose of

determining if a parent is able to parent and should therefore be granted custody or visitation rights, or whether the child should be in some other custodial.

8-2.4 Coding and Billing

Utah Medicaid uses 15-minute units for reporting of psychiatric diagnostic evaluations. See Time Rules in Chapter 5-2 of this manual.

90791	Psychiatric diagnostic evaluation	Per 15 minutes
90792	Psychiatric diagnostic evaluation with medical services	Per 15 minutes

8-3 Mental Health Assessment by a Non-Mental Health Therapist

8-3.1 General

Mental health Assessment by a Non-Mental Health Therapist is when a qualified provider participating in a in multi-disciplinary team assists in the psychiatric diagnostic evaluation process by gathering psychosocial information including information on the individual's strengths, weaknesses, and needs, and historical, social, functional, psychiatric, and other information. The provider may also assist the member to identify treatment goals. The information obtained is provided to the qualified provider who will perform the psychiatric diagnostic evaluation assessment, reassessment, or treatment plan review. Information also may be collected through in-person or telephonic interviews with family/guardians or other sources as necessary.

8-3.2 Provider Participation

The following individuals may provide a mental health assessment when they are under the supervision of a licensed mental health therapist and are participating as part of a multi-disciplinary team:

- licensed social service worker
- substance use disorder counselor licensed as an advanced substance use disorder counselor (ASUDC), certified advanced substance use disorder counselor (CASUDC), certified advanced substance use disorder counselor intern (CASUDC-I), substance use disorder counselor (SUDC), certified substance use disorder counselor (CSUDC), or certified substance use disorder counselor intern (CSUDC-I)
- licensed behavioral health coach
- licensed registered nurse
- licensed practical nurse
- licensed registered nursing apprentice
- individual who has obtained a qualifying bachelor's degree and is actively engaged in meeting the Department of Professional Licensing requirements to obtain licensure as a Social Service Worker in accordance with State law
- individual enrolled in a qualified substance use disorder education program who is exempted from licensure in accordance with State law, and under DOPL-required supervision.

8-3.3 Limitations

This service is meant to accompany psychiatric diagnostic evaluations. If a psychiatric diagnostic evaluation is not conducted after this service is performed, this service may be reported if all the documentation requirements in the Record Keeping Chapter are met and the reason for non-completion of the psychiatric diagnostic evaluation is documented.

If the provider conducting the psychiatric diagnostic evaluation obtains all the psychosocial information directly from the Medicaid member, only that service is reported. The provider does not report this service.

8-3.4 Coding and Billing

H0031	Mental health Assessment by a Non-Mental Health Therapist	15-minute units

8-4 Psychological Testing

8-4.1 General

Medicaid provides coverage for psychological testing as a comprehensive evaluation to assess the presence, type, and severity of a mental illness or disorder. This includes administering psychological tests that are specifically chosen to meet a member's clinical needs. The service also encompasses the interpretation of test results and the preparation of detailed reports as integral components of the psychological assessment process. Provider Participation

Licensed providers acting within their scope of practice may report this service.

8-4.2 Limitations

For more information on psychological testing for physical health purposes, see the Utah Administrative Code R414-10, *Physician Services*, and the *Physician Services provider manual*, Chapter 8-15.1 – "Evaluations and Psychological Testing".

Additional provider requirements apply when testing may be used to qualify a member to receive covered ASD-related services. For information on these requirements and on ASD-related services, refer to the *Autism Spectrum Disorder Services* provider manual.

8-4.3 Coding and Billing

Refer to the CPT manual for psychological testing codes. Psychological testing performed for physical health purposes, including prior to medical procedures, or for diagnosing intellectual or development disabilities, or organic disorders, the services are paid directly by FFS Medicaid and not by ACOs, PMHPs or UMIC Plans. To ensure correct adjudication of the claim, use the UC modifier with the procedure code.

8-5 Psychotherapy

8-5.1 General

Medicaid covers psychotherapy when used for the treatment for mental illness and behavioral disturbances. The provider, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the member may be restored to their best possible functional level. Services are based on measurable treatment goals identified in the treatment plan.

8-5.2 Provider Participation

Psychotherapy must be provided by a licensed mental health therapist. Group psychotherapy may be cofacilitated by licensed mental health therapist and another licensed provider acting within their scope of practice. Psychotherapy with evaluation and management services must be provided by a provider acting within their scope of practice.

8-5.3 Limitations

Group psychotherapy is limited to 12 patients in attendance unless a co-provider is present, then group psychotherapy may not exceed 16 patients in attendance.

Multiple-family group psychotherapy is limited to 12 families in attendance unless there is a co-provider, then groups may not exceed 16 families in attendance.

If the number of patients or families in attendance exceeds the limit, then the group may not be reported for any of the Medicaid members.

8-5.4 Coding and Billing

Utah Medicaid uses 15-minute units when reporting group and family psychotherapy.

90846	Family Psychotherapy - without patient present	per 15 minutes
90847	Family Psychotherapy - with patient present	per 15 minutes
90849	Multiple-Family Group Psychotherapy	per 15 minutes
90853	Group Psychotherapy	per 15 minutes

8-6 Psychotherapy for Crisis

8-6.1 General

Psychotherapy for crisis is an urgent assessment of a crisis state, a mental status exam, and disposition. It includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention for a member in high distress.

8-6.2 Provider Participation

A licensed mental health therapist acting within their scope of practice may provide this service.

8-7 Pharmacologic Management

8-7.1 General

Pharmacologic management service entails reviewing and monitoring the patient's prescribed medication(s) and medication regimen to manage a behavioral health condition. Reviewing and monitoring includes evaluation of dosage, the effect the medication(s) is having on the patient's symptoms, and side effects. Any of the following may also be included in the service: prescription of medications to treat the patient's behavioral health condition, providing information (including directions for proper and safe usage of medications), and/or administering medications as applicable.

8-7.2 Provider Participation

A licensed physician or other qualified provider acting within their scope of practice.

8-7.3 Coding and Billing

Pharmacologic management is reported using the appropriate Evaluation and Management code. When reporting this pharmacologic management service, use the CG modifier with the Evaluation and

Management code. The CG modifier signifies that the service was a behavioral health pharmacologic management service as opposed to a medical Evaluation and Management service.

8-8 Nurse Medication Management

8-8.1 General

Behavioral health nurse medication management is nurse medication management includes reviewing and monitoring the member's prescribed medication(s) and medication regimen to manage a behavioral health condition. Reviewing and monitoring includes evaluation of dosage, the effect the medication(s) is having on the member's symptoms, and side effects.

8-8.2 Provider Participation

A licensed provider acting within their scope of practice.

8-8.3 Limitations

Distributing medications (i.e., handling, setting out or handing medications to members) is not a covered service and may not be reported.

Administration of medications is not covered under this service.

Specimen collection, including urinalysis (UA), is not covered under this service.

8-8.4 Coding and Billing

Nurse medication management is reported using the Evaluation and Management code listed below. When reporting this service, use the CG modifier with the Evaluation and Management code listed below. The CG modifier signifies that the service was a behavioral health service as opposed to a medical service.

99211CG	Nurse medication management	Per encounter

8-9 Therapeutic Behavioral Services

8-9.1 General

Therapeutic behavioral services are behavioral interventions to assist members with specific identified behavior problems. The service may be provided to an individual, family, or group. Individuals receiving this service must be referred by a mental health therapist as part of the assessment and treatment planning process; members must continue with individual mental health treatment in conjunction with therapeutic behavioral services.

8-9.2 Provider Participation

The following providers may report this service:

- licensed mental health therapist,
- licensed social service worker under the supervision of a licensed mental health therapist,
- individual who has obtained a qualifying bachelor's degree and is actively engaged in meeting DOPL requirements to obtain licensure as a social service worker in accordance with state law, and is under the supervision of a licensed mental health therapist,
- licensed registered nurse,
- licensed ASUDC or licensed SUDC under the general supervision of a licensed mental health therapist,

- licensed CASUDC or licensed CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 who is qualified to provide supervision, or a licensed ASUDC qualified to provide supervision,
- licensed CSUDC or licensed CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 who is qualified to provide supervision, or a licensed ASUDC or a licensed SUDC who are qualified to provide supervision,
- licensed behavioral health coach,
- registered nurse apprentice who is exempted from licensure in accordance with State law, and under required supervision, and
- individual enrolled in a qualified substance use disorder counselor education program, who is exempted from licensure in accordance with State law, and under DOPL-required supervision.

8-9.3 Limitations

Groups are limited to 12 patients in attendance unless a co-provider is present, then groups may not exceed 24 patients in attendance.

Multiple family therapeutic behavioral services groups are limited to 12 families in attendance, unless there is a co-provider, then may not exceed 16 families in attendance.

If the number of patients or families in attendance exceeds the limit, then the group may not be reported for any of the Medicaid members.

Co-providers must meet the provider qualifications outlined in the 'Qualified Providers' section above.

8-9.4 Coding and Billing

H2019	Individual/Family Therapeutic Behavioral Services	per 15 minutes
H2019HQ	Group Therapeutic Behavioral Services	per 15 minutes

8-10 Psychosocial Rehabilitative Services

8-10.1 General

Psychosocial rehabilitative services (PRS) are services provided to an individual or group and are designed to restore the member(s) to his or her optimal possible functional level. This service is aimed at maximizing the member's basic daily living and life skills, increasing compliance with the medication regimen as applicable, and reducing or eliminating symptomatology that interferes with the member's functioning.

8-10.2 Provider Participation

- licensed mental health therapist,
- licensed social service worker under the supervision of a licensed mental health therapist,
- individual who has a qualifying bachelor's degree and is actively engaged in meeting DOPL requirements to obtain license as a social service worker in accordance with state law, and is under the supervision of a licensed mental health therapist,
- licensed registered nurse,
- licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist,

- licensed ASUDC or licensed SUDC under the general supervision of a licensed mental health therapist,
- licensed CASUDC or licensed CASUDC-I are under direct supervision of a licensed mental health therapist,
- licensed CSUDC or licensed CSUDC-I under direct supervision of a licensed mental health therapist,
- other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist, a licensed social service worker, or a licensed registered nurse, or a licensed ASUDC or a licensed SUDC when the service is provided to individuals with a SUD,
- licensed behavioral health coach,
- certified behavioral health technician,
- registered nurse apprentice who is exempted from licensure in accordance with state law, and under DOPL-required supervision,
- individual enrolled in a qualified substance use disorder counselor education program, who is exempted from licensure in accordance with State law, and under DOPL-required supervision,

8-10.3 Limitations

PRS groups are limited to 12 or fewer patients per provider, with a maximum of 36 patients. If the number of patients participating in the group exceeds the maximum of 36 patients, the group session may not be reported for any of the Medicaid members.

Intensive PRS groups are limited to five patients per provider, with a maximum of ten patients per intensive PRS group. Intensive PRS groups are planned, structured groups, independent from other PRS groups. They are designed to address the clinical needs of patients who, if in a regular PRS group, would be distracting to other group members and/or require more individualized attention, including one on one, to maintain their focus on their clinical issues and treatment goals. Intensive PRS groups cannot be coded based solely on the number of patients in attendance.

The psychiatric diagnostic evaluation or other clinical documentation must document the need for an intensive PRS group, the member's diagnoses, severity of symptoms and behaviors, and why an intensive PRS group is required. The treatment plan must prescribe intensive PRS and contain goals to ameliorate the symptoms and behaviors that necessitate intensive PRS group.

The following are not to be reported under this service:

- activities in which providers are not present and actively involved helping members regain functional abilities and skills,
- routine supervision of members, including routine 24-hour care and supervision of members (or members' children) in residential settings. Routine supervision includes care and supervision-level providers who may have informal, sporadic interactions with a member that are helpful; however, these types of interactions do not constitute a reportable structured, pre-planned psychosocial rehabilitative individual or group session. Individual and group PRS must be provided in accordance with a formal schedule for the member and must be documented in accordance with the requirements in the 'Record' section below. Otherwise, intermittent unplanned communications with the member are part of the routine supervision and are not reportable,
- activities in which providers perform tasks for the member, including activities of daily living and personal care tasks (e.g., grooming, and personal hygiene tasks, etc.),

- time spent by the member in the routine completion of activities of daily living, including eating meals, doing chores, etc.,
- habilitation Services,
- job training, job coaching and other vocational activities, and educational services and activities such as lectures, presentations, conferences, other mass gatherings, etc.,
- social and recreational activities, including but not limited to routine exercise, farming, gardening, and animal care activities, etc. Although these activities may be therapeutic for the member, and a provider may obtain valuable observations for processing later, they do not constitute reportable activities. However, time spent before and after the activity addressing the members' skills and behaviors related to the member's rehabilitative goals is allowed,
- routine transportation of the member or transportation to the site where a psychosocial rehabilitative service will be provided, and
- any type of childcare (including therapeutic childcare).

8-10.4 Group Psychosocial Rehabilitative Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

For each date of participation in the program, documentation must include:

- name of each group in which the member participated (e.g., anger management, interpersonal relations, etc.),
- date, start and stop time, and duration of each group, and
- setting in which each group service was rendered (e.g., day treatment program). When services are provided via telehealth, the provider setting and a notation that the service was provided via telehealth must be made.

When services are provided in one of these programs, one summary note for each unique type of psychosocial rehabilitative group the member participated in during the immediately preceding two-week period must be prepared at the close of the two-week period. The required summary note may be written by the provider who conducted the group, or by a provider who is most familiar with the member's involvement and progress across groups.

The summary note must include:

- name of the group,
- treatment goal(s) addressed in the group and the member's progress toward treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers, and
- signature and licensure or credentials of the individual who prepared the documentation. If a co-leader is present for the group, the note must contain the co-leader's name and licensure or credentials.

8-10.5 Coding and Billing

H2014	Individual Psychosocial Rehabilitative Services	per 15 minutes
H2017	Group Psychosocial Rehabilitative Services	per 15 minutes
H2017U1	Group Psychosocial Rehabilitative Services – Intensive	per 15 minutes

8-11 Peer Support Services

8-11.1 General

Peer support services are specialized therapeutic interactions that are performed by individuals who are current or past recipients of behavioral health services. These individuals are trained and certified to provide support and assistance to individuals in their recovery and integration into the community. The goal is to provide understanding and coping skills and empowerment through mentoring and other supports so that individuals with severe and persistent mental disorders can cope with stress and achieve personal wellness.

Peer support services are provided to an individual or in group settings. For children, services are provided to their parents or legal guardians or other responsible caregivers, as appropriate to the child's age.

8-11.2 Provider Participation

Peer Support Services must be delivered by a peer support specialist who is certified through the Office of Substance Use and Mental Health (SUMH) certification process as outlined in Utah Administrative Code R523-5 or R523-6.

8-11.3 Limitations

Peer support service groups with a ratio greater than 1:8 are not reportable for any Medicaid member in the group.

Peer support services must be referred by a licensed mental health therapist and must document in the record which licensed mental health therapist recommended peer support services.

8-11.4 Coding and Billing

H0038	Individual Peer Support Services	Per 15 minutes
H0038HQ	Group Peer Support Services	Per 15 minutes

8-12 Assertive Community Treatment and Assertive Community Outreach Treatment

8-12.1 General

Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT) are community-based programs that offer treatment and support services for people with serious and persistent mental illnesses. Their goal is to help members live independently in their chosen communities, rather than relying on hospitals. ACT and ACOT teams provide services in-person and in community settings, including inpatient and outpatient facilities.

8-12.2 Provider Participation

Assertive Community Treatment (ACT) teams must meet Utah Administrative Code R523-22-5 guidelines to report ACT services. Assertive Community Outreach Treatment (ACOT) teams must meet the Office of Substance Use and Mental (SUMH) Assertive Community Outreach Treatment for Clients with the Most Serious and Persistent Mental Illnesses Program Guidelines in order to report ACOT services.

8-12.3 Coding and Billing

ACT and ACOT services are reimbursed on a per month bundled payment basis and the member must receive at least one behavioral health service per billing period. Only one unit of service can be reported each month, and services must be reported only for the month in which at least one service was provided.

A prorated charge is reported when a member enters or discharges from the ACT or ACOT caseload in the middle of a month and does not receive ACT or ACOT services for the entirety of the month. The per diem rate is determined by multiplying the monthly rate by 12 then dividing it by 365. The prorated rate is then multiplied by the number of days of service for the prorated month. Providers report the days of service, one unit, and the prorated charge.

H0040	Assertive Community Treatment	Per month

8-13 Mobile Crisis Outreach Teams

8-13.1 General

Mobile Crisis Outreach Teams (MCOT) offer a community-based intervention to members experiencing a crisis. MCOTs go to homes, schools, shelters, work, or anywhere else in the community where a member is experiencing a crisis.

8-13.2 Provider Participation

MCOTs that meet the standards in Utah Administrative Code R523-18 may report this service.

8-13.3 Coding and Billing

H2000	Comprehensive multidisciplinary evaluation	Per diem

8-14 Clinically Managed Residential Withdrawal Management

8-14.1 General

Clinically Managed Residential Withdrawal Management, sometimes referred to as “social detox”, is a service provides 24-hour supervision, observation, and support for members who are intoxicated or experiencing withdrawal. It emphasizes peer and social support rather than medical and nursing care. Details about this service can be found in *The American Society of Addiction Medicine (ASAM) Criteria* guidelines.

8-14.2 Provider Participation

A program that is licensed through DHHS Office of Licensing as a social detoxification facility and meets *ASAM Criteria* guidelines for this level of care may report this service.

8-14.3 Limitations

Programs must ensure that that members have access to fully integrated comprehensive addiction treatment services which may be through formal affiliation with other providers and programs.

This service is reportable on hospital admission and discharge dates.

8-14.4 Coding and Billing

H0012	Alcohol and/or drug services, sub-acute detoxification	Per diem

8-15 Medically Managed Outpatient Treatment

8-15.1 General

Medically Managed Outpatient Treatment, sometimes referred to as "outpatient detox", is a medically organized outpatient service which may be provided in an outpatient setting such as a healthcare clinic, office setting, or addiction treatment facility by a licensed professional. The primary purpose of the service is to provide medically supervised, withdrawal management, and referral services based on the member's needs. These services are provided in regularly scheduled timeframes and intervals set by the licensed provider once the member has been assessed and it is determined treatment at the outpatient level of care is appropriate.

8-15.2 Provider Participation

A program that is licensed through the Utah Office of Licensing as a Medically Managed Outpatient Treatment facility and meets *The ASAM Criteria* guidelines for this level of care.

8-15.3 Limitations

Programs may only report the per diem bundled service code for dates on which at least one included service is provided to the member. This service is reportable on hospital admission and discharge dates.

8-15.4 Coding and Billing

H0014	Alcohol and/or drug services-Ambulatory Detoxification (with or without extended on-site monitoring)	Per diem

8-16 Behavioral Health Receiving Centers

8-16.1 General

Behavioral Health Receiving Centers (BHRC) are 24/7 community centers designed to support individuals experiencing any type of behavioral health crisis. These centers are staffed by a team that includes psychiatrists, registered nurses, mental health therapists, and peer counselors. The team provides care for those in mental health or substance use crises. At BHRCs, individuals are assessed, stabilized, and can be monitored in a recliner for up to 23 hours.

8-16.2 Provider Participation

BHRCs must be licensed by the DHHS Office of Licensing, be an outpatient hospital, or be included under a hospital's license. All facilities must meet treatment and staffing requirements specified in Utah Administrative Code R523-21.

8-16.3 Coding and Billing

S9485	Crisis intervention mental health services,	Per diem

8-17 Psychiatric Hospitals Considered Institutions for Mental Disease

8-17.1 General

Treatment in a psychiatric hospital considered to be an Institution for Mental Disease (IMD) is covered when medically necessary for up to 60 days for members ages 21 through 64. Prior authorization is

required. No more than 60 calendar days will be authorized per treatment episode. If treatment exceeds 60 days, no part of the stay is eligible for reimbursement.

For members ages 21 and under, stays in IMD facilities are covered as long as the stay is medically necessary. No prior authorization is required.

If the member is enrolled in a PMHP, UMIC Plan or HOME, refer to the plan for their prior authorization requirements.

For information on psychiatric hospital licensing, coverage, and limitations please refer to the *Hospital Services Manual*, Chapter 8-11, Mental Health Services.

8-18 Mental Health Residential Treatment

8-18.1 General

Mental health residential treatment provides a 24-hour group living environment for members, with mental health disorders.

8-18.2 Provider Participation

Providers must be licensed by DHHS Office of Licensing as a licensed residential treatment program and meet the requirements in Utah Administrative Code R501-19. For facilities that are IMDs, accreditation from The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) is also required.

8-18.3 Programs with 16 or fewer beds

For members 21 years of age or older, providers report a per diem code. For members under 21 years of age, providers report the individual services rendered.

8-18.4 Programs with 17 or more beds (Institutions for Mental Diseases)

Programs with 17 or more beds are Institutions for Mental Diseases (IMDs). Utah Medicaid only allows the reporting of services for members 21-64 years of age in IMDs. Prior authorization is required.

Mental health residential treatment in an IMD is limited to 60 days per episode of care, regardless of medical necessity. If a treatment episode exceeds 60 days, then none of the days of the treatment episode of care are reportable or reimbursable.

Mental health residential treatment programs that are IMDs must also meet the following standards:

- Programs must have the capacity to address co-morbid physical health conditions during short-term stays.
- Programs are responsible for ensuring appropriate transitions to other levels of outpatient mental health services, either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.
- Programs must have a process to assess the housing situation of the member transitioning to the community from the program and to connect the member who may experience homelessness upon discharge, or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services.
- Programs must have protocols in place to ensure contact is made with each discharged member within 72 hours of discharge and to assist the member with accessing follow-up care by contacting the community-based provider they were referred to.

8-18.5 Prior Authorization for Mental Health Residential Treatment in Programs that are IMDs

Prior authorization (PA) requests may be approved for up to seven (7) calendar days per PA request or at a time. Members may receive only one initial admission PA per treatment episode in which no clinical documentation is necessary. If a PMHP, UMIC plan, or HOME program has given a non-clinical PA and the member's enrollment changes to FFS during the treatment episode, or vice versa, additional PA requests must be a clinical PA request(s). No more than 60 calendar days may be authorized per treatment episode regardless of medical necessity.

If the member is enrolled in a PMHP, UMIC Plan or HOME, refer to the plan for their prior authorization requirements.

8.18.5.1 Initial Admission PA Request

An initial admission PA request must be submitted no later than two (2) business days after the date of admission. No supporting documentation is required.

8.18.5.2 Ongoing/Continued Stay PA Request

An ongoing/continued stay PA request must include the anticipated discharge date in the 'documentation' section and 'remarks' section that supports medical necessity for continued stay. The submission must be no earlier than four (4) calendar days of (and including) the first requested date of service indicated on the PA request. The clinical documentation must be submitted no later than the first requested date of service indicated on the PA request.

8.18.5.3 Transition Days

If the provider determines that medical necessity for continued stay is not met, the provider may request up to seven (7) calendar transition days to allow time to transition the member to the medically necessary level of care. Providers must complete the PA request submission and ensure that the 'remarks' section indicates that the request is for transition days and must submit the PA request no later than the first date of service requested on the PA request. If the PA team determines that the clinical documentation submitted with a continued stay (clinical) PA request does not support continued stay criteria, the PA team may authorize up to seven (7) calendar days to allow time to transition the member to the medically necessary level of care.

8.18.5.4 Member Absence from the Program

If a member is absent from a program for three (3) calendar days or less, providers must request a modification to the current PA request by completing and submitting a 'modification form'. Providers must include in the comment or remark section the dates the member was absent from the program.

If a member is absent for more than three (3) calendar days, providers must request a new non-clinical PA. Providers must include in the 'remark' section or 'comment' section, including the date the member left the program are included.

8.18.5.5 Modification Requests

If a modification on an authorization is required, the provider must complete and submit the modification request form and any supporting documentation for the existing prior authorization request no later than 10 days after the admission date. Anything submitted after 10 days will not be considered timely and will result in a denial.

8-18.6 Coding and Billing

Facilities may only report the per diem bundled service codes for dates when at least one of the following services are provided:

- psychiatric diagnostic evaluation,
- psychotherapy (individual/group/family),
- injectable administration of a drug,
- nursing assessment, case management,
- mental health assessment,
- peer services,
- training/skills development,
- community support services,
- psychosocial rehabilitative services,
- therapeutic behavioral services,
- or targeted case management.

H0017	Mental Health Residential Treatment IMD Program, ages 21-64	Per diem
H2013	Mental Health Residential Treatment Program non-IMD, 21 years of age and older	Per diem
Individual service codes	Mental Health Residential Treatment Program non-IMD, under 21	

8-19 Substance Use Disorder Residential Treatment

8-19.1 General

Substance use disorder (SUD) residential treatment provides specialized treatment in a 24-hour group living environment for individuals with substance use disorders.

8-19.2 Provider Participation

Providers must be licensed by DHHS Office of Licensing and meet the requirements in Utah Administrative Code R501-19.

8-19.3 Limitations

Prior authorization (PA) is required for all members receiving substance use disorder residential treatment.

SUD residential treatment is limited to members ages 12 and older.

This service is reportable on hospital admission and discharge dates.

8-19.4 Prior Authorization for Substance Use Disorder Residential Treatment Programs

PA requests for adolescent members ages 12 through 18 may be approved for up to 30 calendar days per request. PA requests for adult members 19 years of age or older may be approved for up to 60 calendar days per request. Members may receive one initial PA per treatment episode, without the submission of accompanying medical documentation. If a PMHP, UMIC Plan, or HOME program has given an initial PA and the member's enrollment changes to FFS during the treatment episode, additional ongoing/continued stay PA requests must be submitted.

For more information on PA submissions for SUD providers please see the PRISM Prior Authorization (PA) Facilitator Guide for Providers for SUD training document.

8.19.4.1 Initial Admission PA Request

An initial admission PA request must be submitted no later than 2 business days after the date of admission. No supporting documentation is required with this request.

8.19.4.2 Ongoing/Continued Stay PA Request

An ongoing/continued stay PA request must include a completed reassessment and treatment plan review using ASAM criteria and must be submitted no earlier than seven (7) calendar days of (and including) the first requested date of service indicated on the PA request. The reassessment and treatment plan review must be no later than the first date of service requested on the PA request form.

8.19.4.3 Transition Days

If the provider determines that medical necessity for continued stay is not met, the provider may request up to seven (7) calendar transition days through the standard clinical PA request process to allow time to transition the member to the appropriate ASAM level of care. When Medicaid determines the clinical documentation does not support the need for continued stay, seven (7) transitional calendar days may be authorized to allow time for the transition of the member to the medically necessary ASAM level of care.

8.19.4.4 Member Absence from the Program

If a member is absent from a program for three (3) calendar days or less, providers must request a modification to the current PA request by completing and submitting a 'modification request form'. Providers must ensure the 'remarks' or 'comments' section, include the dates the member was absent.

If a member is absent for more than three (3) calendar days, providers must request a new non-clinical PA. Providers must ensure the 'remarks' or 'comments' section, include the date the member left the.

8.19.4.5 Modification Requests

If a modification to an authorization is required, the provider must complete and submit the modification request form and any supporting documentation for the existing prior authorization request no later than 10 calendar days after the admission date. Anything submitted after 10 calendar days will not be considered timely and will result in a denial.

8-19.5 Coding and Billing

Facilities may only report the per diem bundled service codes for dates when at least one of the following services are provided: Psychiatric diagnostic evaluation, psychotherapy (individual/group/family), injectable administration of a drug, nursing assessment, case management, mental health assessment, peer services, training/skills development, community support services, psychosocial rehabilitative services, therapeutic behavioral services, or targeted case management.

H0018	Substance use disorder residential treatment, IMD	Per diem
H2036	Substance use disorder residential treatment, non- IMD	Per diem

8-20 Supportive Living

8-20.1 General

Supportive living service involves 24-hour staff who create a safe and supportive environment for members. This service is provided directly to members through residential support, crisis intervention, community integration, and ensuring safety and security. It focuses on improving members' living situations, addressing safety concerns, helping resolve interpersonal issues with other residents, and

preventing or managing emergencies to help members reach their best possible functional level. This service does not cover the costs of other covered services or room and board.

8-20.2 Provider Participation

Facilities must be licensed by DHHS Office of Licensing and meet the requirements in Utah Code 62A-2-101(38). This service may be provided by an Other Trained Individual as defined in Chapter 3-1.3 of this manual and other certified and licensed providers.

8-20.3 Limitations

- Costs do not include room and board.
- Supportive living may not be reported when a per diem bundled behavioral health treatment code is reported (codes H0012, H0018, H2036, H0017, or H2013) as supportive living costs are included in the bundled payment rates.

8-20.4 Coding and Billing

H2016	Supportive Living	Per diem

8-21 Recreational Therapy

8-21.1 General

Recreational therapy is a person-centered process that uses recreation activities to improve the physical, cognitive, social, behavioral, emotional, or spiritual well-being of a person with an illness or a disability.

8-21.2 Provider Participation

Recreational therapy services can only be reported by a master therapeutic recreation specialist, a therapeutic recreation specialist, or a therapeutic recreation technician as authorized by Title 58-40, Recreational Therapy Practice Act.

8-21.3 Limitations

A licensed mental health therapist must refer a member for recreational therapy services. The referral must be documented in the behavioral health treatment plan and in the recreational therapy treatment plan.

Recreational therapy can only be reported when provided in the following settings:

- general acute hospital,
- youth residential treatment facility,
- behavioral health program,
- intermediate care facility,
- assisted living facility,
- skilled nursing facility,
- nursing home,
- psychiatric hospital, or
- mental health agency.

8-21.4 Coding and Billing

H2032	Activity Therapy	Per 15 minutes
H2032HQ	Group Activity Therapy	Per 15 minutes

8-22 Methadone Administration Services

8-22.1 General

Methadone administration services are delivered to a member for detoxification from opioids and/or maintenance treatment. Overall treatment must be delivered, which should include counseling/therapy, case review, and medication monitoring. Members may obtain methadone administration services from any Medicaid-enrolled Opioid Treatment Program. However, related outpatient behavioral health services are covered under PMHPs, UMIC Plans and HOME.

8-22.2 Provider Participation

Facilities must be licensed through the DHHS Office of Licensing and certified by the federal Substance Abuse and Mental Health Services Administration in accordance with 42 C.F.R. 8.11.

8-22.3 Coding and Billing

This service is reimbursed through FFS Medicaid and multiple dates of service for take home dosing may be billed on the same line.

H0020	Methadone administration and/or service (provision of the drug by a licensed program)	Per diem

9 Non-covered Services

The following may not be reported:

- Habilitation services are not reportable as mental health or substance use disorder services,
- Community based services such as Alcoholics Anonymous,
- Driving under the influence (DUI) classes or court ordered only programming,
- Evaluations for the sole purpose of determining custodial arrangements or parental custody or visitation rights, are not medically necessary and are not covered,
- Job training, job coaching, vocational, and educational services,
- Social and recreational activities, and
- Routine transportation of the member or transportation to a site where services will be provided.

10 Procedure Code Table

The following table is not an all-inclusive table of Utah Medicaid covered services. This table is for assistance with unique Utah coding policies, modifiers, Medically Unlikely Edit (MUE), and time rules associated with these codes.

Utah Medicaid bypasses CMS' National Correct Coding Initiative (NCCI) MUEs set for the following codes and instead uses the reporting unit specified in the table below for these codes: H0006, H0031, 90791, 90792, 90846, 90847, 90849, and 90853.

SERVICE	CODE	MODIFIER	DESCRIPTION
Psychiatric Diagnostic Evaluation	90791		Psychiatric Diagnostic Evaluation - per 15 minutes

	90792		Psychiatric Diagnostic Evaluation with Medical Services - per 15 minutes
Mental Health Assessment by a Non-Mental Health Therapist	H0031		Mental Health Assessment by a Non-Mental Health Therapist – per 15 minutes
Psychological Testing	CPT Codes		Psychological Testing and Neuropsychological Testing codes
		UC	When performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or development disabilities, or organic disorders.
Group and Family Psychotherapy	90846		Family Psychotherapy - without patient present – per 15 minutes
	90847		Family Psychotherapy - with patient present – per 15 minutes
	90849		Multiple-Family Group Psychotherapy - per 15 minutes per member
	90853		*Group Psychotherapy* - per 15 minutes per member
Pharmacologic Management Services	E/M codes	CG	The CG modifier signifies that the service was a behavioral health pharmacologic management service as opposed to a medical E/M service.
Nurse Medication Management	99211	CG	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician
Therapeutic Behavioral Services	H2019		Individual/Family Therapeutic Behavioral Services - per 15 minutes
	H2019	HQ	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid patient
Psychosocial Rehabilitative Services	H2014		Individual Psychosocial Rehabilitative Services - per 15 minutes

	H2017		Group Psychosocial Rehabilitative Services - per 15 minutes per member
	H2017	U1	Group Psychosocial Rehabilitative Services – Intensive – 15 minutes per member
Peer Support Services	H0038		Individual Peer Support Services - per 15 minutes
	H0038	HQ	Group Peer Support Services - per 15 minutes per member
Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT)	H0040		Assertive Community Treatment, per month
Mobile Crisis Outreach Team (MCOT)	H2000		Comprehensive multidisciplinary evaluation, per diem
Clinically Managed Residential Withdrawal Management	H0012		Sub-acute detoxification (social detox)– per diem
Behavioral Health Receiving Centers	S9485		Crisis intervention mental health services, per diem
Mental Health Residential Treatment	H0017		17 or more beds (IMD) – member is 21 to 65 years of age – per diem
	H2013		16 or fewer beds - member is 21 years of age or older – per diem
	CPT Codes or H codes		16 or fewer beds – member is under 21 years of age
Substance Use Disorder Residential Treatment	H0018		17 or more beds (IMD) Behavioral health; short-term residential (non-hospital residential treatment program), without room and board – per diem
	H2036		16 or fewer beds

			Alcohol and/or drug treatment program, per diem
Supportive Living	H2016		Comprehensive community support services, per diem
Recreational Therapy	H2032		Individual recreational therapy assessments, treatment plan formulation, and recreational therapy interventions – per 15 minutes
	H2032	HQ	Group recreational interventions – per 15 minutes
Methadone administration services	H0020		Methadone administration and/or service (provision of the drug by a licensed program) – per diem