SECTION 2

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1 GENERAL POLICY

1 - 1 Authority

Rehabilitative mental health and substance use disorder services are provided under the authority of §1905(a)(13) of the Social Security Act and 42 CFR §440.130, Diagnostic, Screening, Preventive, and Rehabilitative Services. In accordance with §1905(a)(13) of the Social Security Act, outpatient rehabilitative mental health and substance use disorder services may be provided in settings other than the provider's office, as appropriate.

In this manual, the term 'behavioral health' will include both mental health and substance use disorders (SUDs) unless otherwise specified. When mental health disorders or substance use disorders are referred to separately, the term 'mental health' or 'substance use' will be used.

Rehabilitative mental health and substance use disorder services are designed to promote the individual's behavioral health and to restore the individual to the highest possible level of functioning. Services must be provided to or directed exclusively toward the treatment of the Medicaid individual.

Rehabilitative behavioral health services may be provided to individuals with a dual diagnosis of a mental health and/or substance use disorder and an intellectual disability, developmental disorder or related condition when the services are directed to the treatment of the mental health or substance use disorder.

1 - 2 Definitions

Behavioral health disorders means mental health and substance use disorders.

Behavioral health services means the rehabilitative services directed to the treatment of the mental health and/or substance use disorder.

CMS means the Centers for Medicare and Medicaid Services, the federal Medicaid agency within the Department of Health and Human Services.

Children in Foster Care means children and youth under the statutory responsibility of the Utah Department of Human Services identified as such in the Medicaid eligibility (eREP) system.

Division of Medicaid and Health Financing (DMHF) means the organizational division in the Utah Department of Health which administers the Medicaid program in Utah (herein after referred to as Medicaid).

Division of Occupational and Professional Licensing (DOPL) means the division within the Utah State Department of Commerce responsible for occupational and professional licensing.

Early Periodic Screening Diagnosis and Treatment (**EPSDT)** means the federal preventive health care services program for children, which is known in Utah as the Child Health Evaluation and Care (CHEC) Program.

Enrollee means any Medicaid eligible individual enrolled in the Prepaid Mental Health Plan (PMHP).

Fee-for-Service means Medicaid covered services that are billed directly to and paid directly by Medicaid based on an established fee schedule.

Habilitation Services typically means interventions for the purpose of helping individuals acquire new functional abilities whereas rehabilitative services are for the purpose of restoring functional losses. (See Rehabilitative Services definition below.)

Healthy Outcomes Medical Excellence Program (HOME), operated by the University of Utah, means a voluntary managed care program for Medicaid recipients who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides to its enrollees medical services, mental health/substance use disorder services, and targeted case management services specified in the Utah Medicaid provider manual titled *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*. When Medicaid recipients enroll in HOME, they are removed from their PMHP and physical health plan, if enrolled.

Medically Necessary Services means any rehabilitative service that is necessary to diagnose, correct, or ameliorate a behavioral health disorder or prevent deterioration or development of additional behavioral-health problems, and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Non-Traditional Medicaid means, pursuant to the 1115 Primary Care Network Demonstration Waiver, the reduced benefits plan provided to Medicaid recipients age 19 through 64 who:

1) are not blind, not disabled, not pregnant, or not within 60 days postpartum;

2) are in a medically needy aid category and are not blind, not disabled, not pregnant, or not within 60 days postpartum); or

3) are in a transitional Medicaid aid category.

Services covered under Non-Traditional Medicaid are similar to Traditional Medicaid with some limitations and exclusions.

Prepaid Mental Health Plan (PMHP) means the Medicaid mental and substance use disorder managed care plan that covers inpatient and outpatient mental health services and outpatient substance use disorder services for PMHP-enrolled Medicaid members.

Presumptive Eligibility means temporary Medicaid coverage for qualified low income individuals prior to establishing eligibility for ongoing Medicaid.

Rehabilitative Services means any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts (i.e. licensed mental health therapist) for maximum reduction of an individual's behavioral health disorder and restoration of the individual to his/her best possible functional level.

Traditional Medicaid means the scope of services contained in the State Plan provided to Medicaid recipients who fall under one of the following Medicaid aid groups:

1) Section 1931 children and related poverty-level populations under age 19;

2) Section 1931 pregnant women (including 60 days postpartum);

3) Blind or disabled children and related populations;

4) Blind or disabled adults and related populations under age 65;

5) Aged adults age 65 and older and related populations (SSI, QMB and Medicaid, Medicare and Medicaid);

6) Children in Foster Care;

7) Individuals who qualify for Medicaid by paying a spenddown and are under age 19; or

8) Individuals who qualify for Medicaid by paying a spenddown and are also blind or disabled.

Treatment goals means measures of progress decided jointly with the client whenever possible and may also be referred to as measurable goals or measurable objectives. For purposes of this provider manual, the term 'treatment goals' will be used to specify the measures contained in treatment plans.

1 -3 Medicaid Behavioral Health Service Delivery System

In most areas of the state, rehabilitative behavioral health services are covered under Medicaid's Prepaid Mental Health Plan (PMHP).

The table below shows PMHP coverage by contractor and by county.

Mental Health and Substance Use Disorder Service Coverage

Prepaid Mental Health Plan (PMHP)	Counties Covered Under the PMHP	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Bear River Mental Health	Box Elder, Cache, Rich	Yes	No
Southwest Utah Behavioral Health	Beaver, Garfield, Kane, Iron, Washington	Yes	Yes
Four Corners Community Behavioral Health Center	Carbon, Emery, Grand	Yes	Yes
Northeastern Counseling Center	Daggett, Duchesne, Uintah, San Juan	Yes	Yes
Davis Behavioral Health	Davis	Yes	Yes
Central Utah Counseling Center	Piute, Juab, Wayne, Millard, Sanpete, Sevier	Yes	Yes
Salt Lake County Division of Behavioral Health Services/OptumHealth	Salt Lake	Yes	Yes

Valley Mental Health	Summit & Tooele	Yes	Yes
Wasatch Mental Health	Utah	Yes	No
Utah County Department of Drug & Alcohol Prevention & Treatment	Utah	No	Yes
Weber Human Services	Weber, Morgan	Yes	Yes
Fee-for-Service Counties	**Rehabilitative Services Reimbursed on a Fee-for-Service Basis**		
Box Elder, Cache, Rich	Outpatient substance use disorder services only		
Wasatch	Outpatient mental health and substance use disorder services		

Additional Options:

All Medicaid members enrolled in the PMHP may also get behavioral health services directly from a federally qualified health center (FQHC). PMHP authorization is not required. Medicaid reimburses FQHCs directly.

In addition, American Indian and Alaska Native Medicaid members enrolled in the PMHP may get behavioral health services directly from Indian health care providers, including an Indian Health Program or an Urban Indian Organization. PMHP authorization is not required. Medicaid reimburses providers directly.

Exceptions:

Children in Foster Care

Children in Foster Care are enrolled in the PMHP for mental health inpatient hospital care only. They are not enrolled in the PMHP for outpatient behavioral health services. Qualified providers may bill Medicaid on a Fee-for-Service basis for outpatient behavioral health services provided to Children in Foster Care.

Children with State Adoption Subsidy

Children with state adoption subsidy are enrolled in the PMHP. However, an exemption from PMHP enrollment for outpatient behavioral health services may be granted on a case-by case basis. Children with state adoption subsidy who are exempted from the PMHP for outpatient behavioral health services remain enrolled in the PMHP for mental health inpatient hospital care only.

Medicaid Recipients Enrolled in HOME

Medicaid recipients enrolled in HOME are not enrolled in the PMHP. They must receive all behavioral health services through HOME. (See Chapter 1-2, Definitions.) Providers must follow HOME's network and prior authorization requirements and obtain reimbursement directly from HOME.

Presumptive Eligibility
Individuals with presumptive eligibility are not enrolled in the PMHP. Medicaid reimburses providers on a Fee-for-Service basis.

Evaluations Not Covered by the PMHP for the Following Individuals

1. Evaluations for Individuals with Intellectual Disabilities, Developmental Disorders or Related Conditions

   Psychiatric diagnostic evaluations and psychological testing related to these disorders may be performed in accordance with Chapter 2. If the Medicaid recipient is enrolled in HOME, providers must refer to the section above on HOME enrollment. For Medicaid recipients not enrolled in HOME, providers may bill Medicaid on a Fee-for-Service basis.

   Note: Additional provider requirements apply when evaluations may be used to qualify an individual 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.

2. Evaluations for Individuals with Conditions Requiring Chronic Pain Management

   Evaluations for individuals with a condition requiring chronic pain management services must be performed and billed to Medicaid in accordance with the Utah Medicaid Provider Manual for Physician Services, Chapter 2, Covered Services.

1 - 4 Scope of Services

Behavioral health services are limited to medically necessary services directed to the treatment of behavioral health disorders (see Chapter 1-2 for definition of behavioral health disorders). Services must be provided to the Medicaid individual or directed exclusively toward the treatment of the Medicaid individual.

The scope of rehabilitative behavioral health services includes the following:

- Psychiatric Diagnostic Evaluation
- Mental Health Assessment by a Non-Mental Health Therapist
- Psychological Testing
- Psychotherapy with Patient and/or Family Member
- Family psychotherapy with Patient Present and Family Psychotherapy without Patient Present
- Group Psychotherapy and Multiple Family Group Psychotherapy
- Psychotherapy for Crisis

- Psychotherapy with Evaluation and Management (E/M) Services
- Evaluation and Management (E/M) Services (Pharmacologic Management)
- Therapeutic Behavioral Services
- Psychosocial Rehabilitative Services
- Peer Support Services

See Chapter 2, Scope of Services, for service definitions and limitations.

1 - 5 Provider Qualifications

When applicable to a provider in A. or B. below, providers are responsible to ensure supervision is provided in accordance with requirements set forth in Title 58 of the Utah Code, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, at: www.rules.utah.gov/publicat/code.htm.

A. Providers Qualified to Prescribe Services

Rehabilitative services must be prescribed by an individual defined below:

1. Licensed mental health therapist practicing within the scope of his or her license in accordance with Title 58, Chapter 60, Mental Health Professional Practice Act, of the Utah Code:

    a. physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

    b. psychologist qualified to engage in the practice of mental health therapy;

    c. certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;

    d. clinical social worker;

    e. certified social worker or certified social worker intern under the supervision of a licensed clinical social worker;

    f. advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;

    g. marriage and family therapist;

    h. associate marriage and family therapist under the supervision of a licensed marriage and family therapist;

    i clinical mental health counselor; or

j. associate clinical mental health counselor under supervision of a licensed mental health therapist.

2. An individual working within the scope of his or her certificate or license in accordance with Title 58 of the Utah Code:

   a. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

   b. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty nursing certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

3. An individual exempted from licensure (as a mental health therapist) including:

   a. in accordance with Section 58-1-307 of the Utah Code, a student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL to the extent the activities are supervised by qualified faculty, staff, or designee and the activities are a defined part of the training program; or

   b. in accordance with Subsection 58-61-307(2)(h) of the Utah Code, an individual who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

B. Providers Qualified to Render Services

In accordance with the limitations set forth in Chapter 2, Scope of Services, rehabilitative services may be provided by:

1. an individual identified in A. of this chapter;

2. an individual working within the scope of his or her certificate in accordance with Title 58 of the Utah Code:

   a. licensed physician and surgeon or osteopathic physician regardless of specialty, or other medical practitioner licensed under state law (most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act);

   b. licensed APRN or licensed APRN intern regardless of specialty;

   c. licensed substance use disorder counselor, including licensed advanced substance use disorder counselor (ASUDC), certified advanced substance use disorder counselor (CASUDC) or certified advanced substance use disorder counselor intern (CASUDC-I), licensed substance use disorder counselor (SUDC), certified substance use disorder counselor (CSUDC) or certified substance use disorder counselor intern (CSUDC-I);

d. licensed social service worker;

e. licensed registered nurse;

f. licensed practical nurse; or

g. individual working toward licensure as a social service worker; or a registered nursing student, engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or an individual enrolled in a qualified substance use disorder education program, exempted from licensure in accordance with Section 58-1-307 of the Utah Code and under required supervision;

3. other trained individual; or

4. peer support specialist who has been certified as a peer support specialist under rules promulgated by the Utah Department of Human Services.

C. Training Requirements for Other Trained Individuals

Other trained individuals may provide psychosocial rehabilitative services (see Chapter 2-11) and for Prepaid Mental Health Plans, the services included in Chapter 3.

These individuals must receive training in order to be a qualified provider. The hiring body must ensure the following minimum training requirements are met:

1. 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.

2. 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 clients 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.

3. The hiring body shall maintain documentation of training including dates of training, agendas and training/educational materials used.

4. 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.

1 - 6 Evaluation

In accordance with state law, individuals identified in Chapter 1 – 5, A. are qualified to conduct an evaluation (psychiatric diagnostic evaluation). Evaluations are performed for the purpose of assessing and determining diagnoses, and as applicable, identifying the need for behavioral health services. (See Chapter 2-2, Psychiatric Diagnostic Evaluation.)

1 - 7 Treatment Plan

A. If based on an evaluation it is determined that behavioral health services are medically necessary, an individual identified in Chapter 1-5, A. is responsible for the development of a treatment plan.

B. The treatment plan is a written, individualized person-centered plan which contains measurable treatment goals related to problems identified in the psychiatric diagnostic evaluation. The development of the treatment plan should be a collaborative effort with the client.

C. If the treatment plan includes psychosocial rehabilitative services as a treatment method, there must be measurable goals specific to each issue being addressed with this treatment method.

D. The treatment plan must include the following:

1. measurable treatment goals;
2. the treatment regimen–the specific treatment methods (as contained in Chapter 1-4 and Chapter 2) 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 prescribed services; and

5. the signature and licensure or credentials of the individual defined in Chapter 1-5, A., who is responsible for the treatment plan.

E. An individual identified in Chapter 1-5, A. is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services.

1 - 8 Documentation

A. The provider must develop and maintain sufficient written documentation for each service or session for which billing is made to support the procedure and the time billed. See Chapter 2, Scope of Services, for documentation requirements specific to each service.

B. As specified in Chapter 2, documentation of the start and stop time of the service is required.

C. To ensure accurate documentation and high quality of care, services should be documented at the time of service.

D. The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule, and made available for state or federal review, upon request.

1 - 9 Collateral Services

Collateral services must be directed exclusively toward the treatment of the Medicaid individual and may be billed if the following conditions are met:

1. the service is provided face-to-face to an immediate family member (for example, parent or foster parent) on behalf of the identified client and the client is not present;
2. the identified client is the focus of the session; and
3. the progress note specifies the service was a collateral service and documents how the identified client was the focus of the session. Other documentation requirements under the 'Record' section of the applicable service also apply.
4. if the collateral service is <u>not</u> psychotherapy that qualifies for coding under procedure codes 90832-90838 or 90846, use the procedure code applicable to the service.

1-10 Billings

A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

1-11 Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services has implemented a correct coding initiative that includes two editing modules: the Procedure-to-Procedure (PTP) module and the Medically Unlikely Edits (MUE) module.

Procedure-to-Procedure (PTP) Editing

This editing applies when two services are provided by the same servicing provider on the same day. This module contains a list of procedure code combinations where generally the second service is considered incident to the first service in the procedure code combination. Unless otherwise specified, the provider may not receive separate reimbursement for the second service. When the second service in the code combination cannot be reimbursed separately, the two procedure codes are followed by a '0' in the third column.

For some procedure code combinations, NCCI will allow reimbursement of the second procedure in the combination if the two services are actually separate and distinct services. When CMS allows reimbursement for both procedure codes in the combination, the two procedure codes are followed by a '1' in the third column. In these instances, a provider must use a modifier on the claim to indicate the two services provided were separate and distinct.

When NCCI also allows the second procedure in the procedure combination to be reimbursed, providers must include the '59' modifier on the claim in order to obtain reimbursement for the second service. Please refer to Appendix A of the Current Procedural Terminology (CPT) manual for information on the 59 modifier.

Medically Unlikely Edits

The MUE module contains units-of-service edits. For specified procedure codes, NCCI has set a limit on the number of units of service that Medicaid may reimburse.

NCCI Editing Updates

CMS may update these two modules quarterly. To review the PTP and MUE modules, providers may go to the CMS website at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Index.html. For information on procedure-to-procedure editing, select the NCCI Coding Edits link, then under Related Links, select the Physician CCI Edits link for the effective quarter. For information on medically unlikely edits, select the Medically Unlikely Edits link, and then under Related Links, select the Practitioner Services MUE Table link for the effective quarter. Follow the prompts to access the files.

For information on quarterly additions, deletions and revisions to these modules, select the Quarterly NCCI and MUE Version Update Changes link for the effective quarter. For procedure-to-procedure editing updates, under Related Links, select the Quarterly Additions, Deletions, and Modifier Indicator Changes to NCCI Edits for Physicians/Practitioners link for the effective quarter. For medically unlikely editing updates, under Related Links, select the Quarterly Additions, Deletions, and Revisions to Published MUEs for Practitioner Services, for the effective quarter. Since CMS can update the PTP and MUE modules quarterly, providers are responsible to be familiar with the edits in these modules.

2 SCOPE OF SERVICES

Behavioral health services are covered benefits when the services are medically necessary services. Behavioral health services include psychiatric diagnostic evaluation, mental health assessment by a non-mental health therapist, psychological testing, psychotherapy with patient and/or family member, family psychotherapy with patient present and family psychotherapy without patient present, group psychotherapy, multiple family group psychotherapy, psychotherapy for crisis, psychotherapy with evaluation and

management (E/M) services, evaluation and management (E/M) services (i.e., pharmacologic management), therapeutic behavioral services, psychosocial rehabilitative services and peer support services.

2 - 1 General Limitations

1. Rehabilitative services do not include:

    a. Services provided to inmates of public institutions or to residents of institutions for mental diseases;

    b. Habilitation services;

    c. Educational, vocational and job training services;

    d. Recreational and social activities;

    e. Room and board; and

    f. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy. This also includes services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

2. Medicaid recipients with Non-Traditional Medicaid getting services for mental health disorders have the following limitation:

    There is a maximum of 30 outpatient days per client per year for outpatient mental health care for a mental health disorder. Targeted case management services for individuals with serious mental illness also count toward the outpatient maximum. (See the *Utah Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness*.) This 30-day limitation does not apply to services provided to treat substance use disorders.

    There is also a maximum of 30 inpatient days per client per year for inpatient mental health care.

    Substitutions– Unused inpatient mental health care days, up to 30 days, can be used for additional outpatient mental health days per client per year for a mental health disorder.

3. Service Coverage and Reimbursement Limitations

    Information on Utah Medicaid service coverage and reimbursement limitations is available in Utah Medicaid's web-based lookup tool entitled 'Coverage & Reimbursement Lookup Tool,' located at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php. The Coverage & Reimbursement Lookup Tool contains up-to-date information on coverage, limits, prior authorization requirements, etc. The tool also includes a special notes section that includes any additional information regarding the service, including any manual review requirements associated with the

service. This tool allows providers to search for coverage and reimbursement information by HCPCS/Current Procedural Terminology (CPT) procedure code, date of service and provider type. The 'Limits' sections in Chapter 2 in this manual will address other types of limits and clarifications related to the services.

Fee-for-service claims submitted for neurobehavioral status exams, procedure code 96116, and neuropsychological testing, procedure code 96118, require manual review.

Payment for neurobehavioral status exams is limited to three hours (three units) per year and payment for neuropsychological testing is limited to eight hours (eight units) per year unless additional time is approved based on manual review.

If additional time is billed, providers must submit documentation for the manual review. Documentation consists of medical records that give evidence of and support the billing as correct and valid. The Medicaid reviewer assesses the documentation to determine if additional payment will be made. If supporting documentation is not submitted, no additional payment will be made.

To submit the documentation, either attach it to the claim or submit via FAX to the Bureau of Medicaid Operations at 801-536-0463. If submitting the documentation via FAX, include a cover sheet that specifies whether it is for neurobehavioral status exam manual review or neuropsychological testing manual review.

2 - 2 Psychiatric Diagnostic Evaluation

Psychiatric diagnostic evaluation means a face-to-face evaluation with the individual for the purpose of assessing and determining diagnoses, and as applicable identifying the need for behavioral health services. The evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations, with interpretation and report. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies. In certain circumstances one or more other informants (family members, guardians or significant others) may be seen in lieu of the individual.

Psychiatric diagnostic evaluation with medical services also includes medical assessment and other physical examination elements as indicated and may be performed only by qualified medical providers specified in the 'Who' section of this chapter below.

In accordance with the Current Procedural Terminology (CPT) manual, codes 90791 (psychiatric diagnostic evaluation) and 90792 (psychiatric diagnostic evaluation with medical services) are used for the diagnostic assessment(s) or reassessment(s), if required.

Because ongoing assessment and adjustment of psychotherapeutic interventions are part of psychotherapy, reassessments including treatment plan reviews occurring in psychotherapy session may be coded as such. (See definition of psychotherapy and the 'Record' section of Chapter 2-5, Psychotherapy.

If based on the evaluation it is determined behavioral health services are medically necessary, an individual qualified to perform this service is responsible for the development of an individualized treatment plan. An individual qualified to perform this service also is responsible to conduct reassessments/treatment plan reviews with the client as clinically indicated to ensure the client's treatment plan is current and accurately reflects the client's rehabilitative goals and needed behavioral health services. (See Chapter 1-7, Treatment Plans.)

See Chapter 2-6, Psychotherapy for Crisis, for information on billing urgent assessments of a crisis state as defined under Psychotherapy for Crisis.

Who:

1. **Psychiatric diagnostic evaluation** may be performed by a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. P**sychiatric diagnostic evaluation with medical services** may be performed only by:

   a. a licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

   b. a licensed advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;

   c. a licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

   d. a licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

   When this service is performed to determine the need for medication prescription only, it also may be performed by:

   e. a licensed physician and surgeon or osteopathic physician regardless of specialty;

   f. a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency;

   g. a licensed APRN intern regardless of specialty when practicing within the scope of their practice act and competency, under the supervision of a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency, or a licensed physician and surgeon or osteopathic physician regardless of specialty; or

   h. other medical practitioner licensed under state law when acting within the scope of his/her license, most commonly licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act.

Limits:

1. According to the Psychiatry section of the Current Procedural Terminology (CPT) manual, the following limits apply:

   a. Psychiatric diagnostic evaluation with medical services may not be reported on the same day as an E/M service when performed by the same servicing provider; and

   b. Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including psychotherapy for

crisis, may not be reported on the same day (when performed by the same servicing provider). See the CMS NCCI PTP Module for additional information on this limitation.

2. Evaluations requested by a court of the Utah Department of Human Services, 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 arrangement are not billable to the Medicaid under any service/procedure code.

3. Additional provider requirements apply when evaluations may be used to qualify an individual 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.*

4. Evaluations for individuals with a condition requiring chronic pain management services must be performed and billed to Medicaid in accordance with the *Utah Medicaid Provider Manual for Physician Services*, Chapter 2, Covered Services.

Procedure Codes and Unit of Service:

90791 - Psychiatric Diagnostic Evaluation - per 15 minutes

90792 - Psychiatric Diagnostic Evaluation with Medical Services, by physician or APRN - per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90791 and 90792. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., psychiatric diagnostic evaluation);
4. report of findings from the biopsychosocial assessment that includes:
    a. history, symptomatology and mental status (mental status report may be based on formal assessment or on observations from the evaluation process); and
    b. disposition, including diagnosis(es) as appropriate, and recommendations. If the client does not need behavioral health services, this must be documented in the assessment (along with any other recommended services as appropriate). If behavioral health services are medically necessary, then a provider qualified to perform this service is responsible for the development of a treatment plan and the prescription of the behavioral health services that are medically necessary for the individual. (See treatment plan requirements in Chapter 1-7); or
5. report of findings from a reassessment that includes:
    a. the applicable components in 4.a. and/or b.; and/or
    b. For reviews of the client's treatment plan documentation will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

2 - 3 Mental Health Assessment

Mental Health Assessment means providers listed below, participating as part of a multi-disciplinary team, assisting in the psychiatric diagnostic evaluation process defined in Chapter 2-2, Psychiatric Diagnostic Evaluation. Through face-to-face contacts with the individual, the provider 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, or other information and assisting the individual to identify treatment goals. The provider assists in the psychiatric diagnostic reassessment/treatment plan review process specified in Chapter 2-2 by gathering updated psychosocial information and updated information on treatment goals and assisting the client to identify additional treatment goals. Information also may be collected through in-person or telephonic interviews with family/guardians or other sources as necessary. The information obtained is provided to the individual identified in Chapter 2-2 who will perform the assessment, reassessment or treatment plan review.

Who:

The following individuals when under the supervision of a licensed mental health therapist identified in Chapter 1-5, A. 1:

1. licensed social service worker or individual working toward licensure as a social service worker;
2. licensed registered nurse;
3. licensed ASUDC, CASUDC, SUDC, CSUDC or ASUDC-I or SUDC-I;

4. licensed practical nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or an individual enrolled in a qualified substance use disorder education program, exempted from licensure in accordance with state law, and under required supervision.

Although these individuals may perform this service and participate as part of a multi-disciplinary team, under state law, qualified providers identified in Chapter 2 -2 are the only providers who may diagnose a behavioral health disorder and prescribe behavioral health services determined to be medically necessary to treat the individual's behavioral health disorder(s).

Limits:

1. This service is meant to accompany the psychiatric diagnostic evaluation (see Chapter 2-2). If a psychiatric diagnostic evaluation (assessment or reassessment) is not conducted after this service is performed, this service may be billed if all of the documentation requirements in the 'Record' section are met and the reason for non-completion of the psychiatric diagnostic evaluation is documented.

2. If the provider conducting the psychiatric diagnostic evaluation defined in Chapter 2-2 obtains all of the psychosocial information directly from the client, only that service is billed. The provider does not also bill this service.

Procedure Code and Unit of Service:

H0031 – Mental Health Assessment by a Non-Mental Health Therapist – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;
3. specific service rendered (i.e., assessment);
4. information gathered; and
5. signature and licensure or credentials of the individual who rendered the service.

2 - 4 Psychological Testing

Psychological testing means a face-to-face evaluation to determine the existence, nature and extent of a mental illness or disorder using psychological tests appropriate to the client's needs, with interpretation and report.

Who:

1. licensed physician and surgeon, or osteopathic physician engaged in the practice of mental health therapy;
2. licensed psychologist qualified to engage in the practice of mental health therapy;
3. certified psychology resident qualifying to engage in the practice of mental health therapy under the supervision of a licensed psychologist;
4. a student who is a licensed psychologist candidate due to enrollment in a predoctoral education/degree program exempted from licensure in accordance with state law and under required supervision; or
5. an individual exempted from licensure in accordance with Subsection 58-61-307(2)(h) of the Utah Code who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision.

Limits:

There are coverage and reimbursement limitations on neurobehavioral status exams, procedure code 96116, and neuropsychological testing, procedure code 96118. These services require manual review. Refer to Chapter 2-1, General Limitations, #3, regarding the procedure for accessing information on Utah Medicaid coverage and reimbursement limitations and procedures related to manual review.

Procedure Codes and Unit of Service:

96101 - **Psychological Testing** - includes psychodiagnostic assessment of emotionality, intellectual abilities, and psychopathology, e.g., MMPI, Rorschach, WAIS, with interpretation and report - per hour

96105 - **Assessment of Aphasia** - includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading spelling, writing, e.g., by Boston Diagnostic Aphasia Examination, with interpretation and report - per hour

96110 - Developmental Screening - with interpretation and report, per standardized instrument form - per hour

96111 - Developmental Testing, includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, with interpretation and report - per hour

96116 - Neurobehavioral Status Exam - Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities, with interpretation and report - per hour (Requires manual review. Limited to 3 hours (3 units) per year unless additional time is approved based on the manual review. More than 3 hours (3 units) require supportive documentation for the manual review.)

96118 - Neuropsychological Testing - e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test, with interpretation and report - per hour (Requires manual review. Limited to 8 hours (8 units) per year unless additional time is approved based on the manual review. More than 8 hours (8 units) require supportive documentation for the manual review.)

The following time rules apply for converting the duration of the service to the specified number of units:

Less than 31 minutes equals 0 units;

31 minutes through 90 minutes of service equals 1 unit;

91 minutes through 150 minutes of service equals 2 units;

151 minutes through 210 minutes of service equals 3 units; and

211 minutes through 270 minutes of service equals 4 units; etc.

Record:

Documentation must include:

1. date(s), start and stop time, and duration of testing;
2. setting in which the testing was rendered;
3. specific service rendered (i.e., psychological testing);
4. written test reports which include:
    a. brief history;
    b. tests administered;
    c. test scores;
    d. evaluation of test results;
    e. current functioning of the individual;
    f. diagnoses;
    g. prognosis; and
    h. specific treatment recommendations for behavioral health services if applicable, and other recommended services as appropriate; and

5. signature and licensure or credentials of the individual who rendered the service.

2 - 5 Psychotherapy

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician 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 client may be restored to his/her best possible functional level. Services are based on measurable treatment goals identified in the client's individualized treatment plan.

Psychotherapy codes 90832-90838 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process.

Psychotherapy includes psychotherapy with the client and/or family member, family psychotherapy with patient present, family psychotherapy without patient present, group psychotherapy and multiple-family group psychotherapy.

Individual psychotherapy means in accordance with the definition of psychotherapy face-to-face interventions with the client and/or family member.

Family psychotherapy with patient present means in accordance with the definition of psychotherapy face-to-face interventions with family members and the identified client with the goal of treating the client's condition and improving the interaction between the client and family members so that the client may be restored to their best possible functional level.

Family psychotherapy without patient present means in accordance with the definition of psychotherapy face-to-face interventions with family member(s) without the identified client present with the goal of treating the client's condition and improving the interaction between the client and family member(s) so that the client may be restored to their best possible functional level.

Group psychotherapy means in accordance with the definition of psychotherapy face-to-face interventions with two or more clients or two or more families in a group setting so that the clients may be restored to their best possible functional level.

Who:

1. All psychotherapy may be performed by a licensed mental health therapist, an individual working within the scope of his or her certificate or license, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. In accordance with Subsection 58-60-502(10) of the Utah Code, substance use disorder counselors may co-facilitate group psychotherapy with a licensed mental health therapist identified in Chapter 1-5, A.1; and individuals enrolled in a qualified substance use disorder counseling education program exempted from licensure in accordance with state law, may co-facilitate group psychotherapy with a licensed mental health therapist identified in Chapter 1-5, A. 1.

Psychotherapy with patient and/or family member

Limits:

In accordance with the CPT manual, the following limits apply:

1. Psychotherapy times are for face-to-face services with the client and/or family member. The client must be present for all or some of the service. Procedure codes for psychotherapy with patient and/or family member are used when individual psychotherapy is being provided.

2. If family psychotherapy is prescribed as a service, use the procedure codes for family psychotherapy with patient present or family psychotherapy without patient present. See section below on procedure codes for family psychotherapy.

Procedure Codes and Unit of Service:

90832 – **Psychotherapy, 30 minutes, with patient and/or family member** – **per encounter**

90834 – **Psychotherapy, 45 minutes, with patient and/or family member - per encounter**

90837 – **Psychotherapy, 60 minutes, with patient and/or family member** – **per encounter**

The following time rules apply for converting the duration of the service to the appropriate procedure code:

90832 - 16 through 37 minutes;

90834 - 38 through 52 minutes; and

90837 - 53 minutes through 89 minutes.

Prolonged Services Add-On Codes:

In accordance with the CPT manual, for psychotherapy services not performed with an E/M service of 90 minutes or longer face-to-face with the patient, providers may use the appropriate prolonged services add-on code(s) with psychotherapy code 90837 depending on the duration and place of the psychotherapy service.

+99354 – first hour (60 additional minutes with patient); and

+99355 – each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99354)

In accordance with the CPT coding requirements for prolonged services, if the psychotherapy is provided in a nursing facility or other setting where the Nursing Facility Services range of E/M services codes would be used for E/M services (E/M codes 99304-99310), then prolonged services add-on codes 99356/99357 are used for the additional psychotherapy time. (In the event psychotherapy is provided to a client in an inpatient setting, these prolonged services codes would also be used.)

+99356 – first hour (60 additional minutes with the patient); and

+99357 – each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99356)

In accordance with CPT requirements, prolonged service of less than 30 minutes total duration on a given date is not separately reported. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. The following time rules apply for converting the duration of the service to the appropriate prolonged services add-on procedure code(s):

+99354 or +99356 – 90 minutes through 134 minutes (1 hour 30 minutes through 2 hours 14 minutes) equals 1 unit;

+99355 or +99357 - 135 minutes through 164 minutes (2 hours 15 minutes through 2 hours 44 minutes) equals 1 unit (in addition to the unit of 99354 or 99356); and

165 minutes through 194 minutes (2 hours 45 minutes through 3 hours 14 minutes) equals 2 units (in addition to the unit of 99354 or 99356), etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90832, 90834 and 90837. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy with patient and/or with family member);
4. clinical note that documents:
    a. individual(s) present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and the client's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a psychotherapy visit with patient and or family member is a crisis or a reassessment /review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Family psychotherapy with patient present and family psychotherapy without patient present

Procedure Codes and Unit of Service:

90846 - Family Psychotherapy - without patient present – per 15 minutes

90847 - Family Psychotherapy - with patient present – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., family psychotherapy with patient present or family psychotherapy without patient present)
4. clinical note that documents:
    a. family members present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of a family psychotherapy visit is a crisis or a reassessment/review of the overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Group psychotherapy and multi-family group psychotherapy

Limits:

1. Psychotherapy groups (90853) are limited to twelve clients in attendance unless a co-provider is present; then psychotherapy groups may not exceed 16 clients in attendance.

2. Multiple-family psychotherapy groups (90849) are limited to ten families in attendance and a maximum group size of 24 clients. Groups up to and including 15 clients may have one provider. For groups with 16 to 24 clients, a co-provider must be present.

3. Co-providers must meet the provider qualifications outlined in the 'Who' section above.

Procedure Codes and Unit of Service:

90849 - Multiple-Family Group Psychotherapy - per 15 minutes per Medicaid client 90853 - Group Psychotherapy - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

+90785 – Interactive Complexity Add-On Code - per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with 90853. There is no additional reimbursement for this add-on code.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered (i.e., group psychotherapy or multiple-family group psychotherapy);

4. per session clinical note that documents:

    a. the focus of the group psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and

b. the treatment goal(s) addressed in the session and progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or

5. If the focus of the group psychotherapy visit is a crisis or a reassessment/review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and

6. signature and licensure or credentials of the individual who rendered the service. If a co-provider is present for the group psychotherapy session, the note must contain the co-provider's name and licensure or credentials.

2 - 6 Psychotherapy for Crisis

Psychotherapy for crisis means a face-to-face service with the client and/or family and includes an urgent assessment and history of a crisis state and disposition. The treatment 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 to an individual in high distress. Providers may use CPT coding for this service if the crisis and interventions qualify for this coding.

Who:

Licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

Limits:

In accordance with the CPT manual, the following limits apply:

1. Procedure codes for this service are used to report the total duration of time face-to-face with the individual and/or family spent by the provider, even if the time spent on that date is not continuous.

2. For any given period of time spent providing this service, the provider must devote his or her full attention to the individual and, therefore, cannot provide services to any other individual during the same time period. The individual must be present for all or some of the service.

3. This service cannot be reported in conjunction with procedure code 90791, 90792, psychotherapy codes 90832-90838 or other psychiatric services or 90785-90899. Under CMS' NCCI, this means this service and these other services cannot both be reimbursed when provided on the same day by the same servicing provider. See the January 2013 CMS NCCI PTP Module for additional information on this limitation.

4. If the visit is 30 minutes or less total duration on a given date, the service is reported with psychotherapy code 90832, 30 minutes, with patient and/or family member, or with add-on psychotherapy code 90833, 30 minutes, with patient and/or family member (when provided with E/M

services). See Chapter 2-5 for information on psychotherapy procedure code 90832, and Chapter 2-7 for information on E/M add-on psychotherapy procedure code 90833.

Procedure Codes and Unit of Service

90839 – Psychotherapy for crisis, first 60 minutes, with patient and/or family member - per encounter

The following time rules apply for converting the total duration of the service to the appropriate procedure code:

90839 - 31 through 75 minutes total duration

(If the total duration of the crisis visit is 30 minutes or less– use procedure code 90832, psychotherapy with patient and/or family member, 30 minutes [see Chapter 2-5].)

Crisis for Psychotherapy Add-On Code: 90840 –

In accordance with the CPT manual, for psychotherapy for crisis services 76 minutes or longer, use add-on procedure code 90840 in addition to 90839:

+90840 – additional 30-minute increments – per encounter

The following time rules apply for converting the total duration of the service to the psychotherapy for crisis add-on code:

+90840 – 76 minutes through 105 minutes (1 hour 16 minutes through1 hour 45 minutes) equals 1 unit (in addition to the unit of 90839);

106 minutes through 135 minutes (1 hour 46 minutes through 2 hours 15 minutes) equals 2 units (in addition to the unit of 90839); and

136 minutes through 165 minutes (2 hours 16 minutes through 2 hours 45 minutes) equals 3 units (in addition to the unit of 90839), etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy for crisis);
4. clinical note that documents the crisis visit, including findings, mental status and disposition; and
5. signature and licensure or credentials of the individual who rendered the service.

2 - 7 Psychotherapy with Evaluation and Management (E/M) Services

Psychotherapy with E/M services means psychotherapy with the patient and/or family member when performed with an E/M service on the same day by the same provider. (See Chapter 2-8 for information on E/M services.)

Who:

1. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;

2. licensed APRN with psychiatric mental health nursing specialty certification;

3. licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

4. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification.

Limits:

In accordance with the CPT manual, the two services must be significant and separately identifiable and may be separately identified as follows:

1. The type and level of E/M service is selected first based upon the key components of history, examination, and medical decision-making;

   Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision-making when used for the E/M service is not psychotherapy time). Time may not be used as the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (psychotherapy add-on codes 90833, 90836, 90838) are reported; and

2. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service.

Procedure Codes and Unit of Service:

In accordance with the CPT manual, psychotherapy performed with an E/M service is coded using the applicable psychotherapy add-on code specified below with the applicable E/M code (E/M codes are specified in Chapter 2-8). The psychotherapy add-on code must be on the same claim as the E/M service procedure code.

+90833 – Psychotherapy, 30 minutes, with patient and/or family member – per encounter

+90836 – Psychotherapy, 45 minutes, with patient and/or family member - per encounter

+90838 – Psychotherapy, 60 minutes, with patient and/or family member – per encounter

The following time rules apply for converting the duration of the service to the appropriate procedure code:

+90833 - 16 through 37 minutes;

+90836 - 38 through 52 minutes; and

+90838 - 53 minutes and longer

+90785 – Interactive Complexity Add-On Code- per service

In accordance with the CPT manual, CPT code 90785 is an add-on code for interactive complexity. It may be reported in conjunction with psychotherapy when performed with an E/M service (90833, 90836 and 90838). There is no additional reimbursement for this add-on code.

Record:

For the psychotherapy portion of the service, documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e, psychotherapy with patient and/or with family member);
4. clinical note that documents:
    a. individual(s) present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and the client's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or
5. If the focus of the psychotherapy is a crisis or a reassessment/review of the client's overall treatment plan and 4.b. and/or 4.c. are not applicable, then the clinical note must summarize the crisis visit, including findings, mental status and disposition; or must summarize the reassessment findings and/or the review of the treatment plan. Documentation for reviews of the treatment plan will include an update of the client's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and
6. signature and licensure or credentials of the individual who rendered the service.

Refer to Chapter 2-8 for documentation requirements for the E/M portion of the service.

2 - 8 Pharmacologic Management (Evaluation and Management (E/M) Services)

Pharmacologic management means a service provided face-to-face to the client and/or family to address the client's health issues. This service is provided in accordance with the CPT definitions and coding for E/M services. (Please refer to the E/M services section of the CPT manual for complete information on E/M services definitions.)

Who:

1. licensed physician and surgeon or osteopathic physician regardless of specialty;

2. licensed APRN regardless of specialty when practicing within the scope of their practice act and competency;

3. licensed APRN intern regardless of specialty when practicing within the scope of their practice act and competency under the supervision of a licensed APRN regardless of specialty when practicing within the scope of their practice act and competency, or licensed physician and surgeon or osteopathic physician regardless of specialty; or

4. other medical practitioner licensed under state law who can perform the activities defined above when acting within the scope of his/her license (e.g., licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act).

Limits:

1. Prescribers must directly provide all psychiatric pharmacologic management services (including any services that qualify for coding under E/M code 99211).

2. To ensure correct adjudication of the E/M claim, always use the **CG modifier** with the E/M code. This modifier will identify that the service provided was pharmacologic management covered under this program.

Procedure Codes and Unit of Service:

Office or Other Outpatient Services E/M Codes -

The following codes are used to report E/M services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

Established Patient Codes

99211 – **per encounter** - E/M of an established patient; usually the presenting problems are minimal. Typically, 5 minutes are spent performing this service.

99212- per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99213 – **per encounter -** E/M of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99214 – **per encounter -** E/M of an established patient, which requires at least 2 of these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99215 – **per encounter** – E/M of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive history;
- A comprehensive examination;
- Medical decision making of high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

Subsequent Nursing Facility Care E/M Codes

The following codes are used to report E/M services to patients in nursing facilities (formerly called skilled nursing facilities [SNFs], intermediate care facilities [ICFs], or long-term care facilities [LTCFs]).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential center (a facility or a distinct part of a facility for psychiatric care, which provides 24-hour therapeutically planned and professionally staffed group living and learning environment).

Established Patient Codes

99307- per encounter - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A problem focused interval history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient is stable, recovering or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99308 – per encounter- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99309 – per encounter - Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99310 – **per encounter** – Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- A comprehensive interval history;
- A comprehensive examination;
- Medical decision making of high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

Home Services E/M Codes

The following codes are used to report E/M services provided in a private residence.

Established Patient Codes

99347- per encounter - E/M of an established patient, which requires at least 2 of these 3 key components:

- A problem focused interval history;
- A problem focused examination;
- Straightforward medical decision making.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99348 – **per encounter -** E/M of an established patient, which requires at least 2 of these 3 key components:

- An expanded problem focused interval history;
- An expanded problem focused examination;
- Medical decision making of low complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99349 – **per encounter -** E/M of an established patient, which requires at least 2 of these 3 key components:

- A detailed interval history;
- A detailed examination;
- Medical decision making of moderate complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

99350 – **per encounter** – E/M of an established patient, which requires at least 2 of these 3 key components:

- A comprehensive interval history;
- A comprehensive examination;
- Medical decision making of moderate to high complexity.

*Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problems and the client's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.

*Please refer to the definition of Counseling in the E/M section of the CPT manual.

<u>E/M Code Selection When More Than 50 Percent of Time Is Counseling and/or Coordination of Care</u>

In accordance with the CPT manual, when counseling and or coordination of care with the client and/or family comprises more than 50% of the encounter, then time is considered the "key or controlling factor to qualify for a particular level of E/M services." Also in accordance with time rules specified in the CPT manual, the following applies to E/M code selection: "When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used."

Prolonged Services Add-on Codes:

In accordance with the CPT manual, prolonged services add-on codes may be reported in addition to the designated E/M services at any level.

If the duration of the E/M service with the client and/or family is longer than the typical time associated with an E/M services code, then prolonged services add-on coding may apply.

For example, in accordance with rules for prolonged services add-on codes, if the E/M service qualifying for coding as 99215 is 70 minutes or longer, then the E/M code plus the applicable prolonged services add-on code(s) would be billed depending on the duration and the place of service. Refer to the time rules below and to the Prolonged Services section of the CPT manual for additional information.

Limits:

In accordance with the CPT manual, the following limits apply to prolonged services:

1. Either prolonged service code 99354 or 99356 should be used only once per date, even if the time spent by the physician or other qualified provider is not continuous on that date.
2. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M codes.
3. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Procedure Codes and Unit of Service:

In accordance with the CPT manual, the following prolonged services codes are used depending on the E/M place of service and duration:

Office or Other Outpatient Services and Home E/M codes:

+99354- first hour (60 additional minutes with patient); and

+99355- each additional 30 minutes with the patient (beyond the 60 additional minutes that are coded with 99354)

Subsequent Nursing Facility Care E/M codes (and any inpatient-based E/M codes in the event the E/M service is provided to a client in an inpatient setting):

+99356 – first hour (60 additional minutes with patient); and

+99357- each additional 30 minutes with the patient (beyond the 60 additional minutes that are coded with 99356)

The following time rules apply for converting the duration of the service to the appropriate prolonged services add-on procedure code:

Less than 30 minutes equals 0 units;

30 minutes through 74 minutes (30 minutes through 1 hour 14 minutes) equals 1 unit of 99354 or 99356;

75 minutes through 104 minutes (1 hour 15 minutes through 1 hour 44 minutes) equals 1 unit of 99354 or 99356 plus 1 unit of 99355 or 99357; and

105 minutes through 134 minutes (1hour 45 minutes through 2 hours 14 minutes) equals 1 unit of 99354 or 99356 plus 2 units of 99355 or 99357, etc.

Record:

1. For all E/M services, E/M documentation requirements apply. Please refer to the E/M section of the CPT manual. Providers can also refer to CMS' 1997 publication on documenting E/M services entitled *1997 Documentation Guidelines for Evaluation and Management Services* at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97docguidelines.pdf

   In accordance with the CPT manual, when counseling and/or coordination of care dominates (more than 50 percent) the encounter with the patient and/or family, and is the basis of E/M code selection, the extent of counseling and/or coordination of care must be documented in the medical record;

2. In addition, documentation must include:

   a. date, start and stop time, and duration of the service;

   b. setting in which the service was rendered; and

   c. specific service rendered (i.e, E/M services);

3. If not already addressed in E/M-required documentation referenced in #1:

   a. health issues and medications reviewed/monitored, results of the review and progress toward related treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers;

   b. dosage of medications as applicable;

   c. summary of information provided; and

   d. if medications are administered, documentation of the medication(s) and method and site of administration; and

4. Signature and licensure or credentials of the individual who rendered the service.

2 - 9 Nurse Medication Management

Nurse medication management is provided face-to-face to a client and/or family and includes reviewing/monitoring the client's health issues, medication(s) and medication regimen, providing information, and administering as appropriate. The review of the client's medications and medication regimen includes dosage, effect the medication(s) is having on the client's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage of medications.

Who:

1. licensed registered nurse; or registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision; and

2. licensed practical nurse under the supervision of a licensed physician and surgeon or osteopathic physician, a licensed APRN, a licensed physician assistant or a licensed registered nurse.

Limits:

1. Distributing medications (i.e., handling, setting out or handing medications to clients) is not a covered service and may not be billed to Medicaid.

2. Solely administering medications (i.e., giving an injection only) is covered only when using the procedure code specified below (96372).

3. Performance of ordering labs, including urine analyses (UAs), is not a covered service and may not be billed to Medicaid.

Procedure Code and Unit of Service:

T1001- Nurse Evaluation and Assessment – per encounter

96372- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular – per encounter (use this code when an injection is administered with minimal monitoring only)

When billing these procedure codes, bill one unit regardless of the length of the service as the service is based on an encounter.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered (i.e, medication management or injection);

4. note that documents as applicable:

   a. health issues and medications reviewed/monitored, results of the review and progress toward related treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers;

   b. dosage of medications;

   c. summary of information provided; and

   d. if medications are administered, documentation of the medication(s) (i.e., specify substance or drug) and method and site of administration; and

5. signature and licensure or credentials of the individual who rendered the service.

2 -10 Therapeutic Behavioral Services

Therapeutic behavioral services are provided face-to-face to an individual or a group and is coded when the service provided does not fully meet the definition of psychotherapy. Instead, the provider uses behavioral

interventions to assist clients with a specific behavior problem. This service may be provided to an individual or a group.

Who:

1. Licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

2. This service may also be performed by:

   a. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

   b. licensed registered nurse;

   c. licensed ASUDC or SUDC under the general supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 qualified to provide supervision;

   d. licensed CASUDC or a CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC qualified to provide supervision;

   e. CSUDC or CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC or SUDC qualified to provide supervision; or

   f. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with state law, and under required supervision.

Limits:

1. Groups are limited to twelve clients in attendance unless a co-provider is present; then groups may not exceed 24 clients in attendance.

2. Multiple family therapeutic behavioral services groups are limited to ten families in attendance.

3. Co-providers must meet the provider qualifications outlined in the 'Who' section above.

4. Therapeutic behavioral services do not include DUI classes.

Procedure Codes and Unit of Service:

H2019 - Individual/Family Therapeutic Behavioral Services - per 15 minutes

H2019 with HQ modifier - Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., therapeutic behavioral services);
4. treatment goal(s);
5. clinical note per session that documents:
   a. the nature of the interventions used to address the behavior problem; and
   b. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service. If a co-leader is present for therapeutic behavioral services groups, the note must contain the co-leader's name and licensure or credentials.

2 - 11 Psychosocial Rehabilitative Services

Psychosocial rehabilitative services (PRS) are provided face-to-face to an individual or a group and are designed to restore the client to his or her maximum functional level through the use of face-to-face interventions such as cueing, modeling, and role-modeling of appropriate fundamental daily living and life skills. This service is aimed at maximizing the client's basic daily living and life skills, increasing compliance with the client's medication regimen as applicable, and reducing or eliminating symptomatology that interferes with the client's functioning, in order to prevent the need for more restrictive levels of care such as inpatient hospitalization. Intensive psychosocial rehabilitative services may be coded when a ratio of no more than five clients per provider is maintained during a group rehabilitative psychosocial service.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in paragraph A. 1 of Chapter 1-5;

4. licensed ASUDC or SUDC under the general supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 qualified to provide supervision;

5. licensed CASUDC or a CASUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC qualified to provide supervision;

6. CSUDC or CSUDC-I under direct supervision of a licensed mental health therapist identified in paragraph A.1 of Chapter 1-5 or a licensed ASUDC or SUDC qualified to provide supervision; or

7. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or SUDC when the service is provided to individuals with an SUD; or

8. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or individual enrolled in a qualified substance use disorder counselor education program, exempted from licensure in accordance with state law, and under required supervision.

9. The above are the core providers of this service. In addition, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure as a mental health therapist may also perform this service. (See Chapter 1-5, B. 1.)

Limits:

1. In group psychosocial rehabilitative services, a ratio of no more than twelve clients per provider up to a maximum of 36 clients must be maintained during the entire service.

2. In accordance with 42 CFR 440.130, and the definition of rehabilitative services, the following do not constitute medical or remedial services and may not be billed to Medicaid:

   a. activities in which providers are not present and actively involved helping individuals regain functional abilities and skills;

   b. routine supervision of clients, including routine 24-hour care and supervision of clients (or clients' children) in residential settings. Routine supervision includes care and supervision-level providers who may have informal, sporadic interactions with a client that are helpful; however, these types of interactions do not constitute a billable structured, pre-planned psychosocial rehabilitative individual or group session. Individual and group PRS must be provided in accordance with a formal schedule for the client and must be documented in accordance with the requirements in the 'Record' section below. Otherwise intermittent unplanned communications with the client are part of the routine supervision and are not billable;

   c. activities in which providers perform tasks for the client, including activities of daily living and personal care tasks (e.g., grooming and personal hygiene tasks, etc.);

d. time spent by the client in the routine completion of activities of daily living, including chores, in a residential setting; this time is part of the routine 24-hour supervision;

e. habilitation services;

f. job training, job coaching and other vocational activities, and educational services and activities such as lectures, presentations, conferences, other mass gatherings, etc.;

g. social and recreational activities, including but not limited to routine exercise, farming, gardening & animal care activities, etc. Although these activities may be therapeutic for the client, and a provider may obtain valuable observations for processing later, they do not constitute billable activities. However, time spent before and after the activity addressing the clients' skills and behaviors related to the clients' rehabilitative goals is allowed);

h. routine transportation of the client or transportation to the site where a psychosocial rehabilitative service will be provided; and

i. any type of child care (including therapeutic child care).

3. Intensive PRS groups are limited to five clients per provider, with a maximum of ten clients per intensive PRS group. Intensive PRS groups are planned, structured groups independent from other PRS groups, and are designed to address the clinical needs of clients who, if in regular PRS groups 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 cannot be coded based solely on the number of clients in attendance.

   The psychiatric diagnostic evaluation or other clinical documentation must document the need for an intensive PRS group, the individual'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.

<u>Procedure Codes and Unit of Service</u>:

H2014 – Individual Skills Training and Development - per 15 minutes (This procedure code is used when providing PRS to an individual.)

H2017 - Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid client

H2017 with U1 modifier - Group Psychosocial Rehabilitative Services – Intensive - per 15 minutes per Medicaid client (See #3 of 'Limits' section above.) The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

*Psychosocial rehabilitative services provided in licensed day treatment or licensed residential treatment programs:

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), if attendance in each group meets the minimum time requirement for billing (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for billing purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be billed.

Record:

A. Group Psychosocial Rehabilitative Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

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

      a. name of each group in which the client participated (e.g., anger management, interpersonal relations, etc.);

      b. date, start and stop time, and duration of each group; and

      c. setting in which each group was rendered (e.g., day treatment program).

   2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

      Therefore, at a minimum, one summary note for each unique type of psychosocial rehabilitative group the client 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 provided the group, or by a provider who is most familiar with the client's involvement and progress across groups.

      The summary note must include:

      a. name of the group;

      b. treatment goal(s) related to the group;

      c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

      d. 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.

If the provider prefers, the provider may follow the documentation requirements listed under the next section, section B.

B. Psychosocial Rehabilitative Services Provided to a Group of Individuals in Other Settings

When psychosocial rehabilitative services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each unique type of psychosocial rehabilitative group and for each group session, documentation must include:

1. date, start and stop time, and duration of the group;
2. setting in which the group was rendered;
3. specific service rendered (i.e., psychosocial rehabilitative services) and the name of the group (e.g., relationship skills group, etc.);
4. treatment goal(s) related to the group;
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service. If a co-leader is present for group, the note must contain the co-leader's name and licensure or credentials.

C. Psychosocial Rehabilitative Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., psychosocial rehabilitative services)
4. treatment goal(s);
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service.

If psychosocial rehabilitative services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

2 - 12 Peer Support Services

Peer support services means face-to-face services for the primary purpose of assisting in the rehabilitation and recovery of individuals with mental health and/or substance use disorders. For children, peer support services are provided to their parents/legal guardians as appropriate to the child's age when the services are directed exclusively toward the treatment of the Medicaid-eligible child. Peer support services are provided to an individual, a group of individuals or parents/legal guardians. On occasion, it may be impossible to meet with the peer support specialist in which case a telephone contact with the client or parent/legal guardian of a child would be allowed.

Peers support services are designed to promote recovery. Peers offer a unique perspective that clients find credible; therefore, peer support specialists are in a position to build alliances and instill hope. Peer support specialists lend their unique insight into mental illness and substance use disorders and what makes recovery possible.

Using their own recovery stories as a recovery tool, peer support specialists assist clients with creation of recovery goals and with goals in areas of employment, education, housing, community living, relationships and personal wellness. Peer support specialists also provide symptom monitoring, assist with symptom management, provide crisis prevention, and assist clients with recognition of health issues impacting them.

Peer support services must be prescribed by a licensed mental health therapist identified in paragraph A of Chapter 1-5. Peer support services are delivered in accordance with a written treatment/recovery plan that is a comprehensive, holistic, individualized plan of care developed through a person-centered planning process. Clients lead and direct the design of their plans by identifying their own preferences and individualized measurable recovery goals.

Who:

Peer support services are provided by certified peer support specialists.

To become a certified peer support specialist, an individual must:

1. be at least age 18 and:
    a. a self-identified individual who is in recovery from a mental health and/or substance use disorder; or
    b. parent of a child with a behavioral health disorder; or
    c. other adult who has or has had an ongoing and personal relationship with an individual with a behavioral health disorder; and
2. successfully complete a peer support specialist training curriculum designed to give peer support specialists the competencies necessary to successfully perform peer support services. Curriculums are developed by the State of Utah, Department of Human Services, Division of Substance Abuse and Mental Health (DSAMH), in consultation with national experts in the field of peer support. Training is provided by DSAMH or a qualified individual or organization sanctioned by DSAMH. At the end of the training individuals must successfully pass a written examination. An individual who successfully completes the certification training will receive a written peer support specialist certification from the DSAMH and also will successfully complete any continuing education requirements the DSAMH requires to maintain certification.

Certified peer support specialists are under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, or a licensed ASUDC or SUDC when peer support services are provided to individuals with an SUD.

Supervisors must provide ongoing weekly individual and/or group supervision to the certified peer support specialists they supervise.

Limits:

1. Peer support groups are limited to a ratio of 1:8.

2. Medicaid clients or Medicaid-eligible children's parents/legal guardians may participate in a maximum of four hours of peer support services a day.

3. With the exception of older adolescents (adolescents age 16-18) for children, peer support services are provided to their parents/legal guardians and the services are directed exclusively to the treatment of the Medicaid-eligible child (i.e., toward assisting the parents/legal guardians in achieving the rehabilitative treatment goals of their children.

4. In accordance with 42 CFR 440.130, and the definition of rehabilitative services, the following do not constitute medical or remedial services and may not be billed to Medicaid:

    a. Job training, job coaching, and vocational and educational services. These activities are not within the scope of a peer support specialist's role; however, helping individuals with the emotional and social skills necessary to obtain and maintain employment is within the scope of peer support services;

    b. Social and recreational activities (although these activities may be therapeutic for the client, and the peer support specialist may obtain valuable observations for processing later, they do not constitute reportable services. However, time spent before and after the activity addressing the clients' behaviors related to the clients' peer support goals is allowed); and

    c. Routine transportation of the client or transportation to a site where a peer support services will be provided.

Procedure Code and Unit of Service:

H0038 – Individual Peer Support Services - per 15 minutes

H0038 with HQ modifier - Group Peer Support Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;
3. specific service rendered (i.e., peer support services);
4. treatment goal(s);
5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
6. signature and licensure or credentials of the individual who rendered the service.

If peer support services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

3 1915(b)(3) SERVICES – FOR PREPAID MENTAL HEALTH PLAN (PMHP) CONTRACTORS ONLY

This section applies to PMHP contractors only. The services included in this section are not available to children in foster care, or children with adoption subsidy exempted from the PMHP for outpatient behavioral health services.

In accordance with 1915 (b)(3) of the Social Security Act, services in addition to the scope of Medicaid State Plan-covered services may be provided to enrollees in a managed care plan. The services specified in this chapter may be provided to PMHP enrollees, with the following exceptions.

Exceptions

1. 1915(b)(3) services are a benefit for PMHP enrollees with Traditional Medicaid only. They are not a benefit for Medicaid recipients age 19 and older with Non-Traditional Medicaid.
2. 1915(b)(3) services are not a benefit for individuals enrolled in the PMHP for only inpatient psychiatric care. This includes children in foster care, and children with adoption subsidy exempted from the PMHP for outpatient behavioral health services.
3. 1915(b)(3) services are not covered for PMHP enrollees getting services for SUDs only.

In accordance with Chapter 1-7, Treatment Plan, 1915(b)(3) services must be included on the client's treatment plan and meet requirements of Chapter 1-7.

3 - 1 Personal Services

Personal Services are recommended by a physician or other practitioner of the healing arts (see paragraph A of Chapter 1-5) and are furnished for the primary purpose of assisting in the rehabilitation of clients with serious and persistent mental illness (SPMI) or serious emotional disorder (SED). These services include assistance with instrumental activities of daily living (IADLs) that are necessary for individuals to live successfully and independently in the community and avoid hospitalization. Personal services include assisting the client with varied activities based on the client's rehabilitative needs: picking up prescriptions, income management, maintaining the living environment including cleaning and shopping, and the transportation related to the performance of these activities, and representative payee

activities when the PMHP has been legally designated as the client's representative payee. These services assist clients to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H0046 – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered;

4. treatment goal(s);

5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

6. signature and licensure or credentials of the individual who rendered the service.

3 - 2 Respite Care

Respite care is recommended by a physician or practitioner of the healing arts (see Chapter 1-5, A) and is furnished face-to-face to a child for the primary purpose of giving the parent(s)/guardian(s) temporary relief from the stresses of caring for a child with a serious emotional disorder (SED). Respite care can prevent parent/guardian burn-out, allow for time to be spent with other children in the family, preserve the family unit, and minimize the risk of out-of-home placement by reducing the stress families of children with SED typically encounter.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

S5150 – per 15 minutes

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

Each provider delivering respite care must provide documentation as follows:

1. For each date of respite care:

    a. date, start and stop time, and duration of the service;
    b. setting in which the service was rendered; and
    c. specific service rendered.

2. For each preceding two-week period during which the client received respite services, at a minimum, one summary note that includes:

    a. the name of the service;

    b. treatment goal(s);

    c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

    d. signature and licensure or credentials of the individual who rendered the service(s).

3 - 3 Psychoeducational Services

Psychoeducational Services are recommended by a physician or practitioner of the healing arts (see Chapter 1-5, A) and are provided face-to-face to an individual or a group and are furnished for the primary purpose of assisting in the rehabilitation of Enrollees with serious and persistent mental illness (SPMI) or serious emotional disorders (SED). This rehabilitative service includes interventions which help clients achieve goals of remedial and/or rehabilitative vocational adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H2027 – Psychoeducational Services - per 15 minutes per Medicaid client

The following time rules apply for converting the duration of the service to the specified number of units:

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;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Record:

A. Psychoeducational Services Provided in Licensed Day Treatment Programs, Licensed Residential Treatment Programs, and Licensed or Unlicensed Day Treatment Programs in Schools

   1. For each date of participation in psychoeducational services, documentation must include:

      a. name of the service;

      b. date, start and stop time, and duration of the service; and

      c. the setting in which the service was rendered.

   2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

Therefore, at a minimum, one summary note for each preceding two-week period during which the client received psychoeducational services must be prepared at the close of the two-week period.

The summary note must include:

a. name of the service;

b. treatment goal(s);

c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

d. signature and licensure or credentials of the individual who rendered the service.

If the provider prefers, the provider may follow the documentation requirements listed under the next section, section B.

B. Psychoeducational Services Provided to a Group of Individuals in Other Settings

When psychoeducational services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each psychoeducational group session, documentation must include:

1. date, start and stop time, and duration of the psychoeducational group;

2. setting in which the group was rendered;

3. specific service rendered;

4. treatment goal(s);

5. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

6. signature and licensure or credentials of the individual who rendered the service.

C. Psychoeducational Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date, start and stop time, and duration of the service;

2. setting in which the service was rendered;

3. specific service rendered;

4. treatment goal(s);

5. progress toward treatment goal(s) or if there was no reportable progress, documentation of barriers; and

6. signature and licensure or credentials of the individual who rendered the service.

If psychoeducational services goals are met as a result of participation in the service, then if applicable, new individualized goals must be added to the treatment plan.

Psychoeducational services provided in licensed day treatment or licensed residential treatment programs:

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), in accordance with Chapter 1-12, if attendance in each psychoeducational services group meets the minimum time requirement for reporting (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for reporting purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be reported.

3 - 4 Supportive Living

Supportive Living means costs incurred in residential treatment/support programs when Enrollees are placed in these programs in lieu of inpatient hospitalization. Costs include those incurred for 24-hour staff, facility costs associated with providing discrete Covered Services (e.g., individual psychotherapy, pharmacologic management, etc.) at the facility site, and apportioned administrative costs. Costs do not include the Covered Services costs or room/board costs. This level of care is recommended by a physician or other practitioner of the healing arts (see Chapter 1-5, A), and helps to restore clients with SPMI or SED to their best possible functioning level. Whenever possible, the PMHP will provide this level of care in lieu of inpatient hospitalization so that individuals may remain in a less restrictive community setting.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law under supervision of a licensed mental health therapist;

2. licensed registered nurse;

3. licensed practical nurse under the supervision of a licensed registered nurse or a licensed mental health therapist identified in Chapter 1-5, A. 1;

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.3(b) of Chapter 1-5, a licensed social service worker or a licensed registered nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, exempted from licensure in accordance with state law and under required supervision.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure may also perform this service.

Procedure Code and Unit of Service:

H2016 – 1 unit per day

Record:

Documentation must include:

1. note each month documenting the dates supportive living was provided during the month; and

2. signature and licensure or credentials of the individual who prepared the documentation.

4 PROCEDURE CODES AND MODIFIERS

Procedure Code	Service and Units
90791	Psychiatric Diagnostic Evaluation - per 15 minutes
90792	Psychiatric Diagnostic Evaluation with Medical Services - per 15 minutes
H0031	Mental Health Assessment by Non-Mental Health Therapist - per 15 minutes
96101	Psychological Testing - per hour
96105	Assessment of Aphasia - per hour
96110	Developmental Screening - per hour
96111	Developmental Testing - per hour
96116	Neurobehavioral Status Exam - per hour (Per Chapter 2-1, requires manual review. Limited to 3 hours (3 units) per year unless additional time is approved based on manual review. More than 3 hours (3 units) per year require supportive documentation for the manual review.)
96118	Neuropsychological Testing - per hour (Per Chapter 2-1, requires manual review. Limited to 8 hours (8 units) per year unless additional time is approved based on manual review. More than 8 hours (8 units) per year require supportive documentation for the manual review.)
90832	Psychotherapy with patient and/or family member - 30 minutes
90834	Psychotherapy with patient and/or family member - 45 minutes
90837	Psychotherapy with patient and/or family member - 60 minutes
90846	Family Psychotherapy - without patient present - per 15 minutes
90847	Family Psychotherapy - with patient present - per 15 minutes
90849	Group Psychotherapy - Multiple-family group psychotherapy - per 15 minutes per Medicaid client
90853	Group Psychotherapy – per 15 minutes per Medicaid client
90839	Psychotherapy for Crisis, first 60 minutes* – per encounter
90840	Psychotherapy for Crisis, add-on to 90839, each additional 30 minutes
	*Note: Use 90832 for crisis contacts 30 minutes or less
90833	Psychotherapy add-on code, with patient and/or family member – 30 minutes (added to applicable evaluation and management (E/M) service code)
90836	Psychotherapy add-on code, with patient and/or family member – 45 minutes (added to applicable evaluation and management (E/M) service code)
90838	Psychotherapy add-on code, with patient and/or family member – 60 minutes (added to applicable evaluation and management (E/M) service code)
99211-99215*	Office or Other Outpatient Services Evaluation and Management (E/M) Services Codes- established patient

Procedure Code	Service and Units
99307-99310*	Subsequent Nursing Facility Care E/M Codes – established patient (should be used to report E/M services provided to a patient in a psychiatric residential center [a facility or a distinct part of a facility for psychiatric care, which provides 24-hour therapeutically planned and professionally staffed group living and learning environment])
99347-99350*	Home Services E/M Codes – established patient
99354	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99211-99215 or 99347-99350; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99355	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99354) – per encounter
99356	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99307-99310 or inpatient-based E/M codes; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99357	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99356) – per encounter
T1001	Nurse Evaluation and Assessment (Medication Management) - per encounter
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular – per encounter
90785	Add-on code for interactive complexity (with procedure codes 90791, 90792, 90832, 90834, 90837, 90833, 90836, 90838; and E/M services codes)
H2019	Individual/Family Therapeutic Behavioral Services - per 15 minutes
H2019 with HQ modifier	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client
H2014	Individual Skills Training and Development (Psychosocial rehabilitative services with an individual) - per 15 minutes
H2017	Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid client
H2017 with U1 modifier	Group Psychosocial Rehabilitative Services - Intensive - per 15 minutes per Medicaid client
H0038	Peer Support Services, individual – per 15 minutes
H0038 with HQ modifier	Peer Support Services, group - per 15 minutes per Medicaid client
	Prepaid Mental Health Plans (PMHPs) Only- 1915(b)(3) Services
H0046	Personal Services - per 15 minutes
S5150	Respite Care - per 15 minutes
H2027	Psychoeducational Services – per 15 minutes
H2016	Supportive Living – per day

* To ensure correct adjudication of an E/M claim, always use the CG modifier with the E/M code. This modifier indicates the service provided was pharmacologic management covered under this program.