Chapter 503 – Covered Services, Limitations, and Exclusions For Behavioral Health Rehabilitation Services

Change Log

Replace	Title	Change Date	Effective Date
503.6.2	Psychological Testing	12-19-05	01-01-06
503.3	Medical Necessity	10-17-05	11-01-05
503.4.2	Enrollment Requirements: Staff Qualifications	10-17-05	11-01-05
503.5	Index of Services	10-17-05	11-01-05
503.6.3	Change in Documentation Requirements	10-17-05	11-01-05
503.6.4	Screening by Licensed Psychologist	10-17-05	11-01-05
503.6.5	Developmental Testing: Limited	10-17-05	11-01-05
503.7	Service Planning and Consultation	10-17-05	11-01-05
503.9.1	Pharmacologic Management	10-17-05	11-01-05
503.9.6.1	Injection, Risperidone	10-17-05	01-01-05
503.10.1	Assertive Community Treatment (ACT)	10-17-05	12-01-05
503.10.2	Comprehensive Community Support Services	10-17-05	11-01-05

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503.5	Index of Services - Modifier HE added to T1023, A0120, and A0160	07-01-04	07-01-04
503.6.1	Mental Health Assessment by Non-Physician	07-01-04	07-01-04
503.6.2	Psychological Testing with Interpretation and Report	07-01-04	07-01-04
503.6.3	Psychiatric Diagnostic Interview Examination	07-01-04	07-01-04
503.6.4	Screening by Licensed	07-01-04	07-01-04
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503.7.1	Mental Health Service Plan Development	07-01-04	07-01-04
503.7.2	Mental Health Service Plan Development by Psychologist	07-01-04	07-01-04
503.7.3	Physician Coordinated Care Oversight Services	07-01-04	07-01-04
503.7.4	Case Consultation	07-01-04	07-01-04
503.8.1	Behavioral Health Counseling, Professional, Individual	07-01-04	07-01-04
503.8.2	Behavioral Health Counseling, Professional, Group	07-01-04	07-01-04

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503.8.3	Behavioral Health Counseling, Supportive, Individual	07-01-04	07-01-04
503.8.4	Behavioral Health Counseling, Supportive, Group	07-01-04	07-01-04
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503.12.2	Residential Children's Services Level 2	07-01-04	07-01-04

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503.18.1	Registration/Prior Authorization Procedures	07-01-04	07-01-04

DECEMBER 19, 2005

SECTION 503.6.2

Introduction: Psychological Testing

Old Policy: CPT Code listed as 96100

New Policy: 2006 CPT Code Update list code as 96101

Change: Update CPT Code to state 96101

Directions: Please replace the above section

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OCTOBER 17, 2005

SECTION 503.3

Introduction: Medical Necessity:

Old Policy: Did not contain statement that providers are required to register and/or prior authorize some of the services described in this manual – references Section 503.18.1 (Registration/Prior Authorization Procedures)

New Policy: Added language to include advice early in the manual that providers are required to register and/or prior authorize some of the services described in this manual – references Section 503.18.1 (Registration/Prior Authorization Procedures)

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

Directions: Please replace the above section

Section 503.4.2

Introduction: Enrollment Requirements: Staff Qualifications

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

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

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

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

Regulations set forth in WV Code, Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed.

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

Directions: Please replace the above section

Section 503.5

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Index of Services: Addition

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

New Policy: added Section 503.9.61 Injection, Resperidone, long acting (Resperdal Consta IM)

Change: Addition of Section 503.9.6.1

Directions: Please replace the above section

Section 503.6.3

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

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

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

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

Directions: Please replace the above section

Section 503.6.4

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

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

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

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

Directions: Please replace the above section

Section 503.6.5

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

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

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

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

Directions: Please replace the above section

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Section 503.7

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

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

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

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

Directions: Please replace the above section

Section 503.9.1

Introduction: Pharmacologic Management (90862) Change in Documentation Requirements

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

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

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

Directions: Please replace the above section

Section 503.9.61

Introduction: Add J2794 Injection, Risperidone, long acting

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

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

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

Directions: Please replace the above section

SECTION 503.10.1

Introduction: Assertive Community Treatment (ACT) (H0040) Changes in Staff Composition, Procedure Code Inclusions/Exclusions, Documentation Requirements

Old Policy: Required documentation for Weekly and Monthly Report. Included A0160 and H0036 in the per diem, had specific criteria for **Vocational Specialist**

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New Policy: Removed requirement for a weekly and monthly report. Remove A0160 travel from the per diem rate. Exclude limited amount of H0036 Community Psychiatric Supportive Treatment from the per diem rate

Change: Removed specific criteria for Vocational Specialist; Exclude transportation (A0160) and up to 84 hours of Community Psychiatric Supportive Treatment (H0036) per year from daily per diem. Remove weekly and monthly documentation requirements

Directions: Please replace the above section

SECTION 503.10.2

Introduction: Comprehensive Community Support Services (H2015) – formerly known as Community Focused Treatment - Re-certification Process Requirements

Old Policy: Removed language: All Comprehensive Community Support Programs must be recertified at two-year intervals beginning from the date of their most current certification. To be recertified, a program must submit the Comprehensive Community Support Certification Form at least 30 days prior to their certification end date. The Bureau for Medical Services will review and approve or disapprove the application by means of a desk and/or onsite review.

New Policy: Removed requirement to have program re-certified every two years.

Change: Remove recertification process

Directions: Please replace the above section

July 1, 2004

Section 503.5

Introduction: Index of Services: To introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.6.1

Introduction: Mental Health Assessment by Non- Physician: to introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.6.2

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Psychological Testing with Interpretation and Report: to introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.6.3

Introduction: Psychiatric Diagnostic Interview Examination: to introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.6.4

Introduction: Screening by Licensed Psychologist: to introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.6.5

Introduction: Developmental Testing; Limited: to introduce revisions to Chapter 502 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.7.1

Introduction: Mental Health Service Plan Development: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.7.2

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Mental Health Service Plan Development by Psychologist: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.7.3

Introduction: Physician Coordinated Care Oversight Services: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.7.4

Introduction: Case Consultation: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.8.1

Introduction: Behavioral Health Counseling, Professional, Individual; to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.8.2

Introduction: Behavioral Health Counseling, Professional, Group: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.8.3

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

Introduction: Behavioral Health Counseling, Supportive Individual, to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.8.4

Introduction: Behavioral Health Counseling, Supportive, Group: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.8.5

Introduction: Skills Training and Development, to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.9.1

Introduction: Pharmacologic Management, to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Payment Limits Language, Prior Authorization Language

Directions: Please replace the above section

Section 503.9.7

Introduction: Comprehensive Medication Services; Mental Health: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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

Directions: Please replace the above section

Section 503.10.1

Introduction: Assertive Community Treatment: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

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Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.10.2

Introduction: Comprehensive Community Support Services, formerly known as Community Focused Treatment Services: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.10.3

Introduction: Day Treatment: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.11.1

Introduction: Crisis Intervention: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.11.2

Introduction: Community Psychiatric Supportive Treatment, formerly known as Outpatient Crisis Stabilization Services: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.12.1

Introduction: Residential Children's Services, Level 1: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Payment Limits language added modifier: Prior Authorization Language reference to APS; Documentation Language Delete reference to DSM-IV - TR

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Directions: Please replace the above section

Section 503.12.2

Introduction: Residential Children's Services, Level 2: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Payment Limits Language add modifier to A0120 and A0160; Prior Authorization Language reference to APS; Documentation Language Delete reference to DSM-IV-TR

Directions: Please replace the above section

Section 503.12.3

Introduction: Residential Children's Services, Level 3: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Payment Limits Language add modifier to A0120 and A0160; Prior Authorization Language reference to APS; Documentation Language Delete reference to DSM-IV - TR

Directions: Please replace the above section

Section 503.12.4

Introduction: Residential Children's Services Short-term, Level 4: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Payment Limits Language add modifier to A0120 and A0160; Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.13.1

Introduction: Therapeutic Behavioral Services – Development: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

Section 503.13.2

Introduction: Therapeutic Behavior Services – Implementation: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Prior Authorization Language reference to APS

Directions: Please replace the above section

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Section 503.14.1

Introduction: Non-Emergency Transportation by Minibus (A0120): to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Add modifier HE to A0120

Directions: Please replace the above section

Section 503.14.2

Introduction: Non-Emergency Transportation per mile (A0160): to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Add modifier HE to A0160

Directions: Please replace the above section

Section 503.18.1

Introduction: Registration/Prior Authorization Procedures: to introduce revisions to Chapter 503 – Covered Services, Limitations, and Exclusions for Behavioral Health Rehabilitation Services

Change: Add modifier HE to A0120 and A0160

Directions: Please replace the above section

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CHAPTER 503—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR BEHAVIORAL HEALTH REHABILITATION SERVICES

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CHAPTER 503–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR BEHAVIORAL HEALTH REHABILITATION SERVICES

INTRODUCTION

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

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

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

503.1 BEHAVIORAL HEALTH REHABILITATION SERVICES

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

503.2 MEMBER ELIGIBILITY

Behavioral Health Rehabilitation Services are available to all Medicaid members with a known or suspected behavioral health disorder. Each member's level of services will be determined when registration for Behavioral Health Rehabilitation Services is requested of BMS' contracted agent. The Registration/Prior Authorization process is explained in Section 503.18 of this manual.

503.3 MEDICAL NECESSITY

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

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

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. Diagnostic and standardized instruments (as approved by BMS) must be administered at the initial evaluation and as clinically indicated. The results of these measures must be

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available as part of the clinical record and as documentation of service need and justification for the level and type of service provided.

Refer to Section 503.18.1. The Bureau for Medical Services requires that providers register and/or prior authorize with APS Healthcare, Inc. some of the services described in this manual.

503.4 PROVIDER ENROLLMENT

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

503.4.1 ENROLLMENT REQUIREMENTS: AGENCY ADMINISTRATION

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

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

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

Participating providers must develop standards for staff training, supervision, and compliance monitoring.

503.4.2 ENROLLMENT REQUIREMENTS: STAFF QUALIFICATIONS

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

- The following medically and psychologically based services must be provided by professionally trained and licensed staff:
  - Mental Health Assessment by Non-Physician
  - Case Consultation
  - Skills Training and Development by Professional
  - Crisis Intervention
- Professionally trained and licensed staff approved to provide the above listed services includes:
  - Physicians
  - Psychiatrists

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- Doctoral and Master's prepared staff in appropriate, related fields
- Physician Assistants
- Nurse Practitioners with Psychiatric Specialty
- Registered nurses with appropriate experience and training
- Master's or Bachelor's level staff working under the supervision of fully trained and licensed staff operating within the scope of their professional practice and training.

- The following remedial services may be provided by non-professional staff:
  - Behavioral Health Counseling, Supportive
  - Skills Training and Development by Paraprofessional
  - Comprehensive Community Support Services
  - Therapeutic Behavioral Services – Implementation
  - Transportation Services
- Staff approved to provide the above listed remedial services include:
  - Bachelor's level staff in appropriate related human service fields with certified competencies in service specific areas
  - Paraprofessionally trained staff with either an associate degree in a related field or a high school graduate/GED

Services provided by bachelor's level staff with less than one year experience, paraprofessionally trained staff, or high school graduate/GED staff must be provided under the supervision and training of licensed and certified staff.

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

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

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

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

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psychiatrist. An Advanced RN Practitioner with a psychiatric specialty may practice without direct supervision by a psychiatrist.

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

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

Regulations set forth in WV Code Chapter 30 – Professions and Occupations, Title 11 Legislative Rule – West Virginia Board of Medicine, and Title 19 Legislative Rules – Board of Examiners for Registered Professional Nurses must be followed.

503.4.3 SERVICE CERTIFICATION REQUIREMENTS

A licensed psychologist or physician must certify the need for Behavioral Health Rehabilitation Services by:

- Signing the "Behavioral Health Clinic/Rehabilitation Services, Authorization for Services" form within 72 hours of the member's admission to the program or services and prior to the start of treatment. This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all Behavioral Health Rehabilitation Services until the development and initiation of the Initial Service Plan. Upon initiation of the Initial Service Plan, the "Behavioral Health Clinic/Rehabilitation Services, and Authorization for Services" form is no longer in effect since it is no longer necessary.
- Development of the Initial Service Plan within seven days of the initial admission and intake
- Development of the Master Service Plan within 30 days of the initial admission and intake
- Review and re-evaluation of the service plan at a minimum every 90 days, or sooner if dictated by the member's needs

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

503.4.4 OTHER ADMINISTRATIVE REQUIREMENTS

- The provider must assure implementation of Bureau for Medical Services' policies and procedures pertaining to service planning, documentation, and case record review. Uniform guidelines for case record organization should be used by staff, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.
- Records must contain completed member identifying information. The member's individual plan of service must contain service goals and objectives which are derived from a comprehensive member assessment, and must stipulate the planned service activities and how they will assist in goal attainment. Termination reports must be filed upon case closure.
- In addition to the documentation requirements described in this chapter, Behavioral Health Rehabilitation Service providers must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800, General Administration of the Provider Manual.

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- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.

503.4.5 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES' REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by BMS and/or its contractors. Bureau for Medical Services' contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in Chapter 800, General Administration, of the Provider Manual.

503.5 INDEX OF SERVICES

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– **Psychological Testing with Interpretation and Report**	**96100**	**503.6.2**
– **Psychiatric Diagnostic Interview Evaluation**	**90801**	**503.6.3**
– **Screening by Licensed Psychologist**	**T1023HE**	**503.6.4**
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– **Injection, Fluphenazine Decanoate (Prolixin Decanoate)**	**J2680**	**503.9.4**
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– **Residential Children's Services Level I**	**H0019U1**	**503.12.1**
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503.6 ASSESSMENT SERVICES

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

503.6.1 MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN

DISCLAIMER: This manual does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations.

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

DEFINITION:

Mental Health Assessment by Non-Physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of a member. Additional specialty evaluations such as occupational therapy, nutrition or functional skills assessments may be addressed within the initial or reassessment evaluation.

This code may also be used for special requests of the West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring of functional assessment instruments necessary to determine medical necessity and level of care are included in this service.

DOCUMENTATION:

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

503.6.2 PSYCHOLOGICAL TESTING WITH INTERPRETATION AND REPORT

PROCEDURE CODE: 96101
SERVICE UNIT: 60 minutes
SERVICE LIMITS: All units must be prior authorized
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

DOCUMENTATION:

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

503.6.3 PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION

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

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DEFINITION:

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

DOCUMENTATION:

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

503.6.4 SCREENING BY LICENSED PSYCHOLOGIST

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

DEFINITION:

This is a screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol. Procedure codes 96100 or 90801 must be used when a more in-depth assessment is indicated.

DOCUMENTATION:

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

503.6.5 DEVELOPMENTAL TESTING: LIMITED

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

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

DOCUMENTATION:

Documentation must contain the completed interpretation and report, signed by the licensed psychologist or qualified staff, along with their credentials. The documentation must include the place of the testing

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and date of service. If performed by staff other than a psychologist, a licensed psychologist must review, sign, and date the completed interpretation and report.

503.7 SERVICE PLANNING AND CONSULTATION SERVICES

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

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

503.7.1 MENTAL HEALTH SERVICE PLAN DEVELOPMENT

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

DEFINITION:

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

The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must have a representative participate in the service planning session.

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

All service plans (including updates) must be reviewed, signed, and approved by a physician or licensed psychologist within 72 hours of the service plan meeting and prior to implementing services. The physician or licensed psychologist must be physically present and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications
- Have a diagnosis of major psychosis or major affective disorder
- Have major medical problems in addition to major psychosis and medications

- The presence of the physician or licensed psychologist has been specifically requested by the case manager or the member.

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

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

Individual program plans for Day Treatment, Long Term Residential Services, and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services.

Mental Health Service Plan Development reimburses for team member participation. A written service plan is the product of that process and serves as substantiation that the process took place. Thus reimbursement is for participation in the process, not for the product. A process by which the case manager writes a service plan or takes a written plan and walks it to each team member separately to get it signed does not constitute service planning.

DOCUMENTATION:

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

- Required is a separate activity note by the case manager coordinating the service planning session
  - It must justify each staff person's presence by stating their purpose for participating in the meeting.
  - Each note must include the signature and credentials of the case manager participating in the session, place of session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.
- Also required is a service plan signature page. This document is to be placed in the member's clinical record along with the completed service plan or service plan update.
  - There must be signatures of all participating members of the treatment team (including the member, their guardian, or the member's requested representative).

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- All signatures must be original, **in ink**, must include the title and credentials of the individual, must be dated by the treatment team member, and must include the actual time spent providing the service by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process.

- If a staff person from another agency participates in the service planning session, he/she must:
  - Meet the previously listed requirements of the service plan signature page. This includes signing the signature page along with listing the agency they are representing.
  - Write an activity note (which must be included in **<u>their</u>** agency's clinical record) that states their purpose for participating in the meeting, their signature and credentials, the location of the session, date of session, and the actual time spent participating in the session by listing their start-and-stop times.

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

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

503.7.2 MENTAL HEALTH SERVICE PLAN DEVELOPMENT BY PSYCHOLOGIST

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

DEFINITION:

These are activities performed by a licensed psychologist directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to 507.1 Mental Health Service Plan Development.

DOCUMENTATION:

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

503.7.3 PHYSICIAN COORDINATED CARE OVERSIGHT SERVICES

PROCEDURE CODE: G9008
SERVICE UNIT: 15 minutes
SERVICE LIMITS: One unit per month with registration

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

DEFINITION:

These are activities performed by a physician directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. Also, refer to 503.7.1 Mental Health Service Plan Development.

DOCUMENTATION:

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

503.7.4 CASE CONSULTATION

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

DEFINITION:

A Case Consultation Service is an interpretation or explanation of results of psychiatric, and other medical examinations and procedures through the requesting clinician to family or other responsible persons.

These are services provided at the request of a professional requiring the opinion, recommendation, suggestion and/or expertise of another professional for a specific purpose regarding services and/or activities of a member relevant to the particular area of expertise of the consulting professional. The consulting professional must be licensed or certified in the needed area of expertise.

Case Consultation may not be used during service planning. The member's case manager cannot be a case consultant. Professional staff persons who participated in the member's service plan within the current 90 day period, or were directed to provide treatment, cannot bill for case consultation.

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

DOCUMENTATION:

The consulting professional must document a summary of the consultation that includes: purpose, activities/services discussed, recommendations with desired outcomes, the relationship of the consultation to a specific objective(s) in the service plan, date of service, location, signature and credentials of the consulting professional.

503.8 SUPPORTIVE SERVICES

Supportive services are face-to-face interventions which are intended to provide support to the member in order to maintain or enhance levels of functioning and to assist in day-to-day management and

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problem solving. These services include counseling, individual and group therapy, specially designed behavior plans with scheduled direct intervention, and skills training and development.

503.8.1 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, INDIVIDUAL

PROCEDURE CODE: H0004HO
SERVICE UNIT: 15 minutes
SERVICE LIMITS: 60 units per year with registration
PRIOR AUTHORIZATION: Yes, if units exceed 60 per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

These are face-to-face, structured interventions (e.g., psychotherapy, specialty therapies, family preservation interventions, etc.) designed to improve a member's cognitive processing and/or functional abilities. The intent of this type of intervention is to focus on the dynamics of a member's problems (i.e., the cause of the member's dysfunctions; resolution of intrapsychic/interpersonal conflicts; eliciting change in behavior patterns; and to produce change toward identifiable goals). Interventions are grounded in a specific and identifiable theoretical base that provides a framework for assessing change. This service may be provided in a variety of settings, but in all settings the service must be provided on a scheduled basis by designated staff.

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

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

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to a specific objective(s) in the therapy plan, and the outcome of the service. The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Treatment strategies and objectives utilizing individual therapeutic interventions must be included in the member's Master Service Plan and in an individual therapeutic intervention plan which expands on the more generalized objectives in the Master Service Plan.

503.8.2 BEHAVIORAL HEALTH COUNSELING, PROFESSIONAL, GROUP

PROCEDURE CODE: H0004 HO HQ
SERVICE UNIT: 15 minutes
SERVICE LIMITS: 50 units per year with registration
PAYMENT LIMITS: Behavioral Health Counseling, Professional, Group sessions are limited in size to a maximum of 12 persons per group session.

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PRIOR AUTHORIZATION: Yes, if units exceed 50 per year. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:
These sessions are face-to-face, structured interventions (e.g., psychotherapy, specialty therapies, etc.) in a group setting designed to improve an individual's cognitive processing and/or functional abilities. The intent of this type of intervention is to focus on the dynamics of a member's problems (i.e., the cause of the member's dysfunctions; resolution of intrapsychic/interpersonal conflicts; eliciting a change in behavior patterns; and to otherwise produce change toward identifiable goals). These activities are carried out within a group context where the therapist engages the group dynamics in terms of peer relationships, common problems focus, and mutual support to promote progress for individual members. Interventions are grounded in a specific and identifiable theoretical base that provides a framework for assessing change. This service may be provided in a variety of settings, but in all settings the service must be provided on a scheduled basis by designated staff.

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

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to a specific objective(s) in the therapy plan, and the outcome of the service. The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Treatment strategies and objectives utilized in therapeutic groups must be included in the member's Master Service Plan and in a therapeutic group intervention plan which expands on the more generalized objectives in the Master Service Plan.

503.8.3 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, INDIVIDUAL

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

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

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

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

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to a specific objective(s) in the service plan, and the outcome of the service. The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. If provided due to an unscheduled crisis activity, the activity note must also include a summary of events leading up to the crisis.

503.8.4 BEHAVIORAL HEALTH COUNSELING, SUPPORTIVE, GROUP

PROCEDURE CODE: H0004HQ
SERVICE UNIT: 15 minutes
SERVICE LIMITS: All units must be pre authorized
PAYMENT LIMITS: Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

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

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

DOCUMENTATION:

Documentation must contain a schedule detailing when this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to a specific objective(s) in the service plan, and the outcome of the service. The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

503.8.5 SKILLS TRAINING AND DEVELOPMENT

PROCEDURE CODE: H2014U4 Skills Training 1:1 by Paraprofessional
H2014U1 Skills Training 1:2-4 by Paraprofessional
H2014HNU4 Skills Training 1:1 by Professional
H2014HNU1 Skills Training 1:2-4 by Professional
SERVICE UNIT: 15 minutes

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SERVICE LIMITS: All units must be prior authorized
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

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

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

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

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

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

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

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

- Adaptive, self-help, safety, and nutritional skills
- Parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
- Interpersonal and communication skills

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- Mobility, problem solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

DOCUMENTATION:

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

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

503.9 GENERAL MEDICATION SERVICES

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

503.9.1 PHARMACOLOGIC MANAGEMENT

PROCEDURE CODE: 90862
SERVICE UNIT: Event
SERVICE LIMITS: Two events per month with registration
PAYMENT LIMITS: Members may not receive Psychiatric Diagnostic Interview Evaluation (procedure code 90801) or Mental Health Comprehensive Medication Services (procedure code H2010) on the same day 90862 is provided.
PRIOR AUTHORIZATION: Yes, if units exceed two events per month. Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

DOCUMENTATION:

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

503.9.2 INJECTION, HALOPERIDOL (HALDOL)

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

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

DOCUMENTATION:

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

503.9.3 INJECTION, HALOPERIDOL DECANOATE (HALDOL DECANOATE)

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

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

DOCUMENTATION:

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

503.9.4 INJECTION, FLUPHENAZINE DECANOATE (PROLIXIN DECANOATE)

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

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

DOCUMENTATION:

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

503.9.5 INJECTION, CHLORPROMAZINE HCI (THORAZINE)

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

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

DOCUMENTATION:

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

503.9.6 INJECTION, PERPHENAZINE (TRILAFON)

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

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

DOCUMENTATION:

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

503.9.6.1 INJECTION, Resperidone, long acting (Resperdal Consta IM)

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

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

DOCUMENTATION:

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

503.9.7 COMPREHENSIVE MEDICATION SERVICES: MENTAL HEALTH

PROCEDURE CODE: H2010
SERVICE UNIT: 15 minutes
SERVICE LIMITS: All units must be prior authorized
PAYMENT LIMITS: This service includes all physician and nurse oversight; therefore, neither Community Psychiatric Support Treatment (procedure code H0036), Pharmacologic Management (procedure code 90862), nor

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any other physician code can be billed on the same day as Comprehensive Medication Services; Mental Health.

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Comprehensive Medication Services; Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy along with the injection of medications as required (except psychotropic medications which require administration but no consistent and intensive monitoring. These incidents of medication administration are covered in section 503.9 of this manual.) These services include obtaining the sample for necessary blood work and the laboratory results for a member by a registered nurse and subsequent evaluation of the results by the physician as necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. Because this is a physician directed service, a physician must be on site and available for direct service as needed. Members may be served individually or by a group/clinic model. (The status of psychotropic medications eligible for use in this service is available when seeking prior authorization from BMS' contracted agent.)

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

DOCUMENTATION:

Documentation must contain a written note of the assessment results as completed by the registered nurse, white blood cell level, other laboratory results, and current Clozaril/Clozapine (or other psychotropic medication) dosage with authorized pharmacy name. The documentation must include: place of service, specific time and date of service, and signature of qualified staff providing the service.

503.10 COMPREHENSIVE PROGRAMS OF SERVICES

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

503.10.1 ASSERTIVE COMMUNITY TREATMENT (ACT)

PROCEDURE CODE: H0040
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized
PAYMENT LIMITS: Payment for ACT services is all-inclusive. The only Behavioral Health Rehabilitation Services that can be billed separately are Case Consultation (procedure code 90887), Injection of Haloperidol (procedure code J1630), J1631), Injection of Fluphenazine Decanoate (procedure code J2680), Injection, Chlorpromazine HCI (procedure code J3230), Injection, Perphenazine (procedure code 3310, Injection, Risperidone, long acting (procedure code J2794), and mileage A0160 HE.

No payment will be made for ACT services when the member is hospitalized for a psychiatric condition, or receiving Psychiatric Supportive Services (except for 84 hours per year). However, the

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ACT Team must maintain contact and be part of the hospital discharge efforts.

No Psychiatric services other than 90887, Personal Care Services (procedure codes T1001, T1002, or T1019) or H0036 Community Psychiatric Supportive Services up to 84 hours per year may be billed for members receiving ACT services; however ACT cannot be billed concurrently with Psychiatric Supportive Services.

PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment by direct assistance in meeting basic needs and improving social, family, and environmental functioning. As a research-based comprehensive program model, it requires fidelity to certain program elements to help members with serious and persistent mental illnesses make improvements in their level of functioning in the community, reduce hospitalization, and work toward recovery.

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

PURPOSE:

- To reduce psychiatric hospitalization for members with serious and persistent mental illnesses
- To provide the primary clinical relationship with the member and natural support system, teaching members about their symptoms so as to maximize their functioning and independence in the community
- To improve successful integration into the larger community
- To ensure that the member's basic needs and skills for sustaining community living are addressed
- To mobilize the involvement of the member's support network
- To maintain member engagement in treatment
- To engage members in mental health and support services
- To improve members' skills in self-management of their psychiatric illnesses
- To encourage follow through with a mutually agreed service plan oriented to success and satisfaction in the community

MEMBER PARTICIPATION CRITERIA:

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Members with frequent, lengthy, or repeated admissions to inpatient psychiatric treatment facilities who meet one of the following criteria:

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

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

A member must have an eligible diagnosis as determined by BMS' contracted authorization agent and be in an eligible disability group of “Mental Health” or “Mental Health and Substance Abuse”. The Disability group “Mental Health and Mental Retardation/ Developmental Disabilities” is not eligible for ACT.

TERMINATION CRITERIA:

An ACT Team may serve members as long as their needs dictate following authorization/re-authorization of eligibility for ACT services.

- The provider must request a member's removal from eligibility, explaining the reason(s) for discontinuing this service.
- BMS or its designee will review and approve or disapprove the request.
- Providers must continue to provide ACT services until receiving written approval to discontinue them.
- However, if a member consistently refuses to participate within a six-month period, he/she may be placed on an "inactive roster" and may only be reactivated through the prior authorization process. Providers must not bill ACT services for members on an inactive roster.

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

ACT TEAM COMPOSITION AND STAFF QUALIFICATIONS:

The ACT Team must include a multidisciplinary staff mix, including mental health professionals and substance abuse treatment professionals. The team is composed at a minimum of a psychiatrist and five other staff persons. The additional five (minimum) staff composing the ACT Team must include:

- A team leader with a minimum of three years' experience working with the seriously mentally ill and also having two years' supervisory experience. He/she must have a minimum of a Master's degree in Counseling, Social Work, or Psychology and a Master's level license; or must be actively pursuing a Master's level license. A team leader actively pursuing LPC licensure must be under the supervision of an individual with a Master's level license in Counseling, Social Work, or Psychology.
- A registered nurse with a minimum of two years psychiatric experience.

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- A Substance Abuse Specialist with a Master's degree in Counseling, Social Work, or Psychology and a minimum of two years' experience working with substance abuse, or a Certified Addictions Counselor.
- A Vocational Specialist
- The fifth team member is left undefined, as are other team members if the team is composed of more than five persons. All team members may function as case managers. ACT Teams are encouraged to have a member(s) who is otherwise qualified to serve as a team member or consultant to the team.
- The ACT Team must meet daily to review all cases in their caseload.

ROLE OF THE PSYCHIATRIST:

- The psychiatrist must be actively involved with members and the team. He/she must participate in the daily ACT Team meetings, though they may do so by means of tele-video conferencing when unable to be physically present. The psychiatrist and/or Certified Physicians Assistant and/or Certified Nurse Practitioner must physically attend at least one team meeting per week. The psychiatrist must physically participate in the annual service planning session.
- Certified Physicians Assistants, Certified Nurse Practitioners or Clinical Nurse Specialists with psychiatric experience or certification may substitute for the psychiatrist as long as they are under the direct clinical supervision of the psychiatrist (except for his /her required attendance at the annual service planning session), and the psychiatrist evidences direct clinical involvement with the ACT Team and members.
- The psychiatrist, or his/her substitute (as described above), must be actively involved for a minimum of 16 hours per week.

CASELOAD MIX AND RATIOS:

- The certified ACT Team must always have the required minimum staffing.
- The maximum staff/member ratio is 1:10 (i.e., one staff person to ten members, not counting the Psychiatrist, Physician's Assistant, Nurse Practitioner or Clinical Nurse Specialist). **The ACT Team cannot serve non-ACT members**.
- ACT Teams composed of more than five staff persons can serve more members as long as the 1:10 ratio is maintained.
- The maximum number of members served by an approved ACT Team in an urban area is 120, and the maximum number of members served in a rural area is 80.

ACT SERVICE ELEMENTS AND FIDELITY INDICATORS:

The ACT Team is required to directly provide the following combination of case management and rehabilitation services. (A minimum of 75 percent of service must be delivered outside of program offices):

- Assertive outreach
- Sustained effort to engage the member
- Assessment
- Recovery-oriented Individual Service planning and oversight

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- Linkage with a continuum of mental health services, maintaining on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation center
- Member-specific advocacy
- Assistance with securing basic necessities (e.g., food, income, housing, medical and dental care, other social, educational, vocational, and recreational services)
- On-going services to ensure maintenance of living arrangements during periods of institutional care, such as paying the rent and utilities. The member and his/her support system remains responsible for these expenses. The ACT Team ensures these needs are addressed
- Counseling, problem solving, and personal support
- Psychiatric services
- Medication management
- Activities of daily living/community living skills teaching, behavior management, and/or direct assistance
- 24-hour capability, seven days a week, for crisis response for ACT members
- Providing or assisting with obtaining transportation
- Representative payee-ship when needed
- Collaboration with family/personal support network
- Information on advanced psychiatric directives

DOCUMENTATION:

- Authorization from BMS must be maintained in the member's record.
- The record must sufficiently document assessments, service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT Team can identify the member's treatment needs and services rendered. The individualized member service plan must identify the Qualified Team that is providing ACT to the member. The certification of the team and a roster of members assigned to an ACT Team must be available for review. In addition to other service plan requirements, the service plan must identify objectives for ACT and identify the services to be provided under ACT. The service plan must reflect the member's consent for ACT services. Since the acceptance of ACT services represents a major treatment juncture, the ACT Team, including the member, must amend or develop a service plan specifying ACT Team goals, objectives, and activities within 30 days of receiving ACT authorization.
- All staff contacts with members of the ACT team must be documented. Each entry needs to include date and place of the contact, the purpose, content and outcome of the contact, the start and stop times of the contact, and the signature, credentials, and title of the individual providing the service.
- A 90 day documented narrative review is required for each ACT participant. The 90 day review must include a review that summarizes the amount of services provided, progress towards the documented objectives and indicates problems that impeded progress towards meeting objectives, and problems that impede progress.
- Each member's clinical record must be available for review by the member and the guardian, if any.

ACT TEAM CERTIFICATION PROCESS:

- All ACT Teams require approval through the completion of the ACT Team Certification form. The certification form is reviewed and subject to approval by the Bureau for Medical Services and the Bureau of Behavioral Health and Health Facilities. Certification is specific to the individuals in a team,

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the team composition, and qualifications submitted. A provider must apply for certification of each ACT Team. No ACT services may be billed for a member without a certification of the ACT Team.

- All teams must be based at a site listed on the provider's Behavioral Health License. Administrative support must be provided by the parent agency sufficient to meet scheduling and support needs of the ACT Team. Billing may commence after receiving approval from BMS. After initial approval, a site review will be conducted to validate the approval. BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in Chapter 800, Medicaid regulations.
- Variations from the original certification must be submitted with corresponding rationale for changes. When a team member resigns or is no longer associated with the Certified ACT Team, the ACT Team must replace the team member within 30 days of the team member's last day. Specific content is described in the BMS application form for the ACT Certification.

503.10.2 COMPREHENSIVE COMMUNITY SUPPORT SERVICES

PROCEDURE CODE: H2015
SERVICE UNIT: 15 minutes
SERVICE LIMITS: All units must be prior authorized
PAYMENT LIMITS: Comprehensive Community Support services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

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

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

- Health Education - first aid, pedestrian and passenger safety, home safety
- Meal Preparation - nutrition, menu planning, cooking
- Personal Hygiene - grooming, oral and general body care
- Utilization of Community Resources - church groups, clubs, volunteer work, getting and keeping entitlements, learning to access recreational opportunities, Internet and computer skills, etc. [Note:

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Recreational activities themselves (including trips to a mall, activities which may be reinforcement for a behavioral program, and social events) are not billable under this code.]

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

This service has a maximum staff-to-member ratio of one staff person per 12 members when provided at a licensed site; and a maximum staff-to-member ratio of one staff person to eight members when provided in a community setting.

The amount of Comprehensive Community Support provided is individually determined and should not automatically reflect the program's operating hours. Members eligible for Comprehensive Community Support do not meet medical necessity for Day Treatment services.

Comprehensive Community Support services must be based at a site listed on the agency's behavioral health license. Training may occur onsite or in community settings.

DOCUMENTATION:

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

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needs of the member. Additionally, all documentation requirements for Mental Health Service Plan Development (procedure code H0032) must be satisfied.

STAFF QUALIFICATIONS:

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

COMPREHENSIVE COMMUNITY SUPPORT PROGRAM CERTIFICATION PROCESS:

- All Comprehensive Community Support programs require approval through the completion of the Comprehensive Community Support Certification Form. The application is reviewed and subject to approval by the Bureau for Medical Services.
- New Comprehensive Community Support Programs must submit the Comprehensive Community Support Certification Form to BMS for approval. All programs must be based at a site listed on the provider Behavioral Health License. Billing may commence after receiving initial Bureau approval.
- After initial approval, a desk review and/or an onsite review will be conducted to validate the approval. BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per policy contained in Chapter 800, Medicaid regulations.
- Any changes from an original certification must be submitted with corresponding rationale for the changes. Specific content is described in the application for Comprehensive Community Support Certification Form used by BMS.

503.10.3 DAY TREATMENT

PROCEDURE CODE: H2012
SERVICE UNIT: 60 minutes
SERVICE LIMITS: All units must be prior authorized
PAYMENT LIMITS: Day Treatment services are all-inclusive. This service cannot be billed concurrently with any other Behavioral Health Rehabilitation Service.
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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

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Day Treatment Services for adults have a maximum staff-to-member ratio of one staff person per five- to-seven members. For Day Treatment Services for children under age five, the maximum ratio is one staff per four children.

SCOPE OF SERVICES:

Day Treatment Services for adults must be available for five days a week for a minimum of four hours each day. Day Treatment Services for children under the age of five in a group setting must not be utilized to provide therapeutic activities for more than four hours per day or more than four days per week.

SITE OF SERVICES:

Day Treatment Services must only be provided at a site listed on the license issued to the provider. However, off-site training related to the areas of skill development noted below can be incorporated into the program as part of an approved Day Treatment activity. **Activities provided for the purpose of leisure or recreation are not billable services.**

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

Progress on all objectives must be reviewed at 90 day intervals. Any objective that results in no progress (or desired change) after two consecutive 90 day intervals must be discontinued or modified. Examples of skill development areas for adults and adolescents include:

Daily Living Skills

- Consumerism - banking, budgeting, buying, credit, housing insurance
- Health education - first aid, pedestrian and passenger safety, home safety
- Meal preparation - nutrition, menu planning, cooking
- Human sexuality - sexual awareness, contraception, disease prevention
- Personal hygiene - grooming, oral and general body care
- Utilization of community resources - church groups, clubs, volunteer work, etc.
- Basic literacy skills necessary to live in the community - basic reading and computational skills, reading labels, safety signs.

Interpersonal Skills

- Problem solving and goal setting
- Communications - assertiveness, correspondence, initiating conversation, giving and taking compliments and criticism, body language, active listening
- Stress reduction - relaxation techniques, biofeedback, etc.

Leisure and Social Skill Development

- Leisure skill development - assessing leisure interest, assistance in pursuing leisure interest, hobby development, etc.

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- Social skill development - social skill training, presenting opportunities for social interaction

Prevocational Skills

- Teaching non-job specific work skills and work habits
- Job interviewing techniques
- Increasing attention span
- Task developing, etc.

Disability Coping Skills

- Substance Abuse Education - use/abuse, abstinence strategies, relapse prevention, orientation to 12 step programs
- Understanding mental illness - medication usage, course of the illness, symptom prevention

The following guidelines apply to Day Treatment Services provided to young children:

- The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual children.
- These therapeutic activities for young children must promote the following skill acquisitions, include necessary adaptations and modifications, and must be based upon developmentally appropriate practice. These services must also be provided in a way that supports the daily activities and interactions within the family's routine.

Skill acquisitions for Day Treatment Services for young children include, but are not limited to:

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

PROGRAM SUPERVISION REQUIREMENTS:

The Day Treatment program supervisor must meet one of the educational criteria listed in A below <u>and</u> all training and experience requirements listed in B and C.

(A) Educational Criteria

- Licensed Psychologist (or Master's level psychologist under supervision for licensure)
- Licensed Counselor
- Licensed Certified Social Worker
- Licensed Social Worker, with a minimum of a Bachelor's degree
- Registered nurse
- Individual with a Master's or Bachelor's level in education with specialization in a disability group and teaching certification
- Occupational/Recreational or Physical Therapist with appropriate State certification and licensure

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- Certified Addictions Counselor, with minimum of Bachelor's level degree or a Master's level degree in a human services field. They must also have 20 hours of training specific to the target population served (hours and nature of training must be verified and documented)
- Bachelor's level degree in a human services field plus one year of experience in providing Day Treatment Services under the supervision of a qualified staff person

(B) Training

Each qualified staff person must have verified training, experience, and skills specific to the targeted population served by the day treatment program.

(C) Continued Education

All Bachelor's level staff persons are required to obtain 15 hours every two years of continued education relevant to the targeted population served or to the provision of Day Treatment Services.

DOCUMENTATION:

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

DAY TREATMENT PROGRAM CERTIFICATION PROCESS:

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

Any changes from an approved original certification must be submitted with corresponding rationale for the changes. This submission must include a summary of utilization information for the past year. Specific content is listed on the Application for Day Treatment Program Certification used by BMS.

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503.11 CRISIS SERVICES

Crisis services are provided in settings based on a continuum of care, ranging from a less restrictive setting in the home or the community to a more restrictive setting such as residential treatment.

503.11.1 CRISIS INTERVENTION

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

PRIOR AUTHORIZATION: None Required

DEFINITION:

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

DOCUMENTATION:

Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.

A physician/licensed psychologist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow up and whether the treatment plan is to be modified or maintained, the signature and credentials of the physician/licensed psychologist (**in ink**), date of service, and the actual time spent reviewing the documentation by listing the start-and-stop times. The physician/licensed psychologist signature will serve as the order to perform the service.

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

503.11.2 COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

PROCEDURE CODE: H0036
SERVICE UNIT: 15 minutes
SERVICE LIMITS: 288 units per six months by registration
PAYMENT LIMITS: No payment will be made for any other Behavioral Health Rehabilitation Services, except for Targeted Case Management procedure code T1017). Billing for Community Psychiatric Supportive Treatment cannot exceed 48 units in a 24 hour period (midnight to midnight).

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

DEFINITION:

Community Psychiatric Supportive Treatment is an organized program of services designed to ameliorate or stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate crisis episode.) Any member who still requires additional treatment services at the end of the 288 unit external prior authorization service limit must be referred to either higher or lower service intensity as appropriate. This service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

Services are also available to those members who, after assessment and crisis intervention in an outpatient or natural setting, require continued stabilization and who might otherwise require admission to an inpatient setting.

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

Community Psychiatric Supportive Treatment Programs must be available a minimum of three hours a day, seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must be a clinically qualified professional. Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.

The program must have access to a psychiatrist/physician to provide psychiatric evaluations, medication orders, and/or treatment as needed.

(Methadone administration or case management is not covered.)

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

- Billable activities:
  - Structured, staff-directed activities such as therapies and counseling

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- Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
- Time spent in treatment team meetings or staff consultation
- Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
- Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day.

- Non-billable activities:
  - Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television, etc.
  - Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
  - Time in which the member is sleeping, eating, grooming (except as outlined above).

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

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

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

- Daily psychiatric review and examination (for each day the program operates)
- On going psychotropic medication evaluation and administration
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist
- Individual and small group problem solving/support as needed
- Therapeutic activities consistent with the member's readiness, capacities, and the service plan
- Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include an assessment of the antecedent conditions that caused the need for Community Psychiatric Supportive Treatment. Once identified, these conditions must be addressed to the agencies or agents who can modify them
- Psychological/functional evaluations specific to the disability population where appropriate and
- Family intervention must be made available to the families of members as appropriate

Community Psychiatric Supportive Treatment must be provided at a site licensed by the WVDHHR for the delivery of Behavioral Health Rehabilitation Services.

ADMISSION AND CONTINUED STAY CRITERIA FOR EXCEEDING SERVICE LIMITS:

Criteria must be used for both Registration and Prior Authorization determinations.

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

- Psychiatric signs and symptoms
- Danger to self/others
- Medication Management/Active Drug or Alcohol Withdrawal.

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

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

- **PSYCHIATRIC SIGNS AND SYMPTOMS**

  Admission Criteria (Both criteria must be met)

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

  Continued Stay Criteria (One of the three criterions must be met)

  - The psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharge date based on the change in the care plan.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors may be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.
  - Relevant member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but treatment goals have not been reached.

- **DANGER TO SELF/OTHERS**

  Admission Criteria

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

  Continued Care Criteria (One of the three criterion must be met)

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

- **MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL**

  Admission Criteria (Either criterion must be met)

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

  Continued Stay Criteria (One of the three criterions must be met)

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

DOCUMENTATION:

- There must be a permanent clinical record consistent with licensing regulations and agency records/policies for each member-provided Psychiatric Supportive Treatment Service. Items to be included in the clinical record are written orders (for each crisis episode) from the physician/psychiatrist for the Community Psychiatric Supportive Treatment Program, medication orders for each member as indicated, medication administration records when medications are administered, and the member's individualized service plan.
- There must be a daily summary that describes milieu and each separate service provided to the member, member progress relative to objectives in the service plan, the member's status, and their participation in the service. Also included must be the signature of staff providing the service along

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with their credentials, place of service, date of service, and actual time spent providing each individual service by listing their start and stop times.

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

503.12 RESIDENTIAL CHILDREN'S SERVICES

Residential Children's Services are comprehensive programs for those children who, when professionally evaluated, reflect a combination of diagnostic, functional, behavioral, or social support conditions which indicate they must be served in residential settings outside their families, and in some instances outside a regular school setting. Services must include a comprehensive array of treatment/intervention modalities in accordance with the service description for which the provider is certified, and must be clinically appropriate for the type of child population served.

503.12.1 RESIDENTIAL CHILDREN'S SERVICES LEVEL I

PROCEDURE CODE: H0019U1
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized
PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. Many Behavioral Health Services are included in the provision of this service and; therefore, cannot be billed while a child is reflected in the census of a Residential Children's Service setting. The Behavioral Health Services not included in this service which may be billed separately are: Psychological Testing with Interpretation and Report (procedure code 96100), Psychiatric Diagnostic Interview Examination (procedure code 90801), Screening by Licensed Psychologist (procedure code T1023), Mental Health Service Plan Development by Psychologist (procedure code H0032AH), Physician Coordinated Care Oversight Services (procedure code G9008), Behavioral Health Counseling, Professional (procedure codes H0004HO and H0004HOHQ), Pharmacologic Management (procedure code 90862), Crisis Intervention (procedure code H2011), Therapeutic Behavioral Services - Developmental (procedure code H2019HO), and the Transportation Services (procedure codes A0120HE and A0160HE).
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

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Residential Children's Services, Level I is a structured 24-hour therapeutic group care setting that targets youth with a confirmed International Classification of Diseases, 9th Edition, 4th Edition (ICD-9)diagnosis that manifests itself through adjustment difficulties in school, home, and/or community. This level of service is designed for children or youth whose needs can best be met in a community-based setting where the child can remain involved in community-based school and recreational activities. These youths usually can function in public school and in a group residential setting with a minimal amount of supportive services and behavioral interventions. The goal of supportive residential programs is to enable children to overcome their problems to the degree that they may move to a less restrictive community placement or independent living situation.

This service level is appropriate for members:

- Whose relationship with their families or whose family situations, level of development, and social or emotional problems are such that they cannot accept family ties or establish and maintain relationships in a less restrictive environment, or
- Who are in transition from a more intensive form of care

Members in need of this level of service display impaired abilities in the social, communication, or daily living skills domains. Life threatening symptoms are generally absent. They generally are able to interact appropriately in social settings with a minimal amount of adjustment problems. Although they may display emotional problems such as anxiety, depression, avoidance, etc., these are not part of a persistent, long-term pattern nor do they preclude normal social functioning in most school or community settings. Where aggressive acting out behaviors are present, they are not of a degree or at a frequency to require ongoing measures of control (restraint, hospitalization, and chemical interventions) and generally respond to logical/natural consequences and supportive counseling interventions.

PROGRAM REQUIREMENT:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling, Supportive
- Skills Training and Development

These services must be provided in accordance with the minimum standards established by the Bureau for Medical Services in this chapter of the Provider Manual, and with the certification standards established by the WVDHHR for children's group residential services.

This service can only be reimbursed to agencies dually licensed as behavioral health services and as childcare group residential facilities, and only for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 noon, the eight continuous hours must occur

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between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

DOCUMENTATION:

There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.12.2 RESIDENTIAL CHILDREN'S SERVICES LEVEL II

PROCEDURE CODE: H0019U2
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized
PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. Many Behavioral Health Services are included in the provision of this service and; therefore, cannot be billed while a child is reflected in the census of a Residential Children's Service setting. The Behavioral Health Services not included in this service which may be billed separately are: Psychological Testing with Interpretation and Report (procedure code 96100), Psychiatric Diagnostic Interview Examination (procedure code 90801), Mental Health Service Plan Development by Psychologist (procedure code H0032AH), Physician Coordinated Care Oversight Services (procedure code G9008), Pharmacologic Management (procedure code 90862), and the Transportation Services (procedure codes A0120HE and A0160HE).
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Residential Children's Services, Level II is a structured group-care setting targeting youth with a confirmed ICD-9 diagnosis that manifests itself in the form of moderate to severe adjustment difficulties in school, home, and/or community. These youths cannot function in a public school setting without significant psychosocial and psycho-educational support. In the residential care setting they require substantial professional level treatment services and behavioral interventions that normally require a multidisciplinary team. The goals of intermediate residential treatment programs are to develop

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interpersonal skills and remediate social skill deficits and disruptive behavior patterns that preclude living in a less restrictive environment.

Children served at this level are characterized by persistent patterns of disruptive behavior and exhibit disturbances in age-appropriate adaptive functioning and social problem solving. Disturbance in psychological functioning is common and may present some risk of causing harm to themselves or others.

This population generally displays emotional problems and/or persistent behavior patterns challenging enough to preclude socially appropriate functioning in family, school, and community contacts without behavior management and additional structure and support.

Most often the children display multi-agency needs that require interagency planning and interventions including behavioral health, education, child welfare, juvenile justice, and others. In this target population, children display a persistent pattern of challenging behavior that has been present for at least 1 year and is not a reaction to a single precipitating event.

Children in Level II have an ICD-9 diagnosis usually in the disruptive behavior disorders, mood disorders, or in the psychoactive substance use disorder categories. Their social functioning limitations are significant to a degree that they require up to 24 hours of supervision, structure and support upon admission. Generally, they respond well to structure and treatment, and the level of supervision required initially can be gradually withdrawn. From time-to-time, they can present a danger to themselves or others, but this is not a routine issue in treatment.

They possess cognitive capacity and can participate in academic and vocational education, but often require specialized instruction and a modified learning environment within a public or alternative secondary or primary school setting.

PROGRAM REQUIREMENTS:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certifications standards as established by the WVDHHR for children's group residential services.

This service can only be reimbursed to providers who are dually licensed as behavioral health services and childcare facilities and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour

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period.) Since the daily census time starts at 12:00 noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

DOCUMENTATION:

There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.12.3 RESIDENTIAL CHILDREN'S SERVICES LEVEL III

PROCEDURE CODE: H0019U3
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized
PAYMENT LIMITS: Residential Children's Services are limited in age to members under the age of 21. No other Behavioral Health Services, other than Transportation Services (procedure codes A0120HE and A0160HE), can be billed while a child is reflected in the census of a Residential Children's Service setting.
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Residential Children's Services, Level III is a highly-structured, intensively-staffed, 24-hour group care setting targeting youth with a confirmed ICD-9 diagnosis which manifests itself in severe disturbances in conduct and emotions. As a result, they are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment where all planned activities and applied interventions are designed with the goal of stabilizing the child's serious mental condition.

The service plan is implemented in all aspects of the child's daily living routine. The focus of intensive residential treatment is on psycho-social rehabilitation aimed at returning the child to an adequate level of functioning. In the case of children and adolescents, this includes rehabilitation in instances where psychiatric or substance abuse disorders have significantly disrupted the achievement of the expected development level.

This service level is comprised of children who display seriously disordered behaviors with sufficient frequency to be considered an established pattern of long duration, or are so intense that they preclude

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social interaction in school, family, or community environments. Often, they exhibit persistent or unpredictable aggression, serious sexual acting-out behavior, and marked withdrawal and depression. Symptoms of thought disorder are often present. They routinely present a significant danger to themselves or others.

Children in Level III have ICD-9 diagnoses that include major depression, bipolar disorders, post-traumatic stress disorders, other anxiety disorders, thought disorders, and personality disorders. Where the focus of care has been on antisocial and dangerous behavior patterns, an initial diagnosis of Conduct Disorder, Severe may be present. However, in many of these cases, underlying significant psychiatric disturbance will reveal itself during the course of treatment.

Substantial social, academic, and vocational functional limitations are characteristics of the population's behavior pattern, and as a result they require substantial environmental structure and controls including 24-hour awake supervision, verbal crisis response, medical management, chemical interventions, physical restraint, and alternative learning environments. The key element is that these children present behaviors so intense, severe, and unpredictable to be seriously detrimental to their growth, development, welfare, or to the safety of others.

PROGRAM REQUIREMENTS:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services
- Any needed Behavioral Health Service including psychiatric and medication management services
- On-campus schooling

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certification standards established by the DHHR for children's group residential services.

This service can be reimbursed only to providers who are dually licensed to provide behavioral health services and as childcare group residential facilities, and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

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DOCUMENTATION:

There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.

Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.12.4 BEHAVIORAL HEALTH: SHORT-TERM RESIDENTIAL (FOR CHILDREN)

PROCEDURE CODE: H0019U4
SERVICE UNIT: 24 hours
SERVICE LIMITS: One per day - All units must be prior authorized
PAYMENT LIMITS: Short-Term Residential Services are limited in age to members under the age of 21. No payment will be made for any other Behavioral Health Services, except for Targeted Case Management (procedure code T1017) or Transportation Services (procedure codes A0120HE and A0160HE).
PRIOR AUTHORIZATION: Refer to APS Health Care Utilization Management Guidelines.

DEFINITION:

Short-Term Residential is a structured crisis service for children up to age 21 and provided in a community-based, small-group, residential setting. It must be provided in a site licensed as a Children's Emergency Shelter by the WVDHHR. The service is delivered in an environment that is safe, supportive, and therapeutic. The purpose of this service is to provide a supportive environment designed to minimize stress and emotional instability which may have resulted from family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of a child from a failed placement or other current living situation.

Short-Term Residential involves a comprehensive array of supportive and therapeutic services including, but not limited to, individual and small-group counseling, crisis intervention, behavior management, clinical evaluation, service planning, and enhancement of daily living skills

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at 12:00 noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

ADMISSION CRITERIA FOR SHORT-TERM RESIDENTIAL SERVICES:

In order to be eligible to receive Short-Term Residential Services, a child must meet the following criteria: criteria A and A1, or criteria B, or criteria C.

(A) Child is experiencing a crisis due to a mental condition or impairment in functioning due to a problematic family setting. The child may be displaying behaviors and/or impairments ranging from impaired abilities in the social, communication, or daily living skills domains to severe disturbances in conduct and emotion. The crisis results in emotional instability which may be caused by family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of the child from a failed placement or other current living situation.

AND

(A1) Child is in need of 24-hour treatment intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the child's needs based on the documented response to prior treatment and/or intervention.

OR

(B) Child is in need of 24-hour treatment/intervention to prevent hospitalization (e.g., the child engages in self-injurious behavior, but not at a level of severity that would require psychiatric hospitalization, or the child is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).

OR

(C) The child is in need of step-down from a more restrictive level of care as part of a transitional discharge plan (e.g., behaviors/symptoms remain at a level which requires out of home care, but the placement plan has not been fully implemented).

DISCHARGE CRITERIA FOR SHORT-TERM RESIDENTIAL SERVICES:

It is expected that in most cases, a child's Short-term Residential needs will be met within a 30-day period prior to discharge. In order to be discharged, the child must meet one of the following criteria:

- Appropriate placement has been located which meets the child's treatment and care needs as outlined in the service plan.
- The crisis that necessitated placement has abated, and the child has returned to a level of functioning that allows reintegration into a previous care setting.
- The child exhibits new symptoms or maladaptive behaviors that cannot be treated safely and effectively in the Short-term Residential setting and which necessitate more restrictive care (e.g. inpatient).

CRITERIA FOR APPROVAL OF CONTINUED CARE EXTENSIONS IN A SHORT-TERM RESIDENTIAL PROGRAM:

For those cases in which it is considered necessary to continue a child's participation in the program, a physician's order and appropriate justification with related documentation are required. Short-Term Residential Services may be extended beyond 30 days in those cases where appropriate clinical criteria for continued service are met, and the extension has prior authorization approval by BMS' contracted agent. The child must meet one of the following criteria to receive approval for a continued care extension:

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- Symptoms, behaviors or conditions persist at the level documented upon admission and the projected time frame for accessing longer-term placement has not been reached.
- Relevant member and family progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to this level of care have been observed and documented, but treatment goals have not been reached and/or an appropriate level of care is not available.
- It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement but the treatment/placement plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and placement options.
- New symptoms or maladaptive behaviors have appeared which have been incorporated into the service plan and modified the plan of care for the member.
- These new symptoms and maladaptive behaviors may be treated safely in the Short-term Residential setting and a less intensive level of care would not adequately meet the child's needs.

PROGRAM CERTIFICATION:

Short-Term Residential Programs must be approved by the Bureau for Medical Services and the Bureau of Children and Families (BCF). The Behavioral Health Rehabilitation Services provider proposing to provide the services must submit to BMS and BCF a program description which includes: proposed staffing patterns, staff credentials, service locations, operating hours, service components, and a general schedule of Short-term Residential service component activities.

DOCUMENTATION:

There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Short-Term Residential Services and the member's individualized service plan. Documentation must also include:

- Behavioral observations of the child
- There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary.
- Medication administration records.
- Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

503.13 BEHAVIOR MANAGEMENT SERVICES

Behavioral Management Services means specific activities that have been planned and tailored to eliminate inappropriate (maladaptive) behaviors and to increase or develop desired adaptive behaviors for an individual member. These services result from areas of need identified on the member's service plan. Behavior Management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

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503.13.1 THERAPEUTIC BEHAVIORAL SERVICES - DEVELOPMENT

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

DEFINITION:

Therapeutic Behavioral Services - Development includes four major components:

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

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

BEHAVIOR ASSESSMENT COMPONENT

Behavior Assessment is a process of observation, data collection, behavior and skill assessments, and functional analysis that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms, and they must be stated in terms of an objective, quantifiable measurement. Baseline data (quantified measurements which describe the scope and/or frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan.

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

PLAN DEVELOPMENT COMPONENT

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

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

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Protocol, no further Therapeutic Behavioral Services billing must occur unless a new problem behavior is discovered. If this occurs, behavior assessment on the new behavior must follow, and the process should start anew.

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

IMPLEMENTATION TRAINING COMPONENT

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

DATA ANALYSIS AND REVIEW COMPONENT

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

STAFF QUALIFICATION REQUIREMENTS

- The Behavior Management Specialist must be an individual with a minimum education at the master's level. This individual's graduate training must have included successful completion of course work and practical experience in the techniques of applied behavior analysis. The Behavior Management Specialist is responsible for all aspects of Behavior Management Services provided by Behavior Management Assistants and must sign all documentation of those services
- The Behavior Management Assistant must be an individual with a minimum education of a bachelor's degree in a human services field who has been certified by the agency as having training specific to behavior management which is consistent with techniques of applied behavior analysis. Behavior Management Services provided by Behavior Management Assistants are subject to review and approval by the Behavior Management Specialist. A copy of the provider's training program for its Behavioral Health Assistant staff must be retained and filed by the provider. (The Behavior Management Assistant must use the HO modifier when providing Therapeutic Behavioral Services –

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Development, procedure code H2019HO, since their documentation must be reviewed and signed by the Behavior Management Specialist. Otherwise, the wrong service, Therapeutic Behavioral Services – Implementation, procedure code H2019, would be billed.)

DOCUMENTATION REQUIREMENTS:

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

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

STANDARD ACTIVITY NOTES DOCUMENTATION REQUIREMENTS

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

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

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

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

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

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

Activity notes for **Implementation Training** must document the training of implementation staff (and/or unpaid support staff) as defined by the plan, the definitions of the behavior(s) targeted for change, and

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the specific steps necessary for implementation of the plan. It must also include the standard activity notes documentation requirements.

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

BEHAVIOR MANAGEMENT PLAN DOCUMENTATION REQUIREMENTS

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

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

BEHAVIOR PROTOCOL DOCUMENTATION REQUIREMENTS

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

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

BEHAVIOR MANAGEMENT MAINTENANCE PLAN DOCUMENTATION REQUIREMENTS

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

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

503.13.2 THERAPEUTIC BEHAVIORAL SERVICES - IMPLEMENTATION

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

DEFINITION:

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

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

DOCUMENTATION:

Documentation is required to be in the main clinical record and be available for review. This must contain documentation that occurs as services are being provided (or within a daily period). This must include the place of service, date of service, intervention used (which is individualized to meet the needs of the

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member), methods, measurements, delivery of service, signature of implementing staff (with credential initials), and the actual time spent by listing the start and stop times.

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

503.14 TRANSPORTATION SERVICES

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

503.14.1 NON-EMERGENCY TRANSPORTATION BY MINIBUS

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

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

DOCUMENTATION:

Documentation must contain an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, date of service, number of units documented, and actual time spent providing the service by listing the start-and-stop times.

503.14.2 NON-EMERGENCY TRANSPORTATION: PER MILE

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

Non-emergency Transportation: Per Mile is a service in which the member's transportation by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the

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transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members. Mileage can only be calculated using the shortest, most direct route between the member's place of departure and destination. This code cannot be billed by provider staff unless a member is present in the vehicle.

DOCUMENTATION:

Documentation must consist of an activity note describing the purpose for the transport, signed by the providing staff (along with their credentials), type of vehicle used for the transport, place of departure and arrival, actual billable mileage, date of service, and actual time spent providing the service by listing the start-and-stop times.

503.15 SERVICE LIMITATIONS

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

503.16 SERVICE EXCLUSIONS

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

- Telephone consultations
- Missed appointments
- Time spent in preparation of reports
- A copy of medical report when the agency paid for the original service
- Experimental services or drugs
- Methadone administration or management
- Any activity provided for the purpose of leisure or recreation
- Services rendered outside the scope of a provider's license.

503.17 ROUNDING UNITS OF SERVICE

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

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

- Only whole units of service may be billed.

503.18 REGISTRATION/PRIOR AUTHORIZATION

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

503.18.1 REGISTRATION/PRIOR AUTHORIZATION PROCEDURES

- The Bureau for Medical Services requires that providers register and/or prior authorize **all** Behavioral Health Rehabilitation Services described in this manual (with the exception of General Medication "J" codes, procedure codes J1630, J1631, J2680, J3230, J2794,, and J3310; and Transportation Services, procedure codes A0120HE and A0160HE) with BMS' contracted agent.
- Registration and prior authorization must be obtained from BMS' contracted agent.
- General information on registration requirements, prior authorization requirements for additional services, and contact information for submitting a request may be obtained by contacting BMS' contracted agent.

503.18.2 PRIOR AUTHORIZATION REQUIREMENTS

- Registration and prior authorization requests for Behavioral Health Rehabilitation Services must be submitted within the timelines required by BMS' contracted agent.
- Registration and prior authorization requests must be submitted in a manner specified by BMS' contracted agent.
- Intensive outpatient services for targeted populations are approved by the Administrative Services Organization (ASO) contractor. Approval of Intensive Outpatient Programs (IOP) and prior authorization for members admitted to the IOP must be obtained by contacting BMS' contracted agent. The nature of an intensive outpatient level of care involves an intensive level of service on a frequent basis for a limited period of time. The only services which the contracted agent will consider for inclusion in an IOP are Behavioral Health Counseling Services (procedure codes H0004, H0004HQ, H0004HO, and H0004HOHQ).

503.19 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

- Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, General Provider Participation Requirements and Chapter 800, General Administration of the Provider Manual.
- Providers of Behavioral Health Rehabilitation Services must comply, at a minimum, with the following documentation requirements:
  - Providers must maintain a specific record for all services received for each WV Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number,

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pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times.
  - All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
  - Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

- Providers of Behavioral Health Rehabilitation Services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

503.20 BILLING PROCEDURES

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

503.21 PROGRAM OF SERVICE REQUIREMENTS

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

- Assertive Community Treatment
- Comprehensive Community Support Services
- Day Treatment
- Residential Children's Services

503.22 PERSONAL CARE SERVICES AND THEIR RELATIONSHIP TO BEHAVIORAL HEALTH REHABILITATION SERVICES

Personal Care Services are specific medically necessary activities or tasks ordered by a physician which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. While they may be provided by Behavioral Health Rehabilitation staff, Personal Care Services are separate services; and all regulations pertaining to them are located in the Personal Care Services Manual.

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503.23 MANAGED CARE AND ITS RELATIONSHIP TO BEHAVIORAL HEALTH REHABILITATION SERVICES

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

503.24 HOW TO OBTAIN INFORMATION

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

- Attachment A: Initial Application for Assertive Community Treatment Team Form
- Attachment B: Comprehensive Community Support Services Program Certification Form
- Attachment C: Application for Medicaid Day Treatment Certification
- Attachment D: Behavioral Health Clinic/Rehabilitation Services, Authorization for Services

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

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CHAPTER 503
BEHAVIORAL HEALTH REHABILITATION SERVICES
JULY 1, 2004

ATTACHMENT A
INITIAL APPLICATION FOR ASSERTIVE COMMUNITY TREATMENT TEAM FORM
PAGE 1 OF 5

BUREAU FOR MEDICAL SERVICES, POLICY UNITS
350 CAPITOL STREET ROOM 251
CHARLESTON, WEST VIRGINIA 25301

INITIAL APPLICATION FOR ASSERTIVE COMMUNITY TREATMENT TEAM

Please complete the following identifying information for your agency/company for each team.

PROVIDER IDENTIFYING INFORMATION

Field	Response
Name of Provider/Agency Operating the Assertive Community Treatment Team:	
Address of Provider/Agency:	
Provider/Agency Telephone number:	
Provider/Agency Executive Director/CEO:	
Current Medicaid Provider Number for Rehabilitation Services:	
Address from which the Assertive Community Treatment Team Address is operation from:	
Assertive Community Treatment Team Telephone Number/Extension:	
Date of Approved Certificate of Need (if applicable)	
Name & Title of Individual Completing Application:	
Telephone Number - Fax Number - E-Mail (if available) of Individual completing application	Telephone number: Fax number: E- Mail (if available)

ADMISSION - CONTINUING STAY- DISCHARGE CRITERIA

1. ELIGIBILITY CRITERIA:

2. ADMISSION CRITERIA:

3. CONTINUING STAY CRITERIA:

4. DISCHARGE CRITERIA:

ACT TEAM STAFF COMPOSITION

5. STAFF CREDENTIALS:

- Name of Psychiatrist(s):
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist (if utilizing):
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Registered Nurse(s)
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Team Leader/Coordinator:
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Substance Abuse Specialist:
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Vocational Specialist:
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)
- Name of Other Staff
  Attach Educational Background, Licences/Certifications, and Qualifying Work Experience (Resume may be use if it indicates dates of experience for each position held by month/year)

NOTE: A staff member, if credentialed may serve two functions. An example may be a nurse who is also a Certified Addictions Counselor or a Substance Abuse Specialist who is also credentialed as a Vocational Specialist However, there must be full time staff to fulfill the requirement of the 1:10 ratio. There also must be evidence that the team is adequately staffed by credentialed personnel in order to meet the needs of the team.

ACT TEAM KEY STAFF ROLES

2. JOB DESCRIPTION/STAFF ROLES:
   - Attach a job description for each job title associated with the Assertive Community Treatment Team.

PROGRAM ORGANIZATION AND OPERATION

1. Program Hours - Coverage (Address the following)
   - Description of weekday and weekend hours
   - Description of how after hours on-call will be addressed by the team. to cover 24 hours/7 days week
   - Description of how Psychiatrist will be a after hours
2. Service, Intensity and Location (Address the following)
   - Location of Site Assertive Community Treatment Team will base operations
   - Capacity to provide assertive outreach (multiple contacts per week)
   - Capacity to rapidly increase service intensity for an individual when his or her status requires
   - Capacity to provide 75 % of contacts in a non office or non facility based setting
   - Maintaining ongoing involvement with the client during days in environments such as inpatient care, convalescent care facilities, community care hospitals or rehabilitation centers.
3. Program Size (Address the following)
   - Anticipated number of clients to be served by the Assertive Community Treatment Team.
   - Description of Geographical Area to being served by the team
   - Staff/Client Ratio for the following:
     - Psychiatrist (Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist)
     - Nurse
     - Other Staff
4. Staff Communication (Address the following)
   - Client Roster of Active Team Members
   - Description of how the Daily Staff Assignment will be assigned
   - Schedule of Treatment Plan meetings and Treatment Plan Reviews.
   - Description of how the Daily Meeting will be conducted
   - Procedure for ensuring an intensive review of each active client takes place on a weekly basis
5. Service Scope (Description of the following)
   - Case Management
   - Crisis Assessment and Intervention;
   - Symptom Assessment, Management & Supportive Therapy;
   - Provision of Substance Abuse Services
   - Work Related Services
   - Activities of Daily Living
   - Assistance with securing basic necessities
   - Social, Interpersonal Relationships and Leisure Time Skill Training
   - Support Services
   - Education, Support and Consultation to Clients' Families and Other Major Supports
6. Description of how medication will be handled by the team
   - Medication Prescription
   - Administration
   - Monitoring
   - Documentation
7. Staff Supervision

ASSESSMENT - TREATMENT PLANNING - DOCUMENTATION

1. Procedure for conducting Assessments

2. Procedures for Treatment Planning - Treatment Place Reviews.

OTHER DOCUMENTS

Please indicate that copies of the following documents are attached to this application by placing a check or "X" in each of the blanks below:

	A Behavioral Health License that is current and list the site where the Assertive Community Treatment Team will be implemented:
	Emergency (psychiatric/medical) procedures
	Medication management/monitoring as it relates to the Assertive Community Treatment Team.
	Consumer complaint or grievance policy/procedure related to Assertive Community Treatment Team.
	Procedure for responding to inappropriate behavior/aggressive behavior as it relates to the Assertive Community Treatment Team.

CHAPTER 503
BEHAVIORAL HEALTH REHABILITATION SERVICES
JULY 1, 2004

ATTACHMENT B
COMPREHENSIVE COMMUNITY SUPPORT SERVICES
PROGRAM CERTIFICATION FORM

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES, POLICY UNITS
350 CAPITOL STREET ROOM 251
CHARLESTON, WEST VIRGINIA 25301

APPLICATION FOR COMMUNITY FOCUSED TREATMENT PROGRAM CERTIFICATION

Please complete the following identifying information for your agency:

PROVIDER IDENTIFYING INFORMATION

Name of Provider/Agency Operating Community Focused Treatment Program site listed below:

____

Provider/Agency Address:____
____

Provider/Agency Telephone Number: ____

Provider/Agency Executive Director/CEO ____

Current Medicaid Provider Number: ____

Name of Community Focused Treatment Program:_______________________________________

Community Focused Treatment Program Address (at program) ____________________________

____

Community Focused Treatment Program Telephone Number:______________________Extension_____

Name of Community Focused Treatment Program Director _______________________________

Effective Dates of Behavioral Health License: ____

Date of Approved Certificate of Need: ____

Name & Title of Individual Completing Application: ____________________________________

Telephone Number: ___________________________________ Extension ____________________

Fax Number:__________________________ E-Mail (if available) ___________________________

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

■ HOURS OF OPERATION

Hours of Operation: _____ a.m / p.m. to _____ a.m. / p.m.

Days of Operation: M T W Th F S S

(CIRCLE ALL THAT APPLY)

■ PROGRAM CAPACITY

Maximum Number of Consumers who can be served on any day? _________

■ PROGRAM SUMMARY

- **Program Name**
- **Target Population**
- **Program Description**
  - **Programmatic Approaches**
  - **Differences in programmatic approaches to individuals with lower-versus-higher functional impairment**
  - **Address how activities are fashioned to be age appropriate and functional**
  - **Any specialty programmatic emphasis or focus**
- **Admission Criteria**
- **Continuing stay criteria**
- **Discharge Criteria**

MANAGEMENT AND PERSONNEL

1. COMMUNITY FOCUSED TREATMENT PROGRAM DIRECTOR/SUPERVISOR

NAME:____

EDUCATION:
____

____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year):

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for Community Focused treatment program supervisor in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

   Yes_____________ Date of Review____

B. 1. List each staff member used by your center for community focused treatment program services. (If additional space needed refer to attachment B) (HS = High School - GED) (BA= Bachelors) (MA = Masters +)

	Name	Job Title	Highest Degree Obtained	Major Field of Study	Professional License and/-or Certifications	hrs per week in program
	(First only)	job title center utilizes	HS, BA, MA	for post HS only	For post HS only	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						

2. Attach a job description for *each job title* listed in #1 above.

REQUIRED DOCUMENTATION

Please indicate that copies of the following documents are attached to this application by placing a check or "X" in each of the blanks below:

_____ A Behavioral Health License that is current and lists the site(s) where the Community Focused Treatment Program will be implemented;

_____ Consumer complaint or grievance policy/procedure related to Community Focused Treatment Program.

_____ Emergency (psychiatric/medical) procedures;

_____ Procedure for responding to inappropriate behaviors/aggressive behavior;

_____ Medication management/monitoring as it relates to Community Focused Treatment Program

_____

CHAPTER 503
BEHAVIORAL HEALTH REHABILITATION SERVICES
JULY 1, 2004

ATTACHMENT C
APPLICATION FOR MEDICAID DAY TREATMENT CERTIFICATION

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES, POLICY UNITS
350 CAPITOL STREET ROOM 251
CHARLESTON, WEST VIRGINIA 25301

January 10, 2008

APPLICATION FOR MEDICAID DAY TREATMENT CERTIFICATION

Please complete the following identifying information for your agency:

PROVIDER IDENTIFYING INFORMATION

Name of Provider/Agency operating Day-Treatment at site listed below:___________________________

____

Provider/Agency Address:____

____

Current Medicaid Provider Number:____

Name of Day Treatment Program:____

Day Treatment Program Address: ____

____

Effective Dates of B. H. License:__________________________ Date of Approved CON:____________

Name & Title of Individual Completing Application: ____

Telephone Number: _____________________________Extension_________________

Fax Number: ___________________________

PROGRAM DESCRIPTION

A. THIS AGENCY IS APPLYING FOR CERTIFICATION (PLEASE CHECK ALL BOXES THAT APPLY):

□ Initial or New Certification □ Re-certification

□ Clinic Services Day-Treatment Program: □ Rehabilitation Services Day-Treatment Program:

B. TYPES OF POPULATION(S) TO BE SERVED:

An application must be submitted for each day-treatment licensed program site operated by your agency. If your agency is serving more than one population at one site, a separate program activity time grid must be completed for each of the populations checked below.

1. ADULTS WITH:

□ Alcohol/Substance Abuse □ Mental Illness □ Mental Retardation/Developmental Disability

2. CHILDREN WITH:

□ Developmental Delay □ Serious Emotional Disturbances

C. SITE OF OPERATION

Day Treatment Program Site: ____

Address: ____

D. HOURS OF OPERATION

Hours of Operation: ______a.m./p.m. to _____a.m./p.m.

Days of Operation: _M __T__W__T__F__S__S__
(CIRCLE ALL THAT APPLY)

E. PROGRAM CAPACITY

1. In the last month, what was:
   Average Number of Clients Served in Program Per day? _______
2. Maximum Number of Clients who can be Served on Any Day? _______

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

* Difference in programmatic approaches or emphasis on each population served at this site

* Program admission and discharge criteria

* Differences in programmatic approaches to individuals with lower-versus-higher functional impairment

* Any specialty programmatic emphasis or focus

MANAGEMENT AND PERSONNEL

A.

1. DAY-TREATMENT PROGRAM DIRECTOR: Name ______________________________________

   QUALIFICATIONS

   EDUCATION: ____

   ____

   ____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year):

   Date of Experience:

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for day-treatment program director in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

   ____Yes Date of Review___________________________

4. PROGRAM DIRECTOR TIME SCHEDULE:

   A. Please indicate the number of hours per week the program director spends in program management activities, such as staff scheduling, activities planning, service plan review, treatment planning, etc.
   ____________ Program management hours per week

   B. Please indicate the number of hours per week the program director spends carrying out or participating directly with clients in activities listed on weekly grid.

   ____________ Day treatment activities hours per week

B.

1. List each type of staff member by job title used by your agency for day-treatment services.

JOB TITLE	NUMBER OF STAFF IN DAY-TREATMENT WITH THIS TITLE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

2. Attach a job description for each job title listed in #1 above.

3. Attach a weekly schedule for all staff reflected in #1 above.

CLINIC DAY TREATMENT

A. Program Activities: **Population: MR/DD**

Please indicate which of the following activities are carried out in your agency's day-treatment program by checking the appropriate boxes and filling in the staff-to-client ratio for each activity.

			Staff-to-Client Ratios
Self-care skills	☐ Yes	☐ No	____ to ____
Emergency skills	☐ Yes	☐ No	____ to ____
Mobility skills	☐ Yes	☐ No	____ to ____
Nutrition skills	☐ Yes	☐ No	____ to ____
Social skills	☐ Yes	☐ No	____ to ____
Communications/Speech	☐ Yes	☐ No	____ to ____
Physical/occupational therapy reinforcement exercises	☐ Yes	☐ No	____ to ____
Interpersonal skills	☐ Yes	☐ No	____ to ____
Functional community skills	☐ Yes	☐ No	____ to ____
- recognizes emergency/public signs	☐ Yes	☐ No	____ to ____
- money management	☐ Yes	☐ No	____ to ____
- travel training	☐ Yes	☐ No	____ to ____
Volunteering in community setting	☐ Yes	☐ No	____ to ____
Citizenship, rights, and responsibilities	☐ Yes	☐ No	____ to ____
Self-advocacy	☐ Yes	☐ No	____ to ____
Other services	☐ Yes	☐ No	____ to ____
(Specify)____________________________	☐ Yes	☐ No	____ to ____
____________________________	☐ Yes	☐ No	____ to ____
____________________________	☐ Yes	☐ No	____ to ____

B. Weekly Time Grid:

Please complete a weekly time grid which reflects each activity indicated above. If there are overlapping activities which necessitate more than one time grid, please complete however many it takes to reflect all activities noted above. A Weekly Time Grid Form is attached for this purpose.

REHABILITATION SERVICES

DAY TREATMENT

A. Program Activities **Population: Mentally Ill**
Substance Abusers

Please indicate which of the following activities are carried out on your agency's day-treatment program by checking the appropriate boxes and filling in the staff-to-client ratio for each activity:

			Staff-to-Client Ratio
Daily Living Skills			
Consumerism	☐ Yes	☐ No	____ to ____
Health education	☐ Yes	☐ No	____ to ____
Meal preparation	☐ Yes	☐ No	____ to ____
Human sexuality	☐ Yes	☐ No	____ to ____
Personal hygiene	☐ Yes	☐ No	____ to ____
Utilization of community resource agencies	☐ Yes	☐ No	____ to ____
Basic literacy skills	☐ Yes	☐ No	____ to ____
Interpersonal Skills			
Problem-solving and goal-setting	☐ Yes	☐ No	____ to ____
Communications	☐ Yes	☐ No	____ to ____
Stress reduction	☐ Yes	☐ No	____ to ____
Leisure and Social Skill Development			
Leisure skill development	☐ Yes	☐ No	____ to ____
Social skill development	☐ Yes	☐ No	____ to ____
Pre-vocational skills			
Non-job specific work skills/habits	☐ Yes	☐ No	____ to ____
Job interviewing techniques	☐ Yes	☐ No	____ to ____
Increasing attention span	☐ Yes	☐ No	____ to ____
Task developing	☐ Yes	☐ No	____ to ____
Disability Coping Skills			
Substance abuse education	☐ Yes	☐ No	____ to ____
Understanding mental illness	☐ Yes	☐ No	____ to ____

B. Weekly Time Grid

Please complete a weekly time grid which reflects each activity indicated above. If there are overlapping activities which necessitate more than one time grid, please complete however many it takes to reflect all activities noted above. A Weekly Time Grid Form is attached for this purpose.

REQUIRED DOCUMENTATION

Please indicate that copies of the following documents are attached to this application by placing a check or "X" in each of the blanks below:

_____ An approved Certificate of Need (CON) from the Health Care Cost Review Authority (HCCRA) for the specific day-treatment program (CON must be consistent with population agency proposes to serve);

_____ A Behavioral Health license that is current and lists the site(s) where the day-treatment program will be implemented;

_____ Consumer complaint or grievance policy/procedure related to Day Treatment services;

_____ Emergency (psychiatric/medical) procedures;

_____ Procedure for responding to inappropriate behaviors/aggressive behavior;

_____ Medication management as it relates to Day Treatment;

_____ Fire Marshals report.

Chapter 503
Behavioral Health Rehabilitation Services
July 1, 2004

Attachment D
Behavioral health Clinic/Rehabilitation Services,
Authorization for Services
Page 1 of 2

BEHAVIORAL HEALTH REHABILITATION SERVICES
BEHAVIORAL HEALTH CLINIC SERVICES
AUTHORIZATION FOR SERVICES

MEMBER NAME	
MEDICAID NUMBER	
SERVICE INITIATION/ ADMISSION DATE	
DIAGNOSIS (ES)	

☐ **REHABILITATON** The following medical or remedial services have been authorized for the above named individual in order to reduce physical or mental disability and/or to restore functional ability. (Physician or Psychologist)

☐ **CLINIC** The following medical or remedial services have been authorized for the above named individual to provide preventive, diagnostic, therapeutic, or palliative items or services under the direction of a physician – (Physician only)

TYPE OF SERVICES Crisis Intervention, Counseling, Basic Living Skills, Treatment Planning, Mental Health assessment by non-physician, Pharmacological Management, Behavioral Health Counseling, Supportive, Group, Behavioral Health Counseling, Supportive, Behavioral Health Counseling, Professional, Individual, Behavioral Health Counseling, Professional, Group, Individual, Mental Health Comprehensive Medication Services, Psychiatric diagnostic interview examination, Community Psychiatric Supportive Treatment (Crisis Stabilization) , Therapeutic Behavioral Services – Implementation, Therapeutic Behavioral Services – Development, Crisis Intervention, Day TX, Comprehensive Community Support Services,
LIST OF SERVICES AUTHORIZED

I certify that the services for the above-named individual are medically necessary and appropriate. Any change or extension in services above will be authorized in an individualized treatment plan.

Signature of Initiating/Admitting Staff) (valid for 72 hours)	DATE
Signature of Physician/Licensed Psychologist	DATE