CHAPTER 503 LICENSED BEHAVIORAL HEALTH CENTERS (LBHC)

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BACKGROUND

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

This chapter sets forth the BMS requirements for reimbursement of licensed behavioral health center (LBHC) services provided by behavioral health providers to eligible West Virginia Medicaid members.

Chapter 503, Licensed Behavioral Health Center (LBHC) Services replaces policies previously addressed in *Chapter 502, Behavioral Health Clinic Services* and *Chapter 503, Behavioral Health Rehabilitation Services*. Providers must bill the correct provider type for the population to whom they are rendering the services.

West Virginia Medicaid behavioral health clinic services are defined as services that are preventative, diagnostic, therapeutic, or palliative; provided on an outpatient basis, under the direction of a physician, physician assistant (PA), or advance practice registered nurse (APRN), and available to members to address mental illness and/or intellectual disabilities. Services must be provided by a facility, that is not part of a hospital, but is operated to provide medical care on an outpatient basis.

In contrast, West Virginia Medicaid behavioral health rehabilitation services are defined as medical or remedial services, recommended by a physician, physician assistant (PA), APRN, licensed psychologist, licensed professional counselor (LPC), or licensed independent clinical social worker (LICSW), for reducing physical or mental disability, treating those with substance use issues, and restoration of the member to their best functional level. These services may be provided in a variety of locations such as home, community, or a residential program, but are not available within an inpatient setting.

The policies and procedures set forth herein are promulgated as regulations governing the provisions of LBHC services in the Medicaid Program, administered by the West Virginia Department of Human Services (DoHS), under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

The BMS has a joint goal with Medicaid-enrolled providers to ensure effective services are provided to Medicaid members. Medicaid-enrolled providers must give priority to children who have been identified as being in the foster care system, or children that have received service in facility-based or are at risk of being placed in facility-based care. Addressing children's needs must begin at entry and by making these foster children, or children that have been, or children that have received service in facility-based, or are at risk of being placed in facility-based care, a priority, especially with the assessment and treatment stated in Section 503.14 and Section 503.15 of this chapter. Medicaid-enrolled providers must make a good faith effort to complete assessments, evaluations, testing and begin therapeutic services in a timely manner as well as coordinate and communicate with the Bureau for Social Services (BSS), to ensure that information is shared in a timely manner with the BSS, court systems, as well as other entities involved in the care, and treatment process of the foster child while conforming to state and federal confidentiality requirements.

All Medicaid members have the right to freedom of choice when choosing a provider for treatment. A Medicaid member may receive one type of service from one provider and another type of service from a different provider.

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Providers found to be inhibiting freedom of choice to Medicaid members are in violation of Section 1902(a)(23) of Title XIX of the Social Security Act (the Act) and as such risk continued participation for reimbursement as a Medicaid provider.

All Medicaid-enrolled providers must coordinate care if a Medicaid member has different Medicaid services at different sites with other providers to ensure that quality of care is taking place and that safety is at the forefront of the member's treatment. Appropriate releases of information must be signed in the order that Health Insurance Portability and Accountability Act (HIPAA) Compliant and/or 42 CFR part C Coordination of Care takes place.

POLICY

503.1 MEMBER ELIGIBILITY

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

503.2 MEDICAL NECESSITY

All LBHC services covered in this chapter are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis or treatment of an illness;
- Provided for the diagnosis or direct care of an illness;
- Within the standards of good practice;
- Not primarily for the convenience of the member or provider; and
- The most appropriate level of care that can be safely provided.

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

1. Diagnosis (as determined by a physician or licensed psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Service is the appropriate level of care

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

Providers rendering services that require prior authorization, must register with the UMC and receive authorization before rendering such services. Prior authorization does not guarantee payment for services rendered. See Section 503.28, Prior Authorization.

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503.3 PROVIDER ENROLLMENT

To participate in the West Virginia Medicaid Program and receive reimbursement from the BMS, providers of LBHC services must meet all enrollment criteria as described in *Chapter 300, Provider Participation Requirements*. Out-of-state providers must also align with *Chapter 300, Provider Participation Requirements*.

503.3.1 Enrollment Requirements: Agency Administration

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

- Development of written criteria for each specific type of service provided. These criteria must identify the required education, licensure, certification, training, and experience necessary for each staff person to perform each type of service. These criteria must be age and disability specific to populations served as well as ensuring that staff have demonstrated competency to provide the services rendered.
- All documented evidence of credentials, including, but not limited to, university transcripts with raised seal, copies of professional licenses, certificates or documents relating to the completion of training, and letters of reference and supervision 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 no less than annually, in addition, at initiation of employment, as changes to credentials occur, and as licenses or certifications expire. Documentation of the credentials review must be filed in each staff person's personnel file and available for review.

All documented evidence of staff credentials (including university transcripts and/or copies of diplomas, copies of professional licenses, and certificates or documents relating to the completion of training) must be maintained in staff personnel records. It is the responsibility of the provider to ensure that transcripts, diplomas, and certifications are valid. Utilization of a clearinghouse is sufficient for degree confirmation.

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

503.3.2 Enrollment Requirements: Staff Qualifications

Board-approved supervisors may only bill for the four psychologists they are supervising. Board-approved supervisors may not "trade" supervisees for billing Medicaid services.

Documentation, including required licenses; certifications; proof of completion of training; provider contracts; memorandum of understandings; collaborative agreements including those for prescriptive authority, if applicable; proof of psychiatric certification, as applicable; and any other materials substantiating an individual's eligibility to perform as a practitioner, must be kept on file at the facility.

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

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503.4 CRIMINAL BACKGROUND CHECKS

See *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for criminal background check information.

503.5 CLINICAL SUPERVISION

The purpose of clinical supervision is to improve the quality of services for every member while ensuring adherence to West Virginia Medicaid policy; therefore, the provider must have a policy for clinical supervision including guidelines for the responsibilities of the supervisor, credentialing requirements of the supervisor, and the minimum frequency for which supervision must occur.

Each agency shall have a chart demonstrating clinical chain-of-command and responsibility. Each agency shall have a documented process for ensuring all staff are aware of clinical and administrative supervision structure. The clinical supervisor must have an equal or higher degree, or credential, than those they supervise. If a clinical supervisor is responsible for a Medicaid-funded program, the supervisor must be able to demonstrate familiarity with all Medicaid requirements and relevant policy. All evidence indicating qualifications for clinical supervision must be documented. This applies to all LBHC services rendered. The agency must have a documented internal policy of the frequency that clinical supervision takes place with their agency. The clinical supervision should be documented and located in the staff member's file and made available for review at the request of the State or its contractors.

503.6 SERVICE CERTIFICATION REQUIREMENTS

A physician, PA, APRN, licensed psychologist, supervised psychologist, licensed professional counselor, and/or licensed independent clinical social worker must certify the need for behavioral health rehabilitation coordinated services by:

- Signing the "Authorization for Services" form *(see Appendix 503A, Licensed Behavioral Health Center Authorization for Services)* within 72 hours of the member's admission to the program for services and prior to the start of treatment. **If an Initial Service Plan is created on the day of intake, then a 72-hour authorization form is not required. Upon initiation of the Initial Service Plan, the "Licensed Behavioral Health Center Services, and Authorization for Services" form is no longer in effect since it is no longer necessary.** This form, which is filled out by the provider initiating/admitting staff, authorizes the provision of all LBHC services until the development and initiation of the Initial Service Plan. The Initial Service Plan must include all information that is required on the 72-hour authorization form.
- If a Medicaid member is in Focused Care, then a provider cannot bill for a Service Plan and/or Treatment Plan. No 72-hour authorization is required for individuals receiving only focused treatment services.
- For members receiving Coordinated Care, the following is required:
    - Development of the Initial Service Plan within seven days of the initial admission;
    - Development of the Master Service Plan within 30 days of the initial admission;
    - Review and re-evaluation of the service plan at a minimum of every 90 days or sooner if dictated by the members' needs; and
    - Service plans must be developed in a format consistent with the type of service received.

If any LBHC services are rendered outside the documentation requirements of the forms which authorize services, the services provided are not billable.

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503.7 METHODS OF VERIFYING BUREAU FOR MEDICAL SERVICES REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that have been reviewed and approved by the BMS. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 800, Program Integrity* of the Provider Manual and are subject to review by state and federal auditors.

503.8 LICENSED BEHAVIORAL HEALTH CENTER SERVICE PROVIDER REVIEWS

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

The contracted agent performs on-site and desk documentation provider reviews, virtual/electronic off-site reviews, and face-to-face member/legal representative, and staff interviews to validate documentation and address Center for Medicare and Medicaid Services (CMS) quality assurance standards. Targeted, on-site LBHC services and substance use disorder provider reviews, and/or desk reviews may be conducted by OHFLAC and/or the contracted agent upon receipt of, including, but not limited to, Incident Management Reports, complaint data, and Plan of Corrections (POC).

Upon completion of each provider review, the contracted agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the contracted agent will make available to the provider a draft exit report and a POC to be completed by the LBHC services provider. If potential disallowances are identified, the LBHC services provider will have 30 calendar days from receipt of the draft exit report to send comments back to the contracted agent. After the 30-day comment period has ended, the BMS will review the draft exit report and any comments submitted by the LBHC services provider and issue a final report to the LBHC services provider's executive director. The Final Report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of LBHC services.

A Cover Letter to the LBHC services provider's executive director will outline the following options to effectuate repayment:

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

If the provider disagrees with the final report, the provider may request a document/desk review within 30 days of receipt of the Final Report pursuant to the procedures in *Chapter 800, Program Integrity* of the BMS Provider Manual. The LBHC services provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention.

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The letter must be addressed to the following:

Commissioner
Bureau for Medical Services
Attn: Legal Department/Document Desk Review
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the contracted agent review, then the LBHC services provider will receive a final letter and a final report from the BMS.

For information relating to additional audits that may be conducted for services contained in this chapter, please see *Chapter 800, Program Integrity* which identifies other state/federal auditing bodies and related procedures.

POC

In addition to the draft Exit Report sent to the LBHC services provider, the contracted agent will also send a draft POC electronically. LBHC services providers are required to complete the POC and electronically submit it to the contracted agent for approval within 30 calendar days of receipt of the draft POC from the contracted agent. The BMS may place a pay hold on claims if an approved POC is not received by the contracted agent within the specified time frame. The POC must include the following:

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

The BMS may place a hold on payment of claims if required follow-up is not completed within the specified time frame, or if the provider does not meet the review requirements.

503.9 TRAINING AND TECHNICAL ASSISTANCE

The contracted agent develops and conducts training for providers and other interested parties, approved by the BMS, as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based methods.

503.10 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must ensure implementation of the BMS policies and procedures pertaining to service planning, documentation, and case record review.

- Uniform guidelines for case record organization must 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. If not readily accessible, this could be cause for disallowment.
- Copies of completed release of information forms and consent forms must be filed in the case record.
- Copied or boilerplate language in documentation will not be reviewed and will cause disallowment.
- Records must contain completed member identifying information. The members' Individual Plan of Service must contain service goals and objectives which are derived from a comprehensive member assessment,

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and must stipulate the planned service activities and how they will assist in goal attainment. Discharge Reports must be filed upon case closure.

- Records must be legible. Illegible documentation will result in disallowment.
- Overlapping times will result in disallowment.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.
- If requested, the providers must provide copies of Medicaid members' records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review process.
- A point-of-contact must be provided by the provider throughout the Comprehensive Retrospective Review process.
- In addition to the documentation requirements described in this chapter, LBHC services providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information* and *Chapter 300, Provider Participation Requirements* of the Provider Manual.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Services provided via telehealth or any other modality other than face-to-face must align with requirements in *Chapter 519.17, Telehealth Services*.
- Medicaid will reimburse according to the fee schedule for services provided.
- All documentation must be identified by its Medicaid code and/or descriptor.

503.11 FOCUSED AND COORDINATED CARE SERVICES

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

Focused Care: Members receiving focused services have been determined to have a behavioral health disorder which may be addressed through the provision of low frequency (generally a maximum of once per week, ranging as rarely as once every six months) professional treatment services. Services are provided by a behavioral health professional with at minimum a master's degree in a behavioral health service field, excluding mental health assessment by a non-physician (H0031). The treatment team consists of the professional and the member and/or member's designated legal representative who together establish a treatment strategy which is documented in the member's record. The treatment strategy is a flexible tool guiding treatment which may consist of one or more of the following Medicaid services:

- Medical office services (billed as Evaluation and Management (E&M) codes);
- Professional individual therapy
- Professional group therapy
- Assessment and screening codes

The treatment strategy must lead to a solution of the presenting problem, based on the clinical picture/assessed need, substantiated symptoms and level of functioning and outline the issues to be addressed in the identified service. The treatment strategy may be a separate document, dated and signed by the clinician, or imbedded

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within the first treatment note. The treatment strategy must relate directly to the behavioral health condition(s) identified as being medically necessary to treat. Documentation of ongoing therapeutic and/or medication management contacts must relate directly to the treatment strategy.

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

Documentation consists of a comprehensive service plan. When the member enters the service, an initial plan is developed which dictates care until the Master Service Plan can be developed. An initial plan must be completed within seven days. The Initial and Master Service Plan must be inclusive of all services the member is intended to receive during the treatment period. Those services that are time-limited and of high intensity may require an initial plan immediately upon admission that is then adapted as the member moves through levels of care. Services that are projected to be of unlimited or extended duration are expected to include development of a master service plan within 30 days that describes specific objectives to be achieved during treatment, stated in observable and/or measurable terms. The Master Service Plan must address integration and coordination of various entities and programs providing services to the member. Ongoing documentation must reflect the team's ability to communicate issues of concern, member progress, and barriers to treatment. Services falling under coordinated care may include, but are not limited to, the following:

- Assertive community treatment
- Professional individual and/or group therapy
- Crisis stabilization and detoxification services
- Targeted case management
- Comprehensive community support services
- Basic living skills
- Intensive service programs
- Supportive counseling
- Professional therapy and medication management provided in the context of the coordinated care services
- Residential care for children and youth
- Emergency shelter care
- Day treatment

503.12 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services via telehealth to allow easier access to services for West Virginia Medicaid members. Services provided via telehealth must align with requirements in *Chapter 519.17, Telehealth Services*. Services in this manual are identified as either "Available" or "Not Available" for telehealth and providers must document when services are rendered under this modality and bill the appropriate service code.

503.13 DOCUMENTATION

The BMS recognizes that some providers use an electronic system to create and store documentation while other

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providers choose to use a hard copy-based system, the BMS will accept both types of documentation. Each service code in this chapter describes the required documentation. All requirements must be met no matter the modality of system choice. If the provider uses an electronic based system, a date and time-based stamp must be on documentation to ensure integrity of the document. The system choice must be a valid Electronic Medical Record with password protection.

Documentation of services that include boilerplate, non-specific, and/or non-individualized language is prohibited. All documentation must be identified by its Medicaid code and/or descriptor.

503.14 ASSESSMENT SERVICES

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

503.14.1 Mental Health Assessment by Non-Physician

Procedure Code: H0031
Service Unit: Event
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.

Service Limits: Four per calendar year. Maximum of four per year for members with complex behavioral healthcare needs (Coordinated Care) and two per year per member with relatively simple behavioral healthcare needs (Focused Care). The provider may request more units if a critical treatment juncture arises, however not until all current authorizations for H0031 are expired/utilized. The provider may request authorization to conduct one global/annual assessment per year to reaffirm medical necessity and the need for continued care/services. Change of payer source does not justify H0031. The assessment must be included in the individual's clinical record within 15 calendar days. Use of the AJ modifier is not permitted. H0031 may not be billed for the same initial intake, assessment, or reassessment as 90791 or 90792. H0031 may not be billed for the same initial intake, assessment, or reassessment as T1023HE unless the **H0031** is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation.

Prior Authorization: Required. See Utilization Management Guidelines.

Staff Credentials: Staff must have a minimum of a master's degree, bachelor's degree in the field of human services, or be a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required (See 503.5 Clinical Supervision). Staff must be properly credentialed by the agency's internal credentialing committee.

Definition: Mental health assessment by non-physician is an initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of a member. This code may also be used for special requests of the West Virginia Department of Human Services (DoHS) for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect. The administration and scoring

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of functional assessment instruments necessary to determine medical necessity and level of care are included in this service. **The H0031, 90791, or 90792 must be completed prior to rendering any behavioral health services.**

Approved Causes for Utilization:

1. Intake/initial evaluation;
2. Alteration in level of care with the exception of individuals being stepped down related to function of their behavioral Health condition to a lesser level of care;
3. Critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or the designated legal representative (DLR) and may cause a revision of the service plan;
4. Readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services;
5. No one under the age of three will have a H0031 conducted on them. A Medicaid member under the age of the three should be referred to the Birth-to-Three Program. If the child is aging out of the Birth-to-Three Program, an assessment allowing a smooth transition into other medically necessary behavioral health services may be conducted.

The H0031 service must not be conducted if it is not intended to provide behavioral health services, i.e., 1915 C Waivers or E&M codes only.

Documentation:

1. Initial/intake (may include use of standardized screening tools):
   A. Demographic data (name, age, date of birth, etc.);
   B. Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations);
   C. Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission;
   D. Impact of presenting symptoms on current level of functioning which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning;
   E. History of behavioral health and health treatment (recent and remote);
   F. History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.;
   G. Medical problems and medications currently prescribed;
   H. Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any;
   I. Analysis of available social support system at present;
   J. Mental status examination; The Mental Status Exam, for which a member must be present, must include the following elements:
      - Appearance
      - Behavior

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- Attitude
- Level of consciousness
- Orientation
- Speech
- Mood and affect
- Thought process/form and thought content
- Suicidality and homicidality
- Insight and judgment

K. Recommended treatment including referrals (initial);
L. Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice);
M. Place of evaluation, date of evaluation, start and stop times, signature and credentials of evaluator;
N. Efficacy of and compliance with past treatment. (If past treatment is reported);
O. Past treatment history and medication compliance and efficacy (If past treatment is reported); and
P. Completed Screening, Brief Intervention, and Referral to Treatment (SBIRT) assessment for ages 10 and older.

2. Re-assessment:
   A. Date of last comprehensive assessment;
   B. Current demographic data;
   C. Reason for re-assessment, including description of current presenting problems. Must document medical necessity for evaluation. If the re-evaluation is a global annual assessment, it must be labeled as such;
   D. Changes in situation, behavior, and functioning since prior evaluation;
   E. Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment;
   F. Mental status examination;
   G. Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge;
   H. Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional within seven days of service date; and
   I. Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.

503.14.2 Psychiatric Diagnostic Evaluation (No Medical Services)

Procedure Code: 90791
Service Unit: Event (completed evaluation)
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Service Limits: Two events per calendar year. 90791 may not be billed for the same initial intake, assessment, or reassessment as H0031 or 90792.
Prior Authorization: Required. Refer to Utilization Management Guidelines.

Staff Credentials: Must be performed by a Physician, PA, APRN, licensed independent clinical social worker (LICSW), licensed professional counselor (LPC), West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists, or a supervised psychologist who is supervised by a Board-approved supervisor.

Definition: An integrated biopsychosocial assessment, including history, mental status, and recommendations.

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The evaluation may include communication with family or other sources and reviewing and ordering of diagnostic studies.

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

- Date and location of service
- Start-and-stop times
- Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendation)
- Purpose of evaluation
- Psychiatrist's/psychologist's signature with credentials
- Presenting problem
- History of the presenting illness, including intensity, duration, and frequency of symptoms
- Current and past medication efficacy and compliance
- Completed SBIRT Assessment for ages 10 and older
- Psychiatric history up to present day
- Medical history related to behavioral health condition
- Mental Status Exam, for which the member must be present, must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Diagnosis per current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) methodology and rationale for diagnosis
- Prognosis for treatment and rationale for prognosis
- Appropriate recommendations including referrals consistent with the findings of the evaluation

503.14.3 Psychiatric Diagnostic Evaluation with Medical Services (Includes Prescribing of Medications)

Procedure Code: 90792
Service Unit: Event (completed evaluation)
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Service Limits: Two events per calendar year
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Must be completed by a physician or a physician extender, PA, or APRN.

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication

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with family and other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

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

- Date and location of service
- Start and stop times
- Medically Necessary Purpose Statement (i.e., indicates a known or suspected behavioral health condition requiring an assessment to determine diagnosis(es) and treatment recommendations)
- Purpose of the evaluation
- Psychiatrist's signature with credentials
- Documentation that Medicaid member was present for the evaluation
- Documentation that medical evaluation, including a review of systems (sleep, appetite, pain levels, and other systems directly linked to the member psychiatric symptoms), was completed
- Presenting problem
- History of the presenting illness, including intensity, duration and frequency of symptoms
- Current and past medication includes efficacy and compliance
- Completed SBIRT Assessment for ages 10 and older
- Psychiatric history up to present day
- Medical history related to behavioral health condition
- Mental Status Exam, for which the member must be present, must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Medicaid member's diagnosis per current DSM and ICD methodology and rationale for diagnosis
- Medicaid member's prognosis for treatment and rationale for prognosis
- Appropriate recommendations including referrals consistent with the findings of the evaluation

503.14.4 Screening by Licensed Psychologist

Procedure Code: T1023 HE
Service Unit: Event (completed evaluation)
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Service Limits: One event every six months per calendar year
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists or a supervised psychologist who is supervised by a Board-approved supervisor.

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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 code 90791 must be used when a more in-depth assessment is indicated.

Medically necessary purpose statement must demonstrate the need for differential diagnosis and/or treatment recommendations rendered by a psychologist. If this is completed after a H0031 and/or 90791, documentation must demonstrate the additional symptomology and functional deficits assessed during this service that was not obtained in previous assessments. This service must not be completed for the following reasons:

- Involuntary hospitalization process;
- On a routine basis to co-sign the H0031, or
- To render a diagnosis after completion of other assessments unless there is documented evidence of the need for differential diagnosis by a psychologist.

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

- Date, location, and start/stop times of service
- Purpose of evaluation
- Practitioner signature and credentials
- Appropriate recommendations based on clinical data gathered in the evaluation

503.15 TESTING SERVICES

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

503.15.1 Psychological Testing Evaluation Services by Professional

Procedure Codes:	96130 for the first hour of evaluation; 96131 must be used for each additional hour and may not be billed prior to 96130.
Service Units:	60 minutes
Telehealth:	Not Available
Service Limits:	Must not include Psychometrician/Technician Work; Computer Scoring; Self-Administered Assessments, or Computer Interpretation
Prior Authorization:	Required. Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists or a supervised psychologist who is supervised by a Board-approved supervisor.

Definition: A comprehensive evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to, standard psycho-diagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual are also

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included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations. This code is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously interpreted, completed, and reported technician-and computer-administered tests.

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

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

- Date, location, and start/stop times of service for each test rendered
- Signature with credentials
- Purpose of the evaluation
- Reason for referral
- Presenting problem
- Summary of additional information reviewed relative to the member's presenting problem, including prior treatment and medical history, medications, and/or interviews with the member and/or family
- Documentation that Medicaid member was present for the evaluation
- Results (score and category) and interpretation of the administered tests/evaluations
- Mental Status Exam must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and Affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and Judgment
- Rendering of the diagnosis within the current DSM or ICD methodology
- Recommendations consistent with the findings of administered tests/evaluations

503.15.1.1 Psychological or Neuropsychological Test Administration and Scoring: First 30 Minutes

Procedure Code:	96136
Service Unit:	30 minutes
Telehealth:	Not Available
Prior Authorization:	Required. Refer to Utilization Management Guidelines
Payment Limits:	This code must be billed prior to billing 96137.
Service Exclusions:	Psychometrician/technician work; computer scoring or interpretation; and self-administered assessment

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Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists or a supervised psychologist who is supervised by a Board-approved supervisor.

Definition: Psychological or Neuropsychological test administration and scoring conducted by physicians or other qualified professionals as specified above. This includes two or more tests, conducted using any method, for the first 30 minutes of the test administration and scoring process.

503.15.1.2 Psychological or Neuropsychological Test Administration and Scoring: Additional 30 Minutes

Procedure Code: 96137
Service Unit: 30 minutes
Telehealth: Not Available
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: This code must be used after 96136 is billed and may not be billed prior.
Service Exclusions: Psychometrician/Technician Work; Computer Scoring or Interpretation; and Self-Administered Assessment

Staff Credentials: Must be performed by a West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists or a supervised psychologist who is supervised by a Board-approved supervisor.

Definition: Psychological or neuropsychological test administration and scoring conducted by physicians or other qualified professionals as specified above. This includes two or more tests, conducted using any method, for each additional 30 minutes.

503.15.2 Developmental Testing: Limited

Procedure Code: 96110
Service Unit: Event (completed interpretation and report)
Telehealth: Not Available
Service Limits: Must not include Psychometrician/Technician Work; Computer Scoring; Self-Administered Assessments, or Computer Interpretation
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: This service cannot be billed if Psychological Testing Evaluation Services by Professional (procedure codes 96130, 96131, 96136, and/or 96137 has been billed in the last six months.

Staff Credentials: Must be performed by a physician, PA, APRN, West Virginia licensed psychologist in good standing with the West Virginia Board of Examiners of Psychologists, or a supervised psychologist who is supervised by a Board-approved supervisor.

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

Documentation: Documentation/Report must contain the following and be completed within 15 calendar days

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from the date of service:

- Date, Location, and start/stop times of service for each test rendered
- Signature with credentials
- Purpose of evaluation
- Reason for referral
- Presenting problem
- Summary of additional information reviewed relative to the member's presenting problem, including prior treatment and medical history, medications, and/or interviews with the member and/or family
- Documentation that the member was present for the evaluation
- Results (scores and category) and interpretation of the administered tests/evaluations
- Mental Status Exam, of which a member must be present, must include the following elements:
    - Appearance
    - Behavior
    - Attitude
    - Level of consciousness
    - Orientation
    - Speech
    - Mood and affect
    - Thought process/form and thought content
    - Suicidality and homicidality
    - Insight and judgment
- Rendering of the diagnosis within the current DSM or ICD methodology
- Recommendations consistent with the findings of the administered tests/evaluations

503.16 SERVICE PLANNING REQUIREMENTS

Service planning codes cannot be billed when the development of a service plan is an integral aspect of the service being provided (for example, community psychiatric supportive treatment). Service planning is to be conducted when multiple programs and services need to be coordinated by a team representative of the differing agencies and provider groups providing care to the member.

All members receiving coordinated care must have an active Master Service Plan. The agency may choose to create one plan that is modified as the individual moves through a service or may choose to create an Initial Service Plan followed by a Master Service Plan. Agencies with services with shorter lengths of stay may choose the first option if the length of stay is predicted to be less than 30 days. If an active Master Service Plan does not exist or an updated active Service Plan does not exist, then services that are rendered and reimbursed for may be revoked. The Initial Service Plan must be completed within seven days of admission to a service. The Plan must be completed by the primary clinician and the member and/or member's guardian.

Development of the Initial Plan, without the entire interdisciplinary team, is not a billable service. See Section 503.16.1, Mental Health Service Plan Development for clarification and description of exceptions. The Initial Plan of Service describes the services and/or supports the member is to receive until further exploration of treatment needs is complete and the Master Service Plan is developed. This Initial Plan must consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed.

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- A listing of immediate interventions to be provided along with objectives for the interventions.
- A date for development of a master service plan. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 days from the date of admission. If a program is an intensive service, the Master Service Plan must be completed within seven days; and
- The signature of the member and/or DLR, intake worker, physician, or other approved, licensed clinician, and other persons participating in the development of the initial plan, their credentials, and start/stop times.

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

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

- A statement or statements of the member centered positive and outcome-oriented goal(s) of services in general terms.
- A listing of specific objectives that the service providers and the member hope to achieve or complete. It is expected that objectives be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service.
- The measurable component objectives that provide steps toward achievement of specified outcomes, with realistic dates of achievement specified for each.
- The technique(s) and/or services (intervention) to be used in achieving the objective.
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives and their frequency of intended delivery.
- Discharge criteria that is individualized and measurable relating to service provision.
- A date for review of the plan, timed in consideration of the expected duration of the program/service; and
- A signature page inclusive of credentials, the date, and start/stop times of attendance of all participants in the development of the Plan.

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

503.16.1 Mental Health Service Plan Development

Procedure Code: H0032
Service Unit: 15 minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services.*
Service Limits: 16 units per 90-day period. If member is in focused care, H0032 cannot be billed.
Prior Authorization: Required. Refer Utilization Management Guidelines.

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

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circumstances. A physician or physician extender must participate in service planning to bill for this service under the clinic National Provider Identifier (NPI).

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 at admission and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the members' needs. All service plans (including updates) must be reviewed, signed, and approved by a physician, licensed psychologist, or supervised psychologist, LICSW, LPC, PA, or APRN within 72 hours of the service plan meeting and prior to implementing services.

The Service Plan review must address whether objectives are to be continued, modified, or discontinued; a summary of treatment provided during the period under review, that addresses barriers to progress and identifies whether those barriers are agency or member based.

The physician, PA, APRN, LICSW, LPC, or licensed or supervised psychologist must be present in-person or by telehealth, and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency;
- Have a diagnosis of major psychosis or major affective disorder;
- Have an intellectual/developmental disability (I/DD) diagnosis;
- Have an autism diagnosis;
- Have major medical problems in addition to major psychosis and medications; or
- The presence of the physician, PA, or APRN has been specifically requested by the case manager or the member.

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

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

Individual program plans for day treatment, children's residential services (please refer to *Appendix 503F, Residential Children's 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.

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

Documentation: The following documentation is required for substantiation:

- The Service Plan signature page must include original, dated signatures (with titles and credentials) of all participating members of the treatment team, the member, their guardian, and/or the member's requested representative and must include the actual time all individuals listed participated 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. This document is to be placed in the member's clinical record along with the completed Service Plan or Service Plan update.
- If a staff person from another agency participates in the service planning session, they must also list the agency they are representing on the signature page. Separate documentation must also be included in **their** agency's clinical record in the form of an activity note that states their purpose for participating in the meeting, their signature and credentials, the location, date, and the actual time spent participating in the session by listing their start-and-stop times.

Documentation must contain the physician's, psychologist's, PA's, LICSW's, LPC's, or APRN's dated signature and credential on the completed Service Plan or Service Plan update and the actual time spent providing the service by listing the start-and-stop times of their participation.

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

503.16.2 Mental Health Service Plan Development by Licensed Clinician

Procedure Code: H0032 AH
Service Unit: 15 Minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*
Service Limits: One unit per month
Prior Authorization: Required. Refer to Utilization Management Guidelines

Definition: These are activities performed by a licensed or supervised psychologist, LICSW, or LPC, directly related to service planning: participation in a treatment team meeting or a review and approval of a Service Plan.

Documentation: Documentation must contain the licensed or supervised psychologist's, LICSW, or LPC dated, **original or electronic** signature with credentials on the completed Service Plan or Service Plan update and the actual time spent providing the service by listing the start-and stop times of their participation. If performed by a supervised psychologist, the supervising licensed psychologist must indicate their oversight by also completing this signature requirement within seven days of the date of service.

Documentation of client signature on service plan may be original or electronic. Electronic signatures must meet all HIPAA requirements.

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503.16.3 Physician Coordinated Care Oversight Services

Procedure Code: G9008
Service Unit: 15 Minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*
Service Limits: Two Units per 90 days
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by physician, PA, or APRN

Definition: These are activities performed by a physician, PA, or APRN directly related to service planning: participation in a treatment team meeting or a review and approval of a service plan. See also 503.16.1, Mental Health Service Plan Development.

Documentation: Documentation must contain the physician's, PA's, or APRN's dated signature with credentials, and the actual time spent providing the service by listing the start-and-stop times of their participation.

503.16.4 Case Consultation

Procedure Code: 90887
Service Unit: Event
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*
Service Limits: One unit per 90 days
Prior Authorization: Required. Refer to 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 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 who participated in the current member's service plan within the current 90-day period, or were directed to provide treatment, cannot bill for case consultation.

Only the consulting professional's time may be billed for this service. Any other professional(s) involved in the case consultation may not bill case consultation for their time. The consulting professional whose services are being billed must currently be an enrolled West Virginia Medicaid provider if they are 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 and location of service, signature and credentials of the consulting professional, and the actual time spent providing the service by listing the start-and-stop times of the consultation.

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503.17 THERAPY AND SUPPORTIVE SERVICES

503.17.1 Behavioral Health Counseling, Professional, Individual

Procedure Code: H0004 HO
Service Unit: 15 minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Service Limits: 60 units per year
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Must be performed by a minimum of a master's level therapist using nationally recognized evidence-based therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. May be performed by an alcohol and drug counselor (ADC) with a bachelor's degree in a clinical field, but only when directly addressing substance use disorder treatment issues.

Definition: Behavioral health counseling, professional, and individual, is the treatment of behavioral health conditions in which the qualified healthcare professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. This is a face-to-face medically necessary service provided to the member and/or family member however the member must be present for some or all the service.

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

Documentation: Documentation must indicate how often this service is to be provided. If there is a Master Service Plan, the intervention must be reflective of a goal and/or objective on the Plan. There must be an activity note describing each service/activity provided that includes the following:

- Date, location, and start/stop times of service
- Signature with credentials
- Service code and/or descriptor
- Reason/purpose for the service and relationship of the service to the member's identified behavioral health treatment needs
- Changes in pertinent symptoms and functioning of the member, especially with regard to high-risk factors
- Therapeutic Intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change that is directly related to the diagnosed condition that is the focus of the treatment.
- Individualized member's response to the intervention and/or treatment and
- Plan for continued therapy

503.17.2 Behavioral Health Counseling, Professional, Group

Procedure Code: H0004 HO HQ
Service Unit: 15 minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.

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Service Limits: 50 units per year
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: Maximum of 12 people per group session, regardless of payer source.

Staff Credentials: Must be performed by a minimum of a master's level therapist using nationally recognized evidenced based practices of therapies May be performed by an ADC with a bachelor's degree in a clinical field, but only when directly addressing substance use disorder treatment issues.

Definition: Behavioral health counseling, professional, group is the treatment of behavioral health conditions in which the qualified healthcare professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions. This is a face-to-face medically necessary service provided to the member in a group setting.

Documentation: Documentation must indicate how often this service is to be provided. If there is a Master Service Plan, the intervention must be reflective of a goal and/or objective on the Plan. There must be an activity note describing each service/activity provided that includes the following:

- Date, Location, and start and stop times of service
- Signature with credentials
- Service code and/or descriptor
- Reason/purpose for the service and relationship of the service to the member's identified mental health treatment needs
- Changes in pertinent symptoms and functioning of the member, especially with regard to high-risk factors
- Therapeutic Intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change
- Individualized member's response to the intervention and/or treatment
- Plan for continued therapy
- Group therapy notes must also include group topic

503.17.3 Behavioral Health Counseling, Supportive, Individual

Procedure Code: H0004
Service Unit: 15 minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Individuals providing this service must have a bachelor's degree in a human services field or a high school diploma or Graduate Equivalent Degree (GED) with two years documented experience in mental health and/or substance abuse services. Staff must be properly supervised according to the BMS policy on clinical supervision. The service may be provided in a variety of settings by appropriately designated, trained, and supervised staff. Exclusions include Alcoholics Anonymous or Narcotics Anonymous programs.

Definition: Behavioral health counseling, supportive, individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another behavioral health service to meet service definition and medical necessity; the supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-

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day behavioral and emotional functioning. This is not a professional therapy service but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

Supportive counseling must:

1. Consistently augment other coordinated care services being provided by the agency and, if possible, services being provided to the member by other agencies; and
2. Promote application and generalization of age-appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
3. Assist the individual as they explore newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the Service Plan.

Documentation: Documentation must indicate how often this service is to be provided. This service must be included in the members' Service Plan, be reflective of a goal and/or objective on the Plan and be reviewed at a minimum of each 90 days and at every clinical treatment juncture. There must be an activity note describing each service/activity provided that includes the following:

- Date, location, start/stop times, and the Healthcare Common Procedure Coding System (HCPCS) code and/or descriptor of the service
- Signature with credentials
- Reason/purpose for the service and relationship of the service to the member's identified mental health treatment needs
- Symptoms and functioning of the member, i.e., interval history referencing continuing symptoms and their impact on functional deficits between sessions demonstrated by the member
- Intervention that demonstrates support of another behavioral health service
- Individualized member's response to the intervention and/or treatment Plan for continued treatment
- Plan for continued treatment

503.17.4 Behavioral Health Counseling, Supportive, Group

Procedure Code: H0004 HQ
Service Unit: 15 minutes
Telehealth: Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: Maximum of 12 people per group session, regardless of the payer source.

Staff Credentials: Individuals providing this service must have a bachelor's degree in a human services field or a high school diploma or GED with two years documented experience in mental health and/or substance abuse services. Staff must be properly supervised according to the BMS policy on clinical supervision. The service may be provided in a variety of settings by appropriately designated, trained, and supervised staff.

Definition: Behavioral health counseling, supportive, group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. This is not a professional therapy service but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs. Exclusions include Alcoholics Anonymous or Narcotics Anonymous programs.

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The intervention must be reflective of the goal and/or objective on the Service Plan and must meet all Service Plan requirements. The objectives of the service must be clearly identified and reviewed at a minimum of each 90 days and at every critical treatment juncture.

Supportive counseling must:

1. Consistently augment other coordinated care services being provided by the agency and, if possible, services being provided to the member by other agencies; and
2. Promote application and generalization of age-appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
3. Assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Documentation: Documentation must indicate how often this service is to be provided. This service must be included in the members' Service Plan, be reflective of a goal and/or objective on the Plan and be reviewed at a minimum of each 90 days and at every critical treatment juncture. There must be an activity note describing each service/activity provided that includes the following:

- Date, location, start and stop times, and HCPCS code and/or descriptor of Service
- Signature with credentials
- Reason/purpose for the service and relationship of the service to the member's identified mental health treatment needs
- Symptoms and functioning of the member, i.e., interval history referencing continuing symptoms and their impact on functional deficits between sessions demonstrated by the member
- Intervention that demonstrates support of another behavioral health service
- Individualized member's response to the intervention and/or Treatment Plan for continued treatment
- Plan for continued treatment
- Supportive Group notes must also include group topic

503.17.5 Intensive Outpatient Services

Procedure Codes:	H0004 HO IS	*Behavioral Health Counseling, Professional, Individual*
	H0004 HO HQ IS	*Behavioral Health Counseling, Professional, Group*
	H0004 IS	*Behavioral Health Counseling, Supportive, Individual*
	H0004 HQ IS	*Behavioral Health Counseling, Supportive, Group*
Service Unit:	15 minutes	
Telehealth:	Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.	
Service Limits:	Units are defined by program description	
Prior Authorization:	The number of units approved for this service within a specified time for the approved provider will be authorized when the member meets medical necessity criteria.	
Payment Limits:	Only approved IOS providers. See individual service description limits.	
Staff Credentials:	Please refer to the individual service sections of this chapter.	

Definition: Intensive outpatient services (IOS) are a combination of specific services for a targeted population to be used on a frequent basis for a limited period. Approval for an IOS program and prior authorization for members admitted to an IOS program must be obtained from the BMS or its designee prior to rendering services. If an IOS

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program chooses to close its program down, it must give a 30 calendar days written notice to the BMS prior to closing the program. Services must be rendered according to the latest approved edition of the American Society of Addiction Medicine (ASAM®) criteria for a substance use disorder or co-occurring IOS. IOS programs address mental health and substance use problems and allow for multiple levels of care to be offered which enhance the continuum of services. Revision of program description components allow for greater comparison within levels of care, program evaluation, and identification of multiple funding sources. All IOS programs for children or adolescents, whether new or existing programs, must have an approval letter from the West Virginia Department of Education that is either attached to the application on submission, or filed with the BMS.

Documentation: IOS programs must demonstrate that the program requirements were reviewed with the member prior to the onset of services. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. All services provided within IOS programs must meet the individual service requirements within this chapter. A Master Service Plan, with the entire interdisciplinary team present, must be completed within seven days of admission and meet all requirements set forth in Section 503.16, Service Planning.

To become an approved IOS program, the provider must complete the Intensive Outpatient Services Provider Application in *Appendix 503G, Application for Intensive Outpatient Services*. The provider must be certified to provide IOS Services prior to receiving authorization and payment for services. Intensive Outpatient Services Providers must be recertified by BMS every two years.

503.18 SKILLS TRAINING AND DEVELOPMENT

Procedure Codes:	H2014 U4	Skills Training 1:1 by Paraprofessional
	H2014 U1	Skills Training 1:2-4 by Paraprofessional
	H2014 HN U4	Skills Training 1:1 by Professional
	H2014 HN U1	Skills Training 1:2-4 by Professional
Service Unit:	15 minutes	
Telehealth:	Not Available	
Prior Authorization:	Required. Refer to Utilization Management Guidelines.	

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

The purpose of this service is to provide **therapeutic activities** focused on skills training and development services which are elementary, basic, and fundamental to higher-level skills and are designed to **improve** or **preserve** a member's level of functioning. Therapeutic activities may be provided to a member in their 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; and daily living skills. Rehabilitation Services teach independent living, social, and communication skills to persons) to promote the maximum reduction of behavioral health symptoms and/or restoration of an individual to their best age-appropriate functional level for the purpose of maximizing the person's ability to live independently and function in the community.

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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.

A paraprofessional is defined as an individual with a high school or GED that has received documented training on the target population being served. The paraprofessional must have access to clinical supervisor.
A professional is defined as an individual with a minimum of a master's degree in a human services field.

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 and as specified on the member's individualized Skills Training and Development Plan. These services must also be provided in a way that supports the daily activities and interactions within the family's routine.

Skill acquisitions for skills training and development services for young children include, but are not limited to:

- Adaptive, self-help, safety, and nutritional skills
- Parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
- Interpersonal and communication skills
- Mobility, problem solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills. The skill acquisitions must be related to previously assessed deficits that resulted from severe abuse, neglect, or institutionalization and outlined in the Behavior Support Plan.

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 plan related to the diagnosed behavioral health condition. 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. Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the Initial and/or Master Service Plan of the member. The Skills Training and Development Plan may be incorporated into the Initial or Master Service Plan, or after referencing the service on the Service Plan, or be a separate document created and signed by the professional clinician. The Plan must be signed by the clinicians responsible for implementing the service.

The Plan must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member (e.g., hand over hand, instruction,

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demonstration, practice, independent implementation, mastery). The steps identified must establish a means for measuring achievement of objectives within the specified timeframe. The Plan must establish a realistic timeframe for skill acquisition. If objectives have not been achieved within a realistic timeframe established by the Plan, it must be discontinued or revised.

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 who provided the service. It must not be stored in the main clinical record but must be maintained and be available for review.

503.19 MEDICATION SERVICES

503.19.1 Comprehensive Medication Services: Mental Health

Procedure Code:	H2010
Service Unit:	15 minutes
Telehealth:	Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services*.
Prior Authorization:	Required. Refer to Utilization Management Guidelines
Payment Limits:	This service includes all physician and nurse oversight; therefore, neither community psychiatric support treatment (procedure code H0036), pharmacologic management (E&M Codes), nor any other physician code can be billed on the same day as H2010.

Staff Credentials: Must be performed by a physician, PA, or APRN.

Definition: Comprehensive medication services; Mental health is utilized for Clozaril, Lithium, Depakote case management for face-to-face assessment of medication compliance or efficacy. These services include obtaining the sample for necessary blood work and the laboratory results for a member by appropriate medical staff and subsequent evaluation of the results by the physician, PA, or APRN as necessary for the medical management of the drugs Clozaril, Lithium, and Depakote psychotropic medications which require consistent and intensive monitoring. As this is a physician directed service, a physician, PA, or APRN must be on-site and available for direct service as needed. Members may be served individually or by a group/clinic model.

Members receiving this service are not precluded from receiving other LBHC services on the same day (except for those indicated in this service's definition or "Payment Limits") if the actual time frames do not overlap.

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

503.19.2 Non-Methadone Medication Assisted Treatment

Refer to *Policy 519.22, Mental Health Counseling and Substance Abuse Treatment, Section 519.22.3*.

503.20 COMPREHENSIVE PROGRAMS OF SERVICES

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

503.20.1 Day Treatment

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Procedure Code: H2012
Service Unit: 60 minutes
Telehealth: Not Available
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: Day treatment services are all-inclusive. This service cannot be billed concurrently with any other LBHC service.

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

Day Treatment Program Certification Process: Providers must obtain approval from the BMS to provide day treatment services and to bill the West Virginia Medicaid Program for such services. Providers must complete and submit the Day Treatment Program Certification form to the BMS. Refer to *Appendix 503C, Application for Day Treatment Certification*.

Day treatment services for adults have a maximum staff-to-member ratio of one staff person per five members. They must be available for five days a week for a minimum of four hours each day. If a Day Treatment Program chooses to close its program down, it must give a 30 calendar days written notice to the BMS prior to closing the Program.

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

Day treatment services must only be provided at a site listed on the provider's behavioral health provider license. **Activities provided for leisure or recreations are not billable services.** Day treatment services include activities occurring in a therapeutic environment designed to increase the members' skills in specific areas. These activities may consist of small group activities using training modules or structured developmental exercises which present the opportunities for members to practice, and use developing skills or participate in member meetings designed to develop social skills. The intensity, frequency, and type of Day Treatment activities must be appropriate to the age and functional level of the member.

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

- Self-care skills
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction
- Carryover of physical and/or occupational therapy
- Interpersonal skills instruction
- Functional community skills (such as recognizing emergency and other public signs, money management

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skills, travel training, etc.)
- Volunteering in community service settings
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other services necessary for a member to participate in the community settings of their choice
- **Program Staff Requirements:** The Day Treatment Program supervisor must meet one of the educational criteria in addition to the training and experience criteria listed below:
    - Education Criteria (one of the educational criteria must be met):
        - Licensed psychologist (or master's level psychologist under supervision for licensure)
        - Licensed professional counselor
        - Licensed independent clinical social worker
        - Licensed certified social worker
        - Licensed graduate social worker
        - Licensed social worker with a minimum of a bachelor's degree
        - Registered nurse
        - Master's or bachelor's level in education with a specialization to a disability group and teaching certification
        - Occupational/recreational or physical therapist with appropriate state certification and licensure
        - Certified addiction counselor with minimum of a bachelor's degree
        - Master's degree in a human services field with 20 hours verified of training specific to the target population served
        - Bachelor's degree in a human services field with at least one year of specific experience providing services to the target population served
    - Training Criteria
        - Each qualified staff person must have verified training, experience, and skills specific to the targeted population served by the Day Treatment Program
    - Experience Criteria
        - All bachelor level staff are required to obtain 15 hours every two years of continued education relevant to the targeted population served or the provision of day treatment services
- Staff with a bachelor's degree in a human service field that does not specifically provide training in developmental disabilities services must meet one of the three following criteria:
    - Completion of specific courses relating to developmental disabilities
    - Completion of staff development in-service or classes relating to developmental disabilities
    - Completion of 15 hours every two years of continuing education relating to developmental disabilities
- Paraprofessional staff must have at a minimum, the following qualifications:
    - Be at least 18 years old
    - A high school diploma or GED
    - Be currently certified in Standard First Aid and Adult/Child Cardiopulmonary Resuscitation
    - Successfully completed behavioral health agency training in all the following criteria:
        - Various aspects of developmental disabilities
        - Instructional techniques necessary to achieve objectives of individual's program plans
        - Health related issues
        - Recognition of abuse and neglect
        - Individuals' rights and confidentiality
        - Awareness of, and sensitivity to, family and individual's needs

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- Non-aversive behavior intervention techniques for those providers who are implementing behavior support and intervention plans

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 and credentials of staff providing the service, location, and 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).
- A daily attendance roster listing those members and staff who participate in each ratio. The roster must be signed with credentials 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.
- 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.

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

503.20.2 Comprehensive Community Support Services

Procedure Code: H2015
Service Unit: 15 minutes
Telehealth: Unavailable
Prior Authorization: Required. Refer to Utilization Management Guidelines
Payment Limits: Comprehensive community support services are all-inclusive. This service cannot be billed concurrently with any other LBHC service.

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 members' potential and interests as reflected in the Master Service Plan. The intensity, frequency and type of Comprehensive Community

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Support activities must be appropriate to the age and functional level of the member and individualized to meet their own specific needs and future. Critical skills identified as essential to maintain placement in the community and preventing hospitalization will also be targeted for skill maintenance/enhancement. Examples of skill areas (if the member has the specific need) include:

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

These skill areas must be connected to the behavioral health condition. 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. Other documentation includes:

- A daily attendance roster reflecting all participants (with start-and-stop times of participation specific to each member) must be signed with credentials and dated by all staff that have been providing comprehensive community support services and must list staff start-and-stop times. This 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 and available for review at the community treatment site and 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 related to the behavioral health condition of the member on each objective in the Service Plan being addressed must be noted. Documentation must include the date of service, start-and-stop time spent

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for each specified activity, the location of the service/activity, and the member's response to the activity or level of participation with description. 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 and must include progress toward objectives, problems that impeded progress, and provide a decision to continue the same Plan or adjust the Plan to meet the changing needs of the member. Additionally, all documentation requirements for Mental Health Service Plan development (procedure code H0032) must be satisfied. If a Comprehensive Community Support program chooses to close its program down, it must give a 30 calendar days written notice to the BMS prior to closing the program.

Staff Qualifications: The Comprehensive Community Support Program site must be supervised by an individual with a minimum of a bachelor's degree and documented 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.

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 BMS (See *Chapter 503, Appendix D Comprehensive Community Support Services Program Certification Form*).

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

503.21 CRISIS SERVICES

503.21.1 Crisis Intervention

Procedure Code: H2011
Service Unit: 15 minutes - 16 units per 30 days
Telehealth: Not Available
Prior Authorization: Required. Refer to Utilization Management Guidelines
Staff Credentials: Bachelor's degree in human services with documented training on crisis intervention using nationally recognized evidenced practice.

Definition: Crisis intervention is an unscheduled, direct, face-to-face intervention with a member in need of psychiatric interventions 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

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the situation, stabilize and create a plan as quickly as possible. This service is not intended for use as an emergency response to situations such as members running out of medication or housing problems. Any such activities will be considered inappropriate for billing of this service by the provider.

Documentation: Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the 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, PA, APRN, supervised psychologist, or licensed psychologist LICSW or LPC must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their agreement or needed changes to the 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 practitioner's signature with credentials, and the date of service. The signature will serve as the order to perform the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.

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

Exclusions: The following activities are excluded from being performed through the Crisis Intervention Service Code:

- Response to a domestic violence situation.
- Admission to a Hospital or Crisis Stabilization Unit (CSU).
- Time waiting for transportation or the transportation itself.
- Removal of a minor or an incapacitated adult from an abusive or neglectful household.
- Completion of certification for involuntary commitment.

503.21.2 Community Psychiatric Supportive Treatment

Procedure Code:	H0036
Service Unit:	15 minutes
Telehealth:	Available with POS 02 and POS 10 Codes. Refer to *Chapter 519.17, Telehealth Services* for medical services provided by a physician, PA, or APRN
Service Limits:	288 units per six months
Prior Authorization:	Required. Refer to Utilization Management Guidelines
Payment Limits:	Billing cannot exceed 48 units in a 24-hour period (midnight to midnight) and must be utilized on consecutive days. No payment will be made for any other LBHC service, except for targeted case management (procedure code T1017).

Definition: Community psychiatric supportive treatment also known as the CSU is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time of days in which a person exhibits acute or severe psychiatric signs and symptoms. If the member experiences more than one crisis, each crisis is considered a separate crisis episode. This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services

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immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

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

ASAM® 2.7 Medically Managed Intensive Outpatient services are available to programs that choose to provide services to those who need detoxification before they can stabilize and receive treatment. The staffing requirements remain the same for those programs that choose to render ASAM® Level 2-Withdrawal Management services.

Documentation services shall include progress notes reflecting treatment plan implementation and member's response to treatment; and withdrawal rating scale tables and flow sheets.

Members may continue in ASAM® 2.7 Medically Managed Intensive Outpatient services until one of the following conditions is met: resolution of withdrawal signs and symptoms so that member can be safely managed at a less intensive level or care; withdrawal signs and symptoms have failed to respond to treatment (standardized scoring systems, e.g., Clinical Institute Withdrawal Assessment-Alcohol Revised (CIWA-Ar), have confirmed that signs and symptoms have intensified) such that transfer to a more intensive level of withdrawal management service is needed; or member's inability to complete withdrawal management at ASAM level 2.7 (for example, intense craving or insufficient coping skills to prevent continued use of alcohol, tobacco, and/or other drug use concurrent with the withdrawal management medication) indicates need for more intensive services.

Community Psychiatric Supportive Treatment programs must be available seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite when community psychiatric supportive treatment is provided, one of which must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e., substance abuse, mental health). The other staff must have a licensed practical nurse (LPN) or higher degree in the medical field (See Glossary for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to ensure 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 physician, PA, or APRN to provide psychiatric evaluations and medication orders at all times. This may take place in person or through telehealth modalities. 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. The physician must document the need for the observation as related to the Medicaid member's qualifying behavioral health condition/crisis episode.

Non-billable activities:

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

The following elements are required components of community psychiatric supportive treatment:

- Comprehensive psychiatric evaluation at intake completed within 24 hours of admission to contain documentation of:
    A. Reason for admission/presenting problems: Purpose of evaluation is to assess symptoms to determine need for crisis stabilization services, determine need for changes to medication regimen, and develops an initial plan of care as appropriate.
    B. Presenting problems/reason for the evaluation including list of any collateral interviews conducted
    C. History and description of present illness.
    D. Past psychiatric history including description of any past suicidal or homicidal behavior or threats.
    E. History of alcohol and other substance use including longest period of sobriety, history of prior treatment attempts, and medical risks associated with detoxification as appropriate.
    F. General medical history including list of current medications, current medical providers, and past treatment attempts (may be completed by ancillary staff person).
    G. Developmental, psychosocial, and sociocultural history (may be completed by ancillary staff person).
    H. Occupational and military history (may be completed by ancillary staff person).
    I. Legal history (may be completed by ancillary staff person).
    J. Family history (may be completed by ancillary staff person).
    K. Review of systems (sleep, appetite, pain levels, other systems directly linked to the member's psychiatric symptoms).
    L. Focused physical examination including appearance and vital signs, musculoskeletal review of gait and station and description of any specific physical anomalies and allergies.
    M. Mental status examination including assessment of insight, judgment, and general cognitive functioning.
    N. Assessment of daily functionality and activities of daily living (ADLs) (may be completed by ancillary staff person).
    O. Diagnostic conclusions and prognosis.
    P. Treatment recommendations including clear statement of justification for recommendation for

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admission to the CSU and reasoning for elimination of lesser level of care.

- Daily psychiatric review and examination.
- Ongoing psychotropic medication evaluation and administration.
- Intensive one-on-one supervision, when ordered by a physician/psychiatrist.
- Individual and small group problem solving/support as related to members assessed need and diagnosed condition.
- Therapeutic activities consistent with the members' readiness, capacities, and the Service Plan.
- Disability-specific interdisciplinary team evaluation and service planning before discharge from community psychiatric supportive treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to community psychiatric supportive treatment.
- Psychological/functional evaluations specific to the disability population where appropriate; and
- Family intervention must be made available to the families of members as appropriate Community Psychiatric supportive treatment must be provided at a site licensed by West Virginia DoHS for the delivery of LBHC services.

Admission and Continued Stay Criteria: The criteria for prior authorization to exceed service limits for community psychiatric supportive treatment services are organized around three primary areas that determine the need for this service:

- Acute psychiatric signs and symptoms.
- Danger to self/others.
- Medication management/active drug or alcohol withdrawal.
- There is evidence that the member is using drugs, which have produced a physical dependency as evidenced by clinically significant withdrawal symptoms, which require medical intervention.

Additionally, criteria for continued stay have been devised so that those members who still require community psychiatric supportive treatment services can be authorized to continue services.

To receive or continue to receive community psychiatric supportive treatment services, the following corresponding criteria must be satisfied.

Psychiatric Signs and Symptoms

- **Admission Criteria (both must be met):**
  - The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms. The member may be displaying behaviors and/or impairments ranging from impaired abilities in the daily living skills domains to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability that may be exacerbated by family dysfunction, transient situational disturbance, physical or emotional abuse, failed placement, or other current living situation; and
  - 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 members' needs based on the documented response to prior treatment and/or interventions.
- **Continued Stay Criteria (one of three must be met):**
  - The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A Modified Care Plan must be developed which documents treatment methods and

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projected discharge date based on the Change in the Care Plan.
- New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the Care Plan and modified the discharge date of the member. These new acute psychiatric symptoms and/or maladaptive behaviors can be treated safely in the community psychiatric supportive treatment setting, and a less intensive level of care would not adequately meet the member's needs.
- Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to community psychiatric supportive treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.

Danger To Self/Others

- **Admission Criteria**: The member is in need of an intensive treatment intervention to prevent hospitalization (e.g. the member engages in self-injurious behavior but not at a level of severity that would require inpatient care, the member is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).
- **Continued Care Criteria (one of three must be met):**
  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to community psychiatric supportive treatment have been observed and documented, but symptoms and impairments continue to warrant this level of care.
  - It has been documented that the member has made no progress toward treatment goals, nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the Care Plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the community psychiatric supportive treatment setting, and a less intensive level of care would not adequately meet the member's needs.

Medication Management/Active Drug or Alcohol Withdrawal

- **Admission Criteria (one 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 three must be met):**
  - Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to community psychiatric supportive treatment have been observed and documented, but treatment goals have not been reached.
  - It has been documented that the member has made no progress toward treatment goals, nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the Care Plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options.
  - New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the Care Plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the community psychiatric supportive treatment

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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 completed within 24 hours of admission. If the orders are received verbally, there must be documentation of the verbal order that is signed by the physician within 24 hours. These may be signed electronically with date and time stamp.

Daily documentation:

- Number of treatment hours per day.
- Summary of the member's status – need for continued CSU.
- Member's service participation.
- Symptoms related to the crisis that are being addressed.
- If admitted for detox; vitals and use of nationally recognized withdrawal protocol
- Services provided.
- Individual, Group, and Family Therapy and Individual and Group Supportive Counseling notes, at a minimum, must meet documentation requirements within the service sections of this manual.

The discharge plan should include the following:

- Safety Plan
- Contact information for any referrals that are given for continued services outpatient and or inpatient
- General information on local services available for mental health, substance abuse, and medical services
- Contact Information for member to follow up in case of another crisis episode
- Follow-up goals clearly stated for the member

Note: The provider should do a follow-up contact with the individual one week from the discharge date to work to ensure that appropriate services are in place for the member or if any follow-up referrals need to be given.

503.22 ASSERTIVE COMMUNITY TREATMENT (ACT)

Procedure Code:	H0040
Service Unit:	24 hours
Telehealth:	Available with POS 02 and POS 10 Codes for the following services: Behavioral Health, Supportive, Individual and Group; Behavioral Health Counseling, Professional, Individual and Group; Mental Health Assessment by Non-Physician; Psychiatric Diagnostic Evaluation (no medical services); Psychiatric Diagnostic Evaluation with Medical Services; medication management via E&M codes; and Screening by a Licensed Psychologist. Refer to *Chapter 519.17, Telehealth Services.*
Service Limits:	One per day.
Prior Authorization:	Required. Refer to Utilization Management Guidelines

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Payment Limits: Payment for assertive community treatment (ACT) services is all-inclusive. *POS 02 and POS 10 codes do not need to be billed when Telehealth is utilized, but documentation must reflect that Telehealth was utilized.

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

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, to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have cooccurring conditions including mental health and substance use or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment.

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

Only qualified teams, certified by the Bureau for Behavioral Health (BBH) and the BMS, may provide ACT services. Following initial approval, the team certification must be renewed at Bureau-designated intervals.
Purpose: ACT is a service designed to achieve the following treatment goals:

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

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

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

The BMS 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 arrests or incarceration, or members with co-occurring mental illness and substance use disorder who require consistent monitoring).

A member must have an eligible diagnosis as determined by the UMC and be in an eligible disability group of serious and persistent mental health disorders or co-occurring mental health and substance use disorders or co-occurring mental health disorders and mild intellectual disability as defined in the most current DSM.

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

If an ACT team has less than 50 members the staff may be utilized for other services outside of the ACT program.

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

1. One team leader/supervisor with three years of documented experience in behavioral health services, two of which must be in a supervisory capacity, and a master's degree, and a valid master's level West Virginia license in counseling, social work, psychology, or as a supervised psychologist. A registered nurse may serve as a team leader if the team has additional registered nurse staff equivalent to one full-time employee;
2. One registered nurse with one year of psychiatric experience;
3. Two staff with a master's degree in counseling, social work, or psychology and two years of experience in behavioral health services. At least one of these individuals must have experience in substance use assessment/treatment and/or vocational rehabilitation; and
4. One staff member with a bachelor's degree in social work or an alternative behavioral science, with one year of behavioral health experience.

ACT Weekend and Holiday Requirements: Staff working as weekend and holiday coverage may be on a rotating basis. Staff must be sufficient to meet ACT members' needs including, but not limited to, medication delivery, crisis response via phone or face-to-face, therapeutic services to promote stability. The ACT staff individual on call must review each member with the ACT team leader or the team leader's designee, which must be a master's level staff or registered nurse on the certified ACT team each weekend day and holiday. The physician, PA, or APRN must be accessible for medication adjustments or any issues that arise that would indicate the need for a physician, PA, or APRN to be involved. Daily Logs need to include signatures with credentials, start/stop times of all team members that were available on weekends and holidays. It must also be noted if the team member participated in person or via telehealth.

Role of The Physician: The physician must be actively involved with members and the team. They must participate in the daily ACT team meetings, though they may do so by means of telehealth. A suitably trained and experienced APRN or PA under the direct supervision of the team physician may participate on the team in lieu of

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the physician; however, the substitution on team meetings must be documented. The physician, PA, or APRN must attend at least one team meeting per week.

The physician must participate in the annual service planning session and must demonstrate direct and on-going involvement with the ACT team and ACT members.

The physician, PA, or APRN must be actively involved with the team and the members for a minimum of 16 hours per week.

Caseload Mix and Ratios: The certified ACT team must always have the required minimum staffing unless approval is obtained from the BMS to operate the team in the absence of a member. The maximum number of members served by an approved ACT Team is 120. The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the physician, PA, or APRN when the number of ACT members served by the team exceeds 50).

ACT Service Elements: ACT is a recovery-oriented program**.** "Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential (SAMHSA, 2012)." The ACT team is required to directly provide the following combination of case management and rehabilitation services:

- Assertive outreach designed to identify and engage individuals that meet clinical guidelines and could benefit from the program;
- Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities to facilitate more integrated and successful community living;
- Comprehensive and appropriate assessment of medical, environmental, and social needs;
- Maintenance of on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation centers to assist in transition back to a community placement;
- Member-specific advocacy;
- Assistance with securing necessities (e.g., food, income, safe and stable housing, medical and dental care, other social, educational, vocational, and recreational services);
- Facilitation of maintenance of living arrangements during periods of institutional care. The member and his/her support system remain responsible for these expenses;
- Counseling, problem solving, and personal support;
- Psychiatric services and medication management;
- Assistance in obtaining necessary primary care services;
- Facilitation and improvement of daily living/community living skills;
- Behavior management as necessary and appropriate;
- 24-hour crisis response for ACT members;
- Transportation or facilitation of transportation to necessary community and Medicaid services as specified on the Treatment Plan;
- Representative payee-ship or facilitation of representative payee-ship when needed;
- Collaboration with family/personal support network; and
- Assistance with preparation of advanced psychiatric directives.

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

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ACT fidelity indicators:

- The team works with a small caseload (10 to one preferred when caseloads exceed 50);
- The team is cooperative and collaborative. Team members are familiar with and work with all clients;
- Program meeting occurs daily other than federally recognized holidays;
- The team leader is a practicing clinician providing services at least 50% of the time;
- Program staff remain consistent over time; turnover is low;
- The program operates at 95% or more of full staffing on average over a 12-month period;
- The physician, PA or APRN, works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;
- Each team has the full time equivalent of one registered nurse in a program of 50 clients;
- At least one staff member has training or certification in working with members with substance use issues;
- The program is of sufficient size to provide consistently the necessary staffing, diversity, and coverage (minimum six members);
- The program has explicitly defined admission criteria that address a clearly defined population;
- No more than six new members are admitted per month on average unless approved by the BMS;
- The program requires the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services;
- The program provides 24-hour services for crisis intervention;
- The team is actively involved in admission in 95% or more of hospital admissions. Admission involvement must become active as soon as the team becomes aware that the member is at risk of being admitted or has been admitted without the team's prior knowledge to an institutional environment, including Crisis Stabilization Units. Active involvement is demonstrated by regular contact with the institutional treatment team, exchange of information as necessary, contact with the member as possible and appropriate, and interaction with family members as necessary and desired by the member;
- The team participates in discharge planning for 95% of members, providing assistance to the institutional team with housing, benefits, medication appointments, etc.;
- All members are served on a time-unlimited basis with fewer than 5% of the population expected to graduate annually;
- 75% of member contacts occur outside the clinic setting;
- The team actively pursues engagement of treatment resistant members as described in the policy described below under "Discharge Criteria";
- The program is aggressive in assuring engagement and uses outreach and contacts with corrections and homeless programs to engage members;
- Each member receives an average of two face-to-face valid ACT activities with a team member per week;
- Each member receives at least four valid ACT activities per week of any type;
- With or without the member present, the team provides support and skills for the member's support network: family, landlords, employers, etc.;
- One or more team members provides direct treatment and substance abuse treatment for members with substance use disorders;
- The program uses group modalities as a treatment strategy for people with substance use disorders;
- The program uses a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations of abstinence; and
- Stable recovering members may be involved as members of the team providing direct services.

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Medication Delivery and Monitoring: If a provider delivers medications to a member on a regular basis, the provider must have a policy that ensures that delivery date, time, person receiving, and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location):

- If there are children or other incapacitated adults in the home, medications are at least initially stored properly in a secure location;
- If medications are delivered to a member at a location other than the home, the medications must be delivered in a manner that ensures the confidentiality of the member and shields the nature of the items delivered; and
- A system of monitoring the member's compliance with consumption of medications is created with the agreement and participation of the member. The nature of the monitoring system will be individualized and designed by the clinical team in conjunction with the member. This system may consist of the member logging consumption of his or her own medications. The member has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the member's residence and/or make alternative arrangements for the provision of medications if clinically appropriate.

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

At entry into the program, there must be documentation of a comprehensive assessment and a recommendation by a qualified professional that ACT services are necessary and appropriate.

The team must develop an Initial Service Plan for the ACT member within seven days of admission into the program. The Initial Plan must authorize the services to be provided to the member until the Comprehensive Plan for the member is complete.

The ACT team, including the member, must amend or develop a Comprehensive Service Plan for the member within 30 days. The Plan must describe goals and specific objectives the member hopes to achieve with the assistance of ACT. The Comprehensive Plan must identify the services to be provided under ACT and must be approved by the member, as signified by their signature, date and start/stop time.

The team may elect to create a Comprehensive Plan upon admission into the program without completing an Initial and Subsequent Comprehensive Plan, however the ongoing Plan must reflect amendments made in services, goals, and/or objectives as the team moves forward. The Service Plan is a fluid document which must be amended as the needs of the member change or are newly recognized. The record must sufficiently document assessments, service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT team can identify the member's treatment needs and services rendered.

The Comprehensive Plan must identify the qualified team that is providing ACT to the member. The certification of the team and a roster of members assigned to an ACT team must be available for review.

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

At minimum, the documentation must include the following:

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1. A Daily Log documenting the discussion of each member, including relevant issues, how they will be addressed and who is responsible for addressing them in the daily team meeting (except weekends and federal holidays); Daily Log must include signature with credentials, date, and start-and-stop times.
2. Weekly intensive summary that identifies members' assessed needs, number and type of ACT activities provided for the week, and follow-up plans for meeting ongoing or newly identified needs. The document must show that the team did weekly intensive reviews. Weekly intensive summary must include signatures with credentials, date, and start-and-stop times of core team members. The signature of the person completing the weekly intensive summary may provide the sole signature for the weekly intensive summary if:
    - The weekly intensive reviews were conducted during daily team meetings,
    - The person completing the summary:
        - References the daily log signature sheet with required team signatures, and
        - Documents the date and start/stop times of the daily team meeting during which the weekly intensive reviews were conducted.
3. 90-day reviews of the Comprehensive Plan and/or documentation of team meetings and revisions of comprehensive plans at the time of critical treatment junctures; and
4. Documentation of each member contact as described above.

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

The 90-day review required for each ACT member must summarize progress toward achieving the service objectives and describe problems that impeded progress toward meeting objectives. If a member is clearly not making progress toward achieving an objective after 90 days, the team must either amend the objective or describe why the objective was not amended. An objective on an ACT plan may include activities designed to preserve stability in the community, rather than requiring active progress toward meeting an objective.
A team may maintain an "inactive roster" as described below. The roster must include a list of each ACT recipient who has not received services in the past 30 to 60 days and describe why the member is included on the roster. Members must be discharged from ACT if they have been on the "inactive roster" more than 60 days.

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

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

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

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

The provider is required to notify the contracted agent within 72 hours of discharge of an ACT member to terminate the authorization for services.

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

ACT team certification process:

- All ACT teams require initial approval through the completion of the ACT Team Certification form. The certification form is reviewed and subject to approval by the BMS. Certification is specific to the individuals in a team, the team composition, and qualifications submitted. Specific certification elements are described in the BMS application form for the ACT certification.
- Certification packet may be requested from the BMS and will be sent electronically or through postal service at the request of the provider. *Refer to Appendix 503 E, Application for Assertive Community Treatment Team Modification Form*.
- The BMS will issue a denial or acceptance of a certification team within 30 days of receipt of completed certification packet.
- A provider must apply for certification of each ACT team.
- No ACT services may be billed for a member without written certification of the ACT team by the BMS.
- If a provider plans to close an ACT team, they must send 60 calendar day written notice to the BMS prior to closing.
- All teams must be based on 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 the BMS. After initial approval, a site review will be conducted to validate the approval.
- The BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in *Chapter 100, General Information*.
- 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 calendar days of the team member's last day and this must be documented. Both the ACT Team Modification form and staff roster/personnel files shall be retained for documentation.

503.23 BEHAVIOR MANAGEMENT SERVICES

Behavior management services are to address the symptoms of the diagnosed behavioral health condition that are

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negatively impacting the members' functioning. These services arise in relation to areas of need identified on the member's Service Plan. Behavior management is a time-limited service that must end when the desired outcomes have been achieved (i.e., targeted behaviors have been acquired or eliminated).

503.23.1 Therapeutic Behavioral Services – Development

Procedure Code: H2019 HO
Service Unit: 15 minutes
Telehealth: Unavailable
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: The behavior management specialist must be an individual with at least a master's degree in psychology, psychiatry, education, social work, or counseling. This individual training must have included successful completion of course work and documented training in behavioral theory. The behavior management specialist is responsible for all aspects of behavior management services provided by behavior management assistants and must sign all documentation of those services. The behavior management assistant must be an individual with at least a bachelor's degree in a human services field **(See** Glossary **for complete listing)** who has been certified by the agency as having training specific to behavior management which is consistent with documented training in behavioral theory. Behavior management services provided by behavior management assistants are subject to review and approval by the behavior management specialist. A copy of the provider's training program for its behavioral health assistant staff must be retained and filed by the provider. (The behavior management assistant must use the HO modifier when providing therapeutic behavioral services – development, procedure code H2019 HO, 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).

Definition: Therapeutic behavioral services – development includes four major components:

1. Behavior assessment
2. Plan development
3. Implementation training
4. Data analysis and review of the behavior management plan (once implementation has begun)

Therapeutic behavioral services – implementation is an integral component of behavior management services (detailed under procedure code H2019).

Behavior Assessment Component: Behavior assessment is a process of data collection, behavior and skill assessments, and functional analysis that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms beyond the developmental and they must be stated in terms of an objective, quantifiable measurement. The target behaviors must address symptoms of the diagnosed behavioral health condition that negatively impacts the member's overall functioning. The target behavior(s) is causing a functional deficit and is related to the behavioral health condition. Baseline data (quantified measurements which describe the intensity, frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data collection must be started within the first 30 days of authorization for services. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan. The Behavior Management Plan must be implemented in a timely manner based on

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the severity of the targeted behaviors.

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

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

In those instances when baseline data indicates 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 (H2019 HO) may be billed for the development of the Behavior Protocol**.** Following the development of a Behavior Protocol, no further therapeutic behavioral services billing must occur unless a new problem behavior is discovered. If this occurs, behavior assessment on the new behavior must follow, and the process should start anew.

When a Behavior Management Plan has achieved the criteria for success (the objective, quantified amount of behavior change has been maintained for the time period specified in the Plan), the behavior management specialist or the behavior management assistant may develop a **Behavior Management Maintenance Plan**. A Behavior Management Maintenance Plan is a document that describes a consistent response(s) to the target behavior(s) as a means to maintain target level performance. No more than four units of Therapeutic Behavioral Services – Development (H2019 HO) 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 work 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.

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Documentation Requirements: There are four types of therapeutic behavioral services – development documentation:

1. Activity notes
2. Behavior Management Plan
3. Behavior Protocol
4. 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 the following 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 implemented correctly, further data-based assessment to determine whether to modify the plan will occur. Documentation for the latter must reflect the specific components of the Plan addressed and modified to obtain the desired behavior change.

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

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

Activity notes for **data analysis and review** must document a measured amount of each target behavior, a

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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 and 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 include 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 related to the Plan. It should be noted that implementation staff do not have to be named individually, but they must have received the required implementation training prior to implementing the Plan. The behavior management specialist must sign, and date all plans prior to their implementation (or review and co-sign plans signed and dated by a behavior management assistant). The signature of any individual(s), who participated in the development of the written Plan, must also be included in the Plan (and the date of their participation), along with the degree, and other credentials (license type and number) of each individual.

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

a) A summary of objective, quantified baseline data.
b) A rationale for the development of the protocol.
c) Recommendations for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s).
d) 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.

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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) A summary of objectives.
b) Quantified implementation data (collected during the implementation of the Plan).
c) A rationale for the development of a maintenance plan (i.e., the criteria for success has been achieved).
d) Recommendation for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s).
e) 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.

503.23.2 Therapeutic Behavioral Services – Implementation

Procedure Code: H2019
Service Unit: 15 minutes
Telehealth: Unavailable
Prior Authorization: Required. Refer to Utilization Management Guidelines

Definition: Behavior management implementation services means a face-to-face, hands-on encounter where the actual time is spent in the delivery of a behavioral health service to a specific member (i.e., any delivery of the service must be on a strictly one staff to one-member basis). Such encounters are interventions, or reinforcements that have been previously described in the Behavior Management Plan and are measured and recorded. Any and all therapeutic behavioral services – implementation activities under this procedure will be considered non-reimbursable if the activities are not supported by a Behavior Management Plan that meets the documentation requirements detailed under therapeutic behavioral services – development (procedure code H2019 HO).

Staff Credential: High School or GED and documented training on the population being served.

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

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

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

503.23.3 Positive Behavioral Support Services - Development

Procedure Code: H2019 HO HA
Service Unit: 15 minutes
Telehealth Unavailable
Prior Authorization: Required. Refer to Utilization Management Guidelines

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Staff Credentials: The positive behavior support specialist must have and/or meet all the following criteria:

- A bachelor's degree in a human service field (or a Board of Regents with at least 15 hours in human services related courses)
- At least one-year professional experience in social services
- Completion of Trauma-Informed Positive Behavior Support Certificate Curriculum.
- Be listed on the West Virginia Association for Positive Behavior Support Endorsement Registry

Definition: Positive behavioral support is a form of applied behavior analysis that uses a behavior management system to understand what maintains an individual's challenging behavior and how to change these behaviors. Positive behavioral support development includes the following major components:

- Mental and behavioral health assessments - Functional Behavior, Quality of Life and Trauma Assessment (FBA)
- Person-Centered Planning (Making Action Plans/Planning Alternative Tomorrows with Hope (MAPS/PATHS)
- Development of a Positive Behavior Support Plan (PBSP)
- Modeling for the family and other caregivers on how to implement the PBSP.
- Skill building services aligned with the individual's PBSP and goals
- Data analysis and periodic review of the PBSP once implementation begins

Documentation: A detailed progress note for each service is required and must include:

- Name of the individual receiving service
- Date of service
- Start-and-stop times for service
- Total time spent
- Analysis of the data collected, or the problem identified
- Clinical outcome of or goal aligned with the service provided
- Plan of intervention as a result of data collection and analysis
- Signature and credentials of the positive behavior support specialist

503.23.4 Positive Behavioral Support Services - Implementation

Procedure Code: H2019 HA
Service Unit: 15 minutes
Telehealth Unavailable
Prior Authorization: Required. Refer to Utilization Management Guidelines

Staff Credentials: Direct-care providers must have the following credentials and training:

- Background check
- High school diploma or GED
- Overview of positive behavioral support training including trauma informed approaches

Definition: Positive behavioral support services - implementation services mean 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.,

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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.

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

503.24 TRANSPORTATION SERVICES

Transportation services for community integration transportation are the services used to physically transport a Medicaid member to and/or from a community activity within the ACT Program.

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

503.24.1 Transportation by Minibus

Procedure Code: A0120 DD HE
Service Unit: Trip
Service Limits: Six trips daily – This code is only reimbursable for the following programs under this chapter. Intensive outpatient services, comprehensive community support services, and ACT. All other transportation services fall under *Chapter 524, Transportation Services*.
Prior Authorization: Not required.

Definition: Community integration transportation by minibus is a service in which a one-way transport of a member by a vehicle is provided. If more than one member is being transported, each member's transport to the community activity is billable. However, if multiple stops must be made for multiple members, the service provider must only bill for each member's transport to their community activity service.

Documentation: Documentation must contain an activity note for each separate transport describing the purpose for the transport, type of vehicle used for the transport, place of departure and arrival, date of service, signature of the providing staff with credentials, and actual time spent providing the service by listing the start-and-stop times.

503.24.2 Transportation: Per Mile

Procedure Code: A0160 DD HE
Service Unit: One mile
Service Limits: 500 miles per month. This code is only reimbursable for the following programs under this chapter. Intensive outpatient services, comprehensive community support services, and ACT. All other transportation services fall under *Chapter 524, Transportation Services*.
Prior Authorization: Not required

Definition: Community integration transportation per mile is a service in which the member's transportation to their

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community activity by the provider is documented and subsequently billed by the mile. Mileage cannot be accumulated during the transport of other members to their destinations even if the member remains in the vehicle during the transport of the other members.

Documentation: Documentation must consist of an activity note describing the purpose for the transport, signed by the providing staff with their credentials, type of vehicle used for the transport, place of departure and arrival, actual billable mileage, and date of service.

503.25 SERVICE LIMITATIONS

Service limitations governing the provision of all West Virginia Medicaid services will apply in accordance to *Chapter 100, General Information* of the Provider Manual.

503.26 SERVICE EXCLUSIONS

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

- Telephone consultations.
- Meeting with the member or their family for the sole purpose of reviewing evaluation and/or results.
- Missed appointments, including but not limited to, canceled appointments and appointments not kept.
- Services not meeting the definition of medical necessity.
- A copy of medical report when the agency paid for the original service.
- Experimental services or drugs.
- Any activity provided for leisure or recreation.
- Services rendered outside the scope of a provider's license.
- Alcoholics Anonymous, Narcotics Anonymous, or other support groups available to the general public;
- Group psychotherapy services which only consist of activities such as socialization, music therapy, recreational activities, art classes, excursions, dining together, sensory stimulation, cognitive stimulation, motion therapy, and non-directional play therapy.
- Services provided by a supervised psychologist in a "satellite" office, which is not the primary site of the practice, and the Board approved supervising psychologist is not available for direct face-to-face supervision, unless express permission for non-face-to-face supervision hours has been granted by the West Virginia Board of Examiners of Psychologists, this permission applies to the date services are rendered, and express permission is documented in the file.

503.27 ROUNDING UNITS OF SERVICE

Services covered by Medicaid are, by definition, either based on the time spent providing the service or episodic. **Units of service based on an episode or event cannot be rounded**. Many services are described as "planned," "structured", or "scheduled". If a service is planned, structured, or scheduled, this would ensure 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)

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- Mental Health Service Plan development by psychologist (H0032AH)
- Physician coordinated care oversight services (G9008)
- Case consultation (90887)
- Comprehensive medication services; mental health (H2010)
- Crisis Intervention (H2011)
- Therapeutic behavioral services – development (H2019HO)
- Therapeutic behavioral services – implementation (H2019)

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

503.28 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. In addition, the following limitations also apply to the requirements for payment of LBHC services described in this chapter.

The BMS requires that providers register and prior authorize **all** LBHC services described in this manual with exception of transportation services, (procedure codes A0120 DD HE and A0160 DD HE)

- Prior authorization must be obtained from the UMC.
- Prior authorization requests must be submitted within the timelines required by and in a manner specified by the UMC.
- General information on prior authorization requirements for additional services and contact information for submitting a request may be obtained by contacting the UMC.

503.29 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

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

Providers of LBHC services must comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each West Virginia Medicaid eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, service code and/or descriptor; designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by the BMS of

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any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.
- Providers of LBHC services must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.

503.30 BILLING PROCEDURES

Claims from providers must be submitted on the BMS designated form or electronically transmitted to the BMS fiscal agent and must include all information required by the BMS to process the claim for payment.

- The amount billed to the 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 the date of service, and a separate claim must be completed for each individual member.

503.31 PROGRAM OF SERVICE REQUIREMENTS

Approval from the BMS is required for the following LBHC services programs:

- Day treatment
- ACT
- Comprehensive community supportive services
- Intensive outpatient services

GLOSSARY

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

Abuse and Neglect: As defined in and West Virginia Code §9-6-1 and West Virginia Code §49-1-201.

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

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

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

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license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner."

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

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

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

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

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

Current Procedural Terminology (CPT): Is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations

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

DEA-X: A designation given as part of the Children's Health Act of 2000 that permits physicians who meet certain qualifications to treat opioid dependency with narcotic medications approved by the Food and Drug Administration (FDA), including buprenorphine, in treatment settings other than Opioid Treatment Programs. The designation is given after successfully completing the required training.

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

Diagnostic and Statistical Manual of Mental Disorders (DSM): A comprehensive classification of officially recognized psychiatric disorders, published by the American Psychiatric Association, for use by mental health professionals to ensure uniformity of diagnosis.

External Credentialing: A process by which an individual's external credential is verified to provide Medicaid Licensed Behavioral Health Center Services by the agency's working committee composed of experienced licensed and/or certified staff representative of the appropriate disciplines or practitioners. A provider agency with

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few clinical staff may designate a credentialing officer.

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

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

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

General Equivalency Development or General Equivalency Diploma (GED): Is used for educational testing services designed to provide a high school equivalency credential.

HCPCS: An acronym for Healthcare Common Procedure Coding System

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

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

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

The International Classification of Disease (ICD): Is the global health information standard for mortality and morbidity statistics.

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

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

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

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

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

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

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

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

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT): An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs

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

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

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Behavioral Health Rehabilitation Services	April 25, 2016
Entire Chapter	Changes were made consistent with Chapter 504, Substance Use Disorder Services. Added SBIRT requirement to Sections 503.19; 503.19.1; and 503.26 Removed references to Methadone in Sections 503.19; 503.19.1; and 503.26. Added reference to the Methadone policy in Chapter 504 and added Staff Credentials to Section 503.19.2.	April 1, 2018

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Entire Chapter	Licensed Behavioral Health Center (LBHC) Services Combined Chapter 502 Behavioral Health Clinic Services and Chapter 503 Behavioral Health Rehabilitation Services.	July 15, 2018
Entire Chapter	Updated section references where applicable throughout. Included references to Telehealth policy 519.17 where applicable. The following content changes were also made: 503.3 Provider Enrollment – additional provider responsibilities added. 503.5 Clinical Supervision – additional requirements for agency policies added. 503.6 Service Certification Requirements – made updates to align with changes made to service planning. 503.8 Provider Reviews – added virtual/electronic reviews as an option, added clarification for when BMS may put a hold on payment. 503.10 Administrative Requirements – updated to add two additional requirements. 503.13 Documentation – updated to include parameters for electronic documentation. 503.14 Assessment Services – updated service limits and added additional documentation specifics 503.15 Testing Services – updated services and codes. Added new subservices for test administration and scoring. 503.17 Therapy and Behavioral Support Services – updated staff credentials and documentation requirements for professional counseling. 503.18 Skills Training and Development – added definition for paraprofessional and professional 503.19 Non-Methadone Assisted Treatment – section removed, refer to *Chapter 519.22* 503.20.1 Day Treatment – updated program staff requirements 503.22 ACT – updated member participation criteria, documentation requirements, ACT team certification process requirements. Added Positive Behavioral Support Services, Development and Positive Behavioral Support, Implementation. Removed full-time from section. 503.23 Behavior Management Services –updated service limits. Updated language regarding service exclusions.	May 1, 2025
Entire Chapter	503.3 Provider Enrollment – updated to clarify documentation requirements for annual credential reviews.	December 1, 2026

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	503.6 Service Certification Requirements – updated to clarify review requirements. 503.10 Other Administrative Requirements – updated telehealth-related language to align with Chapter 519.17. 503.14 Assessment Services – updated language to eliminate duplication of services across assessment codes and align documentation and assessment requirements. 503.15 Testing Services – updated to align with assessment and evaluation requirements. 503.16 Service Planning Requirements – updated to include licensed clinicians in service planning requirements and clarify service planning documentation and signature requirements. 503.17 Therapy and Supportive Services – updated to align documentation requirements across services and to align Intensive Outpatient Services with ASAM guidance and clarify program requirements. 503.21 Crisis Services – updated language to align with current ASAM criteria. 503.22 ACT – updated to clarify documentation, staffing, and program requirements. 503.24 Transportation Services – updated to clarify applicability to comprehensive community support services. 503.26 Service Exclusions – updated to align supervision requirements with West Virginia Board of Examiners of Psychologists requirements and include additional exclusions. 503.29 Documentation and Record Retention Requirements – updated to clarify documentation requirements. 503.32 – updated to align with West Virginia Board of Examiners of Psychologists requirements.	

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