SECTION 2

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1 GENERAL POLICY

1 - 1 Authority

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

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

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

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

1 - 2 Definitions

Accountable Care Organization (ACO) means a Utah managed care organization that contracts with Division of Medicaid and Health Financing to provide medical services to Medicaid members.

Adult Expansion Medicaid Members mean parents and adults without dependent children earning up to 138% of the federal poverty level.

Behavioral health disorders means mental health disorders and SUDs.

Behavioral health services mean the rehabilitative services directed to the treatment of the mental health disorders and/or SUDs.

Centers for Medicare and Medicaid Services (CMS) means the federal agency within the Department of Health and Human Services that administers the Medicare and Medicaid programs, and works with states to administer the Medicaid program.

Children in Foster Care means children and youth under the statutory responsibility of the Utah Department of Human Services identified as su99211ch in the Medicaid eligibility (eREP) system.

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

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

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

Early Periodic Screening Diagnostic and Treatment (**EPSDT)** means the federally mandated program that provides comprehensive and preventive health care services for children under age 21. For more information on EPSDT, refer to the *Utah Medicaid Provider Manual for EPSDT Services*.

Enrollee means any Medicaid member enrolled in the Prepaid Mental Health Plan (PMHP), UMIC Plan or HOME.

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

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

Healthy Outcomes Medical Excellence Program (HOME), operated by the University of Utah, means a voluntary managed care program for Medicaid members who have a developmental disability and mental health or behavioral challenges. HOME is a coordinated care program that provides to its enrollees medical services, behavioral health services, and targeted case management services.

Institution of Mental Diseases (IMD) means pursuant to 42 CFR §435.1010, a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for individuals with intellectual disabilities is not an institution for mental diseases.

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

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

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

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

Targeted Adult Members means adults age 19-64 without dependent children whose income is zero percent of the Federal Poverty Level and who meet the criteria for one of the following groups: (1)

chronically homeless individuals, (2) individuals involved in the justice system and in need of SUD or mental health treatment, or (3) individuals in need of SUD or mental health treatment.

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

Utah Medicaid Integrated Care (UMIC) Plans mean managed care plans responsible to provide both physical health services and behavioral health services (i.e., mental health and substance use disorder services) to their enrollees. HOME is not a UMIC plan.

1 - 3 Medicaid Behavioral Health Service Delivery System

Utah operates a behavioral health managed care plan under a federal freedom-of-choice waiver. This managed care plan is called the Prepaid Mental Health Plan (PMHP).

Under the PMHP, DMHF contracts with local county mental health and substance abuse authorities or their designated entities to provide inpatient hospital psychiatric services, and outpatient mental health and outpatient substance use disorder services to Medicaid members.

The PMHP covers most counties of the state. Medicaid members are automatically enrolled with the PMHP contractor serving their county of residence, and must receive inpatient and outpatient mental health services and outpatient substance use disorder services through that PMHP contractor. See Table 1 of this Chapter for PMHP coverage. Under Utah's 1115 Demonstration Waiver, Adult Expansion Medicaid members in certain counties of the state are enrolled in UMIC Plans, and must receive behavioral health services through their UMIC Plans. See Table 2 of this Chapter for UMIC Plan coverage.

Prior to delivering services, providers must verify eligibility and determine if a member is enrolled in the PMHP or a UMIC Plan. For tools to verify eligibility, refer to *Chapter 6, Member Eligibility*, of Section I of the Utah Medicaid Provider Manual. If a Medicaid member is enrolled in the PMHP or a UMIC Plan, and the provider is not on the member's PMHP or UMIC Plan panel, the provider must refer the member to the PMHP or UMIC Plan, or contact the PMHP or UMIC Plan prior to delivering services to seek prior authorization.

The tables below show by county whether mental health and substance use disorder services are paid FFS, or whether they are covered under the PMHP or UMIC Plans.

In Table 1, when services are paid Fee-for-Service, , 'FFS' is specified. When services are covered under the PMHP, the name of the PMHP contractor is specified.

Table 1 - Mental Health and Substance Use Disorder Services Coverage

Counties	Inpatient & Outpatient Mental Health Services	Outpatient Substance Use Disorder Services
Box Elder, Cache, Rich	Bear River Mental Health	FFS
Beaver, Garfield, Kane, Iron, Washington	Southwest Behavioral Health Center	Southwest Behavioral Health Center
Carbon, Emery, Grand	Four Corners Community Behavioral Health	Four Corners Community Behavioral Health
Daggett, Duchesne, Uintah, San Juan	Northeastern Counseling Center	Northeastern Counseling Center
Davis	Davis Behavioral Health	Davis Behavioral Health
Piute, Juab, Wayne, Millard, Sanpete, Sevier	Central Utah Counseling Center	Central Utah Counseling Center
Salt Lake	Salt Lake County Division of Behavioral Health Services/Optum	Salt Lake County Division of Behavioral Health Services/Optum
Summit	Healthy U Behavioral	Healthy U Behavioral
Tooele	Optum Tooele County	Optum Tooele County
Utah	Wasatch Behavioral Health	Wasatch Behavioral Health
Wasatch	FFS	FFS
Weber, Morgan	Weber Human Services	Weber Human Services

For PMHP contact information, please refer to the Medicaid Managed Care website at:
https://medicaid.utah.gov/managed-care

Adult Expansion Medicaid Members

Adult Expansion Medicaid members living in Davis, Salt Lake, Utah, Washington, and Weber counties are not enrolled in the PMHP. These Medicaid members are enrolled in UMIC Plans that cover both physical health and behavioral health (i.e., mental health and substance use disorder) services.

Table 2 below shows by county, the UMIC Plans Adult Expansion Medicaid members can select for enrollment.

Table 2 - Mental Health and Substance Use Disorder Services – UMIC Plans

UMIC Plans by County County	Integrated Health Choice	Integrated Healthy U	Integrated Molina	Integrated SelectHealth
Davis	•	•	•	•
Salt Lake	•	•	•	•
Utah	•	•	•	•
Washington	•	Not Available	•	•
Weber	•	•	•	•

For UMIC Plan contact information, please refer to the Medicaid Managed Care website at: https://medicaid.utah.gov/managed-care

Adult Expansion Medicaid members living in other counties are enrolled in the PMHP serving their county of residence according to Table 1 above.

Behavioral health services provided by an Indian health care provider operated by Indian Health Services, an Indian Tribe, Tribal Organization, or an Urban Indian Organization to Medicaid members enrolled in UMIC Plans are billed directly to Medicaid. Authorization from the member's UMIC Plan is not required. Medicaid reimburses the providers directly.

Additional Provider Options for Prepaid Mental Health Plan Enrollees

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

Behavioral health services provided by an Indian health care provider operated by Indian Health Services, an Indian Tribe, Tribal Organization, or an Urban Indian Organization are billed directly to Medicaid. Authorization from the member's PMHP is not required. Medicaid reimburses the providers directly.

Medicaid members enrolled in the PMHP who are also Medicare beneficiaries may obtain behavioral health services directly from providers who accept Medicare. Authorization from the member's PMHP is not required. For providers also enrolled as Medicaid providers, crossover claims will be processed through FFS Medicaid, and will be subject to crossover adjudication logic for payment of co-insurance and deductible, if applicable.

Exceptions to Prepaid Mental Health Plan Enrollment

Children in Foster Care

Children in Foster Care are enrolled in the PMHP only for inpatient hospital psychiatric services. They are not enrolled in the PMHP for outpatient behavioral health services. They may obtain outpatient services from any qualified Medicaid provider. Providers may report services to Medicaid on a FFS basis.

Children with State Adoption Subsidy

Children with state adoption subsidy are enrolled in the PMHP. However, an exemption from PMHP enrollment for outpatient behavioral health services may be granted on a case-by case basis. Once disenrolled, these children remain enrolled in the PMHP only for inpatient hospital psychiatric services. They may obtain outpatient services from any qualified Medicaid provider. Providers may report services to Medicaid on a FFS basis.

Exceptions to Prepaid Mental Health Plan and UMIC Plan Enrollment

Medicaid Members Enrolled in HOME

Medicaid members enrolling in HOME are disenrolled from their PMHP or UMIC Plan. HOME enrollees must receive all behavioral health services through HOME (see Chapter 1-2, Definitions). Providers must follow HOME's network and prior authorization requirements and obtain reimbursement directly from HOME.

Presumptive Eligibility

Medicaid members with presumptive eligibility are not enrolled in the PMHP or UMIC Plans. Providers may report services to Medicaid on a FFS basis.

Targeted Adult Members

Targeted Adult Members are not enrolled in the PMHP or UMIC Plans. Providers may report services to DMHF on a FFS basis.

Exceptions to Prepaid Mental Health Plan and UMIC Plan Coverage

Evaluations

When mental health evaluations and psychological testing are performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or developmental disabilities, or organic disorders, they are carved out services from the PMHPs, UMIC Plans and the ACOs.

When these services are performed for the purposes stated above, providers must report the services through FFS with the UC modifier on the procedure code. If the UC modifier is not included with the procedure code, then the line will be denied.

For information on mental health evaluations and psychological testing for physical health purposes, also refer to the Utah Administrative Rule R414-10, Physician Services, and the Utah Medicaid Provider Manual for Physician Services.

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

This carve-out policy does not apply to: (1) developmental screenings performed as part of a preventive EPSDT service (see the Utah Medicaid Provider Manual for EPSDT Services); and (2) psychiatric consultations performed during a physical health inpatient hospitalization. The ACOs remain responsible for these services.

This carve-out policy does not apply to mental health evaluations and psychological testing for the primary purpose of diagnosing or treating behavioral health disorders. The PMHPs and UMIC Plans remain responsible for these services.

This carve-out policy does not apply to HOME enrollees. If the Medicaid member is enrolled in HOME, refer to the section above on HOME enrollment.

Methadone Administration Services

Methadone administration services are not covered under the PMHP or UMIC Plans. Medicaid members may obtain methadone administration services from Medicaid-enrolled Opioid Treatment Programs (OTPs). OTPs may bill DMHF on a FFS basis. However, related outpatient behavioral health services that Medicaid members require are covered under the PMHP and UMIC Plans.

1 - 4 Scope of Services

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

Telemedicine:

Services may be provided via telemedicine when clinically appropriate. Services must be provided in accordance with telemedicine policy contained in the Utah Medicaid Provider Manual, Section I: General Information. When services are provided by telemedicine, providers must specify the place of service as '02' in the place of service field on the claim.

The scope of rehabilitative behavioral health services includes the following:

- Psychiatric Diagnostic Evaluation
- Mental Health Assessment by a Non-Mental Health Therapist
- Psychological Testing
- Psychotherapy with Patient and/or Family Member

- Family psychotherapy with Patient Present and Family Psychotherapy without Patient Present
- Group Psychotherapy and Multiple Family Group Psychotherapy
- Psychotherapy for Crisis
- Psychotherapy with Evaluation and Management (E/M) Services
- Evaluation and Management (E/M) Services (Pharmacologic Management)
- Therapeutic Behavioral Services
- Psychosocial Rehabilitative Services
- Peer Support Services
- SUD Services in Licensed SUD Residential Treatment Programs
- Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT)
- Mobile Crisis Outreach Teams (MCOT)
- Clinically Managed Residential Withdrawal Management
- Mental Health Services in Licensed Mental Health Residential Treatment Programs
- Behavioral Health Receiving Centers

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

1 - 5 Provider Qualifications

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

A. Providers Qualified to Prescribe Behavioral Health Services

Rehabilitative services must be prescribed by an individual defined below:

1. Licensed mental health therapist practicing within the scope of practice defined in the individual's respective licensing act and licensed under Title 58-60, Mental Health Professional Practice Act, as:

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

b. advanced practice registered nurse (APRN) specializing in psychiatric mental health nursing;

c. APRN intern specializing in psychiatric mental health nursing;

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

e. certified psychology resident qualifying to engage in the practice of mental health therapy;

f. physician assistant specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code;

g. clinical social worker;

h. certified social worker or certified social worker intern;

i marriage and family therapist;

j. associate marriage and family therapist;

k clinical mental health counselor; or

l. associate clinical mental health counselor.

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

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

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

B. Providers Qualified to Render Services

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

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

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

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

b. licensed APRN or APRN intern regardless of specialty working within the scope of the Nurse Practice Act and competency;

c. other medical practitioner licensed under state law, most commonly licensed physician assistants regardless of specialty when practicing within the physician assistant's skills and scope of competence;

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

e. licensed social service worker;

f. licensed registered nurse;

g licensed practical nurse; or

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

3. other trained individual; or

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

C. Training Requirements for Other Trained Individuals

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

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

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

   - Fraud, waste or abuse detection and reporting;
   - HIPAA and confidentiality/privacy policy and procedures;
   - Emergency/crisis procedures; and
   - Other relevant administrative-level subjects.

2. Individuals shall also receive information and training in areas including:

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

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

4. The supervising provider must ensure individuals complete all training within 60 calendar days of the hiring date, or for existing providers within 60 calendar days from the date of enrollment as a Medicaid provider.

1 - 6 Evaluation

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

When evaluations performed in accordance with Chapter 2-2, Psychiatric Diagnostic Evaluation, may be used to qualify an individual to receive Medicaid-covered autism spectrum disorder (ASD)-related services, additional provider requirements apply. For information on these requirements and on ASD-related services, refer to the Utah Medicaid Provider Manual for Autism Spectrum Disorder Related Services for EPSDT Eligible Individuals.

For information and requirements regarding evaluations for individuals with a condition requiring chronic pain management services, refer to the Utah Medicaid Provider Manual for Physician Services, Chapter 2, Covered Services. For evaluations required prior to certain surgical procedures, refer to Chapter 1-3, Medicaid Behavioral Health Service Delivery System, Evaluations Not Covered by the PMHP, in this Section 2, and to the Utah Medicaid Provider Manual for Physician Services, Chapter 2, Covered Services

1 - 7 Treatment Plan

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

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

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

D. The treatment plan must include the following:

1. measurable treatment goals;
2. the treatment regimen–the specific treatment methods (as contained in Chapter 1-4 and Chapter 2) that will be used to meet the measurable treatment goals;
3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method;
4. the licensure or credentials of the individuals who will furnish the prescribed services; and
5. the signature and licensure or credentials of the individual defined in Chapter 1-5, A., who is responsible for the treatment plan.

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

1 - 8 Documentation

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

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

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

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

1 - 9 Collateral Services

Collateral services must be directed exclusively toward the treatment of the patient and may be reported if the following conditions are met:

1. the service is provided face-to-face to an immediate family member (for example, parent or foster parent) on behalf of the identified patient and the patient is not present;

2. the identified patient is the focus of the session; and
3. the progress note specifies the service was a collateral service and documents how the identified patient was the focus of the session. Other documentation requirements under the 'Record' section of the applicable service also apply.
4. if the collateral service is not psychotherapy that qualifies for coding under procedure codes 90832-90838 or 90846, use the procedure code applicable to the service.

1 - 10 Billings

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

When services are provided by telemedicine, providers must specify the place of service as '02' in the place of service field on the claim.

In integrated care settings that provide both physical and behavioral services, when a provider renders a physical health service and a behavioral health service on the same day, each service may be reported separately.

When providers listed in Chapter 1-5 are not qualified to practice independently, the behavioral health services they provide may be reported in the name and NPI of their licensed supervisor.

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

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

Procedure-to-Procedure (PTP) Editing

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

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

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

Medically Unlikely Edits

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

NCCI Editing Updates

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

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

2 SCOPE OF SERVICES

Behavioral health services are covered benefits when the services are medically necessary services. Behavioral health services include psychiatric diagnostic evaluation, mental health assessment by a non-mental health therapist, psychological testing, psychotherapy with patient and/or family member, family psychotherapy with patient present and family psychotherapy without patient present, group psychotherapy, multiple family group psychotherapy, psychotherapy for crisis, psychotherapy with evaluation and management (E/M) services, evaluation and management (E/M) services (i.e., pharmacologic management), therapeutic behavioral services, psychosocial rehabilitative services, peer support services, SUD residential treatment, assertive community treatment (ACT) and assertive community outreach treatment (ACOT), mobile crisis outreach teams (MCOT), clinically managed residential withdrawal management, mental health residential treatment, and behavioral health receiving centers. For treatment of SUDs, these services cover the American Society of Addiction Medicine (ASAM) levels of care 1.0, 2.1, 2.5, 3.1, 3.3, 3.5 and 3.7.

2 - 1 General Limitations

1. Rehabilitative services do not include:

    a. Services provided to inmates of public institutions;

    b. Services provided to residents of IMDs, except as allowed for in Utah's 1115 Demonstration Waiver which allows payment for SUD residential treatment in licensed SUD residential treatment programs with 17 or more beds and for mental health residential treatment in licensed mental health residential treatment programs with17 or more beds;

    c. Habilitation Services;

d. Educational, vocational and job training services;

e. Recreational and social activities;

f. Room and board; and

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

2. Service Coverage and Reimbursement Limitations

Information on Utah Medicaid service coverage and reimbursement limitations is available in Utah Medicaid's web-based lookup tool entitled 'Coverage & Reimbursement Lookup Tool, located at: http://health.utah.gov/stplan/lookup/CoverageLookup.php. The Coverage & Reimbursement Lookup Tool contains up-to-date information on coverage, limits, prior authorization requirements, etc. The tool also includes a special notes section that includes any additional information regarding the service, including any manual review requirements associated with the service. This tool allows providers to search for coverage and reimbursement information by HCPCS/ Current Procedural Terminology (CPT) procedure code, date of service and provider type. The 'Limits' sections in Chapter 2 in this manual will address other types of limits and clarifications related to the services.

See Chapter 10 of the Utah Medicaid Provider Manual, Section I: General Information for information on prior authorization. Also see the Coverage & Reimbursement Lookup Tool located at: http://health.utah.gov/stplan/lookup/CoverageLookup.php for information on prior authorization for these procedure codes.

2 - 2 Psychiatric Diagnostic Evaluation

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

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

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

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

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

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

Who:

1. **Psychiatric diagnostic evaluation** may be performed by a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

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

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

    b. licensed advanced practice registered nurse (APRN) or APRN intern specializing in psychiatric mental health nursing; or

    c. licensed physician assistant specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code.

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

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

    e. licensed APRN or APRN intern regardless of specialty working within the scope of the Nurse Practice Act and competency;

    f. other medical practitioner licensed under state law, most commonly licensed physician assistants regardless of specialty when practicing within the physician assistant's skills and scope of competence.

Limits:

1. According to the Psychiatry section of the CPT manual, the following limits apply:

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

    b. Codes 90791, 90792 are used for the diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapeutic services. Psychotherapy services, including psychotherapy for crisis, may not be reported on the same day (when performed by the same servicing provider). See the CMS NCCI PTP Module for additional information on this limitation.

2. Evaluations requested by a court of the Utah Department of Human Services, Division of Child and Family Services, solely for the purpose of determining if a parent is able to parent and should therefore

be granted custody or visitation rights, or whether the child should be in some other custodial arrangement are not reportable to Medicaid under any service/procedure code.

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

4. For information and requirements regarding evaluations for Medicaid members with a condition requiring chronic pain management services, and evaluations required prior to certain surgical procedures, see Chapter 1-6, Evaluation.

Procedure Codes and Unit of Service:

90791 - Psychiatric Diagnostic Evaluation - per 15 minutes

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

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

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

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

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., psychiatric diagnostic evaluation);

4. report of findings from the biopsychosocial assessment that includes:

    a. history, symptomatology and mental status (mental status report may be based on formal assessment or on observations from the evaluation process); and

    b. disposition, including diagnosis(es) as appropriate, and recommendations. If the Medicaid member does not need behavioral health services, this must be documented in the assessment (along with any other recommended services as appropriate). If behavioral health services are medically necessary, then a provider qualified to perform this service is responsible for the development of a treatment plan and the prescription of the behavioral health services that are medically necessary for the Medicaid member. (See treatment plan requirements in Chapter 1-7); or

5. report of findings from a reassessment that includes:

    a. the applicable components in 4.a. and/or b.; and/or

    b. For reviews of the patient's treatment plan documentation will include an update of the patient's progress toward treatment goals contained in the treatment plan, the appropriateness of the services being prescribed, and the medical necessity of continued behavioral health services; and

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

2 - 3 Mental Health Assessment

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

Who:

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

1. licensed social service worker or individual working toward licensure as a social service worker in accordance with state law;

2. licensed registered nurse;

3. licensed ASUDC, CASUDC, SUDC, CSUDC or ASUDC-I or SUDC-I;

4. licensed practical nurse; or

5. registered nursing student engaged in activities constituting the practice of a regulated occupation or profession while in training in a recognized school approved by DOPL, or an individual enrolled in a

qualified substance use disorder education program, exempted from licensure in accordance with state law, and under required supervision.

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

Limits:

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

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

Procedure Code and Unit of Service:

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

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., assessment);

4. information gathered; and

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

2 - 4 Psychological Testing

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

Who:

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

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

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

4. a student who is a licensed psychologist candidate due to enrollment in a predoctoral education/degree program exempted from licensure in accordance with state law and under required supervision; or

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

6. a technician for specific codes.

Limits:

NCCI MUE and PTP limits would apply. See Chapter 1-11, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI).

Procedure Codes and Unit of Service:

Assessment of Aphasia and Cognitive Performance Testing

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

96125 - Standardized Cognitive Performance Testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report, per hour

Developmental/Behavioral Screening and Testing

96110 - Developmental Screening – Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96112 - Developmental Test Administration – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by

standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report, first hour

+96113 - Each additional 30 minutes (List separately in addition to code for primary procedure, 96112)

Psychological/Neuropsychological Testing

Neurobehavioral Status Examination

96116 - Neurobehavioral Status Examination - Clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report, first hour

+96121 - Each additional hour (List separately in addition to code for primary procedure, 96116)

Testing Evaluation Services

Psychological Testing

96130 - Psychological Testing Evaluation - services by physician or other qualified health care professional, including integration of data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour

+96131 - Each Additional Hour (List separately in addition to code for primary procedure, 96130)

Neuropsychological Testing

96132 - Neuropsychological testing evaluation - services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical

data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed, first hour

+96133 - Each additional hour (List separately in addition to code for primary procedure, 96132)

Testing Administration and Scoring

96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes

+96137 - Each additional 30 minutes (List separately in addition to code for primary procedure, 96136)

96138- Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes

+96139 - Each additional 30 minutes (List separately in addition to code for primary procedure, 96138)

Automated Testing and Result

96146 - Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only.

CPT Time Rules

The time reported under 96116, 96121, 96130, 96131, 96132, 96133, and 96125 also includes the face-to-face time with the patient.

In order to report the per hour codes (96105, 96125, 96112, 96116, 96121, 96130, 96131, 96132, and 96133), a minimum of 31 minutes of service must be provided.

In order to report the 30-minute codes (96113, 961136, 96137, 96138, and 96139) a minimum of 16 minutes of service must be provided.

Report the total time at the completion of the entire episode of evaluation.

Record:

Documentation must include:

1. date(s), start and stop time, and duration of testing;
2. setting in which the testing was rendered;
3. specific service rendered (i.e., psychological testing);
4. written report which includes:
    a. tests administered and test scores;
    b. interpretation of test results; or
    c. for the Developmental Screening, scoring and documentation per standardized instrument;
    d. diagnoses; and
    e. as applicable to the procedure performed, brief history, current functioning, prognosis and specific treatment recommendations for behavioral health services or other recommended services; and
5. signature and licensure or credentials of the individual who rendered the service.

2 - 5 Psychotherapy

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the patient may be restored to his/her best possible functional level. Services are based on measurable treatment goals identified in the treatment plan.

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

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

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

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

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

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

Who:

1. All psychotherapy may be performed by a licensed mental health therapist or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

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

Psychotherapy with patient and/or family member

Limits:

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

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

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

Procedure Codes and Unit of Service:

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

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

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

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

90832 - 16 through 37 minutes;

90834 - 38 through 52 minutes; and

90837 - 53 minutes through 89 minutes.

Prolonged Services Add-On Codes:

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

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

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

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

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

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

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

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

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

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

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

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

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., psychotherapy with patient and/or with family member);

4. clinical note that documents:

   a. individual(s) present in the session;

   b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and

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

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

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

Family psychotherapy with patient present and family psychotherapy without patient present

Procedure Codes and Unit of Service:

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

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

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., family psychotherapy with patient present or family psychotherapy without patient present)

4. clinical note that documents:

    a. family members present in the session;

    b. in accordance with the definition of psychotherapy, the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and

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

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

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

Group psychotherapy and multi-family group psychotherapy

Limits:

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

2. Multiple-family psychotherapy groups (90849) are limited to twelve families in attendance unless there is a co-provider, then groups may have 13 to 16 families in attendance.

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

Procedure Codes and Unit of Service:

90849 - Multiple-Family Group Psychotherapy - per 15 minutes per Medicaid patient

90853 - Group Psychotherapy - per 15 minutes per Medicaid patient

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

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

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

Record:

Documentation must include:

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

2 - 6 Psychotherapy for Crisis

Psychotherapy for crisis means a face-to-face service with the patient and/or family and includes an urgent assessment and history of a crisis state and disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to an individual in high distress. Providers may use CPT coding for this service if the crisis and interventions qualify for this coding.

Who:

Licensed mental health therapist, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B. 1.)

Limits:

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

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

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

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

4. If psychotherapy for crisis services on a given date total 30 minutes or less, the service is reported with psychotherapy code 90832, 30 minutes, with patient and/or family member, or with add-on psychotherapy code 90833, 30 minutes, with patient and/or family member when provided with evaluation and management (E/M) services. See Chapter 2-5 for information on psychotherapy procedure code 90832, and Chapter 2-7 for information on E/M add-on psychotherapy procedure code 90833.

Procedure Codes and Unit of Service:

90832 – Use for psychotherapy for crisis services of 30 minutes or less total duration on a given date even if the time spent on that date is not continuous, or 90833 when provided with E/M services. (See #4 of Limits above.)

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

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

90839 - 31 through 75 minutes total duration on a given date even if the time spent on that date is not continuous

Psychotherapy for Crisis Add-On Code: 90840 –

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

+90840 – **additional 30-minute increments – per encounter**

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

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

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

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

Record:

Documentation must include:

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

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

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

Who:

1. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
2. licensed APRN or APRN intern specializing in psychiatric mental health nursing; or
3. licensed physician assistant specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code.

Limits:

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

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

   Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy service (i.e., time spent on history, examination and medical decision-making when used for the E/M service is not psychotherapy time). Time may not be used as

the basis of E/M code selection and prolonged services may not be reported when psychotherapy with E/M (psychotherapy add-on codes 90833, 90836, 90838) are reported; and

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

Procedure Codes and Unit of Service:

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

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

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

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

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

+90833 - 16 through 37 minutes;

+90836 - 38 through 52 minutes; and

+90838 - 53 minutes and longer

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

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

Record:

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

1. date, start and stop time, and duration of the service;
2. setting in which the service was rendered;
3. specific service rendered (i.e., psychotherapy with patient and/or with family member);
4. clinical note that documents:
    a. individual(s) present in the session;
    b. in accordance with the definition of psychotherapy, the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, encouragement of personality growth and development); and
    c. the treatment goal(s) addressed in the session and the patient's progress toward the treatment goal(s), or if there was no reportable progress, documentation of reasons or barriers; or

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

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

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

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

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

Who:

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

2. licensed APRN or APRN intern regardless of specialty working within the scope of the Nurse Practice Act and competency;

3. licensed physician assistant specializing in mental health care in accordance with Section 58-70a-501 of the Utah Code; or

4. other medical practitioner licensed under state law, most commonly licensed physician assistants regardless of specialty when practicing within the physician assistant's skills and scope of competence.

Limits:

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

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

Procedure Codes and Unit of Service:

Office or Other Outpatient Services E/M Codes -

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

Established Patient Codes

99211 – **per encounter -** E/M of an established patient; usually the presenting problems are minimal.

99212- per encounter - E/M of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

99213 – **per encounter -** E/M of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

99214 – **per encounter -** E/M of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

99215 – **per encounter** – E/M of an established patient, which requires a medically appropriate history and /or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Prolonged Services Add-on Code 99417

Limits:

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

1. 99417 may be reported only with the longest timed E/M codes in the Office or Other Outpatient Services range when the code is selected based on time alone, and not on medical decision making.

2. In the Established Patient code range, 99417 may be reported with the longest timed E/M code 99215 when the time spent is 55 minutes or longer.

Procedure Codes and Unit of Service:

+99417- per 15 minutes

The following time rules apply for converting the duration of the service to prolonged services add-on code 99417:

Less than 55 minutes – not reported;

55-69 minutes equals 99215 and 1 unit of 99417;

70-84 minutes equals 99215 and 2 units of 99417;

85 or more minutes equals 3 or more units of 99417 for each additional 15 minutes.

Subsequent Nursing Facility Care E/M Codes

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

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

Established Patient Codes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Home Services E/M Codes

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

Established Patient Codes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prolonged Services Add-on Codes 99354-99357:

In accordance with the CPT manual, these prolonged services add-on codes may be reported in addition to the designated E/M codes at any level, except the E/M codes in the Office or Other Outpatient Services range.

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

For example, in accordance with rules for prolonged services add-on codes, if the E/M service qualifying for coding as 99350 is 90 minutes or longer, then the E/M code plus the applicable prolonged services add-on code(s) would be reported depending on the duration and the place of service. Refer to the time rules below and to the Prolonged Services section of the CPT manual for additional information.

Limits:

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

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

Procedure Codes and Unit of Service:

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

Home E/M codes:

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

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

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

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

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

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

Less than 30 minutes equals 0 units;

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

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

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

Record:

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

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

2. Documentation for E/M codes in ranges other than the Office or Other Outpatient Services range must include:

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

   b. setting in which the service was rendered; and

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

3. Documentation for E/M codes in the Office or Other Outpatient Services range:

   a. When the E/M code is selected based on medical decision making, the components in 2. above are required.

   b. When the E/M code is selected based on time, documentation must include:

      (1) for the time spent face-to-face with the patient, the components in 2. above; and

      (2) for the time spent in non-face-to-face E/M activities specified in the CPT manual:

         (i) date and duration of the total non-face time;

         (ii) setting in which the service was rendered and

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

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

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

   b. dosage of medications as applicable;

   c. summary of information provided;

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

e. summary of non-face-to-face activities if applicable; and

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

2 - 9 Nurse Medication Management

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

Who:

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

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

3. for procedure code 96372, a medical assistant under the supervision of a licensed physician and surgeon or osteopathic physician, a licensed APRN, a licensed physician assistant or a licensed registered nurse, may administer the therapeutic, prophylactic, or diagnostic injection specified below.

Limits:

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

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

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

Procedure Codes and Unit of Service:

T1001- Nurse Evaluation and Assessment – per encounter

96372- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Record:

Documentation must include:

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

2. setting in which the service was rendered;

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

4. note that documents as applicable:

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

   b. dosage of medications;

   c. summary of information provided; and

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

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

2 - 10 Therapeutic Behavioral Services

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

Who:

1. Licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B. 1.), or an individual identified in Chapter 1-5, B. 2.a. or B. 2. b.

2. This service may also be performed by:

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

   b. licensed registered nurse;

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

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

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

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

Limits:

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

2. Multiple family therapeutic behavioral services groups are limited to twelve families in attendance, unless there is a co-provider, then groups may have 13 to 16 families in attendance.

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

4. Therapeutic behavioral services do not include DUI classes.

Procedure Codes and Unit of Service:

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

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

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., therapeutic behavioral services);

4. treatment goal(s);

5. clinical note per session that documents:

   a. the nature of the interventions used to address the behavior problem; and

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

6. signature and licensure or credentials of the individual who rendered the service. If a co-leader is present for therapeutic behavioral services groups, the note must contain the co-leader's name and licensure or credentials.

2 - 11 Psychosocial Rehabilitative Services

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

Who:

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

2. licensed registered nurse;

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

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

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

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

7. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2. (b.) of Chapter 1-5; a licensed social service worker or a licensed registered nurse; or a licensed ASUDC or SUDC when the service is provided to individuals with a SUD; or

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

9. The above are the core providers of this service. In addition, a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.), or an individual identified in Chapter 1-5, B. 2.a. or B.2.b., may perform this service

Limits:

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

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

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

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

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

d. Time spent by the patient in the routine completion of activities of daily living, including eating meals, doing chores, etc. (In a residential setting this time is part of the routine 24-hour care and supervision specified in b. above.);

e. Habilitation Services;

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

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

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

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

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

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

Procedure Codes and Unit of Service:

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

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

H2017 with U1 modifier - Group Psychosocial Rehabilitative Services – Intensive - per 15 minutes per Medicaid patient (See #3 of 'Limits' section above.)

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

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

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

Record:

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

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

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

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

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

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

    Therefore, at a minimum, one summary note for each unique type of psychosocial rehabilitative group the patient participated in during the immediately preceding two-week period must be prepared at the close of the two-week period. The required summary note may be written by the

provider who provided the group, or by a provider who is most familiar with the patient's involvement and progress across groups.

The summary note must include:

a. name of the group;

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

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

d. signature and licensure or credentials of the individual who prepared the documentation. If a co-leader is present for the group, the note must contain the co-leader's name and licensure or credentials.

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

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

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

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

2. setting in which the group was rendered;

3. specific service rendered (i.e., psychosocial rehabilitative services) and the name of the group (e.g., relationship skills group, etc.);

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

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

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

C. Psychosocial Rehabilitative Services Provided to an Individual

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

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., psychosocial rehabilitative services)

4. treatment goal(s);

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

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

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

2 - 12 Peer Support Services

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

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

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

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

Who:

Peer support services are provided by certified peer support specialists.

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

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

completes the certification training will receive a written peer support specialist certification from the DSAMH and also will successfully complete any continuing education requirements the DSAMH requires to maintain certification.

Certified peer support specialists are under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2.b. of Chapter 1-5, or a licensed ASUDC or SUDC when peer support services are provided to patients with a SUD.

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

Limits:

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

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

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

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

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

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

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

Procedure Code and Unit of Service:

H0038 – Individual Peer Support Services - per 15 minutes

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

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Documentation must include:

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

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

2 – 13 Substance Use Disorder (SUD) Treatment in Licensed SUD Residential Treatment Programs (ASAM Levels 3.1, 3.3, 3.5, 3.7)

Medicaid's 1115 Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 21 through 64 in these larger programs are now eligible for Medicaid reimbursement. Reimbursement is made on a per diem bundled payment basis.

For dates of service on or after April 1, 2019, DMHF will also reimburse licensed SUD residential treatment programs with 16 or fewer beds on a per diem bundled payment basis. These programs are no longer required to report the individual services.

SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services provided in accordance with this Section 2. Services are provided according to each patient's ASAM assessment and treatment plan and are provided to treat the patient's documented SUD.

These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another FFS provider. For PMHP, UMIC Plan and HOME enrollees, the program must coordinate transitions to other levels of outpatient SUD services with the enrollee's PMHP or UMIC Plan, or with HOME.

Who:

The following individuals, in accordance with their licensure or credentials, may perform the services delivered in the licensed SUD residential treatment program:

1. licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.);

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

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

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

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

6. licensed registered nurse;

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

8. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2.b. of Chapter 1-5; a licensed ASUDC or SUC, a licensed social service worker, or a licensed registered nurse;

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

10. certified peer support specialist.

Limits:

1. For Medicaid members enrolled in the PMHP, UMIC Plans, or HOME, SUD residential treatment must be provided through the member's plan. DMHF does not reimburse programs on a FFS basis for PMHP, UMIC Plan, or HOME enrollees.

2. For Medicaid members not enrolled in the PMHP, UMIC Plans, or HOME, DMHF reimburses programs on a FFS basis.

3. Residential treatment is limited to Medically Necessary Services for documented SUD diagnoses for Medicaid members age 12 and older.

4. When children accompany their parents who are receiving treatment in the program, the children are not eligible for reimbursement under this service unless they qualify for their own SUD residential treatment under #3 above. Otherwise, programs may report the individual rehabilitative services provided to the children if they have their own diagnoses, and must report the services in accordance with this Section 2, Chapters 2-2 through 2-12.

5. Programs are reimbursed on a per diem bundled payment basis using the applicable procedure code specified in the 'Procedure Codes and Unit of Service' section below. All services included in this Section 2, Chapters 2-2- through 2-12, are included in the per diem bundled payment rate. Programs may not report these services under any other procedure codes.

6. Services not included in the per diem bundled payment rate are drug-administered codes (e.g., J codes).

7. Programs may only report the per diem bundled service codes for dates when individual rehabilitative service(s) are provided to the Medicaid member in accordance with this Section 2, Chapters 2-2 through 2-12.

8. If a Medicaid member is hospitalized, the program may report the hospital admission and discharge dates only if rehabilitative service/s were provided to the Medicaid member in accordance with this Section 2, Chapters 2-2 through 2-12, prior to the hospital admission and/or post discharge from the hospital. The per diem reimbursement is not available for any other dates of service while the Medicaid member is an inpatient of a hospital.

9. If an adolescent/youth turns 19 during an SUD residential treatment stay, then the adult day limit applies.

10. For programs with 17 or more beds:

    When requested prior authorization (PA) is denied for additional days beyond the number of days approved under the prior PA request (See Chapter 5), then Medicaid reimbursement is no longer available.

11. If a Medicaid member is quarantined in a different location due to COVID-19, as long as the member continues to receive therapeutic services covered under the bundled procedure code (H0018 or H2036), the program may bill for these dates of service.

<u>Prior Authorization for 30-Day or 60-Day Periods:</u>

A. <u>Fee-for-Service Medicaid Members</u>

   1. All licensed SUD residential treatment programs, regardless of the number of beds, must request PA from DMHF's Prior Authorization Unit in accordance with PA policy and procedures contained in Chapter 5 of this Section 2.

   2. For adolescent/youth Medicaid members age 12 through age 18 no more than 30 days will be prior authorized at a time.

   3. For adult Medicaid members age 19 and older no more than 60 days will be prior authorized at a time.

B. Prepaid Mental Health Plan, UMIC Plan and HOME Enrollees

PMHPs, UMIC Plans, and HOME may also implement utilization review, including prior authorization of services. For information on PMHPs', UMIC Plans', and HOME's PA and utilization review requirements and processes, programs must contact these plans.

Procedure Codes and Unit of Service:

Programs with 17 or more beds: H0018 – Behavioral health; short-term residential (non-hospital residential treatment program), without room and board – per diem (Alcohol and/or drug services), per Medicaid patient

Programs with 16 or fewer beds: H2036 - Alcohol and/or drug treatment program, per diem, per Medicaid patient

Record:

Licensed SUD residential treatment programs must maintain the following documentation:

1. In accordance with Chapters 1-6 and 1-7, an assessment and treatment plan that clearly document the medical necessity for SUD residential treatment according to ASAM diagnostic admission criteria and ASAM dimensional admission criteria;

2. Documentation for the specific services rendered in the program in accordance with the 'Record' section in Chapters 2-2, through 2-12 as applicable;

3. At least every two weeks, documentation of an update of the ASAM criteria, by an individual specified in Chapter 1-5, A. The review must include progress toward treatment goal(s) and clinical justification for continued SUD residential treatment using ASAM dimensional admission criteria; and

4. If continued SUD residential treatment is no longer medically necessary according to ASAM dimensional criteria, then documentation must include transition/discharge plans. The documentation must include the signature and credentials of the individual performing the review.

2 - 14 Assertive Community Treatment and Assertive Community Outreach Treatment

Assertive Community Treatment (ACT) and Assertive Community Outreach Treatment (ACOT) are an evidence-based psychiatric rehabilitation practice that provides a comprehensive approach to service delivery to patients with serious mental illness. Services are provided by a multidisciplinary team of providers whose backgrounds and training include psychiatry, nursing, social work or other related mental health therapist field, and rehabilitation. The entire team shares responsibility for each patient, with each team member contributing expertise as appropriate. The team approach ensures continuity of care for patients and creates a supportive environment for providers. ACT and ACOT teams are characterized by low patient-to-staff ratios, provide services in community, provider 24/7 staff availability, provider services directly rather than referring patients to other agencies, and provide services on a time unlimited basis.

Who:

The ACT and ACOT teams consist of the following positions: team lead, prescriber, nurse, mental health therapist, SUD counselor, peer support specialist, other mental health professionals (e.g., case managers), employment specialist, and program assistant.

Limits:

1. The ACT team must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of and guidelines for ACT teams in order to report services under the per month bundled payment procedure code. If SAMHSA's guidelines are not met, then the individual services must be reported.

2. The ACT team maintains a 10:1 patient-to-staff ratio. The 10:1 patient-to-staff ratio includes all direct service staff except for the prescriber and the program assistant.

3. The ACOT team must meet DSAMH's Assertive Community Outreach Treatment for Clients with the Most Serious and Persistent Mental Illnesses Program Guidelines as set forth on DSAMH's website.

4. These services are reimbursed on a per month bundled payment basis; therefore, providers must report only one unit of service.

5. For patients who are on the ACT or ACOT team's caseload for the entire month, the ACT and ACOT team may report the team's standard monthly charge.

6. For patients who are not on the ACT or ACOT team's caseload for the entire month, the ACT and ACOT team must prorate its charge by multiplying a calculated per diem rate by the number of days of service. The per diem rate is determined by taking the monthly rate multiplied by 12 and then divided by 365. For example, if the patient were on the team's caseload from the 1st through the 16th, then the team would report this range of dates, one unit, and a prorated charge based on 16 days of the calculated per diem.

7. Providers may not report a range of dates of service that span over a month. For example, if a patient is on the ACT caseload from April 2nd through May 13th, the provider must report April 2nd through April 30th separately from the May range of dates.

Procedure Code and Unit of Service:

H0040 – Assertive Community Treatment, per month

Record:

Documentation must include:

1. In accordance with Chapters 1-6 and 1-7, an assessment and treatment plan that clearly document the medical necessity for services; and

2. Documentation for the specific services rendered in accordance with the 'Record' section in Chapters 2-2 through 2-12 as applicable.

3. A general summary note per team shift documenting other activities the team performed (e.g., patient staffing, team meetings, outreach phone calls, etc.)

2 - 15 Mobile Crisis Outreach Team

Mobile Crisis Outreach Team (MCOT) means a mobile team defined by Administrative Rule R523-18 that consists of at least two members who are deployed to the community to perform behavioral health crisis evaluations. Based on the assessment, the team also coordinates with local law enforcement, emergency medical service personnel, and other appropriate state or local resources.

Who:

An MCOT certified through the DSAMH that meets the standards set forth in Administrative Rule, R523-18, and that includes:

1. a licensed mental health therapist identified in Chapter 1-5, A who is a certified crisis worker and who meets any other requirements as specified Rule R523-18 of the Utah Code Annotated; and

2. a second team member who is also a certified crisis worker.

The MCOT must also have access to a designated examiner and a medical professional for consultation during the MCOT response in accordance with Rule R523-18 of the Utah Code.

Limits:

1. This procedure code may be reported only when the two team members specified above are deployed to the community to perform the assessment. If only one team member is deployed, then this code may not be reported. The provider must report the procedure code for the individual service provided as defined in this Chapter 2 (e.g., psychotherapy for crisis, etc.)

2. This service is reimbursed on a per diem bundled payment basis. Therefore, regardless of the number of visits made to a Medicaid member on a given date, only one unit of service may be reported and reimbursed.

Procedure Code and Unit of Service:

H2000 – Comprehensive multidisciplinary evaluation, per diem

Record:

Documentation must include:

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

2. setting in which the service was rendered;

3. specific service rendered (i.e., mobile crisis outreach);

4. clinical note that documents the crisis visit, including findings, mental status and disposition; and

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

2 - 16 Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)

Clinically Managed Residential Withdrawal Management, sometimes referred to as "social detox", is 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal and are appropriated to be managed in a social setting. This level of care emphasizes peer and social supports rather than medical and nursing care. Staff trained in withdrawal signs and symptoms of alcohol and other drug intoxication and withdrawal monitor the patients. Programs rely on established clinical protocols to identify patients who are in need of medical services beyond the capacity of the facility and transfer such patients to a more appropriate level of care. Programs have access to 24-hour medical and nursing supports.

Who:

A program that is licensed through the Utah Office of Licensing as a Social Detoxification facility, meets the ASAM Criteria guidelines for level 3.2-WM, and include the following staff under the clinical management of a licensed mental health therapist identified in Chapter 1-5, A. 1:

1. staff trained to monitor intoxication and withdrawal signs and symptoms, and

2. medical and nursing personnel.

Limits:

1. This service may only be reported by Volunteers of America.

Procedure Code and Unit of Service:

H0012 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)

Record:

Documentation must include:

1. date of the service;

2. setting in which the service was rendered;

3. assessment findings; and

4. signature, licensure, credentials, or job title of the individuals who rendered the service.

2 – 17 Mental Health Treatment in Licensed Mental Health Residential Treatment Programs

Medicaid's 1115 Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed mental health residential treatment programs with 17 or more beds that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). This means that licensed and accredited residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement for Medicaid members age 21 through 64. Reimbursement is made on a per diem bundled payment basis and is available for admissions on or after January 1, 2021.

Mental health residential treatment in these programs means face-to-face services that are a combination of medically necessary services provided in accordance with this Section 2. Treatment is provided to treat the patient's documented mental health disorder.

In accordance with the 1115 Demonstration Waiver, these programs must have the capacity to address co-morbid physical health conditions during short-term stays in residential treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with the patient's ACO or UMIC Plan, HOME, or a FFS provider if not enrolled in a plan).

These programs are also responsible to ensure appropriate transitions to other levels of outpatient mental health services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another FFS provider. For PMHP, UMIC Plan and HOME enrollees, the program must coordinate transitions to other levels of outpatient mental health services with the enrollee's PMHP or UMIC Plan, or with HOME.

These programs must have a process to assess the housing situation of the patient transitioning to the community from the program and to connect the patient who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services.

These programs must have protocols in place to ensure contact is made with each discharged patient within 72 hours of discharge and to help ensure the patient accesses follow-up care by contacting the community-based provider they were referred to.

Who:

The following individuals, in accordance with their licensure or credentials, may perform the services delivered in the licensed mental health residential treatment program:

1. licensed mental health therapist, or an individual exempted from licensure as a mental health therapist. (See Chapter 1-5, B.1.);

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

3. licensed registered nurse;

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

5. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2. b. of Chapter 1-5; a licensed social service worker, or a licensed registered nurse;

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

7. certified peer support specialist.

Limits:

1. Stays of up to 60 days may be reimbursed based on medical necessity. Medicaid will not reimburse any part of a stay (days 0-60) that exceeds 60 days.

2. Residential treatment is limited to medically necessary services for documented mental health diagnoses for Medicaid members age 21 through 64.

3. For Medicaid members enrolled in the PMHP, UMIC Plans, or HOME, mental health residential treatment must be provided through the member's plan. DMHF does not reimburse programs on a FFS basis for PMHP, UMIC Plan, or HOME enrollees.

4. For Medicaid members not enrolled in the PMHP, UMIC Plans, or HOME, DMHF reimburses programs on a FFS basis.

5. Programs are reimbursed on a per diem bundled payment basis using the applicable procedure code specified in the 'Procedure Codes and Unit of Service' section below. All services included in this Section 2, Chapters 2-2- through 2-12, are included in the per diem bundled payment rate. Programs may not report these services under any other procedure codes.

6. Services not included in the per diem bundled payment rate are drug-administered codes (e.g., J codes).

7. Programs may only report the per diem bundled service codes for dates when individual rehabilitative service(s) are provided to the Medicaid member in accordance with this Section 2, Chapters 2-2 through 2-12.

8. If a Medicaid member is hospitalized, the program may report the hospital admission and discharge dates only if rehabilitative service/s were provided to the Medicaid member in accordance with this Section 2, Chapters 2-2 through 2-12, prior to the hospital admission and/or post discharge from the hospital. The per diem reimbursement is not available for any other dates of service while the Medicaid member is an inpatient of a hospital.

9. When requested prior authorization (PA) is denied for additional days beyond the number of days approved under the prior PA request (See Chapter 6), then Medicaid reimbursement is no longer available.

10. If a Medicaid member is quarantined in a different location due to COVID-19, as long as the member continues to receive therapeutic services covered under the bundled procedure code (H0017), the program may bill for these dates of service.

Prior Authorization for 7-Day increments up to 60 days:

Fee-for-Service Medicaid Members

1. All licensed mental health residential treatment programs with 17 or more beds must request PA from DMHF's Prior Authorization Unit in accordance with PA policy and procedures contained in Chapter 6 of this Section 2.

2. For adult Medicaid members age 21 through 64, no more than 7 days will be prior authorized at a time.

3. No more than 60 days may be authorized per stay, per member (see #1 in the Limits Section above).

Prepaid Mental Health Plan, UMIC Plan, and HOME Enrollees

PMHPs, UMIC Plans, and HOME must also implement utilization review, including prior authorization of services. For information on PMHPs', UMIC Plans', and HOME's PA and utilization review requirements and processes, programs must contact these plans.

Procedure Codes and Unit of Service:

Programs with 17 or more beds: H0017 – Behavioral health; residential (hospital residential treatment program), without room and board – per diem, per Medicaid patient

Record:

Licensed mental health residential treatment programs must maintain the following documentation:

1. In accordance with Chapters 1-6 and 1-7, an assessment and treatment plan that clearly document the medical necessity for mental health treatment in a residential setting and address InterQual criteria; and

2. Documentation for the specific services rendered in the program in accordance with the 'Record' section in Chapters 2-2, through 2-12 as applicable.

2 - 18 Behavioral Health Receiving Centers

Behavioral Health Receiving Centers (Receiving Centers) are centers that provide services to individuals experiencing any level of behavioral health crisis in the community. Pursuant to Rule R523-21 of the Utah Administrative Code, receiving centers are no-refusal centers that are capable of accepting referrals, individuals who walk in or are dropped off, as well as individuals first responders bring for crisis services.

Receiving centers are staffed 24 hours a day, 365 days a year. Receiving centers have a multidisciplinary team capable of providing biopsychosocial assessments of behavioral health issues, and observation, stabilization, crisis management and support. The team also has the capability to provide assessments of the individual's physical health needs and care for most minor physical health challenges, with protocols for transferring individuals to additional medical services if needed.

Receiving centers must also adhere to all other requirements of Rule R523-21 of the Utah Administrative Code to qualify for Medicaid reimbursement.

Medicaid reimbursement is available to receiving centers effective October 1, 2020 and is made on a Fee-for-Service basis.

Who:

1. Receiving centers must be licensed by Department of Human Services, Office of Licensing, or must be a facility that is licensed as an outpatient hospital.

2. Pursuant to Rule R523-21 of the Utah Administrative Code, receiving centers must have a team that includes psychiatrists or psychiatric nurse practitioners, registered nurses, licensed mental health

therapists specified in Chapter 1-5, A, with at least one licensed mental health therapist present 24 hours a day, 7 days a week, and certified peer support specialists with lived behavioral health experience similar to the experience of the population served. A licensed mental health therapist may be off-site during graveyard hours if they can respond on-site within an average response time of 30 minutes.

Limits:

1. Pursuant to Rule R523-21 of the Utah Administrative Code, receiving centers provide services to an individual for up to 23 hours.

2. Receiving centers must meet staffing ratios specified in Rule R523-21 of the Utah Administrative Code.

3. Receiving centers are eligible for reimbursement effective October 1, 2020. Receiving Centers are reimbursed FFS.

Procedure Code and Unit of Service:

S9485 – Crisis intervention mental health services; per diem

Record:

Documentation must include:

1. the receiving center must maintain documentation, including the date of service at the receiving center, patient name, and Medicaid identification number;

2. a note by each provider delivering a service during the patient's stay that includes:

   a. date and duration of the service;

   b. setting in which the service was rendered;

   c. summary of the service provided; and

   d. signature, licensure, or credentials of the individual preparing the note; and

3. a note summarizing the discharge disposition that must be written by a registered nurse or licensed mental health therapist. The note must include the signature, and licensure of the individual preparing the note.

3 1915(b)(3) SERVICES/ADDITIONAL SERVICES - FOR PREPAID MENTAL HEALTH PLANS (PMHP) CONTRACTORS AND UTAH MEDICAID INTEGRATED CARE (UMIC) PLANS ONLY

This Chapter applies to PMHP contractors and UMIC Plans.

The services contained in this Chapter are authorized under the PMHP 1915(b) Waiver, and under the 1115 Demonstration Waiver. The services are available only for Medicaid members enrolled in the PMHP or in UMIC Plans.

Under the PMHP 1915(b) Waiver, these services are referred to as 1915(b)(3) services.

1915(b)(3) services are not a benefit for Medicaid members enrolled in the PMHP for only inpatient psychiatric care. This includes children in foster care, and children with adoption subsidy exempted from the PMHP for outpatient behavioral health services.

Effective January 1, 2020, the 1115 Demonstration Waiver authorized these same services for Medicaid members eligible for Medicaid under this waiver, and enrolled in the PMHP or in UMIC Plans. Under the 1115 Demonstration Waiver, these services are referred to as Additional Services.

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

3 - 1 Personal Services

Personal Services are recommended by a physician or other practitioner of the healing arts (see paragraph A of Chapter 1-5) and are furnished for the primary purpose of assisting in the rehabilitation of patients with serious mental illness (SMI) or serious emotional disorder (SED). These services include assistance with instrumental activities of daily living (IADLs) that are necessary for patients to live successfully and independently in the community and avoid hospitalization. Personal services include assisting the patient with varied activities based on the patient's rehabilitative needs: picking up prescriptions, income management, maintaining the living environment including cleaning and shopping, and the transportation related to the performance of these activities, and representative payee activities when the PMHP has been legally designated as the patient's representative payee. These services assist patients to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

Who:

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

2. licensed registered nurse;

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

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2.b of Chapter 1-5; a licensed social service worker or a licensed registered nurse; or

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

6. The above are the core providers of this service. In addition, a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.), or an individual identified in Chapter 1-5, B.2.a or B.2.b., may perform this service.

Procedure Code and Unit of Service:

H0046 – per 15 minutes

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Documentation must include:

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

3 - 2 Respite Care

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

family unit, and minimize the risk of out-of-home placement by reducing the stress families of children with SED typically encounter.

Who:

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

2. licensed registered nurse;

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

4. other trained individual under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2.(b) of Chapter 1-5; a licensed social service worker or a licensed registered nurse; or

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

6. The above are the core providers of this service. In addition, a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.), or an individual identified in Chapter 1-5, B.2.a. or B.2.b., may perform this service.

Procedure Code and Unit of Service:

S5150 – per 15 minutes

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

Each provider delivering respite care must provide documentation as follows:

1. For each date of respite care:

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

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

   a. the name of the service;

   b. treatment goal(s);

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

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

3 - 3 Psychoeducational Services

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

Who:

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

2. licensed registered nurse;

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

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2 (b.) of Chapter 1-5; a licensed social service worker or a licensed registered nurse; or

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

6. The above are the core providers of this service. In addition , a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.), or an individual identified in Chapter 1-5, B.2.a. or B.2.b., may perform this service.

Procedure Code and Unit of Service:

H2027 – Psychoeducational Services - per 15 minutes per Medicaid patient

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

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 67 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

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

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

Record:

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

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

   a. name of the service;

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

   c. the setting in which the service was rendered.

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

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

   The summary note must include:

   a. name of the service;

   b. treatment goal(s);

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

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

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

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

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

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

C. Psychoeducational Services Provided to an Individual

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

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

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

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

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

3 - 4 Supportive Living

Supportive Living means costs incurred in residential treatment/support programs when Enrollees are placed in these programs. These programs assist patients to avoid and/or reduce risk for inpatient hospitalization. Costs include those incurred for 24-hour staff, facility costs associated with providing individual Covered Services (e.g., individual psychotherapy, pharmacologic management, etc.) at the facility site, and apportioned administrative costs. Costs do not include the services costs or room/board costs. This level of care is recommended by a physician or other practitioner of the healing arts (see Chapter 1-5, A), and helps to restore patients with serious mental illness (SMI) or SED to their best

possible functioning level. Whenever possible, the PMHP will provide this level of care in lieu of inpatient hospitalization so that individuals may remain in a less restrictive community setting.

Who:

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

2. licensed registered nurse;

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

4. other trained individual (but not including foster parents or other proctor parents) under the supervision of a licensed mental health therapist identified in paragraph A.1 or A.2 (b.) of Chapter 1-5; a licensed social service worker or a licensed registered nurse; or

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

6. The above are the core providers of this service. In addition, a licensed mental health therapist, or an individual exempted from licensure as a mental health therapist (see Chapter 1-5, B.1.), or an individual identified in Chapter 1-5, B.2.a. or B.2.b., may perform this service.

Procedure Code and Unit of Service:

H2016 – 1 unit per day

Record:

Documentation must include:

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

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

4 PROCEDURE CODES AND MODIFIERS

Procedure Code	Service and Units
90791**	Psychiatric Diagnostic Evaluation - per 15 minutes
90792**	Psychiatric Diagnostic Evaluation with Medical Services - per 15 minutes
H0031	Mental Health Assessment by Non-Mental Health Therapist - per 15 minutes
96130**	Psychological testing evaluation services by physician or other qualified health care professional - first hour
96131**	Each additional hour of 96130
96132**	Neuropsychological testing evaluation services by physician or other qualified health care professional - first hour
96133**	Each additional hour of 96132
96136**	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137**	Each additional 30 minutes of 96136
96138**	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139**	Each additional 30 minutes of 96138
96146**	Psychological or neuropsychological test administration with single automated, standardized instrument via electronic platform, with automated result only, encounter
96105**	Assessment of Aphasia - per hour
96125**	Standardized cognitive performance testing – per hour
96110**	Developmental Screening - per standardized instrument
96112**	Developmental test administration – first hour
96113**	Each additional 30 minutes of 96112
96116**	Neurobehavioral Status Exam - first hour
96121**	Each additional hour of 96116
90832	Psychotherapy with patient and/or family member - 30 minutes
90834	Psychotherapy with patient and/or family member - 45 minutes
90837	Psychotherapy with patient and/or family member - 60 minutes
90846	Family Psychotherapy - without patient present - per 15 minutes
90847	Family Psychotherapy - with patient present - per 15 minutes
90849	Group Psychotherapy - Multiple-family group psychotherapy - per 15 minutes per Medicaid patient
90853	Group Psychotherapy – per 15 minutes per Medicaid patient
90839	Psychotherapy for Crisis, first 60 minutes* – per encounter
90840	Psychotherapy for Crisis, add-on to 90839, each additional 30 minutes

	*Note: Use 90832 for crisis contacts 30 minutes or less
90833	Psychotherapy add-on code, with patient and/or family member – 30 minutes (added to applicable evaluation and management (E/M) service code)
90836	Psychotherapy add-on code, with patient and/or family member – 45 minutes (added to applicable evaluation and management (E/M) service code)
90838	Psychotherapy add-on code, with patient and/or family member – 60 minutes (added to applicable evaluation and management (E/M) service code)
99211-99215*	Office or Other Outpatient Services Evaluation and Management (E/M) Services Codes- established patient
99307-99310*	Subsequent Nursing Facility Care E/M Codes – established patient (should be used to report E/M services provided to a patient in a psychiatric residential center [a facility or a distinct part of a facility for psychiatric care, which provides 24-hour therapeutically planned and professionally staffed group living and learning environment])
99347-99350*	Home Services E/M Codes – established patient
99354	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99347-99350; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99355	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99354) – per encounter
99356	Prolonged Services, first hour (60 additional minutes with patient) - per encounter (Use with E/M codes 99307-99310 or inpatient-based E/M codes; and with 90837 when psychotherapy place of service is where these E/M codes would be used.)
99357	Prolonged Services, each additional 30 minutes with patient (beyond the 60 additional minutes that are coded with 99356) – per encounter
99417	Prolonged Services- per 15 minutes (Use with Outpatient or Other Outpatient Services E/M code 99215)
T1001	Nurse Evaluation and Assessment (Medication Management) - per encounter
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug) subcutaneous or intramuscular – per encounter
90785	Add-on code for interactive complexity (with procedure codes 90791, 90792, 90832, 90834, 90837, 90833, 90836, 90838; and E/M services codes)
H2019	Individual/Family Therapeutic Behavioral Services - per 15 minutes
H2019 with HQ modifier	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid patient
H2014	Individual Skills Training and Development (Psychosocial rehabilitative services with an individual patient) - per 15 minutes
H2017	Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid patient
H2017 with U1 modifier	Group Psychosocial Rehabilitative Services - Intensive - per 15 minutes per Medicaid patient
H0038	Peer Support Services, individual patient – per 15 minutes
H0038 with HQ modifier	Peer Support Services, group - per 15 minutes per Medicaid patient

H0018	Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem
H2036	Alcohol and/or drug treatment program, per diem
H0040	Assertive Community Treatment (ACT) or Assertive Community Outreach Treatment (ACOT), per month
H2000	Comprehensive multidisciplinary evaluation, (MCOT), per diem
H0012	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board – per diem, per Medicaid patient
S9485	Crisis intervention mental health services; per diem, per Medicaid patient
Prepaid Mental Health Plan Contractors and UMIC Plans Only- 1915(b)(3) Services and Additional Services	
H0046	Personal Services - per 15 minutes
S5150	Respite Care - per 15 minutes
H2027	Psychoeducational Services – per 15 minutes
H2016	Supportive Living – per day

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

** When evaluation or psychological testing is performed for physical health purposes, including prior to medical procedures, or for the purpose of diagnosing intellectual or development disabilities, or organic disorders, to ensure correct adjudication of the claim, use the UC modifier with the procedure code.

5 PRIOR AUTHORIZATION POLICIES and PROCEDURES FOR LICENSED SUBSTANCE USE DISORDER RESIDENTIAL TREATMENT PROGRAMS

To prevent the delivery of unnecessary and inappropriate care to Medicaid members who have FFS Medicaid, and to provide for both necessity for care and appropriateness of care requests, a prior authorization (PA) process has been implemented to review SUD treatment provided in licensed SUD residential treatment program, ASAM levels of care 3.1, 3.3, 3.5, and 3.7.

In order to accomplish this, there is a two-part process.

1. The program must submit an initial non-clinical PA request within three business days of admission.
2. The program must submit a clinical PA request within five calendar days before the end of the current treatment episode, with appropriate documentation.

Please note: If the program has obtained a PA from a PMHP, UMIC Plan or HOME for a Medicaid member who changes to the Fee-for-Service Network, then the program's first PA request to the Medicaid PA Unit must be a clinical PA request, following the clinical PA request policy below.

Initial Non-Clinical PA Request

Programs must submit an initial non-clinical PA request.

1. Submit the "SUD Residential Treatment Services Prior Authorization Request Form"
   a. Form is found at: https://medicaid.utah.gov/forms
   b. Fax to the Medicaid Prior Authorization Unit (PA Unit): 801-323-1587 or email at fax_mentalhealthservices_prior@utah.gov
   c. Fax or email within three business days of admission
2. PA Unit will fax or email a PA number for reporting the service
3. Non-clinical PA requests will be approved for the number of days requested but not to exceed 60 calendar days for adults and 30 calendar days for adolescents
4. No other documents are needed

Clinical PA Request

1. Submit the "SUD Residential Treatment Services Prior Authorization Request Form"
   a. Form is found at: https://medicaid.utah.gov/forms
2. Submit Clinical Documents:
   a. ASAM assessment
      i. Must be completed, with updated ASAM ratings in each dimension, no more than 14 calendar days prior to the requested PA start date
      ii. Reassessments for ASAM level of care 3.1 must be completed every 30 days.
      iii. Reassessments for ASAM level of care 3.5 must be completed every 14 days.
   b. Updated treatment goals (treatment/service plan)
   c. Estimated length of stay
   d. Discharge Plan

   Documentation must clearly articulate how the beneficiary meets the diagnostic and dimensional admission criteria found in *The ASAM Criteria* book for the requested level of care
3. Fax all documents to the PA Unit: 801-323-1587 or email at fax_mentalhealthservices_prior@utah.gov

4. Fax or email the PA request form within five calendar days before the end of the current treatment episode.
5. PA Unit will fax or email a PA number for reporting the service
6. A treatment episode can be approved for up to 60 calendar days for adults, and 30 calendar days for adolescents.

The PA Unit will review the request and the attached clinical documentation for appropriateness and approve or deny the request based on medical necessity and the information provided. If the PA Unit has any concerns with the PA request or documentation, staff will either contact the treatment program at the number listed on the PA request form to address the concerns or the PA Unit will return the PA request to the program. The PA Unit will detail in the returned documentation the corrections needed in order to process the PA request. The PA Unit will follow these steps prior to issuing a denial. If the PA Unit issues a denial, see Section 1 of the Provider Manual for information on Hearings and Administrative Review processes: https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf.

PA requests will be approved for the following situations: (*The ASAM Criteria* pg. 300)

1. The patient is making progress, but has not yet achieved goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;
2. The patient is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;
3. New problems or priorities have been identified that are appropriately treated at present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care in which the patient is receiving treatment is therefore the least intensive level at which the patient's new problems can be addressed effectively.

Adults: The PA Unit may approve a PA request for up to 60 additional calendar days at a time based on medical necessity. Programs must submit PA requests to the PA Unit within at least five calendar days prior to the 61st calendar day of treatment. The program must submit all subsequent PA requests within at least five calendar days prior to the end of the previous PA period. Each PA request must include a completed SUD Residential Treatment Services Prior Authorization Request Form and updated clinical documentation.

Adolescents/Youth (12-18): The PA Unit may approve a PA request for up to 30 additional days at a time based on medical necessity. Programs must submit PA requests to the PA Unit within at least five calendar days prior to the 31st calendar day of treatment. The program must submit all subsequent PA requests within at least five calendar days prior to the end of the previous PA period. Each PA request must include a completed SUD Residential Treatment Services Prior Authorization Request Form and updated clinical documentation.

The PA Unit will deny PA requests for the following situations: (*The ASAM Criteria* pg. 303)

1. The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;
2. The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;
3. The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

4. The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

In situations where the patient no longer meets medical necessity criteria, the PA Unit will authorize 14 transitional calendar days to allow time to transition the patient to a more appropriate ASAM level of care.

In situations where the patient leaves treatment, by either transitioning to a different level of care, whether higher or lower, or leaves against medical advice, the program must submit a new non-clinical PA if the lapse in treatment is more than three calendar days. If the lapse in treatment is less than three calendar days, programs will use the PA already in place.

6 PRIOR AUTHORIZATION POLICIES and PROCEDURES FOR LICENSED MENTAL HEALTH TREATMENT PROGRAMS WITH 17 OR MORE BEDS

To prevent the delivery of unnecessary and inappropriate care to Medicaid members who have FFS Medicaid, and to provide for both necessity for care and appropriateness of care requests, a prior authorization (PA) process has been implemented to review mental health treatment provided in licensed and accredited mental health residential treatment programs.

In order to accomplish this there is a two-part process.

1. Programs must obtain a non-clinical PA at admission as notification of admission. A non-clinical PA request may be approved for up to seven days. The program must submit an initial non-clinical PA request within one business day of the admission.
2. For stays that may exceed seven days, programs must submit clinical PA requests with a maximum of seven days per request. The program must submit a clinical PA request no more than two business days before the end of the current PA-approved period, with appropriate documentation (specified below).

Please note: If the program has obtained a PA from a PMHP, UMIC Plan or HOME for a Medicaid member who changes to the Fee-for-Service Network, then the program's first PA request to the Medicaid PA Unit must be a clinical PA request, following the clinical PA request policy below.

Initial Non-Clinical PA Request

Programs must submit an initial non-clinical PA request.

1. Submit the "Mental Health Residential Treatment Services (Individuals Age 21 through 64) Prior Authorization Request Form"
   a. Form is found at: https://medicaid.utah.gov/forms
   b. Fax to the Medicaid Prior Authorization Unit (PA Unit): 801-323-1587 or email at fax_mentalhealthservices_prior@utah.gov
   c. Fax or email within one business day of the admission
2. PA Unit will fax or email a PA number for reporting the service
3. Non-clinical PA requests will be approved for the number of days requested but not to exceed seven calendar days
4. No other documents are needed

Clinical PA Request

1. Submit the "Mental Health Residential Treatment Services (Individuals Age 21 through 64) Prior Authorization Request Form" Form is found at: https://medicaid.utah.gov/forms
2. Submit Clinical Documents:
   a. Interqual Criteria
      i. Documentation submitted must address InterQual criteria
   b. Updated treatment goals (treatment plan)
   c. Number of days requested, estimated length of stay, and anticipated discharge date
   d. Discharge Plan
3. Fax all documents to the PA Unit: 801-323-1587 or email at fax_mentalhealthservices_prior@utah.gov

4. Fax or email the PA request form no more than two business days before the end of the current PA-approved treatment period
5. PA Unit will fax or email a PA number for reporting the service

The PA Unit will review the request and the attached clinical documentation for appropriateness and approve or deny the request based on medical necessity and the information provided. If the PA Unit has any concerns with the PA request or documentation, staff will either contact the treatment program at the number listed on the PA request form to address the concerns or the PA Unit will return the PA request to the program. The PA Unit will detail in the returned documentation the corrections needed in order to process the PA request. The PA Unit will follow these steps prior to issuing a denial. If the PA Unit issues a denial, see Section 1 of the Provider Manual for information on Hearings and Administrative Review processes: https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf