



**Kansas
Medical Assistance
Program**



KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

**Community Mental Health
Center**

PART II
COMMUNITY MENTAL HEALTH CENTER PROVIDER MANUAL

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PART II

COMMUNITY MENTAL HEALTH CENTER PROVIDER MANUAL

This is the provider specific section of the manual. This section was designed to provide information and instructions specific to Community Mental Health Center (CMHC) providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The **Billing Instructions** subsection gives an example of the billing form applicable to CMHC services. The form is followed by directions for completing and submitting it.

The **Benefits and Limitations** subsection defines specific aspects of the scope of CMHC services allowed within the Kansas Medical Assistance Program.

The **Appendix** subsection contains information concerning procedure codes. The appendix was developed to make finding and using procedure codes easier for the biller.

HIPAA Compliance

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. COMMUNITY MENTAL HEALTH CENTER BILLING INSTRUCTIONS

Introduction to the HCFA-1500 Claim Form Updated 11/03

CMHC providers must use the HCFA-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program. An example of the HCFA-1500 claim form is in the forms section at the end of this manual. Instructions for completing this claim form are included in the following pages. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the HCFA-1500 claim form to providers. Refer to Section 1100.

Complete, line by line instructions for completion of the HCFA 1500 is available in the General Billing manual, pages 5-14 through 5-19.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571

CMHC SPECIFIC BILLING INFORMATION

7010. Updated 11/03

Off-Site Services:

Utilize place of service "99" - Other Locations in field 24B of the HCFA-1500 claim form when billing for off-site CMHC services.

Partial Hospitalization and Targeted Case Management:

When billing for partial hospitalization, bill Medicare Part A first. If Targeted Case Management is provided in conjunction with partial hospitalization, bill Medicare first.

Unit Billing:

Appendix I provides procedure code and time definitions for billing specific procedures (i.e., 30 minutes, 1 hour, etc.). When billing according to this definition, bill one (1) unit in field 24G.

When billing for less than the amount of time indicated in the definition (less than one unit), bill as follows:

- ".3" represents one quarter of the time specified.
- ".5" represents one-half of the time specified.
- ".8" represents three-fourths of the time specified.

When billing for more than the amount of time indicated in the definition (more than one unit), bill as follows:

- "1.3" represents one and one-quarter units of the time specified.
- "1.5" represents one and one-half units of the time specified.
- "1.8" represents one and three-quarters units of the time specified.
- "2.0" represents two units of the time specified, etc.

Services Provided by PA's or ARNP's:

A performing number is required for **ONLY** the following billing categories:

Case Consultation - 99241 99242 99243 99244 99261 99263

Hospital Care - 99221 99222 99223 99232

Subsequent Nursing Facility Care - 99311 99312 99313

- Indicate the PA's or ARNP's number in field 24K as the performing provider
- Indicate the CMHC's provider number in field 33 as the billing provider.

BENEFITS AND LIMITATIONS

COPAYMENT

8100. Updated 11/03

CMHC services require a copayment of \$3.00 for individual psychotherapy, per date of service.

Dietitian services require a copayment of \$2.00 per date of service for KAN Be Healthy participants 18 years of age and older.

Do **not** reduce charges or balance due by copayment amount. This reduction is made automatically during claim processing.

BENEFITS AND LIMITATIONS

8200. Updated 11/03 MEDICAL ASSESSMENT

Psychological Testing/Assessment:

Psychological testing/assessment documentation must:

- Clearly identify the questions and issues to be addressed
- Describe the individual at the time of the assessment
- Illustrate the need for initiating/continuing intervention
- Include the interpretation of findings with impressions and observations
- Give suggestions and recommendations

The consumer's record must include the following components. (Documentation need not be in a standard format.)

A. Referral

- Source of referral
- Reason for referral

B. Pertinent Past and Present History

C. Treatment Plan

- Psychological tests, procedures and techniques to be used
- Reviewed and updated appropriately

D. Evaluation

- Interpretation of all completed/attempted psychological tests, procedures and techniques utilized with conclusions reached
- Recommendations that are related to meaningful aspects of the individual's everyday existence

It is recommended that if an underlying cause of the maladaptive behavior is suspected of being physical in origin, a medical evaluation should precede a psychological evaluation. Results of the medical evaluation must also be documented in the record.

All limitations for psychological testing identified in Section 8400 of the provider manual remain in effect.

BENEFITS AND LIMITATIONS

8300 Benefit Plan Updated 4/04

Kansas Medical Assistance beneficiaries will be assigned to one or more Medical Assistance benefit plans. The assigned plan or plans will be listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990

For example, **MediKan** coverage is the same as for Medicaid beneficiaries (Section 8400) with the following exceptions:

- Individual outpatient psychotherapy is limited to 24 hours per calendar year per beneficiary.
- Group and family therapy in any combination are limited to 24 hours per calendar year per beneficiary.
- Psychological testing and assessment is limited to **four** (4) hours every three calendar years, per beneficiary, regardless of provider. **Prior authorization will not override this limitation.**
- Partial Hospitalization Activity and Medication Group in any combination, are limited to 720 hours per calendar year, per beneficiary. (Partial Hospitalization is also restricted to 120 units per month.)
- Targeted Case Management is limited to 80 hours per calendar year per beneficiary.

BENEFITS AND LIMITATIONS

8400. Updated 11/03 MEDICAID

Only services described herein, provided by individuals listed, and provided in the manner described are reimbursable by Kansas Medicaid for community mental health centers.

Approved Center Staff:

Provided professional staff members rendering Medicaid-reimbursable services are licensed within the State of Kansas to render that service, no “approval” process is required through The Consortium’s Professional Standards/Credentialing Committee. For those staff members who do not meet this licensure requirement, application to and approval through The Consortium’s Professional Standards/Credentialing Committee must be on file prior to deeming these individuals as Medicaid-reimbursable staff under the approved center staff designation.

Admission Evaluation (Diagnostic):

The initial evaluation is a face to face interview with the client, family members, and/or other informants. It may also include a request for a social history and examinations or reports. Psychological testing must be billed separately.

Five hours of evaluation are allowed per calendar year per beneficiary (does not include outpatient therapies or psychological evaluation.)

Behavior Management Preadmission Assessments:

A preadmission assessment by a community mental health center is required for Behavior Management Group Care and Observation/Stabilization Placement. The community mental health center shall determine, based on standardized admission criteria, whether or not a highly structured residential program is required to meet the child's needs.

The SRS social worker will contact the Mental Health Consortium (MHC) and arrange for the assessment. Preadmission assessments must be completed face-to-face with the Medicaid beneficiary by the community mental health center. Following completion of the assessment, the behavior management group care or observation/stabilization provider will be notified of the results via a letter from the MHC.

Case Conferences:

A case conference is a scheduled face to face meeting between two or more individuals to discuss problems associated with the beneficiary's treatment. The conference may include treatment staff, collateral contact, or the consumer's other agency representatives, not including court appearances and/or testimony.

Six hours of case conferences are allowed per calendar year for consumers not participating in the KAN Be Healthy Program. KAN Be Healthy participants are allowed twelve hours per calendar year.

8400. Updated 11/03

Case Consultations :

Case consultations are covered when provided by a physician (or by an ARNP/PA with the performing provider number noted). Written consultation of the consultation is required.

Consultations are not based on time but rather on the extent of the consultation. Reference the CPT manual to determine criteria for various service levels. The following Medicaid limitations apply:

- Consultations for a new patient are not covered if a consultation has been paid to the same provider for the same patient in the previous 60 days.
- Inpatient consultations for established patients are limited to one consultation per 10 days per provider, per diagnosis, unless medical necessity documents otherwise.
- Outpatient and in-office consultations for established patients are limited to one consultation every 60 days, per provider, per diagnosis unless medical necessity documents otherwise.

Children and Family Services (CFS) Contractors:

Privatization of Adoption, Foster Care, and Family Preservation services through contractual arrangements with the Commission of Children and Family Service (CFS) include an assortment of services other than the usual behavior management services. The children under contract will continue to have a medical card and the contractor will be indicated on the medical card. The contractors are paid a bundled case rate, therefore, if any provider bills for services which are covered in the contract, the claim will be denied.

Refer to Section 2900 of your General Provider Manual for an all-inclusive list of the categories of service covered under the CFS contract.

Community Psychiatric Supportive Treatment (CPST):

CPST shall be face-to-face interventions with the individual. In addition, a majority of these contacts must occur in customary and usual community locations where the person lives, works, or socializes. All interventions provided shall be related to specific goals set forth in the consumer's treatment plan. Documentation in progress notes is required to support the CPST intervention. CPST interventions include the following:

- Assistance in improving symptom self-management, which shall have as its goal the identification and minimization of the negative effects of psychiatric symptoms or emotional disturbances which interfere with an individual's daily living, financial management, academic progress, personal development, family and/or interpersonal relationships and community integration. This may include counseling the individual to recognize symptoms for self-management.

8400. Updated 11/03

- Individual therapeutic intervention, which always involves face-to-face contact with the individual. The family, or other collaterals may also be involved. The service will have as its objective the development of interpersonal, self-care skills and an understanding of mental illness or emotional disturbance which assists the individual to gain control over his or her psychiatric or emotional symptoms and life situation and to adapt to community settings in which he or she lives and functions.
- Participation in a strengths assessment and planning process with the individual including identifying strengths, resources, and natural supports. The family or other collaterals may also be involved. Also included would be assistance in defining goals based on the assessment, and tracking and monitoring individual progress in meeting the goals identified in the treatment plan.
- Assistance which shall have as its objective the development and implementation of a plan for assuring consumer income maintenance. This includes the provision of both supportive counseling and problem-focused interventions in whatever setting is required, to enable the consumer to manage the symptoms of their illness. Services provided at the work site must be focused on assisting the individual to manage the symptoms of mental illness, and not to learn job tasks. These interventions will fall primarily in the areas of achieving required level of concentration and task orientation and facilitating the establishment and maintenance of effective communications with employers, supervisors and co-workers.
- Medication education, which shall have as its objective the development of the skills necessary for an individual (or family) to comply with physician prescribed medication.
- Crisis management, which shall include training approved by the Division regarding management of a psychiatric and/or emotional/behavioral crisis and shall have as its objective the ability of an individual to identify a psychiatric or personal crisis, implement the crisis management plan identified in the individual's treatment plan, if appropriate, and/or seek needed support from clinical staff. The focus of the service must be on the eligible adult or child.
- Assistance which shall have as its objective achieving academic progress, including the provision of both supportive counseling and problem-focused interventions in whatever setting is required.

Each person providing CPST shall, at a minimum:

- Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education;
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations.

8400. Updated 11/03

- Meet the specifications for targeted case management as outlined in the CMHC licensing standards in regard to any ongoing requirements (as in completion of the training requirements according to a curriculum approved by the Division of Health Care Policy); and
- Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens.

The CPST worker is supervised by “approved center staff” which may include a MSW (Master’s Level Social Worker), LMLP (Licensed Master’s Level Psychologist), licensed psychologist or master’s degree psychiatric nurse within the agency delivering CPST services.

If a center has a question about whether a particular staff member meets the criteria to be a CPST worker, a written description of his/her qualifications should be sent to Mental Health/Substance Abuse Treatment and Recovery in the Division of Health Care Policy which will make a determination.

Crisis Resolution Services:

Hospitals may be reimbursed when Medicaid patients are admitted to observation/stabilization beds for crisis resolution services in accordance with the following conditions:

- There shall be an affiliation agreement between the admitting hospital and the licensed community mental health center.
- The patient must be referred by the primary care case manager, or the agency or health professional currently providing care (whichever is applicable).
- The patient shall have demonstrated an acute change in mood or thought that is reflected in behavior, indicating the need for crisis intervention to stabilize and prevent hospitalization.
- The patient must have a diagnosed psychiatric disorder.
- The patient shall not be in need of acute detoxification or be experiencing withdrawal symptoms.
- The patient must be medically stable.
- The following documentation shall be completed:
 - nursing assessment (including physical review, mental status, and medication)
 - strength assessment
 - personal crisis plan, and
 - at least one progress note

Crisis resolution services are covered up to two consecutive days.

8400. Updated 11/03

Dietitian Services:

Dietitian services are covered for **KAN Be Healthy participants only**.

Dietitians employed by a CMHC shall bill for their services under the provider number of the CMHC. The dietitian providing the service shall be registered and licensed through the Kansas Department of Health and Environment. Dietitian services may only be rendered as the result of a medical or dental KAN Be Healthy screening referral.

Other insurance and Medicare are primary and must be billed first.

Individual focused services are limited to two (30 minute) initial evaluation and 11 follow-up visits per consumer, per year. Additional visits may be covered with approved prior authorization (PA).

Group focused services are non-covered.

Hospital Care:

Inpatient psychiatric admissions are covered only after a psychiatric preadmission assessment has been completed and a determination made that the most appropriate treatment setting is the hospital. No payment will be made for the hospital admission or related physician services without the completion of the preadmission assessment and determination that the hospital admission meets criteria. When seeking to admit a Kansas Medical Assistance Program consumer for inpatient treatment call **1-800-466-2222** to arrange for an assessment to be completed. This toll free number is staffed 24 hours a day by the Mental Health Consortium (MHC).

After receiving a request for a psychiatric preadmission assessment the MHC will contact the appropriate CMHC (or other approved provider if the admission is out of state), to complete the assessment face-to-face with the consumer. Following completion of the assessment, the hospital and admitting physician will be notified of the results verbally and via a letter from the MHC. If the admission is approved, a prior authorization (PA) number will be included in the letter to the physician for use when billing the admission and related services.

Any individual who is **potentially** eligible for Kansas Medical Assistance Program benefits (as determined by the hospital) must have a psychiatric preadmission assessment **prior** to admission in an acute care general or specialty hospital. The hospital will contact the Mental Health Consortium (MHC) and arrange for the preadmission assessment to be completed.

8400. Updated 11/03

Claims for the preadmission assessment may be submitted for payment as soon as the determination of Kansas Medical Assistance Program eligibility is made. In some instances this determination may take up to 90 days. The MHC will notify the CMHC of the consumer's ID number so that the claim for the preadmission assessment can be submitted to the fiscal agent for processing should this individual become Medicaid-eligible retroactive to the date of the screen.

A HealthConnect referral is not required for psychiatric hospital stays or related physician and ancillary services provided during a psychiatric hospitalization approved through the preadmission assessment process.

Emergency Psychiatric: Screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric care. The individual is in crisis and not currently in a place of safety. A screening is completed immediately (no later than 3 hours) to determine appropriate placement.

Urgent Psychiatric: Screening is initiated if the individual meets one of the four independent criteria and is currently in a place of safety. An observation bed may be used to provide security and “observation” for individuals in imminent danger and to assist in the determination of the need for psychiatric hospitalization. In this instance, the screening must be completed as soon as possible and within two (2) days of the Consortium’s receipt of the request.

Planned Psychiatric: Non-crisis in nature, the screening must be completed within two (2) days of the Consortium’s receipt of the request. The admission must occur within two (2) days of the completion of the screening.

Retroactive Psychiatric: Individuals whose Medicare or other primary insurance denied payment for treatment, and who were Medicaid eligible at the time of admission. Other retroactive screens may be authorized for denied requests when eligibility is in question. If the individual receives a valid Medicaid card after a hospital admission has been completed, the Consortium requests the admission information, and completes a pre-admission screening within five (5) working days of the receipt of that information.

8400. Updated 11/03

Cases Involving Retroactive Eligibility

The assessment must be requested and completed prior to the admission and related services being billed to Medicaid. The assessment will not be face-to-face and will be completed by the MHC. The MHC must complete the assessment within **five (5)** working days of receiving the request.

Cases Involving Other Insurance Or Medicare

If the admission and related services are billed to other insurance or Medicare first, the psychiatric preadmission assessment is not necessary. If the other insurance or Medicare makes no payment on the claim, prior to the claim being billed to Medicaid, an assessment must be completed. The MHC will complete the assessment within five (5) working days of receiving the request. The assessment will not be face-to-face.

A face-to-face psychiatric preadmission assessment consists of a psychiatric diagnostic interview examination including history, mental status examination, and communication with family members and other collateral contacts in order to develop an appropriate treatment plan. Standard hospital rounds including hospital visits and/or medication checks by the consumer's physician (or by an ARNP/PA with the performing provider number noted) are allowed. Only one hospital round per day is covered.

Daily individual or group psychotherapy is required for inpatient hospital and is content of service of the DRG reimbursement to the hospital.

CMHC emergency services provided in a general hospital emergency room as part of the comprehensive mental health program are covered if provided by "center staff," as previously defined. This service is reimbursed as individual clinic therapy. When a psychiatric emergency is billed, hospital emergency room services are not covered unless there is an accompanying medical or surgical emergency.

Individual Community Support (ICS):

ICS shall be face-to-face interventions, in a community setting. This includes activities which assist persons to function more independently in natural community settings of their choice. The need and level of this service is determined by the treatment team in collaboration with the consumer and family. Services include the following:

- Personal support, which shall have its objective assistance with *daily* activities necessary to maintain personal stability in a community setting.

8400. Updated 11/03

- Support provided to an individual adult or child, which shall include education and in-home consultation and shall have as its objective the delivery of specific training in daily living to an individual, which will be needed to provide natural supports, maintain the family support system, improve self-help skills, interpret policies, procedures and regulations that impact the individual living in the community, and monitor progress with treatment plan goals and objectives.
- Under supervision, personal support provided to individuals in crisis situations.

Each person working as an ICS worker shall, at a minimum:

- Have one year of college course work in the field of human services or one year of experience in the field of human services; or a combination of education and work experience in the field of human services;
- Be 18 years or older; if consumer is under the age of 18, the ICS worker must be at least three years older than the consumer. (For adult consumers, this requirement does not apply; however, provider agencies are expected to use good judgement when making work assignments;
- Have other experience in the provision of services to persons with mental illness or severe emotional disturbance which may be substituted for one year of education or work experience in the human service field. This includes experience acquired by family members or others about persons with mental illness or SED and includes persons who are themselves recovering from such an illness;
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations;
- Have certification of completion of basic attendant care training within 30 days of employment and additional training within 6 months of employment according to curriculums approved by the Division of Health Care Policy; and
- Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens.

The ICS worker is supervised by a staff person meeting the qualifications for targeted case management and/or community psychiatric supportive treatment or other “approved center staff” which may include a MSW (Master’s Level Social Worker), LMLP (Licensed Master’s Level Psychologist), licensed psychologist or master’s degree psychiatric nurse within the agency delivering ICS services, and is available at all times to provide backup support and/or consultation.

If a center has a question about whether a particular staff member meets the criteria to be an ICS worker, a written description of his/her qualifications should be sent to Mental Health/Substance Abuse Treatment and Recovery in the Division of Health Care Policy which will make a determination.

8400. Updated 11/03

Medication Group:

A medication group provides information about prescribed drugs, their effects, side effects and general health issues. A registered nurse, physician, or physician assistant must supervise the medication group.

A medication group must be provided as part of a partial hospitalization program and may be billed for outpatient consumers. Alone or in conjunction with partial hospitalization activity, a combined total of **1560** hours is allowed per consumer, per calendar year. Outpatient consumers are allowed one hour per week.

Medication Review:

The evaluation of the medication's effect on the patient including side effects, appropriate dosage and patient's compliance with prescription instructions.

One medication review by an RN is allowed per day, per patient. Medication reviews and monitoring by the CMHC physician are allowed for consumers who require psychotropic medications.

Mental Health Attendant Care:

Attendant care shall be one-to-one support or supervision with the goal of maintaining an individual with severe and persistent mental illness or a child with severe emotional disturbance in natural community locations, such as where the person lives, works or socializes. All supports provided must relate to the specific goals set forth in the consumer's treatment plan and must be provided under the supervision of a qualified mental health professional. Service may include the following activities:

- Direct support and supervision in accomplishing activities of daily living.
- Support to the consumer and or the family in maintaining daily routines critical to a stable lifestyle.

Each person working as an attendant care worker shall, at a minimum:

- Be 18 years or older; if consumer is under the age of 18, the attendant care worker must be at least three years older than the consumer. (For adult consumers, this requirement does not apply; however, provider agencies are expected to use good judgement when making work assignments;
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations;

8400. Updated 9/04

- Have completed a basic training program developed by the provider agency within 30 days of employment, according to curriculums approved by the Division of Health Care Policy; and
- Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens.

The attendant care worker is supervised by a staff person meeting the qualifications for targeted case management and/or community psychiatric supportive treatment or other “approved center staff” which may include a MSW (Master’s Level Social Worker), LMLP (Licensed Master’s Level Psychologist), licensed psychologist or master’s degree psychiatric nurse within the agency delivering attendant care services, and is available at all times to provide backup support and/or consultation.

If a center has a question about whether a particular staff member meets the criteria to be an attendant care worker, a written description of his/her qualifications should be sent to Mental Health/Substance Abuse Treatment and Recovery in the Division of Health Care Policy which will make a determination.

Mental Health Services for NF/MH Consumers:

Mental health services to consumers residing in a Nursing Facility for Mental Health are non-covered. Exception will be made for up to eight hours of therapy (90806) for individuals in acute trauma and for Targeted Case Management and Community Psychiatric Supportive Treatment during the 120 days just prior to discharge. These exceptions must be approved by the local quality enhancement coordinator. Other exceptions are psychiatric diagnostic interview (90801), and psychiatric pre-admission assessments (Y9514) which require no special approval.

The annual screen for continued stay for individuals residing in a Nursing Facility for Mental Health (NFMH) (T2011) is completed to determine the individual's continued need for this level of care. The annual screen is a scheduled face-to-face interview with the resident by a trained CMHC screener and a screening facilitator who is registered with SRS/MH. Additional information should be gathered from other sources including the guardian/family member, treatment staff and other informants. A review of the facility chart should be made and pertinent information included on the screening tool. Payment for annual screens will require prior authorization by SRS/MH Division staff following established guidelines and protocols for this process and will be communicated to the fiscal agent. Payment is for one screen per resident per year.

Personal Care Service is one-to-one support and/or supervision for persons transitioning from an NFMH to community living, and facilitates identification of needed services and supports a person will require to live in the community. Personal Care Service is provided by Community Mental Health Center staff who has completed Attendant Care Training approved by SRS/MH. Up to 120 hours of Personal Care Service can be provided per beneficiary per year.

Personal Care Services (Attendant Care) can be provided when a screen for continued stay in an NFMH has been completed and approved by SRS/MH Division within the last year with a recommendation of "discharge", and the under the following additional conditions:

- A treatment plan has been developed with a goal of "community integration", and
- Personal care services are provided in the intended discharge community.

Partial Hospitalization Activity:

The ongoing medically directed daily partial hospitalization group activities which provide "goal-oriented" treatment within partial hospitalization to meet the needs of the patient population by addressing psychological, interpersonal, intrapersonal, self-care and daily living issues. This includes planned treatment activities of maximizing the consumer's skills in the following areas: self-care, communication, appropriate social interaction, daily living functions, reliability, responsibility, self-control, reality orientation, and emotional adjustment. The content of an individual program varies according to the specific needs of the client, therapeutic philosophy, function of the specific partial hospitalization program and the specific skills of the program staff.

For partial hospitalization activity, records are a written progress note indicating the type of services received, the time spent in partial hospitalization, and the individual's responses to the service. Must be approved (signed) by "treatment team" members.

CMHCs providing partial hospitalization services must be certified by Medicare and enrolled in the Kansas Medical Assistance Program to provide these services.

Up to **200** hours of partial hospitalization are covered for children and adolescents prior to the KAN Be Healthy screen. The **200** hours apply toward the **1560** hours covered per consumer, per calendar year, regardless of provider.

Alone or in conjunction with medication group, a combined total of **1560** hours are allowed per calendar year, per consumer.

Only **six** hours outpatient psychotherapy (individual, group, family therapy) are covered for a period of 90 days following admission to a partial hospitalization activity and targeted case management services for the long-term mentally ill. Hours in addition to the six require medical necessity documentation and prior authorization.

Partial hospitalization activity and outpatient psychotherapy (individual, group, family therapy, in-home family based services) may be provided concurrently to KAN Be Healthy participants without PA.

Partial hospitalization activity and psychosocial treatment group cannot be billed/reimbursed for the same date of service on the same consumer.

Psychiatric Observation Beds:

Outpatient psychiatric observation beds are covered for up to two consecutive days. During the observation period the consumer must receive a physical examination along with a history and psychiatric assessment which contains recommendations for ongoing treatment. An initial nursing assessment must be completed and nursing progress notes written for each shift. A discharge summary must be completed when the consumer is discharged.

A physician must admit the consumer to an observation bed and discharge the consumer at the end of the observation stay. When an admission follows an observation stay, the physical examination report and the psychiatric assessment must be included in the consumer's medical record.

The physical examination and preadmission assessment must be billed by the provider of the service.

The psychiatric observation bed provides an option to assess the consumer's condition, formulate a treatment plan, and make other arrangements while having the consumer in a controlled setting.

Psychological Testing:

Psychological Testing/Assessment is defined as the use, in any manner, of established psychological tests, procedures and techniques with the intent of diagnosing adjustment, functional, mental, vocational or emotional problems, or establishing treatment methods for persons having such problems.

Reimbursement for psychological testing includes the administration of standardized psychological tests, their interpretation with consumer interview and the preparation of a written test report by approved center staff.

Psychological testing and assessment is limited to **four** (4) hours every two calendar years, per consumer, regardless of provider. KAN Be Healthy participants are limited to **six** (6) hours of psychological testing and assessment every two calendar years. **Prior authorization (PA) will not override these limitations.**

Psychosocial Treatment Group:

Psychosocial treatment group is a covered service for individuals who do not require the more structured service of a partial hospitalization program, or who have "graduated" from partial hospitalization but still require support of psychosocial services.

Psychosocial treatment group is a self-contained, goal-directed group designed to assist Medicaid consumers in minimizing or resolving the effects of mental and emotional impairments which previously required clinical and/or hospital services. The objectives of group activities shall be designed to:

- 1) Assist individuals (children and adults) in daily problem solving,
- 2) Improve social skills,
- 3) Provide leisure time training,
- 4) Promote health, and
- 5) Enhance personal relationships.

All psychosocial treatment group activities must be documented in notes that include the name of the client, the date of service, the length of the activity, and the type of activity. At least once a month a progress note should reflect the goal addressed, the progress towards the goal, and signed by the qualified mental health professional.

Group activities must be facilitated by or under the direction of a qualified mental health professional. The maximum number of clients for each staff in adult groups is 8. Maximum number of client for each staff in child and adolescent groups is 4.

Transportation to group activity during the group session is content of service of the psychosocial treatment group and should not be billed separately.

Targeted Case Management:

Targeted Case Management is designed to provide medically necessary services, under a treatment plan approved by the psychiatrist or physician skilled in the treatment of mental disorders and to assist Medicaid beneficiaries in resolving or minimizing the effects of the mental and emotional impairment for which clinical and/or hospital services have previously been provided. The goal is to enhance independent functioning through which the consumer is integrated into and/or maintained within the community, so that institutionalization is not as likely or frequent.

This goal-directed medically necessary service is for adults with severe and persistent mental illness or children with severe emotional disturbance through which the individual is assisted in obtaining access to needed medical, social, educational and other services. All interventions provided shall be related to specific goals set forth in the consumer's treatment plan. Documentation in progress notes is required for each billed service. Interventions include the following:

- Treatment Planning: This includes facilitating the team treatment planning process, including documenting the individualized plan, developing goals and objectives based on a strengths assessment, monitoring to ensure that the plan is working, and making changes when needed. It is expected that the treatment planning process include participation of consumers, families, and natural supports, and that documentation reflect this involvement.
- Collateral Contacts: This includes phone and written correspondence, as well as face-to-face contacts with other social service agencies, schools, housing and employment resources, and medical services.
- Access to Supports: This includes assisting individuals in obtaining access to needed medical, social, educational, and other services. In addition, the service would assist with applications for benefits, and arrange transportation to needed services.
- Service Coordination For Youth: This includes the coordination of services and supports identified in an individual's wraparound plan which has as its objective the assurance of an integrated, comprehensive plan of supports and services which includes family members, natural supports, and relevant community providers/stakeholders.

Targeted case management is considered content of service of the daily rate paid to therapeutic foster or group care providers when provided within the same calendar month.

Each person working as a Targeted Case Manager shall, at a minimum:

- Have at least a BA/BS degree or be equivalently qualified by work experience or a combination of work experience in the human services field and education, with one year of experience substituting for one year of education;
- Possess demonstrated interpersonal skills, ability to work with persons with severe and persistent mental illness and/or severe emotional disturbance, and the ability to react effectively in a wide variety of human service situations.
- Meet the specifications outlined in the CMHC licensing standards in regard to any ongoing requirements (as in completion of the training requirements according to a curriculum approved by the Division of Health Care Policy); and
- Pass KBI, SRS child abuse check, adult abuse registry and motor vehicle screens.

The Targeted Case Manager is supervised by "approved center staff" which may include a MSW (Master's Level Social Worker), LMLP (Licensed Master's Level Psychologist), licensed psychologist or master's degree psychiatric nurse within the agency delivering CPST services.

Telemedicine:

Telemedicine is the use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.

Consultations, office visits, individual psychotherapy, and pharmacological management services may be reimbursed when provided via telecommunication technology. The consulting or expert provider must bill the procedure codes (CPT codes) listed below using the GT modifier and will be reimbursed at the same rate as face to face services. The originating site, with the consumer present, may bill code Q3014 (telemedicine originating site facility fee).

99241GT - 99245GT
99251GT - 99255GT
99261GT - 99263GT
99271GT - 99275GT
99201GT - 99205GT

99211GT - 99215GT
90801GT
90804GT - 90809
90847GT
90862

Therapy-Family:

Client centered treatment to help the person functioning with the family. Therapy must be conducted by approved center staff under a treatment plan approved by the physician.

Family therapy or a combination of family and group therapy is limited to **40** hours per calendar year, per consumer.

Therapy-Group:

Therapy delivered in a group setting to two or more unrelated consumers. Service must be conducted by approved center staff under a treatment plan approved by the physician.

Group therapy or a combination of group and family therapy is limited to **40** hours per calendar year, per consumer.

Group therapy is not covered when provided by psychologists, physicians or CMHC's in an inpatient setting since it is content of service of the DRG reimbursement to the hospital.

Therapy-Individual:

This is one-to-one therapy by approved center staff conducted under a treatment plan approved by a psychiatrist or physician skilled in the treatment of mental disorders.

Outpatient individual therapy is limited to 32 hours per calendar year for consumers not participating in the KAN Be Healthy Program. Forty (40) hours per calendar year are allowed for KAN Be Healthy participants.

Individual and group psychotherapy or family therapy are covered when there is a treatment plan containing a psychiatric diagnosis and goals of treatment. This limitation will be monitored post-pay and will require the provider to document, in legible writing, the amount of time spent in therapy, major issues covered and changes in medication, diagnosis, condition, treatment plan or course of treatment. The provider must document that a review of the treatment plan has been conducted every three months. Scheduled utilization reviews will meet the requirement that a review of the treatment plan has been conducted every three months.

Only six hours of outpatient psychotherapy (individual, group, family) will be covered for Kansas Medical Assistance Program consumers when provided in the quarter following admission to a partial hospitalization activity **and** targeted case management services. If more than six hours of individual, group, or family therapy are billed in the same quarter a Medical Necessity form must be completed and attached to the claim. Medical necessity is defined as the individual exhibiting behavior that is dangerous to himself/herself or others, and without additional therapy inpatient hospitalization would be required.

KAN Be Healthy participants continue to be eligible for outpatient psychotherapy (individual, group, family), targeted case management, and partial hospitalization services concurrently.

Therapy-In-home:

Home based family therapy is client centered treatment designed to focus attention and change, specifically to the Medicaid consumer within the family. Therapy must be conducted by approved center staff under a treatment plan, approved by the physician. Multiple units of service each week are included. Documentation in the treatment plan must support that in-home therapy is necessary to prevent hospitalization or out-of-home placement. The in-home therapy treatment plan must be reviewed and updated every 90 days as required in the utilization review process.

In-home crisis intervention is intended for adults with severe and persistent mental illness, or children and adolescents with severe emotional disturbance.

In-home therapy is covered **only** for the purpose of preventing the out-of-home placement of a child under 18 years of age.

8400 Updated 9/04

Community Mental Health Centers providing in-home therapy must have program approval from Mental Health, demonstrating the agency's ability to meet the Kansas home-based intervention standards, and do the following:

- identify the target population
- respond to families in crisis (within 24-48 hours)
- provide intensive services (6-20 hours per week)
- identify treatment goals
- work in collaboration with local SRS offices
- demonstrate educationally the understanding of crisis and short-term intensive interventions

For more information regarding the SRS authorization procedure, contact Mental Health and Retardation Services (MH/RS) at (785) 296-3471.

8410. DEFINITIVE CRITERIA Updated 11/03

Medical records for Medicaid consumers are comprised of:

- 1) Patient Medicaid identification number.
- 2) Date of admission to treatment service.
- 3) Treatment plan that has been completed within 14 days of admission to treatment services, not necessarily intake, includes recommendations for treatment and has been reviewed and updated within the last 90 days. This treatment plan must meet the following criteria:
 - treatment objectives
 - treatment regimen to achieve those objectives
 - projected schedule for service delivery
 - type of personnel required to deliver the services
 - projected schedule for review of the patient's condition updating the treatment plan
- 4) Current diagnosis that has been reviewed and updated within the last 90 days. This update must also describe the patient's progress.
- 5) Prognosis that has been reviewed and updated within the last 90 days.
- 6) Utilization review
- 7) The 90-day review is not required if the services are provided solely by a medical professional such as a physician or registered nurse, for medical conditions such as medication check or other medical treatment and are documented by clinical notes.
- 8) Pre-admission evaluations of all partial hospitalization program patients.

NOTE: For outpatient treatment, a chronological record includes all treatment provided to the patient, all activities performed in the patient's behalf, the type or mode of treatment and the amount of time per session of treatment. These entries must include the initials of the person responsible for the entry and the date the service was rendered. The record must reflect the relationship of the services to the treatment plan.

In the event services not shown in the treatment plan are delivered to the consumer (or services differing from the treatment plan in scheduling frequency, duration, etc. are delivered to the recipient), a detailed explanation of how these services relate to the treatment plan must be prepared, signed by the physician and included in the record.

8410. Updated 11/03

If the Center is providing inpatient services, the Center's records should bear the notation "detailed notes contained in hospital charts" or similar notation to denote deliverance of inpatient services. Such notations must be signed and dated by the provider.

Physician Extenders:

All services that Physician Assistants (PAs) are legally allowed to perform are covered with the same limitations that apply to physician services.

Utilization Review Plan:

The utilization review plan must be maintained and requires the following:

- 1) The utilization review team must include a physician skilled in the treatment of mental diseases and at least one or more other mental health professionals.
- 2) The utilization review team cannot be directly responsible for the care and treatment of the patient or the direct supervision of the therapists providing treatment. In certain instances, when another appropriate physician is not available, a waiver of this requirement may be obtained for one year upon written request to the Division of Adult and Medical Services of SRS. Such a request must include documentation of the Center's attempt to locate another qualified physician.
- 3) The utilization review plan shall set forth criteria to be used for initial and continued treatment. The criteria are:
 - The consumer is in sufficient need of treatment at this time to justify the expenditure of the consumer's and facility's time, energy and resources.
 - Treatment at this facility seems to be the best choice for helping the consumer with his/her problems after considering all reasonable options available to the consumer in the community and surrounding area.
 - The proposed or revised treatment plan is the most efficient and appropriate use of the facility to meet the particular needs of the consumer.

8410. Updated 11/03

- 4) The Utilization Review Committee's evaluation of each case must include a review of:
 - the treatment plan
 - the diagnosis
 - statement of prognosis
 - documentation of treatment provided
 - all entries in the consumer's record that are initiated by the person responsible for entry including the date of service, type or mode of treatment and length of session
 - appropriateness of treatment being received is considered and approved, or alternate treatment suggested, or disapproval made of continued treatment

- 5) The following utilization review documentation must be included in the Medicaid consumer's chart:
 - names of committee members
 - date of review
 - recommendations made regarding continuing, altering or terminating the treatment
 - date(s) proposed for implementation of the recommendations of Utilization Review Committee to become effective
 - assigned date of next utilization review

- 6) Utilization reviews must be made at the following intervals for each Medicaid consumer:
 - Initial treatment plan within 30 days after intake,
 - Just prior to each 90 days of treatment in a partial hospitalization program and for case management services,
 - Just prior to the end of each 90 day period for outpatient psychotherapy.

- 7) Minutes or logs of the Utilization Review Committee's meetings are to be maintained and should contain the following information:
 - Date of meeting,
 - Members present,
 - Names of patients reviewed,
 - Recommendations made by committee concerning continuing, altering, or terminating treatment of those patients reviewed.

**APPENDIX I
PROCEDURE CODES AND NOMENCLATURE Updated 5/04**

The following codes represent an all inclusive list of CMHC services billable to the Kansas Medical Assistance Program. Procedures not listed here are considered non-covered. Utilize the CPT codes listed [90000 series codes] for services rendered by a physician or licensed psychologist.

COVERAGE INDICATORS

- KBH - KAN Be Healthy medical participation is required.
- NC - Non-covered Kansas Medical Assistance Program service.
- PA - Prior Authorization is required.

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE</u>
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ADMISSION EVALUATION (DIAGNOSTIC)

- | | | |
|--------|--|---|
| *90801 | | Psychiatric diagnostic interview examination |
| 90802 | | Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication |

BEHAVIOR MANAGEMENT PREADMISSION ASSESSMENT

- | | | |
|------------------|--|---|
| H0002 | | Behavioral Health screening to determine eligibility for admission to a treatment program |
| Y9570 | | Behavior management preadmission assessment (one unit = one hour). |
| H0032HA | | Mental health service plan development by non-physician, child/adolescent program |

CASE CONFERENCE

- | | | |
|--------|--|---|
| *99361 | | Medical conference by a physician or approved center staff with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes. |
|--------|--|---|

* **Service can be provided by either a CMHC or non-CMHC.**

PROCEDURE Updated 11/03
COV. CODE NOMENCLATURE

CASE CONSULTATION

99241 Office consultation for a new or established patient, which requires these three key components:

- **a problem focused history;**
- **a problem focused examination; and**
- **straightforward medical decision making.**

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

99242 Office consultation for a new or established patient, which requires these three key components:

- **an expanded problem focused history;**
- **an expanded problem focused examination; and**
- **straightforward medical decision making.**

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office consultation for a new or established patient, which requires these three key components:

- **a detailed history;**
- **a detailed examination; and**
- **medical decision making of low complexity.**

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

99244 Office consultation for a new or established patient, which requires these three key components:

- **a comprehensive history;**
- **a comprehensive examination; and**
- **medical decision making of moderate complexity.**

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE</u>
		Updated 11/03
	99245	<p>Office consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.</p>
	99251	<p>Initial inpatient consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a problem focused history; • a problem focused examination; and • straightforward medical decision making. <p>Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99252	<p>Initial inpatient consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused history; • an expanded problem focused examination; and • straightforward medical decision making. <p>Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99253	<p>Initial inpatient consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a detailed history • a detailed examination; and • medical decision making of low complexity <p>Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.</p>

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 11/03</u>
	99254	<p>Initial inpatient consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99255	<p>Initial inpatient consultation for a new or established patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. <p>Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99261	<p>Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a problem focused interval history; • a problem focused examination; • medical decision making that is straightforward or of low complexity. <p>Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99262	<p>Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of moderate complexity. <p>Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.</p>

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 12/03</u>
	99263	<p>Follow-up inpatient consultation for an established patient which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a detailed interval history; • a detailed examination; • medical decision making of high complexity. <p>Usually, the patient is unstable or has developed a significant new problem.</p> <p>Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.</p>

Please Note: If case consultation is provided by either an ARNP or PA, their performing provider number must appear on the HCFA-1500 claim form.

COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

Y9118	Community Psychiatric Supportive Treatment (one unit = one hour)
H0036	Community Psychiatric Supportive Treatment per 15 minutes

DIETITIAN SERVICES

KBH	97802	Medical Nutrition Therapy - Initial Assessment
KBH	97803	Medical Nutrition Therapy - Reassessment and Intervention

HOSPITAL CARE

99221	<p>Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making that is straightforward or of low complexity. <p>Usually, the problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.</p>
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<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 11/03</u>
	99222	<p>Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of moderate complexity. <p>Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99223	<p>Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:</p> <ul style="list-style-type: none"> • a comprehensive history; • a comprehensive examination; and • medical decision making of high complexity. <p>Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99231	<p>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a problem focused interval history; • a problem focused examination; • medical decision make that is straightforward or of low complexity. <p>Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.</p>

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 12/03</u>
	99232	<p>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • an expanded problem focused interval history; • an expanded problem focused examination; • medical decision making of moderate complexity. <p>Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99233	<p>Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a detailed interval history; • a detailed examination; • medical decision making of high complexity. <p>Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.</p>
	99238	Hospital discharge day management; 30 minutes or less
	99239	Hospital discharge day management; more than 30 minutes

Please Note: If hospital care is provided by either an ARNP or PA, their performing provider number must appear on the HCFA-1500 claim form.

INDIVIDUAL COMMUNITY SUPPORT

Y9119	Individual Community Support (one unit = one hour)
T1019HK	Personal care services, per 15 minutes not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment, use modifier HK

MEDICATION - ADMINISTRATION

Z2636	Prolixin Enanthate 25 mg (1 cc medication & injection)
J2680	Fluphenazine Decanoate up to 25 mg (1 cc med. & injection)
J1631	Haloperidol Decanoate 50mg (medication injection)
90782	Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular (patient supplies own medication)

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 9/04</u>
		<u>MEDICATION - GROUP</u>
	*S9446	Patient education, not otherwise classified, non-physician, group, per session
		<u>MEDICATION - REVIEW</u>
	*H2010 *90862	Comprehensive Medication Services, per 15 minutes (may bill 2/day) Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (by a physician or approved center staff, brief service).
		<u>MENTAL HEALTH ATTENDANT CARE</u>
	T1019HE	Personal Care Services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, part of the individualized plan of treatment, use HE modifier
		<u>PARTIAL HOSPITALIZATION</u>
	G0176	Activity therapy, such as music, dance, art or play therapies not for recreation related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
	G0177	Training and education services related to the care and treatment of a patient's disabling mental health problems per session (45 minutes or more)
		<u>PERSONAL CARE SERVICE</u>
	T1019	Personal Care Service is one to-one-support and/or supervision for persons transitioning from an NFMH to community living
		<u>SCREENS FOR CONTINUED STAY IN AN NFMH</u>
	T2011	The annual screen for continued stay for individuals residing in a Nursing Facility for Mental Health (NFMH)
		<u>PSYCHIATRIC PREADMISSION ASSESSMENTS</u>
	T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specific program, project, or treatment protocol, per encounter
	H0032	Mental health service plan development by non-physician
		<u>PSYCHOLOGICAL TESTING</u>
	96100	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour

* **Service can be provided by either a CMHC or non-CMHC.**

PROCEDURE
CODE **NOMENCLATURE Updated 12/03**

PSYCHOSOCIAL TREATMENT GROUP

*Y9564	Adult psychosocial treatment group (one unit = one hour)
*H2017	Adult Psychosocial Rehabilitation Group, per 15 minutes
*H2017Tj	Child and Adolescent Psychosocial Treatment Group 15 minutes
Y9565	Child and adolescent psychosocial treatment group (one unit = one hour).
H2017	Psychosocial Rehabilitation Group per 15 minutes

TARGETED CASE MANAGEMENT

*Y9117	Targeted Case Management not otherwise covered by Medicare (one unit = 15 minutes)
*T1017	Targeted case management per 15 minutes

THERAPY - FAMILY

90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
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THERAPY - GROUP

90853	Group psychotherapy (other than of a multiple-family group)
Y9108 , 90853	Group therapy by approved center staff in free-standing psychiatric hospital (45-50 minutes).

THERAPY - INDIVIDUAL

90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90807	with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90809	with medical evaluation and management services

* **Service can be provided by either a CMHC or non-CMHC.**

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 11/03</u>
	90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
	90811	with medical evaluation and management services
	90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
	90813	with medical evaluation and management services
	90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
	90815	with medical evaluation and management services
	90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
	90817	with medical evaluation and management services
	90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
	90819	with medical evaluation and management services
	90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
	90822	with medical evaluation and management services
	90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient
	90824	with medical evaluation and management services
	90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient
	90827	with medical evaluation and management services

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE Updated 5/04</u>
	90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient
	90829	with medical evaluation and management services
	Y9105, 90804 90816	Individual therapy by approved center staff in free-standing psychiatric hospital (20-30 minutes).

THERAPY - IN-HOME

S9484 Crisis Intervention

SUBSEQUENT NURSING FACILITY CARE

99311 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- **a problem focused interval history;**
- **a problem focused examination;**
- **medical decision making that is straightforward or of low complexity.**

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.

99312 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:

- **an expanded problem focused interval history;**
- **an expanded problem focused examination;**
- **medical decision making of moderate complexity.**

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.

<u>COV.</u>	<u>PROCEDURE CODE</u>	<u>NOMENCLATURE</u> Updated 11/03
	99313	<p>Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • a detailed interval history; • a detailed examination; • a medical decision making of moderate to high complexity. <p>Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.</p>

Please Note: If subsequent nursing facility care is provided by either an ARNP or PA, their performing provider number must appear on the HCFA-1500 claim form.

FORMS SECTION

HCFA 1500

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM										PICA												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)													
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)														
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY			STATE											
ZIP CODE		TELEPHONE (Include Area Code) () ()			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (INCLUDE AREA CODE) () ()												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			SEX M <input type="checkbox"/> F <input type="checkbox"/>														
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			c. INSURANCE PLAN NAME OR PROGRAM NAME														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					13. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.														
								SIGNED _____														
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER			29. RESERVED FOR LOCAL USE														
					24. A			B		C		D		E		F		G		H		I
DATE(S) OF SERVICE From MM DD YY To MM DD YY			Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		GOB		RESERVED FOR LOCAL USE	
1																						
2																						
3																						
4																						
5																						
6																						
25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		28. AMOUNT PAID \$		30. BALANCE DUE \$								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____												