PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

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FORMS
All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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PART II
MENTAL HEALTH FEE-FOR-SERVICE PROVIDER MANUAL

This is the provider specific section of the provider manual. This section (Part II) was designed to provide information and instructions specific to mental health providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendix.

The **Billing Instructions** subsection gives instructions for completing and submitting the billing form mental health providers must use when the individual is **not assigned** to a managed care organization (MCO). If the individual is assigned to an MCO, contact the specific health plan for managed care assistance.

The **Benefits and Limitations** subsection defines specific aspects of the scope of mental health services allowed within the Kansas Medical Assistance Program (KMAP).

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

**Access to Records**
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. The provider agrees to furnish records and original radiographs and other diagnostic images which may be requested during routine reviews of services rendered and payments claimed for KMAP consumers. If the required records are retained on machine readable media, a hard copy of the records must be made available.

The provider agrees 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.

**Confidentiality & HIPAA Compliance**
Providers shall follow all applicable state and federal laws and regulations related to confidentiality 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.
MENTAL HEALTH FEE-FOR-SERVICE BILLING INSTRUCTIONS

7000. Created 11/17

Introduction to the CMS 1500 Claim Form and UB-04

Mental health providers must use the CMS 1500 or UB-04 paper or equivalent claim form when requesting payment for medical services and supplies provided under KMAP. Claims can be submitted on the KMAP secure website, through Provider Electronic Solutions (PES), or by paper. When a paper form is required, it must be submitted on an original, red claim form and completed as indicated or it will be returned to the provider.

Examples of the CMS 1500 Claim Form and UB-04 along with their instructions are available on the KMAP public and secure websites on the Forms page under the Claims (Sample Forms and Instructions) heading.

The fiscal agent does not furnish the CMS 1500 Claim Form or UB-04 to providers. Refer to Section 1100 of the General Introduction Fee-for-Service Provider Manual.

Submission of Claim

Send completed claim and any necessary attachments to:
KMAP
Office of the Fiscal Agent
PO Box 3571
Topeka, KS  66601-3571
MENTAL HEALTH FEE-FOR-SERVICE SPECIFIC BILLING INFORMATION

7010. Created 11/17

Unit Billing

The appendix provides procedure code and time definitions for billing specific procedures (for example, 15 minutes). When billing according to this definition, bill 1 unit in Field 24G.

When billing for less than the amount of time indicated in the definition (less than 1 unit), bill as follows:

.25 represents one-quarter of the time specified.
.50 represents one-half of the time specified.
.75 represents three-fourths of the time specified.

When billing for more than the amount of time indicated in the definition (more than 1 unit), bill as follows:

1.25 represents one and one-quarter units of the time specified.
1.50 represents one and one-half units of the time specified.
1.75 represents one and three-quarters units of the time specified.
2.00 represents two units of the time specified, and so forth.
BENEFITS AND LIMITATIONS

8100. COPAYMENT  Updated 03/18

Mental health services (including psychotherapies) require a copayment of $3 per office visit for psychologists and community mental health centers (CMHCs). Psychology services provided by a physician or physician assistant require a copayment of $2 per office visit.

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

See the General TPL Payment Fee-for-Service Provider Manual for a list of individuals who are exempt from copayments.
8200. MEDICAL ASSESSMENT Created 11/17

PROVIDERS*

- **Allowed providers**
  - **Licensed Mental Health Professional (LMHP)** – An individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license.
  - **Qualified Mental Health Professional (QMHP)** – A Master’s level clinician licensed by the Kansas Behavioral Sciences Regulatory Board and employed by a community mental health center (CMHC), an individual holding a medical degree, or an advanced practice registered nurse (APRN).

  - LMHP providers licensed to practice independently:
    - Licensed psychologist
    - Licensed clinical marriage and family therapist
    - Licensed clinical professional counselor
    - Licensed specialist clinical social worker
    - Licensed clinical psychotherapist

  - LMHP providers licensed to practice under supervision or direction:
    - Licensed Masters level marriage and family therapist
    - Licensed Masters level professional counselor
    - Licensed Masters level social worker
    - Licensed Masters level psychologist

  - A physician, physician assistant, or an advanced practice Nurse Practitioner working under protocol of a physician

  - Nonlicensed mental health service providers

  *Note:* Specific provider qualifications are noted with the associated service.

- **Training**
  - Supervision must be provided by a person eligible to provide Medicaid services and licensed at the clinical level or by a licensed physician. All services must be rendered within the scope of the provider's professional license.

  - Training approved by the Kansas Department for Aging and Disability Services (KDADS) for nonlicensed mental health service providers can be found on the KDADS website:
    - [Training, Registration and Surveys](#) page
    - [Medicaid Mental Health Service Provider Training](#) page

*Note:* Some Mental Health services can only be provided by a CMHC. Refer to Section 8400 of this manual for specific services.
8200. MEDICAL ASSESSMENT  Updated 03/18

DOCUMENTATION
Documentation is not required to be in a standard format. The individual's record must include the following components:

A. Referral
   a. Source of referral
   b. Reason for referral

B. Pertinent Past and Present History

C. Treatment Plan
   a. Psychological tests, procedures, and techniques to be used
   b. Reviewed and updated appropriately

D. Evaluation
   a. Interpretation of all completed/attempts psychological tests, procedures, and techniques used with conclusions reached
   b. Recommendations related to meaningful aspects of the individual's everyday existence

Note: 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.

Note: Per the Centers for Medicare & Medicaid Services (CMS) and Kansas Medicaid, any claim submitted for reimbursement is subject to the applicable national coding guidelines. Payment received for claims not adhering to those standards is subject to recoupment upon review.
KMAP service participants are assigned to one or more KMAP benefit plans. These benefit plans entitle the individual to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Fee-for-Service Provider Manual for information on eligibility verification.

- If the individual is assigned to an MCO:
  - All mental health services are the responsibility of the appropriate MCO. For more information, contact the specific health plan for managed care assistance.
  - To prevent potential billing and reimbursement errors, services provided when an individual is assigned to an MCO must be billed on a separate CMS 1500 Claim Form than services provided when an individual is not assigned to an MCO.

- If the individual resides in a psychiatric residential treatment facility (PRTF), all mental health services are the PRTF’s responsibility.

- MediKan coverage is the same as for Medicaid service recipients with the following exceptions:
  - Individual outpatient psychotherapy is limited to 24 hours per calendar year per individual.
  - Group and family therapy in any combination are limited to 24 hours per calendar year per individual.
  - Psychological testing and assessment is limited to four hours every three calendar years, per individual, regardless of provider. Prior authorization will not override this limitation.
  - Targeted Case Management is limited to 80 hours per calendar year per individual.

  Note: For specific instructions, reference the Targeted Case Management – Mental Health Fee-for-Service Provider Manual on the Provider Manuals page of the KMAP website.

Telemedicine

Refer to Section 2720 of the General Benefits Fee-for-Service Provider Manual for complete details regarding Telemedicine.

Limitations

Electroshock treatments and psychotherapy may not be performed on the same date of service, regardless of provider.

Mental Health Services Not Covered by Medicaid

- Conference call
- Consultation in an ICF/IID facility
- Crisis Intervention in an institutional setting
- Holding therapy
- Hypnosis, biofeedback, or relaxation therapy
- Occupational therapy
- Perceptual therapy
- Phone call
Evaluation and Management – These codes are used for encounters with health care professionals to evaluate and manage health conditions. National coding guidelines specify the criteria for the appropriate billing code to be utilized. 

Note: Code 99211 (with modifier TD) may be reimbursed when provided by a registered nurse (RN) employed by a CMHC when the guidelines for billing this code are followed.

Psychiatric Evaluation – Assessment of the patient’s psychosocial history, current mental status, and other physical examination elements and the ordering of diagnostic studies followed by treatment recommendations. Depending on the service delivered and code billed, additional medical services may be provided (such as prescribing medication).

Individual and Group Psychotherapy

- Individual and group psychotherapy are covered when a treatment plan contains a psychiatric diagnosis and treatment goals. Psychotherapy is not covered for individuals whose only diagnosis is for intellectual or developmental disabilities. Therapy provided by a nonlicensed person is also not covered.

- These mental health services are covered when provided by a Kansas LMHP as defined previously in Section 8200. Reimbursement will not be allowed for LMHPs to supervise a nonlicensed person who is doing therapy. This limitation is monitored postpay and requires 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 treatment course. The provider must document a review of the treatment plan every three months.

Family Therapy

- Family therapy involves treatment of the family as a "system" with the family being the focus of attention and change, specifically including children (may refer to adult children). Therefore, the service shall be billed as a family unit and not by the number of individuals involved in the treatment. The individual who is the primary KMAP recipient of services must be present during the delivery of service.

- Family therapy is covered when a treatment plan contains a psychiatric diagnosis and treatment goals. This limitation is monitored postpay and requires 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 treatment course. The provider must document a review of the treatment plan every three months.

- Home Based Family Therapy (HBFT) is a theoretical approach of counseling where the family system is the focus of treatment. Therapy is delivered in the family’s home rather than in the therapist’s office and is provided to a child with Serious Emotional Disturbance (SED) and the child’s family by professionals who meet specific requirements. The service must be billed by the provider using modifier HK. Reference the Home Based Family Therapy policy on the KDADS website for more information on the requirements for providing these services, guidelines for documentation, and process for billing.
Psychological Testing/Assessment

- 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 individuals having such problems.

- Testing performed by an uncertified assistant and supervised by a PhD psychologist is covered when the psychological assessment conforms to the rules and regulations of the Behavioral Sciences Regulatory Board, 102-1-11.

- Reimbursement for psychological testing includes the administration of standardized psychological tests, interpretation, and preparation of a written test report.

- 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

Note: Positive Behavior Supports (PBS) and Screening, Brief Intervention, and Referral for Treatment (SBIRT) information is available in Section 8400 of the Professional Fee-for-Service Provider Manual on the Provider Manuals page of the KMAP website.

Services Provided to an Individual in an Inpatient or Residential Setting

- Inpatient hospital visits are limited to those ordered by the individual’s physician. Daily individual or group psychotherapy is required for inpatient hospital stays for psychiatric illness; however, group psychotherapy is not covered when provided by psychologists, physicians, or CMHCs in a hospital setting. Inpatient group psychotherapy is content of service of the DRG reimbursement to the hospital.

- Services provided to a resident of an intermediate care facility for individuals with an intellectual disability (ICF/IID) or an individual receiving treatment in an institution for mental diseases (IMDs), including a PRTF, are considered content of the institutional or residential stay and should not be billed to KMAP.
**Community-Based Services Team Meeting**
This service provides a forum where an individual, family caregivers, providers, and engaged community representatives can meet to discuss recommendations for treatment needs, which may include a recommendation for inpatient treatment.

**Mental Health Services for Nursing Facility for Mental Health Recipients of Services**
- The State of Kansas provides the following state-funded services to individuals residing in an nursing facility for mental health (NF/MH):
  - **Annual Screen**
    - The annual screen for continued stay for individuals residing in an NF/MH (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 individual by a trained CMHC screener and a screening facilitator who are registered with KDADS Behavioral Health Services (BHS) Commission.
    - 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 require prior authorization by KDADS BHS staff following established guidelines and protocols for this process and are communicated to the fiscal agent. Payment is for one screen per individual per year.
  - Other services provided to individuals residing in an NF/MH include:
    - **Therapy**
      - Up to eight hours of Individual Therapy for individuals in acute trauma and up to four hours per year for Diagnostic Admission Evaluation are allowed.
    - **Targeted Case Management**
      - Codes T1017 and H0036HB may be provided during the 120 days prior to discharge.
      - Targeted Case Management is provided by CMHC staff who have completed training approved by KDADS BHS.
      - Note: For specific instructions, reference the Targeted Case Management – Mental Health Fee-for-Service Provider Manual on the Provider Manuals page.
    - **Personal Care Services**
      - Up to 180 hours of code T1019HE may be provided per individual per calendar year for up to 60 days prior to discharge.
      - Personal Care Services (Attendant Care) may be provided when a screen for continued stay in an NF/MH has been completed and approved by KDADS BHS within the last calendar year with a recommendation of "discharge" and under the following additional conditions:
        - A treatment plan has been developed with a goal of "community integration".
        - Personal Care Services are provided in the intended discharge community.
      - Personal Care Services provide one-to-one support or supervision for individuals transitioning from an NF/MH to community living and facilitate identification of needed services and supports an individual will require to live in the community. Personal Care Services are provided by CMHC staff who have completed Attendant Care training approved by KDADS BHS.
**Mental Health Assessment**
This service can be provided by a nonphysician at a professional level and delivered either face-to-face or through Telemedicine. Code H0031HO is reimbursed per session.

**Note:** Codes 99366, 99367, and 99368 are currently not considered “content of service” when provided by a CMHC.

**Specialized Community-Based Rehabilitation Services**
- Community-Based Psychiatric Rehabilitation Services are only provided by CMHCs. These services are part of a comprehensive specialized psychiatric program available to all KMAP service recipients with significant functional impairments resulting from an identified mental health diagnosis or substance abuse diagnosis. The medical necessity for these rehabilitative services must be determined by an LMHP or physician who is acting within the scope of his or her professional license and applicable state law. The services must be furnished by or under the direction of a physician to promote the maximum reduction of symptoms or restoration of an individual to his or her best possible functional level.

- Services must be medically necessary, must be recommended by an LMHP or physician according to an individualized treatment plan, and must be furnished under the direction of a physician. The activities included in the service must be intended to achieve identified treatment plan goals or objectives.

- Services provided at a work site must not be job-task oriented. Services provided in an educational setting must not be educational in purpose. Any services or components of services of which the basic nature is to supplant housekeeping, homemaking, or basic services for the convenience of a person receiving covered services (including housekeeping, shopping, childcare, and laundry services) are noncovered. Services, other than those described in the Mental Health Services for Nursing Facilities for Mental Health Recipients of Services section above, may not be provided in an IMD.

1. **Community Psychiatric Support and Treatment (CPST)** is goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the service recipient’s individualized treatment plan. CPST is a face-to-face intervention with the service recipient present; however, family or other collaterals may also be involved. The majority of CPST contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

   - **CPST may include the following components:**
     - Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness, with the goal of minimizing the negative effects of mental illness symptoms or emotional disturbances or associated environmental stressors which interfere with the individual’s daily living; financial management; housing; academic and/or employment progress; personal recovery or resilience; family and/or interpersonal relationships; and community integration.
THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS.**

**Specialized Community-Based Rehabilitation Services (continued)

- Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual to develop and implement social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.
- Participate in and use strengths-based planning and treatments, which include assisting the individual and family members or other collaterals to identify strengths and needs, resources, and natural supports; to develop goals and objectives; and to use personal strengths, resources, and natural supports to address functional deficits associated with the individual’s mental illness.
- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk the individual remaining in a natural community location, including assisting the individual and family members or other collaterals to identify a potential psychiatric or personal crisis, develop a crisis management plan, and/or (as appropriate) seek other supports to restore stability and functioning.

** Provider qualifications:
- BA/BS degree or four years of equivalent education and/or experience working in the human services field
- Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Completion of a training program approved by KDADS

** To bill CPST, submit the following procedure codes and modifiers*:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0036HA</td>
<td>Child (17 years or under)</td>
</tr>
<tr>
<td>H0036HB</td>
<td>Adult (18 years or over)</td>
</tr>
</tbody>
</table>

*Note: If conditions are present that support an individual 18 years of age or over would benefit from services provided in a group of individuals 17 years of age or under, the justification requires documentation and services can be provided under H0036 HA. The same would apply if an individual 17 years of age or under would benefit from services provided in a group of individuals 18 years of age and over. In these cases, services can be provided under H0036 HB as long as the justification is properly documented.

** Service limitations ratio: Caseload size must be based on the needs of the clients and families with an emphasis on successful outcomes and client satisfaction and must meet the needs identified in the individual treatment plan. The following general ratio should serve as a guide:
- 1 full-time equivalent (FTE) to 15 youth clients
- 1 FTE to 25 adult clients
**Specialized Community-Based Rehabilitation Services (continued)**

2. **Psychosocial Rehabilitation (PSR)** services are designed to assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with the individual’s mental illness. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s individualized treatment plan. The intent of PSR is to restore the fullest possible integration of the individual as an active and productive member of his or her family, community, and/or culture with the least amount of ongoing professional intervention. PSR is a face-to-face intervention with the individual present. Services may be provided individually or in a group setting. The majority of PSR contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

- **PSR may include the following components:**
  - Restore and support with the development of social and interpersonal skills to increase community tenure, enhance personal relationships, establish support networks, increase community awareness, and develop coping strategies and effective functioning in the individual’s social environment including home, work, and school.
  - Restore and support with the development of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with an individual’s daily living.
  - Support the individual with development and implementation of daily living skills and daily routines critical to remaining in home, school, work, and community.
  - Implement learned skills so the individual may remain in a natural community location.
  - Assist the individual to effectively respond to or avoid identified precursors or triggers that result in functional impairments.

- **Provider qualifications:**
  - Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
  - Must have a high school diploma or equivalent
  - Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
  - Must complete a training program approved by KDADS

- **To bill PSR, submit the following procedure codes and modifiers:**
  - H2017 Individual
  - H2017TJ Child Group
  - H2017HQ Adult Group

- **Service limitations:**
  - 1 FTE to 8 individuals is the maximum group size for adults.
  - 1 FTE to 4 individuals is the maximum group size for youth.
THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS.**

**Specialized Community-Based Rehabilitation Services (continued)

3. **Peer Support (PS)** services are individual-centered services with a rehabilitation and recovery focus. These services are designed to promote skills to cope with and manage psychiatric symptoms while facilitating the use of natural resources and the enhancement of community living skills. Activities included must be intended to achieve the identified goals or objectives as set forth in the recipient’s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for individuals to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. PS is a face-to-face intervention with the service recipient present. Services may be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the individual lives, works, attends school, and/or socializes.

- PS services may include the following components:
  - Help the individual to develop a network for information and support from others who have been through similar experiences
  - Assist the individual with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses, or treatment with his or her clinician
  - Assist the individual to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments

- Provider qualifications:
  - Must be at least 18 years of age and at least 3 years older than a client under 18 years of age
  - Must have a high school diploma or equivalent
  - Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
  - Must complete a training approved by KDADS
  - Must self-identify as a present or former recipient of mental health services

- To bill for PS, submit the following procedure codes and modifiers:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038PS</td>
<td>Individual</td>
</tr>
<tr>
<td>H0038HQ</td>
<td>Group</td>
</tr>
</tbody>
</table>

- Service limitations:
  - 1 FTE to 8 individuals is the maximum group size.

- Approved training:
  - [Training, Registration and Surveys](#)
  - [Medicaid Mental Health Service Provider Training](#)
**Specialized Community-Based Rehabilitation Services (continued)**

4. **Crisis Intervention (CI)** services are provided to an individual who is experiencing a psychiatric crisis. CI is designed to interrupt and/or ameliorate a crisis experience, including a preliminary assessment; immediate crisis resolution and de-escalation; and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of CI are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. CI is a face-to-face intervention and may occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations, including an emergency room, clinic setting, or other community location where the individual lives, works, attends school, and/or socializes.

- There are three tiers of CI that are provided to individuals who are experiencing a psychiatric crisis and require the assistance of another person to regulate their behavior:
  - Basic Crisis Intervention
  - Intermediate Crisis Intervention
  - Advanced Crisis Intervention

- CI is provided based on the assessed needs of the individual in crisis. The individual needs are assessed by a CMHC and identified in the individual’s chart.

- A QMHP from a CMHC shall re-evaluate the need for crisis services for an individual every 72 hours or more frequently as needed.

**Eligibility criteria**

- All individuals experiencing a serious psychological/emotional change that results in a marked increase in personal distress and exceeds the abilities and resources of those involved to effectively resolve it are eligible for CI services. The intent of CI services is to give the level of intervention necessary to help stabilize the individual so a higher level of care is not necessary.
- An individual in crisis may be represented by a family member or other collateral contact who has knowledge of the individual’s capabilities and functioning.
- Individuals in crisis who require this service may be using or abusing substances, such as illegal substances or prescription medications. Substance use or abuse should be recognized and addressed in an integrated fashion since it may be contributing to the personal distress that exceeds the abilities and resources of the individual.

**Additional service criteria**

- Services provided to children and youth must include coordination with family and significant others and, when feasible and appropriate, other systems of care such as education, juvenile justice, and child welfare. Coordination with other systems of care occurs mainly as a part of referral and follow-up after the crisis has been resolved. This coordination must be documented in the individual’s chart.
**Specialized Community-Based Rehabilitation Services (continued)**

- When the individual is unknown or new to the CMHC, the initial preliminary diagnostic and face-to-face assessment of risk, mental status, and medical stability must be completed by a QMHP or contractor-designated LMHP with experience regarding this specialized mental health service.
- The crisis plan developed from the assessment and all the services delivered to the individual by anyone other than a QMHP or contractor-designated LMHP must be provided under the supervision of a QMHP or contractor-designated LMHP. In addition, a QMHP or LMHP must be available at all times to provide back up, support, and/or consultation to the supporting staff member who is not a QMHP or LMHP and is providing CI services.

- **Limitations/exclusions**
  - The appropriate MCO(s) shall be notified for any of their assigned individuals after 72 hours of crisis stabilization services have been provided and it has been determined additional crisis services are required in order to resolve the current crisis. CI services include residential stabilization services as well as placement in facilities offering short-term crisis stabilization beds. For services provided to individuals not assigned to an MCO, KDADS shall be notified as indicated.
  - Basic Crisis Intervention (H2011) does not have a daily limit.  
    **Note:** Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record and made available to the assigned MCO and KDADS upon request.
  - Intermediate Crisis Intervention (H2011HK) requires detailed documentation when it is provided more than 7 hours a day.  
    **Note:** Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record.
  - Advanced Crisis Intervention (H2011HO) requires detailed documentation when it is provided more than 3 hours a day.  
    **Note:** Re-evaluation for the need for crisis services is to be completed by a QMHP every 72 hours or more frequently as needed. Documentation of the re-evaluation shall be maintained in the medical record.
  - H2011 and H2011HK are limited to a combined 72 continuous hours unless, through re-evaluation, a QMHP determines this level of care is further indicated. For individuals assigned to an MCO, after 72 continuous hours of crisis intervention services, if the current crisis is not anticipated to be resolved within 14 days, the MCO shall be notified and may require additional documentation to determine if additional services and continued services are justified. For services provided to individuals not assigned to an MCO, KDADS shall be notified.
8400. MEDICAID Updated 03/18

THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS.**

**Specialized Community-Based Rehabilitation Services (continued)

- H2011 and H2011HO are limited to a combined 72 hours, unless, through re-evaluation, a QMHP determines this level of care is further indicated. For individuals assigned to an MCO, after 72 continuous hours of crisis intervention services, if the current crisis is not anticipated to be resolved within 14 days, the MCO shall be notified and may require additional documentation to determine if additional services and continued services are justified. For services provided to individuals not assigned to an MCO, KDADS shall be notified.
- For the safety of the individual and staff, H2011 may be billed concurrently with H2011HK or H2011HO, not to exceed three hours (for a total of six hours), when the need is identified. The need for this level of support must be documented in the individual’s chart and be re-evaluated by a QMHP every 72 hours.
- The individual’s chart must document the cause for termination of the crisis services to either a restored level of functioning or a higher level of care.

**Basic Crisis Intervention: H2011**

Basic Crisis Intervention (Basic CI) is a face-to-face intervention provided to an individual in crisis who requires the assistance of another person for stabilization and support. Intervention activities include assistance with immediate crisis resolution and de-escalation; individual support; and assistance with referral and linkage to appropriate community services to avoid more restrictive levels of treatment. All activities must occur within the context of a potential or actual psychiatric crisis. The goals of Basic CI are symptom reduction, stabilization, and restoration to a previous level of functioning.

- **Components**
  - Short-term crisis interventions including crisis resolution and debriefing with and in support of the individual.
  - Follow-up with the individual, and as necessary, with the individual’s caregiver and/or family members.

- **Provider qualifications**
  - Must be at least 18 years of age and at least 3 years older than an individual under 18 years of age
  - Must have the appropriate certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
  - Must complete a state-approved standardized basic training on the Kansas Train site - [KDADS: Crisis Intervention](1065738)
THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS.**

**Specialized Community-Based Rehabilitation Services (continued)

Intermediate Crisis Intervention: H2011HK

Intermediate Crisis Intervention (Intermediate CI) is a face-to-face intervention provided to an individual in crisis who requires the assistance of another person to regulate behavior and/or for stabilization. Intervention activities include a preliminary visual assessment to determine risk and ability to engage; immediate crisis resolution and de-escalation; and referral and linkage to appropriate community services to avoid more restrictive or higher levels of care. All activities must occur within the context of a potential or actual psychiatric crisis. Intermediate CI may occur without the presence of a QMHP if the individual in crisis is engaged in services at a CMHC and has a crisis plan or if the individual is a frequent user of crisis services and methods for intervening have been identified in a crisis plan. The goals of Intermediate CI are symptom reduction, stabilization, and restoration to a previous level of functioning.

- **Components**
  - A preliminary nondiagnostic assessment of risk, mental status, and medical stability, along with the need for further evaluation or other mental health services
    - **Note:** This shall include contact with the individual, family members, or other collateral contacts (e.g. caregiver, school personnel) with pertinent information for the purpose of determining the best possible interventions including effective supports.
  - Short-term crisis goal interventions including crisis resolution and debriefing with the individual
  - Follow-up with the individual and, as necessary, with the individual’s caregiver and/or family members
  - Consultation with a physician or other providers to assist with the individual’s specific crisis
    - **Note:** This level of CI may be billed either face-to-face or via Telemedicine.

- **Provider qualifications**
  - Must be a QMHP as defined by the state plan or the contractor(s) designated LMHP with experience regarding this specialized mental health service
  - Must be certified in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
  - Must complete a state-approved standardized basic training program

- **Documentation**
  - The chart shall document the individual’s medical necessity for crisis intervention, crisis plan, treatment plan, re-evaluation for continued crisis intervention, and coordination of services with the family and other system of care (i.e. education, juvenile justice, substance use provider, child welfare).
THE FOLLOWING SERVICES CAN CURRENTLY ONLY BE BILLED BY CMHCS.**

**Specialized Community-Based Rehabilitation Services (continued)

- Re-evaluation to justify continued need for crisis services shall document the specific needs to be addressed during a continuation of services and the specific services to be provided.

- **Quality assurance**
  For individuals assigned to an MCO, the assigned MCO shall be responsible for ensuring quality assurance for crisis intervention. This may include reviewing charts, requesting additional information, and monitoring services. The MCOs shall notify any CMHC of concerns related to crisis intervention and address any noncompliance issues as needed. KDADS shall be responsible for quality assurance for those receiving CI services who are not assigned to an MCO.

- **Definition**
  - **Collateral contact** - A source of information knowledgeable about the individual’s situation. The collateral contact typically either corroborates or supports information provided by household members. Collateral contacts provide a third-party validation of the individual’s circumstances and help ensure correct eligibility determinations are made.

*Note:* Per national guidance, a new patient visit is not covered when it is within three years of any professional services rendered by qualified health care professionals of the exact same specialty and subspecialty who belong to the same group practice. CMHC-employed professionals are considered to be practicing under the same specialty even though their licensure may vary.
8410. **DEFINITIVE CRITERIA Created 11/17**

Providers must keep and maintain, in accordance with K.A.R. 30-5-59, medical records for Medicaid service recipients to consist of, at least, the following:

- Individual’s identification number.

- Date of admission to treatment service.

- Treatment plan that has been completed within 14 days of admission to treatment services, not necessarily intake, which includes recommendations for treatment and has been reviewed and updated within the last 90 days.

  *Note:* This treatment plan must meet the following 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 individual's condition and updating of the treatment plan

- Current diagnosis that has been reviewed and updated within the last 90 days.

  *Note:* This update must also describe the individual's progress.

- Prognosis that has been reviewed and updated within the last 90 days.

  *Note:* 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.

  *Note:* For outpatient treatment, a chronological record includes all treatment provided to the individual, all activities performed on the individual's behalf, the type or mode of treatment, and the amount of time per session of treatment. These entries must include the signature and credentials 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.

  *Note:* If services not shown in the treatment plan or services differing from the treatment plan in scheduling frequency, duration, or designated staff are delivered to the individual, a detailed explanation of how these services relate to the treatment plan must be included in the record.
The following codes represent a list of mental health services billable to KMAP for individuals **not assigned** to an MCO.

Use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the participant ID number or benefit plan. Information is available:
- On the public website
- On the secure website under Pricing and Limitations

Charts have been developed to assist providers in understanding how KMAP will handle specific modifiers. The Coding Modifiers Table and Ambulance Coding Modifiers Table are available on both the public and secure websites. They can be accessed from the Reference Codes link under the Interactive Tools heading on the Provider page and Pricing and Limitations on the secure portion. Information is also available on the American Medical Association website.

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**Note:** When billing J-codes, the National Drug Codes (NDCs) making up the HCPCS code being billed must be submitted on the claim detail.

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