KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Non-PAHP Outpatient Mental Health
PART II
NON-PAHP OUTPATIENT MENTAL HEALTH PROVIDER MANUAL

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FORMS All forms pertaining to this provider manual can be found on the public website at
https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at

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PART II
NON-PAHP OUTPATIENT MENTAL HEALTH 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 outpatient mental health providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices. Part I of the provider manual consists of five parts: General Information, General Benefits, General Billing, General Special Requirements, and General Third Party Liability (TPL) Payment. Part I contains information that applies to all providers, including Non-prepaid Ambulatory Health Plan (Non-PAHP) outpatient mental health providers.

The Billing Instructions subsection gives instructions for completing and submitting the billing form outpatient mental health providers must use when the beneficiary is not assigned to the Pre-paid Ambulatory Health Plan (PAHP).

If the beneficiary is assigned to the PAHP, contact Kansas Health Solutions (KHS) by mail at 720 S. Jackson St., Suite 310, Topeka, KS 66603 or by phone at 1-866-547-0222.

The Benefits and Limitations subsection defines specific aspects of the scope of outpatient mental health services allowed within the KHPA Medical Plans.

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 KHPA Medical Plans, 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.

Access to Records
Kansas Regulation K.A.R. 30-5-59 requires providers to maintain and furnish records to KMAP upon request. Providers must also supply records to the Department of Health and Human Services upon request.

The provider is required to supply records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's office upon request from such office as required by the Kansas Medicaid Fraud Control Act, K.S.A. 21-3844 to 21-3855, inclusive, as amended.

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 the provider’s employees. The provider shall not charge a fee to retrieve and copy documents and records related to compliance reviews and complaint investigations.
NON-PAHP OUTPATIENT MENTAL HEALTH BILLING INSTRUCTIONS

7000. Updated 12/09

Introduction to the CMS-1500 and UB-04 Claim Forms
Outpatient mental health providers must use the red CMS-1500 or UB-04 claim forms (unless submitting electronically) when requesting payment for medical services provided under the KHPA Medical Plans. Any CMS-1500 or UB-04 claim form not submitted on the red claim form will be returned to the provider. Examples of the CMS-1500 and UB-04 claim forms are on the public (https://www.kmap-state-ks.us/Public/forms.asp) and the secure (https://www.kmap-state-ks.us/provider/security/logon.asp) websites in the Forms section at the end of this manual. The interChange Medicaid Management Information System (MMIS) uses electronic imaging and optical character recognition (OCR) equipment. Therefore, information must be submitted in the correct claim fields to be recognized by the equipment.

The fiscal agent does not furnish the CMS-1500 or UB-04 claim forms to providers. Refer to Section 1100 of the General Introduction Provider Manual.

Complete, line-by-line instructions for completion of the CMS-1500 are available in Section 5800 of the General Billing Provider Manual.

Complete, line-by-line instructions for completion of the UB-04 are available in Section 7000 of the Hospital Provider Manual.

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

KHPA Medical Plans
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS  66601-3571
Unit Billing

The appendix provides procedure code and time definitions for billing specific procedures (for example, 30 minutes, 1 hour). When billing according to this definition, bill one unit in field 24G.

When billing for less than the amount of time indicated in the definition (less than one 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 one 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 Issued 7/07

Outpatient 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 Third Party Liability Payments Provider Manual* for a list of beneficiaries who are exempt from copayments.
BENEFITS AND LIMITATIONS

8200. MEDICAL ASSESSMENT Issued 7/07

Allowed Providers

- Mental health professional 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

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

- A physician, physician assistant, or an advanced registered nurse practitioner working under protocol of a physician

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.

Psychological Testing

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

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

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 used with conclusions reached
- Recommendations 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.
BENEFITS AND LIMITATIONS

8300. BENEFIT PLAN  Updated 06/10

KMAP beneficiaries are assigned to one or more KMAP benefit plans. These benefit plans entitle the beneficiary to certain services. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility verification.

If the beneficiary is assigned to the PAHP, all mental health services are the responsibility of the PAHP. For more information, contact Kansas Health Solutions (KHS) by mail at 720 South Jackson Street, Suite 310, Topeka, KS 66603 or by phone at 1-866-547-0222.

To prevent potential billing and reimbursement errors, services provided when a beneficiary is assigned to the PAHP must be billed on a separate CMS-1500 claim form than services provided when a beneficiary is not assigned to the PAHP.

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

If the beneficiary is Title XXI, contact Cenpatico Behavioral Health at 1-866-896-7293.
Outpatient mental health services are covered when provided by a Kansas licensed mental health practitioner (LMHP) as defined in Section 8200. Services are covered only for those beneficiaries not covered under the PAHP. The provider must bill KMAP directly for services. KMAP does not reimburse LMHPs to supervise a nonlicensed person who is doing therapy. Uncertified assistants may be used to administer tests.

**Individual and Group Psychotherapy**
Individual and group psychotherapy are covered when a treatment plan contains a psychiatric diagnosis and treatment goals. This limitation is monitored post-pay 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 that a review of the treatment plan has been conducted every three months.

**Family Therapy**
Family therapy involves treatment of the family as a "system" with family being the focus of attention and change, specifically including children (may refer to adult children). The individual who is the KMAP cardholder 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 post-pay 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 that a review of the treatment plan has been conducted every three months.

In-home family therapy is covered as a specialized mental health service for children with special healthcare needs and is intended to reduce psychiatric institutionalization of the child. In-home family therapy is covered when a treatment plan contains a psychiatric diagnosis and treatment goals with supporting documentation justifying the provision of this modality of treatment. The provider must use modifier HK when billing in-home family therapy.

**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 beneficiaries having such problems.

Testing performed by an uncertified assistant and supervised by a Ph.D. 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 the preparation of a written test report.
Services Provided to a Beneficiary in an Inpatient or Residential Setting

Inpatient hospital visits are limited to those ordered by the beneficiary’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 residents of a nursing facility, intermediate care facility for mental retardation (ICF/MR), PRTF, or other institutions for mental disease (IMDs) are considered content of the institutional or residential stay and should not be billed to the KHPA Medical Plans.

Mental Health Services for Nursing Facility for Mental Health Beneficiaries

Mental health services for beneficiaries residing in a nursing facility for mental health (NF/MH) are noncovered by the KHPA Medical Plans. The State of Kansas provides the following state funded service to residents of an NF/MH:

Annual Screen
The annual screen for continued stay for beneficiaries residing in an NF/MH (T2011) is completed to determine the beneficiary's continued need for this level of care. The annual screen is a scheduled face-to-face interview with the beneficiary by a trained CMHC screener and a screening facilitator who are registered with the Social and Rehabilitative Services, Mental Health (SRS/MH) Division.

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 (PA) by SRS/MH staff following established guidelines and protocols for this process and are communicated to the fiscal agent. Payment is for one screen per beneficiary per year.

Other services provided to beneficiaries residing in an NF/MH include:

Therapy
Up to eight hours of code 90806 for beneficiaries in acute trauma and up to four hours per year for code 90801 are allowed. These services may only be provided by a CMHC and must be approved by the local quality enhancement coordinator.

Targeted Case Management
Codes T1017 and H0036HB may be provided during the 120 days prior to discharge. Targeted case management and community psychiatric support are provided by CMHC staff who have completed training approved by SRS/MH. These services must be approved by the local quality enhancement coordinator.
Mental Health Services for NF/MH Beneficiaries (cont.)

Personal Care Services
Up to 180 hours of code T1019HE may be provided per beneficiary per calendar year for up to 60 days post 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 the SRS/MH Division 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 beneficiaries transitioning from an NF/MH to community living and facilitate identification of needed services and supports a beneficiary will require to live in the community. Personal care services are provided by CMHC staff who has completed attendant care training approved by SRS/MH.

Inpatient Psychiatric Admissions
Inpatient psychiatric admissions are covered only after a psychiatric preadmission assessment or certification of need has been completed and a determination made that the most appropriate treatment setting is the hospital or other institutional setting. No payment will be made for inpatient psychiatric services without the completion of the preadmission assessment and determination that the admission meets medical necessity criteria. When seeking to admit a KMAP beneficiary for inpatient treatment, call 1-800-466-2222 to arrange for the assessment to be completed. This toll-free number is staffed 24 hours a day by KHS.

The hospital and admitting physician are notified of the results verbally and via a letter from KHS. If the admission is approved, a PA number is included in the letter for the hospital and physician to use when billing for the approved admission and related services.

The primary care case manager's referral is not required when the hospital admission has been approved by KHS. The PA number assigned by KHS must be noted on the claim.
Specialized Community Based Rehabilitation Services

Community-based psychiatric rehabilitation services are provided as part of a comprehensive specialized psychiatric program available to all KMAP beneficiaries 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 a beneficiary to his or her best possible functional level.

Services are subject to prior approval, 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 education 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 may not be provided in an IMD.

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

CPST may include the following components:

- Assist the beneficiary and family members or other collaterals to identify strategies or treatment options associated with the beneficiary’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 beneficiary’s daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- Individual supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the beneficiary, with the goal of assisting the beneficiary 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.
Participation in and use of strengths-based planning and treatments, which include assisting
the beneficiary 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
beneficiary’s mental illness.
Assist the beneficiary with effectively responding to or avoiding identified precursors or
triggers that would risk the beneficiary remaining in a natural community location,
including assisting the beneficiary and family members or other collaterals to identify a
potential psychiatric or personal crisis, develop a crisis management plan, and/or as
appropriate, to seek other supports to restore stability and functioning.

Provider qualifications:
- B.A./B.S. 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 standardized basic training program

To bill community psychiatric support and treatment submit the following procedure codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>H0036</td>
<td>HA CPST – Child</td>
</tr>
<tr>
<td>H0036</td>
<td>HB CPST – Adult</td>
</tr>
</tbody>
</table>

Service Limitations:
Services are limited to beneficiaries who have been discharged within the last 60 days from an
institutional level of care.

2. **Psychosocial rehabilitation (PSR)** services are designed to assist the beneficiary with
compensating for or eliminating functional deficits and interpersonal and/or environmental
barriers associated with the beneficiary’s mental illness. Activities included must be intended to
achieve the identified goals or objectives as set forth in the beneficiary’s individualized treatment
plan. The intent of PSR is to restore the fullest possible integration of the beneficiary 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 beneficiary present.
Services may be provided individually or in a group setting. The majority of PSR contacts must
occur in community locations where the beneficiary lives, works, attends school, and/or
socializes.

PSR may include the following components:
- Restoration 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
  beneficiary’s social environment including home, work, and school.
Restoration 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 a beneficiary’s daily living. Supporting the beneficiary 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 beneficiary may remain in a natural community location.

Assist the beneficiary to effectively respond to or avoid identified precursors or triggers that result in functional impairments.

Provider qualifications:
- Must be at least 18 years old and have a high school diploma or equivalent
- Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks
- Completion of a standardized basic training program

To bill psychosocial rehabilitation submit the following procedure codes:

- H2017  PSR – Individual
- H2017 TJ  PSR – Child Group
- H2017 HQ  PSR – Adult Group

Service Limitations:
One full-time equivalent (FTE) to eight beneficiaries is the maximum group size for adults. One FTE to four beneficiaries is the maximum group size for youth.

Services are limited to beneficiaries who have been discharged within the last 60 days from an institutional level of care.

3. Peer support (PS) services are beneficiary 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 beneficiary’s individualized treatment plan. The structured, scheduled activities provided by this service emphasize the opportunity for beneficiaries 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 beneficiary present. Services may be provided individually or in a group setting. The majority of PS contacts must occur in community locations where the beneficiary lives, works, attends school, and/or socializes.

PS services may include the following components:
- Help the beneficiary to develop a network for information and support from others who have been through similar experiences.
Assist the beneficiary 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 beneficiary 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 old and have a high school diploma or equivalent.
- Certification in the State of Kansas to provide the service, which includes criminal, abuse/neglect registry, and professional background checks.
- Completion of a standardized basic training program. Self identify as a present or former beneficiary of mental health services.

To bill for peer support submit the following procedure codes:

- H0038  PS – Individual
- H0038 HQ PS – Group

Service Limitations:
One FTE to eight beneficiaries is the maximum group size.

Services are limited to beneficiaries who have been discharged within the last 60 days from an institutional level of care.

4. Crisis intervention (CI) services are provided to a beneficiary 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 where the beneficiary lives, works, attends school, and/or socializes. This service may include the following components:

- A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation for other mental health services. Includes contact with the beneficiary, family members, or other collateral sources (such as caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to alternative mental health services at an appropriate level.
- Short-term CI, including crisis resolution, debriefing, and follow-up with the beneficiary, and as necessary, with the beneficiary’s caretaker and/or family members.
- Consultation with a physician or with other providers to assist with the beneficiary’s specific crisis.
Provider qualifications:
- Must be at least 18 years old and have an A.A./A.S. degree or two 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 standardized basic training program.

To bill for crisis intervention submit the following procedure codes:
- H2011 A.A./A.S.
- H2011 HK B.A./B.S.
- H2015 A.A./A.S.
- H2015 HK B.A./B.S.

Service Limitations:
- Crisis Intervention – Emergent is limited to six hours per episode.
- Crisis Intervention – Ongoing is limited to 66 hours per episode.
- H2011 and H2015 are limited to a combined 72 continuous hours per episode.
- H2011(HK) and H2015(HK) are limited to a combined 72 hours per episode (not required to be continuously provided).
- For the safety of the beneficiary and staff, H2011 may be billed concurrently with H2011 or H2011(HK) within the first three hours (for a total of six hours). The need for this level of support must be documented in the beneficiary’s chart.

**Example:** A crisis responder arrives at a potentially dangerous situation with law enforcement. After an initial evaluation, it is determined that mental health staff can handle the situation. To maintain the safety of the staff and beneficiary, a second crisis responder arrives. For the first three hours, both responders can be reimbursed for the services they are rendering.

- For the safety of the beneficiary and staff, H2015 may be billed concurrently with H2015 and H2015(HK) within the first 24 hours per episode. The need for this level of support must be documented in the beneficiary’s chart.

An episode is defined as the initial face-to-face contact with the beneficiary until the current crisis is resolved, not to exceed 14 days. The beneficiary’s chart must reflect resolution of the crisis which marks the end of the current episode. If the beneficiary has another crisis within seven calendar days of a previous episode, it shall be considered part of the previous episode, and a new episode will not be allowed.

Services are limited to beneficiaries who have been discharged within the last 60 days from an institutional level of care.
Telemedicine

Telemedicine is the use of communication equipment to link healthcare practitioners and patients in different locations. Healthcare providers use this technology 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 CPT® codes listed below using the GT modifier. They are reimbursed at the same rate as face-to-face services. The originating site, with the beneficiary present, may bill code Q3014.

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Limitations

- Consultations and hospital visits may not be performed on the same date of service by the same provider.
- Psychotherapy treatment and hospital visits may not be billed for the same date of service by the same provider.
- Electroshock treatments and psychotherapy may not be performed on the same date of service, regardless of provider.
- Partial hospitalization activity and psychosocial treatment may not be performed on the same date of service for the same beneficiary, regardless of provider.

Outpatient Mental Health Services Not Covered by Medicaid

- Conference calls
- Consultation in an ICF/MR facility
- Crisis intervention in an institutional setting
- Holding therapy
- Hypnosis, biofeedback, or relaxation therapy
- Occupational therapy
- Perceptual therapy
- Phone calls
- Psychometric testing when there is not continuous psychologist/beneficiary contact
- Psychotherapy for beneficiaries whose only diagnosis is mental retardation
- Therapy provided by a nonlicensed person
Providers must keep and maintain, in accordance with K.A.R. 30-5-59, medical records for Medicaid beneficiaries to consist of, at least, the following:

- Beneficiary’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, 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 beneficiary's condition and updating of the treatment plan
- Current diagnosis that has been reviewed and updated within the last 90 days. This update must also describe the beneficiary's progress.
- Prognosis that has been reviewed and updated within the last 90 days.
- 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 beneficiary, all activities performed on the beneficiary'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.

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 beneficiary, a detailed explanation of how these services relate to the treatment plan must be included in the record.
APPENDIX

CODES

Updated 08/10

The following codes represent an all-inclusive list of outpatient mental health services billable to KMAP for beneficiaries not assigned to the PAHP. Procedures not listed here are considered noncovered.

Please use the following resources to determine coverage and pricing information. For accuracy, use your provider type and specialty as well as the beneficiary ID number or benefit plan.

- Information from the public website is available at: https://www.kmap-state-ks.us/Provider/PRICING/RefCode.asp.
- Information from the secure website is available under Pricing and Limitations after logging on at: https://www.kmap-state-ks.us/provider/security/logon.asp.

A chart has been developed to assist providers in understanding how KHPA will handle specific modifiers. The Coding Modifiers chart is available on both the public and secure websites. It is under Reference Codes on the main provider page and Pricing and Limitations on the secure portion. Information on the American Medical Association is available at http://www.ama-assn.org.

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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. Refer to Professional Bulletin 6132d for specific billing instructions.*
**NEUROPSYCHOLOGICAL TESTING**

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**PSYCHOLOGICAL TESTING**

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**SPECIALIZED COMMUNITY BASED REHABILITATION SERVICES**

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**THERAPY – FAMILY**

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**THERAPY – GROUP**

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**THERAPY – INDIVIDUAL**

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**THERAPY – INDIVIDUAL WITH EVALUATION AND MANAGEMENT SERVICES**

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