

KEPRO Healthcare Utilization Management Guidelines
for West Virginia Licensed Independent Clinical Social Workers
Version 1.0

CHANGE LOG

Replace	Changes	Date of Change
No replacement	LICSW provider enrollment	July 1, 2015

**KEPRO Healthcare
Utilization Management Guidelines
For
West Virginia Medicaid Services by
Licensed Independent Clinical Social Workers
Version 1.0**

Service Utilization Management Guidelines

LICSW Services – CPT Codes

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Service Utilization Management Guidelines
LICSW Services – CPT Codes
KEPRO
West Virginia Medicaid ASO

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services Licensed Independent Social Workers may provide Medicaid beneficiaries and invoice the WV Bureau for Medical Services for reimbursement. Notice that each service listing provides:

- a definition,
- level of benefit,
- initial authorization limits,
- increments of re-authorization, and
- service exclusions.

In addition, the service listing provides:

- member-specific criteria, which discusses the conditions for
 - admission,
 - continuing stay,
 - discharge,
- clinical exclusions, and
- basic documentation requirements.

The elements of these service listings will be the basis for utilization reviews and management by KEPRO. Additional detail regarding service definitions and documentation requirements can be found in the WVDHHR Bureau for Medical Services Medicaid Manual Chapter 537 – Licensed Independent Clinical Social Worker Services and the American Medical Association Current Procedural Terminology (CPT) Manual. The WV Licensed Independent Clinical Social Worker Medicaid manual can be accessed at the following web link:

http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_Chapter_537_Licensed_Independent_Clinical_Social_Worker_%28LICSW%29.pdf

Request for Prior Authorization

KEPRO has developed a tiered system for initial and continuing-stay service authorizations. While most services require the provider submit only minimal information for the initial authorization, others require the provision of more clinical information to establish medical necessity. Continued-stay authorizations most frequently require the additional clinical information be submitted. Admission and continued stay criteria for these services were developed based upon the intensity of the service in question, as members are best served

when services are tailored to individual needs and are provided in the least restrictive setting.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to KEPRO. The provider will be notified if the request is authorized, pended (additional information is needed to make the decision), closed or denied and/or what alternative services may be recommended.

KEPRO strives to assist the provider in gaining authorization for services the member needs. Before a service request not clearly meeting medical necessity is denied, a KEPRO Care Manager will discuss the request with the provider to determine whether a renegotiation for a different intensity, duration or service can be accomplished. In the event that a member truly does not have a demonstrated behavioral health or I/DD diagnosis and/or need that meet the guidelines for care, the request will be reviewed by a physician reviewer and denied. In this event, both the provider and member will receive notification of the denial. Please see the KEPRO Provider Manual for additional information regarding the denial and appeals process.

Multiple Service Providers

Each provider is responsible for obtaining authorization for the service(s) they provide an individual. In cases where one provider has already received prior authorization to perform a service and an additional provider(s) attempts to obtain an authorization that would exceed the client benefit, KEPRO Care Managers will make every effort to determine the provider the member chooses to provide the service. We are hopeful that providers will continue to coordinate services for members to avoid duplication and maximize the therapeutic benefit of interventions.

Note: It is the provider's responsibility to coordinate care and establish internal utilization management processes to ensure members meet all medical necessity/service utilization guidelines and to obtain authorization prior to the onset of service when required. In instances where another provider is performing the service requested or the member benefit is exhausted, requests will not be authorized.

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. In the Managed Care position paper, published in 1999, the State of West Virginia introduced the following definition of medical necessity:

“services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided.”

The CPT code services rendered by Licensed Independent Clinical Social Workers more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition

above. In determining the appropriateness and necessity of services for the treatment of specific individuals, the diagnosis, level of functioning, clinical symptoms, and stability and availability of the member's support system are evaluated.

The current role of the ASO is to devise clinical rules and review processes that evaluate these characteristics of individuals, ensure that Licensed Independent Clinical Social Worker services requested are medically necessary and to enforce the policies of the Bureau for Medical Services. The Utilization Management Guidelines published by KEPRO serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

Part (4) of the state's medical necessity definition, in the context of CPT code services rendered by Licensed Independent Clinical Social Workers, relates to services requested by the member that may be helpful but are not medically necessary, as well as to alternative and complementary services not provided by the Licensed Independent Clinical Social Workers but to which the member may be referred. This portion of the definition prohibits the utilization of treatment codes to provide service that meets a member need but does not meet the medical necessity criteria. Prior authorization review will utilize these guidelines as well as specific clinical requirements for the specific service(s) requested.

Part (5) of the definition which refers to the "most appropriate level of care that can be safely provided", in the context of CPT codes used by Licensed Independent Clinical Social Workers, relates to the least restrictive type and intensity of service acceptable to meet the member's needs while ensuring that the member does not represent a direct danger to himself or others in the community.

Prior Authorization Request Tiered System

The information submitted at the "Core" tier (Tier 1) is brief and is primarily used to track utilization of various services as well as diagnostic groups and focus of treatment.

The information submitted at the second tier (Tier 2) through the Behavioral Health CareConnection® provides a clinically relevant summary of symptomatology and level of functioning, but it alone is not always sufficient documentation of a member's medical necessity. For this reason, KEPRO Care Managers may request additional information to make prior authorization decisions for members who do not clearly meet the UM guidelines for the service or do not clearly meet medical necessity requirements. The assessment, plan of care and proposed discharge criteria all serve to document the appropriateness and medical necessity of services provided to a member.

Provider Reviews

Provider reviews may determine that services as planned and documented do not meet the criteria requirements in the Medicaid manual. Through internal utilization management processes, providers need to ensure that medical necessity documentation is complete and consistent throughout the clinical record. Additional information regarding provider reviews can be found in the WV Licensed Independent Clinical Social Worker Medicaid Manual, Chapter 537 at:

http://www.dhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_Chapter_537_Licensed_Independent_Clinical_Social_Worker_%28LICSW%29.pdf

90791 Psychiatric Diagnostic Evaluation

Definition: An integrated bio-psychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources and review and ordering of diagnostic studies.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	LICSW Services
Telehealth	Available
Initial Authorization	Core-Tier 1 required for 2 events/per member/per year from start date of initial service Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission required to exceed limit of two (2) units per member/per year (member benefit is two (2) sessions per year from any/all providers). This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	<ol style="list-style-type: none"> 1. Member has, or is suspected of having, a behavioral health condition, -or- 2. Member is entering or reentering the service system, -or- 3. Member has need of an assessment due to a change in clinical/functional status, -or- 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	<p>Code 90791 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient.</p> <p>Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792.</p>
Clinical Exclusions	None
Documentation Requirement	Documentation must contain the following and be completed in 15 calendar days from the date of service.

	<ul style="list-style-type: none"> • Date of Service • Location of Service • Purpose of Evaluation • Signature with credentials • Presenting Problem • History of Medicaid Member's presenting illness • Duration and Frequency of Symptoms • Current and Past Medication efficacy and compliance • Psychiatric History up to Present Day • Medical History related to Behavioral Health Condition • Mental Status Exam - The Mental Status Exam must include the following elements: <ul style="list-style-type: none"> ○ Appearance ○ Behavior ○ Attitude ○ Level of Consciousness ○ Orientation ○ Speech ○ Mood and Affect ○ Thought Process/Form and Thought Content ○ Suicidality and Homicidiality ○ Insight and Judgment • Members diagnosis per current DSM or ICD methodology • Medicaid Member's prognosis for Treatment • Rational for Prognosis • Rationale for Diagnosis • Appropriate Recommendations consistent with the findings of the evaluation
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Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

90832 Individual Psychotherapy (16-37 minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services (90832, 90834, 90837 and 90853) include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 16-37 minutes
Re-Authorization	<p>1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 16-37 minutes</p> <p>NOTE: Tier 2 data submission required for a provider to exceed limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	<p>Psychotherapy for patients in a crisis state is reported with codes 90839 and 90840.</p>
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirements	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Examiners of Social Work.

90834 Individual Psychotherapy (38-52 minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services (90832, 90834, 90837 and 90853) include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30-52 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30-52 minutes NOTE: Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services -and- 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and- 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and- 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. For family psychotherapy without the patient present, use the 90846 service. 2. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 3. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 4. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Documentation Requirements	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

90837 Psychotherapy (53 or more minutes)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services (90832, 90834, 90837 and 90853) include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 53 or more minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 53 or more minutes NOTE: Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services -and- 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and- 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member’s problem, -and- 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing

	change.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. For family psychotherapy without the patient present, use the 90846 service. 2. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 3. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 4. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Documentation Requirements	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

90839 Psychotherapy for Crisis; First 60 Minutes

Definition: Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

This code is used to report the total duration of time face-to-face with the patient and/or family spent by the Licensed Independent Clinical Social Worker providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the Licensed Independent Clinical Social Worker must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service.

Code 90839 should be used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the Licensed Independent Clinical Social Worker is not continuous. If the crisis episode has continued for more than 74 minutes, the 90840 code should be requested to address the additional time.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Not Available
Initial Authorization	Core-Tier 1 for 2 units/per 30 calendar days/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Another request for prior authorization is required for any provider to exceed the limit of 2 units/per member/ per 30 calendar days for utilization review purposes – or- if this is a new crisis episode. 2 additional units/per member/30 calendar days Unit = 60 minutes
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis -and- 2. The member presents the need for an urgent assessment of their crisis state – and- 3. Member demonstrates severe to acute psychiatric symptoms, impaired functional abilities due to the crisis – and – 4. Requires the immediate, direct attention of the Licensed Independent Clinical Social Worker to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in

	high distress.
Continuing Stay Criteria	This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.
Discharge Criteria	Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.
Service Exclusions	<p>Not to be used as an emergency response to a member running out of medications or housing problems.</p> <p>Psychotherapy for a crisis of less than 30 minutes total duration on a given date should be reported with the 90832 or 90833 (when provided with an E/M service).</p> <p>Psychotherapy for crisis should not be used in conjunction with 90791 or 90792.</p> <p>No other Licensed Independent Clinical Social Worker service may be provided and billed during this service.</p> <p>This service should not be used for:</p> <ul style="list-style-type: none"> • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	None.
Documentation Requirements	<p>Documentation must contain the following:</p> <p>There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis.</p> <p>The documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Safety Plan • Place of service • Date of service • Start-and-Stop times

	<ul style="list-style-type: none">• Mental Status Exam - The Mental Status Exam must include the following elements:<ul style="list-style-type: none">○ Appearance○ Behavior○ Attitude○ Level of Consciousness○ Orientation○ Speech○ Mood and Affect○ Thought Process/Form and Thought Content○ Suicidality and Homicidality○ Insight and Judgment
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Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

90840 Psychotherapy for Crisis; Additional 30 Minutes

Definition: Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

This code is used to report the total duration of time face-to-face with the patient and/or family spent by the Licensed Independent Clinical Social Worker providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the Licensed Independent Clinical Social Worker must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same time period. The patient must be present for all or some of the service.

Code 90840 is an add-on service to 90839 and should be used to report the additional 30 minutes following the first 74 minutes of psychotherapy for crisis on a given date.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Initial Authorization	Core-Tier 1 for 2 units/per 30 calendar days/per member from start date of initial service Unit = 30 minutes An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.
Re-Authorization	2 units/per member/ per 30 calendar days for utilization review purposes Unit = 30 minutes Another request for prior authorization is required for any provider to exceed the limit of 74 minutes for a crisis response on a specific date. An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis -and- 2. The member presents the need for an urgent assessment of their crisis state – and- 3. Member demonstrates severe to acute psychiatric symptoms, impaired functional abilities due to the crisis – and – 4. Requires the immediate, direct attention of the Licensed Independent Clinical Social Worker to address the

	<p>presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.—and-</p> <p>5. The 74 minutes of 90839 have been exhausted for this date of service.</p>
Continuing Stay Criteria	<p>This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.</p>
Discharge Criteria	<p>Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.</p>
Service Exclusions	<p>Not to be used as an emergency response to a member running out of medications or housing problems.</p> <p>Psychotherapy for a crisis of less than 74 minutes total duration on a given date should be reported with the 90839 service.</p> <p>Psychotherapy for crisis should not be used in conjunction with 90791 or 90792.</p> <p>No other psychiatric service may be provided and billed during this service.</p> <p>This service should not be used for:</p> <ul style="list-style-type: none"> • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	<p>None</p>
Documentation Requirements	<p>Documentation must contain the following:</p> <p>There must be a progress note for this service. The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment for the crisis</p> <p>The documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Safety Plan • Place of service

	<ul style="list-style-type: none">• Date of service• Start-and-Stop times• Mental Status Exam - The Mental Status Exam must include the following elements:<ul style="list-style-type: none">○ Appearance○ Behavior○ Attitude○ Level of Consciousness○ Orientation○ Speech○ Mood and Affect○ Thought Process/Form and Thought Content○ Suicidality and Homicidality○ Insight and Judgment
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Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

90846 Family Psychotherapy (without patient present)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy without the patient present in the therapeutic session.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	<p>1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes</p> <p>NOTE: Tier 2 data submission required for a provider to exceed limit of ten additional units/per member/per year. This level of data is required to exceed authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>
Continuing Stay Criteria	<p>1. The service is necessary and appropriate to meet the member's identified treatment need(s).</p> <p>2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.</p>

Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	90846 Family Psychotherapy (without patient present) has a combined service limit with 90847 Family Psychotherapy (with patient present) of 10 units/per member/per year.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirements	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.
- This service may not be used solely to communicate the results of an evaluation.

90847 Family Psychotherapy (with patient present)

Definition: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse of change maladaptive patterns of behavior, and encourage personality growth and development. This code is specific to family psychotherapy with the patient present in the therapeutic session.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	<p>1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes</p> <p>NOTE: Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and-</p> <p>4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.</p>
Continuing Stay Criteria	<p>1. The service is necessary and appropriate to meet the member's identified treatment need(s).</p> <p>2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.</p>

Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	90847 Family Psychotherapy (with patient present) has a combined service limit with 90846 Family Psychotherapy (without patient present) of 10 units/per member/per year.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirements	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.
- This service may not be used solely to communicate the results of an evaluation.

90853 Group Psychotherapy

Definition: Group psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, 90837, and 90853 include ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family member(s) or others in the treatment process.

These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual members. A maximum of 12 individuals may participate in a group setting. This code may not be utilized for multiple family group therapy.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual disability/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	Licensed Independent Clinical Social Worker Services
Telehealth	Available
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit= 75-80 minutes
Re-Authorization	<p>1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 75-80 minutes</p> <p>NOTE: Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.</p>
Admission Criteria	<p>1. Member has a behavioral health diagnosis which qualifies for Medicaid behavioral health services, -and-</p> <p>2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -and-</p> <p>3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and-</p> <p>4. Interventions are grounded in a specific and identifiable</p>

	theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care.
Documentation Requirement	<ul style="list-style-type: none"> • Documentation must indicate how often this service is to be provided. • There must be a progress note describing each service provided, the relationship of the service to the identified mental health treatment needs, and the member's response to the service. • The progress note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment. <p>Documentation must also include the following:</p> <ul style="list-style-type: none"> • Signature with credentials • Place of service • Date of service • Start-and-Stop times

Additional Service Criteria:

- Must be performed by a West Virginia Licensed Independent Clinical Social Worker in good standing with WV Board of Social Work.

Appendix A

WV Medicaid Non-Methadone Medication Assisted Treatment Policy

WV Medicaid Non-Methadone Medication Assisted Treatment Policy

West Virginia Medicaid covers non-Methadone Medication Assisted Treatment Services under the following circumstances:

- Individuals seeking opioid addiction treatment for Suboxone®/Subutex® or Vivitrol® for the treatment of opioid/alcohol dependence must be evaluated by an enrolled physician as specified below, before beginning medication assisted treatment.
- An initial evaluation may be completed by a staff member other than the physician however no medication may be prescribed until the physician has completed their evaluation.
- Members seeking treatment must have an appropriate diagnosis for the medication utilized.
- All physicians agree to adhere to the Coordination of Care Agreement (Please see Appendix B) which will be signed by the member, the treating physician, and the treating therapist.
- Each member receiving non-methadone medication assisted treatment must also be involved in individual therapy and/or group therapy as specified in the Coordination of Care Agreement.
- If a change of physician or therapist takes place, a new agreement must be signed. This agreement must be placed in the member's record and updated annually.
- The agreement is not required if the member is receiving services at an agency where both the physician and therapist are employed.

Therapy Services: Psychotherapy is the treatment of mental illness and behavioral disturbances in which the Licensed Independent Clinical Social Worker through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. The psychotherapy codes 90832, 90834, and 90837 include ongoing assessment and adjustment of psychotherapeutic interventions and may include the involvement of family member (s) or others in the treatment process. Psychotherapy times are face-to-face services with patient and/or family member. The patient must be present for all or some of the service. In reporting, choose the code closest to the actual time (i.e., 16-37 minutes for 90832, 38-52 minutes for 90834, and 53 or more minutes for 90837. ([See 90832, 90834, and 90837 Psychotherapy Requirements](#)).

Provider Requirements: Any therapeutic intervention applied must be performed by a Licensed Independent Clinical Social Worker.

Documentation: Documentation will require a treatment strategy, the signature, and credentials of the staff providing the service, place of service, and date of service. The activity note must include the reason for the service, symptoms and functioning of the member, a therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change, and the member's response to the intervention and/or treatment.

Consumer compliance with treatment and other information must be shared with the physician as per the Coordination of Care Agreement.

Program Guidelines:

Note: These are the minimum requirements that are set forth in this manual. Physicians and/or agencies may have more stringent guidelines set forth in their internal policy.

Phase 1: Members in phase 1 (less than 12 months of compliance with treatment) will attend a **minimum** of four (4) hours of psychotherapy services per month. The four hours must contain a **minimum** of one (1) hour individual psychotherapy session per month. Frequency of therapeutic services may increase based upon medical necessity.

Phase 2: Members in phase 2 (12 months or more of compliance with treatment) will attend a minimum of (1) hour of psychotherapy services per month with individual, family, or group modalities. Frequency of therapeutic services may increase based upon medical necessity.

Drug Screens: A minimum of two (2) random urine drug screens per month are required for members in phase 1. A minimum of one (1) random urine drug screen per month is required for members in phase 2. A record of the results of these screens may be requested from the physician. The drug screen must test for, at a minimum, the following substances:

- Opiates
- Oxycodone
- Methadone
- Buprenorphine
- Benzodiazepines
- Cocaine
- Amphetamine
- Methamphetamine

Instructions for non-compliance with treatment:

Non-compliance is defined as failure of a drug screen or failure to meet the monthly requirement of therapeutic services.

Members in phase 1 must demonstrate increased treatment frequency after two instances of non-compliance such as: two failed drug screens, two months of not meeting therapeutic requirements, or a combination of one failed drug screen and one month of failed therapeutic requirements. If increase in treatment frequency is not demonstrated consistently within seven days, the patient may be terminated from the program at the physician's discretion.

The physician and/or treatment program has the option to allow the patient to reapply to the program after 30 days with proven participation in professional therapies. With three violations within six months, the physician will terminate the individual from the program. The program has the option to allow the patient to reapply after 30 days during which time the patient must demonstrate compliance with professional therapies. An exception is made for pregnant women at physician discretion.

Members in phase 2 will be returned to phase 1 of treatment after one instance of non-compliance (see Phase 1 required timelines).

Individuals discharged for non-compliance and ineligible for re-start must receive information describing alternative methods of treatment and listing contact information for alternative treatment providers as appropriate.

Titration Policy: Titration due to non-compliance is per Physician order when the Medicaid Member is found to be non-compliant during treatment. Titration must be completed within four (4) weeks of the physicians order to stop medication assisted treatment. Vivitrol will be discontinued immediately due to non-compliance.

Any physician that prescribes medication under the Non-Methadone Medication Assistance Treatment must have a plan in place for when they are unavailable to address any medical issues or medication situations that should arise. At no time is a Nurse Practitioner or a Physician's Assistant to prescribe Suboxone/Subutex.

Appendix B

Information shared from WV Medicaid:

Chapter 537, Licensed Independent Clinical Social Worker Services, Appendix 537A

Coordination of Care and Release of Information Form

Suboxone®/Subutex® or Vivitrol® Providers

[http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Appendixes/Appendix 537A Coordination%](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Appendixes/Appendix_537A_Coordination%20of%20Care%20and%20Release%20of%20Information%20Form%20for%20Suboxone%20and%20Subutex%20Providers%20and%20Vivitrol%20Providers.pdf)

Coordination of Care and Release of Information between Suboxone®/Subutex®/Vivitrol® Provider and BH Provider

Communication between behavioral health providers and your Suboxone®/Vivitrol® Prescribing Physician other Behavioral Health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. **This consent expires in one year (12 months) from the date of my signature below unless otherwise stated herein.**

_____ (*BH Provider*) is authorized to release protected health information related to the evaluation and treatment of _____ (*Member*) to _____ (*Suboxone®/Vivitrol® Prescribing Physician*).

(Member Name) _____

(Medicaid ID#) _____

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

(Date of Birth – MM/DD/YYYY) ____/____/____

Suboxone® or Vitriol® Prescribing Physician: _____

Physician Phone: (____) _____ - _____

Physician Address: _____

BH Provider Name: _____

BH Provider Phone: (____) _____ - _____

BH Provider Address: _____

Disclosure may include the following verbal or written information: (check all that apply)

Demographic Information History & Physical Laboratory/diagnostic testing results

Discharge Summary Medication records Psychological Eva/Testing Results

Psychiatric evaluation ER record Service Plan

Behavioral health/psychological consults Psychosocial Assessment report

Summary of Treatment records, progress Substance abuse treatment record

Other (specify below)

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

(Print Provider Name) _____

(Signature) _____

(Date) ____ / ____ / _____

**I want to inform you that _____ was seen by me for the
treatment of:** (Member Name)

DSM-V and/or medical diagnosis:

Date of appointment: ____ / ____ / _____

Summary:

The treatment plan consists of the following modalities:

- € Individual Psychotherapy € Group Psychotherapy € Family Psychotherapy
- € Psychological Testing € Medication Management (see next page)
- € Other (please specify)

**Coordination of Care and Release of Information between
Suboxone®/Subutex®/Vivitrol® Provider and BH Provider**

Current Medication(s) (Dosage, Frequency and Delivery)

The following medication was or will be started (indicate medication and dosage):

Estimated length of treatment:

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients. WV Department of Health and Human Resources Bureau for Medical Services.