KEPRO Utilization Management Guidelines
For Federally Qualified Health Centers (FQHC)
and Rural Health Clinics (RHC)
Version 1.2

CHANGE LOG

Replace	Changes	Date of Change
Service definitions for the following services have been modified to identify newly eligible staff: H0031AJ, 90832, 90834, 90837, 90839, 90840, 90846, & 90847	Include Master's Level Licensed Social Workers (LGSW, LCSW & LICSW) and Licensed Professional Counselors as eligible to provide this service.	December 1, 2015

KEPRO
Utilization Management Guidelines
For
Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providing WV Medicaid Behavioral Health Services

Version 1.2

KEPRO Utilization Management Guidelines For FQHC's and RHC's

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Service Utilization Management Guidelines
For Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
KEPRO

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the approved CPT code services available for FQHC and RHC to 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 American Medical Association Current Procedural Terminology (CPT) Manual.

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 may 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 servicing provider electronically

submits the required information to KEPRO via the Behavioral Health CareConnection®. 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.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and KEPRO. KEPRO strives to assist the provider in developing an appropriate plan of care for each member. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a member truly does not have a demonstrated behavioral health or ID/DD diagnosis and/or need that meets the guidelines for care, the request will be 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 which provider the member chooses to have render 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. The State of West Virginia utilizes 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 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, stability, and availability of the member's support system are evaluated. The role of the ASO is to devise clinical rules and review processes that

evaluate these characteristics of individuals, ensure that 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 psychiatrists, relates to services requested by the member that may be helpful but are not medically necessary, as well as to alternative and complementary services 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 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 with the initial service request (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.

Retrospective Reviews

Retrospective 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.

90791 Psychiatric Diagnostic Evaluation

Definition: Initial or reassessment evaluation by a Licensed Psychologist or Psychiatrist. Psychiatric Diagnostic Examination includes an integrated biopsychosocial assessment, including history, mental status, and recommendations. This 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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2 sessions/per member/ per year Unit= Session/Event 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	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	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status.

Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Codes 90791 and 90792 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. 2. Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792. (per 2013 CPT manual, Professional Edition, pg. 484).
Clinical Exclusions	None
Documentation Requirement	Documentation must include a written record of findings, recommendations from the interview examination, and evidence of provision of results to appropriate parties. Documentation must be signed with credentials and dated (date of service).

90792 Psychiatric Diagnostic Evaluation with Medical Services

Definition: Initial or reassessment evaluation by a Psychiatrist. Psychiatric Diagnostic Examination includes an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. This evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other 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)
Option	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	1. Core-Tier 1 data submission is required for additional units after one year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of two (2) sessions/per member/per year. This level of data is required to exceed 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	1. Member has a known or suspected behavioral health diagnosis, **-and-** 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.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals of member's Individualized Treatment Plan have been substantially met.
Service Exclusions	Codes 90791 and 90792 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. Psychotherapy, including for crisis, may not be reported

	on the same day as 90791 or 90792. (per 2013 CPT manual, Professional Edition, pg. 484).
Clinical Exclusions	None
Documentation	Documentation must include a written record of findings, recommendations from the interview examination, and evidence of provision of results to appropriate parties. Documentation must be signed with and dated (date of service).

H0031 AJ Mental Health assessment by a non-physician

Definition: Initial or reassessment evaluation to determine the needs, strengths, functioning level(s), mental status, and/or social history of an individual. Specialty evaluations such as occupational therapy, nutritional and functional skills assessments are included. The administration and scoring of functional skills assessments are included. This code is to be utilized by Master's Level Licensed Social Workers (LGSW, LCSW or LICSW) or Licensed Professional Counselors (LPC).

Level of Service	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability /Developmental Disability (ID/DD), Child and Adult (C&A)
Medicaid Option	FQHC/RHC-CPT Codes
Initial Authorization	Core-Tier 1 required for 1 session/per member/per year/per provider from start date of initial service Unit= Session/Event
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 1 session/per member/ per year/per provider Unit= Session/Event 2. Tier 2 data submission required to exceeding the limit of four (4) units per member/per year (member benefit is four (4) 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	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	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	1. Member has withdrawn or been discharged from service.

	2. Goals for the member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	None
Documentation	Documentation shall consist of the completed evaluation, (signed with credential initial(s) by the staff member who provided the service.) The documentation must include the place of evaluation, the date of service, and the actual time spent providing the service. The actual time spent must be documented by listing the start and stop times.

Additional Service Criteria:

1. The assessments are evaluative services and standardized testing instruments.

90832 Psychotherapy, 30 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a Psychiatrist, Licensed Psychologist or Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services 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.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 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 = 30 minutes **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.
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	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	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.
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90833 Psychotherapy, 30 min. with Patient and/or Family Member with Evaluation and Management Service

Definition: Face-to-face structured intervention by a Psychiatrist with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services 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.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

This service is an add-on code to an Evaluation and Management Service (E/M).

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 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 = 30 minutes **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.
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, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90791 and 90792 Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Evaluation and 90836 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 45 minutes may not be billed *on the same day as* 90833 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 30 minutes.
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90834 Psychotherapy, 45 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by a Psychiatrist, Licensed Psychologist or Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services 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.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45 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 = 45 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	1. The service is necessary and appropriate to meet the member's identified treatment needs. 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	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.
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90836 Psychotherapy, 45 min. with Evaluation and Management Services

Definition: Face-to-face structured intervention by a Psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. This service includes medical evaluation and management services and may include more intensive medical psychotherapy than is allowable under the Pharmacologic Management 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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 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 = 45-50 minutes **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.
Admission Criteria	1. Member has a behavioral health diagnosis (other than a V-code) 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, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	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) by the physician. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792. For family psychotherapy without the patient present, use the 90846 service for the physician.
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions

90837 Psychotherapy, 60 minutes with Patient and/or Family Member

Definition: Face-to-face structured intervention by Psychiatrist, Licensed Psychologist or Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) with the patient and/or family member, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Psychotherapy services 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.

This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Mental Retardation/Developmental Disability (ID/DD), Child and Adult (C&A)
Program Option	FQHC/RHC -CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 60 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 = 60 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	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	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.
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with and dated (date

	of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

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 Physician, Licensed Psychologist, Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the clinician 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.

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	FQHC/RHC-CPT codes
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. If the crisis episode has continued for more than 74 minutes, the 90840 code should be requested to address the additional time. 2 additional units/per member/30 calendar days Unit = 60 minutes
Admission Criteria	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 clinician 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	Not to be used as an emergency response to a member running out of medications or housing problems. 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). Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. No other psychiatric service may be provided and billed during this service.
Clinical Exclusions	None.
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

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 physician providing psychotherapy for crisis, even if the time spent on that date is not continuous. For any given time spent providing this service, the physician 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. Psychiatrists, Licensed Psychologists, Master's Level Licensed Social Workers (LGSW, LCSW or LICSW) or Licensed Professional Counselors (LPC) may provide this 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	FQHC/RHC-CPT codes
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	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 physician to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.— and- 5. The 74 minutes of 90839 have been exhausted for this date of service.
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	Not to be used as an emergency response to a member running out of medications or housing problems. Psychotherapy for a crisis of less than 74 minutes total duration on a given date should be reported with the 90839 service. Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. No other psychiatric service may be provided and billed during this service.
Clinical Exclusions	None
Documentation Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

90846 Family Psychotherapy (without patient present)

Definition: Face-to-face structured family intervention by a Psychiatrist, Licensed Psychologist, Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 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 = 45-50 minutes **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.
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	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	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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.
2. This service may not be used solely to communicate evaluation and test results.

90847 Family Psychotherapy (with patient present)

Definition: Face-to-face structured family intervention by a Psychiatrist, Licensed Psychologist, Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. The identified patient must be present to utilize this code.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45-50 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 = 45-50 minutes **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.
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	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	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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.
2. This service may not be used solely to communicate evaluation and test results.

90853 Group Psychotherapy

Definition: Face-to-face structured intervention by a Psychiatrist, Licensed Psychologist, Master's Level Licensed Social Worker (LGSW, LCSW or LICSW) or Licensed Professional Counselor (LPC) to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. 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. 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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 75-80 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 = 75-80 minutes **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.
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	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

Additional Service Criteria:

1. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90875 Individual Psychotherapy Biofeedback 30 minutes

Definition: Face-to-face structured intervention by a Psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 30 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 minutes **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.
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, **-and-** 5. Service includes biofeedback training by any modality.

Continuing Stay Criteria	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

Additional Service Criteria:

1. Psychiatrists billing this code must have specific training in biofeedback techniques.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

90876 Individual Psychotherapy Biofeedback 45 minutes

Definition: Face-to-face structured intervention by a Psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes individual psychophysiological therapy incorporating biofeedback training by any modality with psychotherapy to provide therapeutic change in an outpatient setting.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 for 10 units/per year/per member from start date of initial service Unit = 45 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 = 45 minutes **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.
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, **-and-** 5. Service includes biofeedback training by any modality.

Continuing Stay Criteria	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	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
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 Requirement	Documentation shall consist of a note describing the type of service, outcomes, assessment and progress. Documentation must be signed with credentials and dated (date of service).

Additional Service Criteria:

1. Psychiatrists billing this code must have specific training in biofeedback techniques.
2. Supportive interactions must be part of the therapeutic process/psychotherapy service and are not "stand-alone" interventions.

96101 Psychological Testing with Interpretation and Report

Definition: Psychological testing by a Licensed Psychologist with interpretation and report. Psychological testing includes, but is not limited to psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities (e.g., WAIS-R, Rorschach, and MMPI). Academic assessment and assessment required to determine the needs, strengths, functioning level(s), mental status and/or social history of an individual are also included. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 4 hours/per member/per year/per provider 4 units for one year from start date of initial service Unit = One hour
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 4 units for one year Unit = One hour 2. Tier 2 data submission required for any provider to exceed the limit of four (4) units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having a behavioral health diagnosis, **-or-** 2. Member requires psychological testing or evaluation for a specific purpose, **-or-** 3. Psychological testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service

Service Exclusions	Cannot be billed *on the same day as* 96116 Neurobehavioral status exam or 96118 Neuropsychological testing battery.
Clinical Exclusions	None
Documentation Requirement	Documentation must include scoring and interpretation of testing and a written report of findings and recommendations (including provision of results to appropriate parties). Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. A Licensed Psychologist must complete the testing and report/interpretation.

96110 Developmental Testing: Limited

Definition: Developmental Testing by a Licensed Psychologist including limited developmental testing with interpretation and report. Developmental testing includes, but is not limited to: Developmental Screening Test II, Early Language Milestone Screen and other developmental screening instruments. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations.

Note: Limited developmental testing is provided under this code; extensive developmental testing should be provided using 96111 Developmental Testing. Extensive and general psychological testing should be provided utilizing 96101 Psychological Testing.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 4 hours/per member/per year/per provider 4 units for one year from start date of initial service Unit = One hour
Re-Authorization	1. Core-Tier 1 Required for additional units after one year by any provider previously utilizing the benefit for the same member. 4 units for one year Unit = One hour 2. Tier 2 data submission required to exceed the limit of four (4) units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having a developmental delay and/or behavioral health condition, **-or-** 2. Member requires developmental testing or evaluation for a specific purpose, **-or-** 3. Developmental testing/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. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	The **combination** of ▪ 96110 Developmental Testing: Limited **-and-** ▪ 96111 Developmental Testing: Extended may not exceed 4 hours/per member/per year/per provider.
Clinical Exclusions	Testing that encompasses more extensive assessment than developmental assessment should be performed using 96101 Psychological Testing.
Documentation Requirement	Documentation must include scoring and interpretation of testing and a written report of findings and recommendations (including provision of results to appropriate parties). Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. A Licensed Psychologist must complete the testing and report/interpretation.

96111 Developmental Testing: Extended

Definition: Developmental Testing by a Licensed Psychologist including extended developmental testing with interpretation and report. Developmental testing includes, but is not limited to: assessment of motor, language, social, adaptive, and/or cognitive functioning through the use of standardized developmental instruments (e.g., Bayley Scales of Infant Development). Documentation requires scoring and interpretation of testing and a written report including findings and recommendations.

Note: Extensive developmental testing is provided under this code; limited developmental testing should be provided using 96110 Developmental Testing. Limited and general psychological testing should be provided utilizing 96101 Psychological Testing.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 4 hours/per member/per year/per provider 4 units for one year from start date of initial service Unit = One hour
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 4 units for one year Unit = One hour 2. Tier 2 data submission is required to exceed the limit of four (4) units per member/per provider/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having a developmental delay and/or behavioral health condition, **-or-** 2. Member requires developmental testing or evaluation for a specific purpose, **-or-** 3. Developmental testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.

Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	The **combination** of ▪ 96110 Developmental Testing: Limited **and** ▪ 96111 Developmental Testing: Extended may not exceed 4 hours/per member/per year/per provider.
Clinical Exclusions	Testing that encompasses more extensive assessment than developmental assessment should be performed using 96101 Psychological Testing.
Documentation Requirement	Documentation must include scoring and interpretation of testing and a written report of findings and recommendations (including provision of results to appropriate parties). Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. A Licensed Psychologist must complete the testing and report/interpretation.

96116 Neurobehavioral Status Exam

Definition: Neurobehavioral status exam by a Licensed Psychologist including clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report. Documentation requires scoring and interpretation of any testing and a written report including findings and recommendations.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 2 sessions/per member/per year 2 sessions/year from start date of initial service Unit = Event/Session
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 2 sessions for one year Unit = Event/Session 2. Tier 2 data submission is required to exceed the limit of two (2) units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	Cannot be billed on the same day as 96118 Neuropsychological testing battery or 96101 Psychological Testing.

Clinical Exclusions	None
Documentation Requirement	Documentation must include scoring and interpretation of testing and a written report of findings and recommendations (including provision of results to appropriate parties). Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Neurobehavioral Status Exam is indicated and purpose(s) is stated in the report.
2. The client requires more evaluation than a standard mental status examination and the neurobehavioral status exam is completed by a Licensed Psychologist who has specialized training in neuropsychological screening and/or evaluation and is recognized by the West Virginia Board of Examiners as having such training/experience.

96118 Neuropsychological Testing Battery

Definition: Neuropsychological testing battery (e.g., Halstead-Patton, Luria, WAIS-R) administered by a Licensed Psychologist with interpretation and report. Documentation requires scoring and interpretation of any testing and a written report including findings and recommendations.

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	FQHC/RHC-CPT codes
Initial Authorization	Core-Tier 1 required for 12 units/per member/per year 12 units/year from start date of initial service Unit = One hour
Re-Authorization	1. Core-Tier 1 required for additional units after one year by any provider previously utilizing the benefit for the same member. 12 units for one year from start date of initial service Unit = One hour 2. Tier 2 data submission is required to exceed the limit of twelve (12) units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. The total number of additional units being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit will be granted.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	Cannot be billed on the same day as 96116 Neurobehavioral status exam or 96101 Psychological Testing
Clinical Exclusions	None

Documentation Requirement	Documentation must include scoring and interpretation of testing and a written report of findings and recommendations (including provision of results to appropriate parties). Documentation must be signed and dated (date of service).

Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. The testing and report/interpretation must be completed by a Licensed Psychologist who has specialized training in neuropsychological evaluation and is recognized by the West Virginia Board of Examiners as having such training/experience.