

**KEPRO Utilization Management Guidelines for West Virginia CLINIC,
REHABILITATION, TARGETED CASE MANAGEMENT OPTIONS**

CHANGE LOG

Replace	Changes	Date of Change
UM Guidelines Version 3.2	Align with Revised WV Medicaid Clinic and Rehabilitation manuals dated July 1, 2014	July 1, 2014
Targeted Case Management (T1017 & T1017CM) pages in Version 3.3	Align with revised WV Medicaid TCM Manual dated July 1, 2016	July 1, 2016
Statement regarding daily census time as midnight for H0019 U1, H0019 U2, H0019 U3, and H0019 U4 services	The daily census time as indicated in the WV Rehabilitation Manual for these services is noon.	January 1, 2018
H0019 U4 Short Term Residential Children's Services (Emergency Shelter) providers were able to request separate Targeted Case Management services	Targeted Case Management services are now included within the services provided by Short Term Residential Children's Services (Emergency Shelter)	January 1, 2018

KEPRO
Utilization Management Guidelines
For West Virginia Medicaid
CLINIC, REHABILITATION, TARGETED CASE
MANAGEMENT OPTIONS
Version 3.4

*Version applies to both BBHMF Contracted Providers and Non-BBHMF
Contracted Providers*

KEPRO - West Virginia

West Virginia Medicaid Clinic, Rehabilitation, and Targeted Case Management Options for both BBHF Contracted Providers and Non-BBHF Contracted Providers

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West Virginia Medicaid Clinic, Rehabilitation, and Targeted Case Management Options for both BBHHF Contracted Providers and Non-BBHHF Contracted Providers

KEPRO West Virginia Medicaid ASO

The purpose of Utilization and Service Guidelines are to provide an overview of the WV Medicaid Clinic, Rehabilitation, and Targeted Case Management Options for providers of behavioral health services. Each service listing provides a definition, service tier, program option, 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.

The Bureau for Behavioral Health and Health Facilities (BBHHF) provides funding to West Virginia's fourteen contracted providers for charity care services. Beginning 07/01/2012, those contracted providers will submit Clinic, Rehabilitation, and TCM services (with the exception of Residential Children's Services I, II, III, and IV) for individuals deemed eligible for charity care funding. Only BBHHF contracted providers may submit for services for this population.

Prior authorization for services requires completion of the West Virginia KEPRO CareConnection®. To request an authorization, the provider registers with KEPRO to access the submission website. The service provider may then submit the appropriate required information. The provider will be notified if the request is approved, if additional information is needed to make the decision (pend), and/or what alternative services may be recommended. In the event the member needs service beyond the initial authorized units, the provider will submit another prior authorization request for the service. It is recommended the provider submit a prior authorization request before an existing service authorization expires.

Duplication of services by providers is not allowed. It is the responsibility of the provider(s) to coordinate care and to authorize service appropriately. For the members served by multiple behavioral health providers, the provider providing the case management services or the lead provider in service planning is considered the primary provider by KEPRO. Each provider is responsible for submitting the request for authorization for the services they provide. We are hopeful that this will encourage continued community coordination of services for members.

The information provided at the *Core-Tier 1* is brief and is primarily used to track the utilization of various services as well as diagnostic groups and focus of treatment. Tier 1 also provides the information necessary for the submission of the Mental Health and Substance Abuse Block Grants for BBHHF. The information submitted at Tier 2 and Tier 3 of the West Virginia KEPRO CareConnection® provides a clinically relevant summary of symptomatology and level of functioning but alone is not always sufficient documentation of medical necessity.

Information at Tier 2 and Tier 3, along with the BBHHF Data Segment (formerly known as the Federal Substance Abuse Reporting Data), is also utilized for completing required tables for federal reporting, as well as linking to the Client Service Data Report (CSDR) and other financial reporting by BBHHF Contract Providers. Tier 4 is designated for crisis stabilization, which is the highest intensity of service available within the options.

KEPRO Healthcare will continually communicate with providers regarding services requested. Typically, the vast majority of discrepancies or questions related to a service request can be resolved through our communication efforts. In the event a mutually agreeable decision cannot be reached, the service request will be sent for physician review and potential denial. If the outcome of the denial process yields a denial, notice of the denial and appeal options will be sent to the provider and the member/guardian.

Prior authorization approval 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 Clinic and Rehabilitation Services Manual more clearly defines the services and criteria utilized to meet parts (1) and (2) of the definition above. In determining the appropriateness and necessity of services under the Clinic and Rehabilitation Options for the treatment of specific individuals, the diagnosis, level of functioning, clinical symptoms and stability and available support system are evaluated. The Utilization Management Guidelines for the WV Rehabilitation and Clinic Options published by KEPRO serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the service. Level of available support is evaluated based on treatment history, along with the level of assistance required for the member to perform activities of daily living. Additionally, the UM guidelines outline standards of good clinical practice.

Part (4) of the definition, in the context of the Clinic and Rehabilitation Options, 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 addressed in the manuals. 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 service delivery under the Clinic and Rehabilitation Options, relates to the least restrictive service acceptable to meet the member’s needs while ensuring that the member does not represent a direct danger to self or others in the community.

While the information submitted on the West Virginia KEPRO CareConnection® is a clinically relevant summary, KEPRO 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 meet clearly meet medical necessity requirements. The assessment, service plans and documentation of services all serve to document the appropriateness and medical necessity of services provided to a member.

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.

The purpose of the utilization review and management system is to assure that the member receives the appropriate service in an appropriate setting for an appropriate duration of treatment and support among service providers and throughout regions. Member choice and individual specific treatment are necessities of recovery. While this document specifically relates to Clinic, Rehabilitation, and TCM, it is well documented of the need to explore all service options within the realm of availability for the member.

KEPRO West Virginia Medicaid ASO Definitions

Behavioral Health Rehabilitation Services:

Includes the medical and remedial services included in the Rehabilitation Option, recommended by a physician or licensed psychologist, for the purpose of reducing physical or mental disability and restoration of a recipient to his/her best functional level.

- A. All services are subject to a determination of medical/clinical necessity. The following five factors and the definition listed above will be included as part of this determination:
 1. Diagnosis
 2. Level of functioning
 3. Evidence of clinical stability
 4. Available support system
 5. Service is the appropriate level of care
- B. Consideration of the above factors in the service planning process will be documented and re-evaluated at regular service plan reviews.
- C. When required, diagnostic and standardized instruments to measure functioning which are approved by the Bureau for Medical Services will be administered at the initial evaluation and as necessary to represent the clinical condition of the member.
- D. The results of above measures will be included as part of the clinical record and serve as a part of the required documentation of service needs and justification for the levels and type of services requested and provided.

Behavioral Health Clinic Services:

Includes preventive, diagnostic, therapeutic or palliative items or services included in the Clinic Option and provided to outpatients under the direction of a physician. These services must be furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. Clinic Services must be provided at the clinic, the only exception being services provided to the homeless.

- A. Clinic Services are under the direction of a physician:
 1. A physician must sign the Authorization for Services Form unless in Focused Care.
 2. The physician must have a face-to-face contact with the member before or at the master service planning juncture to authorize services unless in Focused Care.
 3. Physician will periodically review the continued need for care unless in Focused Care.
- B. All Clinic Services are subject to a determination of medical/clinical necessity. The following five factors and the definition listed above will be included as part of this determination:
 1. Diagnosis
 2. Level of functioning
 3. Evidence of clinical stability
 4. Available support system
 5. Service is the appropriate level of care
- C. Consideration of these factors in the service treatment planning process will be documented and re-evaluated at plan reviews.
- D. When required, diagnostic and standardized instruments to measure functioning which are approved by the Bureau for Medical Services will be administered at the initial evaluation and as necessary to represent the clinical condition of the member.
- E. The results of the above measures will be available as part of the clinical record and serve as a part of the required documentation of service need and justification for the level and type of service requested and provided.

Member:

- A. One who is determined Medicaid eligible for Behavioral Health Rehabilitation Services designated for all individuals with conditions associated with mental illness, substance abuse and/or drug dependence. **-or-**
- B. One who is eligible for the Behavioral Health Clinic Services receiving professional services at an organized medical facility, or distinct part of such a facility, neither of which is providing the member with room and board and professional services on a continuous 24 hour-a-day basis. **-and/or-**
- C. One who is eligible for Targeted Case Management Services:
 - Children with mental illness
 - Adults with mental illness
 - Children with substance-related disorders
 - Adults with substance-related disorders
 - Children who qualify for early intervention
 - Children with intellectual/developmental disabilities
 - Adults with intellectual/developmental disabilities **-and-**
- D. One who is approved for specific Clinic, Rehabilitation, and/or Targeted Case Management Services based on meeting eligibility for specific service levels.

BBHHF Eligible Member: Members eligible for BBHHF services must:

- Be a West Virginia Resident **-and-**
- Be at or below 200% of the current Federal Poverty Guidelines for the 48 contiguous states – **and-**
- Meet **at least one (1)** of the following conditions:
 - Have an eligible DSM or ICD diagnosis (under the Medicaid Clinic, Rehabilitation or Targeted Case Management options) **-or-**
 - Meet the state eligibility requirements for an intellectual/developmental disability **-or-**
 - Has a history of inpatient hospitalization for a mental health, substance abuse or developmental disability **-or-**
 - Lives in a 24 hour supervised setting (such as a group home) **-or-**
 - Receives supportive residential services to assist in management of symptoms or functional impairments related to a mental health condition, substance abuse condition or developmental disability **-or-**
 - Receives services required by West Virginia Code, Chapter 27 **-or-**
 - Receives a crisis service

BBHHF Contract Provider: These providers have Grant Agreements with the Bureau for Behavioral Health and Health Facilities to provide services required by the West Virginia Code, Chapter 27 and other specific policies promulgated by BBHHF to provide behavioral health services through the use of indigent care dollars and other state and discretionary dollars. These providers are required to meet specific data submission and reporting requirements set forth in their Grant Agreement. Providers who **only** receive Federal Mental Health and/or Substance Abuse Block Grant funds to provide specific targeted services are **not BBHHF contract providers BUT** are required to meet specific data and reporting requirements set forth in their Grant Agreement related to the receipt of Block Grant funds.

Service Tier General Criteria:

Core-Tier 1 Services:

- ❖ All Medicaid members with a known or suspected behavioral health disorder.
- ❖ Brief, low intensity outpatient services are required to treat the identified behavioral health condition, with the purpose of reducing symptoms and/or returning the individual to their previous level of functioning.
- ❖ BBHHF Contract Providers complete additional fields for prior authorization to meet Federal Mental Health and Substance Abuse Block Grant requirements. All provider groups complete these data elements but for non-BBHHF contract providers the fields are part of the Tier 2 data set.

Tier 2 Services:

- ❖ Members who meet the following criteria:
 1. Member requires continued services 1-2 times a week or less.
 2. Symptoms are mild to moderate.
 3. Member manages tasks of community living with moderate to no support.
 4. Member has a severe and persistent behavioral health disorder requiring low intensity outpatient care.

Tier 3 Services:

- ❖ Members who meet the following criteria:
 1. Member requires services 3-5 days per week.
 2. Symptoms are moderate to severe.
 3. Member requires direct assistance to manage tasks of community living.
 4. Member has a severe and persistent behavioral health disorder (MH or SA) which requires intensive services and in which the individual displays a high level of symptoms and a low level of functioning. The required services are often residential in nature and withdrawal of services may result in hospitalization or institutionalization.

Tier 4 Services:

- ❖ Members who meet the following criteria:
 1. Member requires intensive crisis services.
 2. Symptoms are severe and/or acute crisis.
 3. Member requires direct assistance to manage tasks of community living, maintaining safety, etc.
 4. Member has a severe and persistent behavioral health disorder (MH or SA) which requires stabilization and in which the individual displays a high level of symptoms and a low level of functioning. The required services short term although inability to stabilize may result in inpatient hospitalization.

H2011 CRISIS INTERVENTION

Definition: Unscheduled, direct face-to-face intervention with a recipient in need of emergency or psychiatric interventions in order to resolve a crisis related to acute or severe psychiatric signs and symptoms. Depending on the specific type of crisis, an array of treatment modalities is available. These include, but are not limited to, individual intervention and/or family intervention. The goal of crisis intervention is to respond immediately, assess the situation, stabilize and create a plan as quickly as possible. This service is not intended for use as an “emergency response” to situation such as a member running out of medication or housing problems. Any such activities will be considered inappropriate for billing of this service by the provider.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A & C BBHMF Members*
Option	Clinic/Rehabilitation, BBHMF Charity Care,
Initial Authorization	16 units/ per member/per 30 days Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after 30 days by any provider previously utilizing the benefit for the same member 2. Another request for prior authorization is required for any provider to exceed the limit of sixteen (16) units/ per member/per 30 days for utilization review purposes –or- if the service is provided to address a new crisis episode.
Admission Criteria	<ol style="list-style-type: none"> 1. The member has a known or suspected behavioral health diagnosis, -and- 2. Treatment at a lower level of care has been attempted or given serious consideration, -and- 3. Psychiatric signs and symptoms are acute or severe, -and- 4. Member has insufficient or severely limited resources or skills necessary to cope with the immediate crisis, -and- 5. Member exhibits lack of judgment and/or impulse control and/or cognitive/perceptual abilities, -and- 6. Member requires an unscheduled face-to-face intervention -or- 7. The member is a risk to self, others and/or property.
Continuing Stay Criteria	This service may be utilized at various points in the members’ course of treatment and recovery; however, each intervention is intended to be a discreet time-limited service, which stabilizes the member and moves him/her to the appropriate level of care.
Discharge Criteria	<ol style="list-style-type: none"> 1. Crisis situation is resolved and an adequate continuing care plan is established. 2. Member no longer meets admissions criteria.
Service Exclusions	<p>Activities that are excluded from being performed through the Crisis Intervention Service Code are:</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

	<p>neglectful household.</p> <ul style="list-style-type: none"> • Completion of certification for involuntary commitment. <p>This service is also not to be used as an “emergency response” to a situation such as a member running out of medication or housing problems.</p> <p>No other Clinic, Rehabilitation or Targeted Case Management Service may be provided during the period for which Crisis Intervention Services are being billed.</p>
Clinical Exclusion	The member does not require inpatient care due to level of danger to self or others.
Documentation	<p>Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.</p> <p>A physician, physician extender, supervised psychologist or licensed psychologist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow up and whether the service plan is to be modified or maintained, the signature and credentials of the physician, physician extender, supervised psychologist or licensed psychologist and the date of service. The signature will serve as the order to perform the service. If a supervised psychologist is utilized to provide approval for this service, the supervised psychologist must have completed an appropriate training in crisis intervention and systematic de-escalation.</p> <p>Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations.</p>

Additional Service Criteria:

1. *BBHMF follows the same utilization management guidelines as Medicaid for data submission and prior authorization of this service
2. The mix of services offered to the member will be important in determining the appropriateness of this service. The use of crisis intervention will be retrospectively reviewed and the evaluation will include the clinical appropriateness of the service in conjunction with other services offered to and provided to the member. For example, if a person presents in crisis and the crisis is alleviated within an hour, ongoing supportive services may then be utilized to support the member or targeted case management services may be provided to link and refer to needed services.
3. Physician Assistant may also perform this service. Permissions granted to Physician Assistants can be found in the West Virginia Code 30-3-16 [(b) and (o)] and legislative rule 11 CSR 1B. Program Instruction MA-01-06 issued January 6, 2001 allows the Physician Assistant to be reimbursed for services rendered to Medicaid eligible individuals as outlined in their job description submitted to the West Virginia Board of Medicine.
4. A Nurse Practitioner with a Psychiatric Certification may perform this service. Any other Nurse Practitioner may perform this service provided it is within their scope of practice as defined by their Licensing Board and their contract with the Bureau for Medical Services and under the supervision of a psychiatrist.

H0031 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. The administration and scoring of functional assessment instruments necessary for the medical necessity determination and level of care needed as part of this service are included. This code may also be used for special requests of West Virginia Department of Health and Human Resources for assessments, reports, and court testimony on adults or children for cases of suspected abuse or neglect.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Adult & Child (A & C)
Option	Clinic/Rehabilitation, BBHHC Charity Care
Telehealth	Available
Initial Authorization	<p>Unit = Event</p> <p>Maximum of (four) 4 per year for members with complex behavioral healthcare needs (Coordinated Care) and (two) 2 per year per member with relatively simple behavioral healthcare needs (Focused Care).</p> <p>The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services. Provider should indicate "global assessment" in text field.</p>
Re-Authorization	<ol style="list-style-type: none"> 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 for any provider to exceed the limit. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. The need for the additional unit should be described in the free-text field.
Admission Criteria	<ol style="list-style-type: none"> 1. Intake/Initial evaluation for a member with a known or suspected behavioral health condition – or- 2. Member has an alteration in level of care with the exception of individuals being stepped down related to function of their behavioral health condition to a lesser level of care;-or- 3. Member requires an assessment due to a clinical change qualifying for a critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services; - or - 4. Member requires readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Member has an alteration in level of care with the exception of individuals being stepped down related to function of their behavioral health condition to a lesser level of care. 2. Member requires an assessment due to a clinical change qualifying for a critical treatment juncture, defined as: The occurrence of an unusual or significant event which has an impact on the process of treatment. A critical treatment juncture will result in a documented meeting between the provider and the member and/or DLR and may cause a revision of the plan of services; 3. Member requires readmission upon occurrence of unusual or significant events that justify the re-initiation of treatment or that have had an impact on the individual's willingness to accept treatment; 4. The provider may request authorization to conduct one global assessment per year to reaffirm medical necessity and the need for continued care/services.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	<p>Change of payer source does not justify H0031.</p> <p>This service should not be utilized for members under the age of three (3). The member should be referred to the Birth to Three Program.</p>
Clinical Exclusions	H0031, T1023HE and 90791 or 90792 are not to be billed at the same initial intake or re-assessment unless the H0031 is performed first and the evaluator recommends more specific assessment by a medical or psychological professional for further evaluation of the need for medical or other specialty treatment. Documentation must justify need for further evaluation using 90791 or 90792.
Documentation	<ol style="list-style-type: none"> 1) When completing an initial evaluation/intake, the following must be included (may include use of standardized screening tools): <ol style="list-style-type: none"> a) Demographic data (name, age, date of birth, etc.); b) Presenting problem(s) (must establish medical necessity for evaluation) including a description of frequency, duration, and intensity of presenting symptomatology that warrants admission; c) Impact of the current level of functioning (self-report and report of others present at interview), which may include as appropriate a description of activities of daily living, social skills, role functioning, concentration, persistence, and pace; for children, current behavioral and academic functioning; d) History of behavioral health and health treatment (recent and remote); e) History of any prior suicide/homicide attempts, high risk behaviors, self-injurious behaviors, etc.; f) Medical problems and medications currently prescribed; g) Social history which may include family history as relevant, description of significant childhood events, arrests, educational background, current family structure, vocational history, financial status, marital history, domestic violence (familial and/or personal), substance abuse (familial and/or personal), military history if any; h) Analysis of available social support system at present; i) Mental status examination; j) Recommended treatment (initial);

	<ul style="list-style-type: none"> k) Diagnostic Impression, (must be approved/signed by licensed clinical professional with diagnostic privileges in scope of practice); and l) Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator. m) Efficacy of and compliance with past treatment. (If past treatment is reported) n) Past treatment history and medication compliance (If past treatment is reported) <p>2) When completing a re-assessment the following must be included:</p> <ul style="list-style-type: none"> a) Date of last comprehensive assessment; b) Current demographic data; c) Reason for re-assessment, including description of current presenting problems (must document medical necessity for evaluation. If the re-evaluation is a global annual assessment it must be labeled as such). d) Changes in situation, behavior, functioning since prior evaluation; e) Summary of treatment since prior evaluation including a description of treatment provided over the interval and response to treatment; f) Mental status examination; g) Suggested amendments in treatment/intervention and/or recommendations for continued treatment or discharge; h) Specific rationale for any proposed amendment in diagnosis which must be analyzed and approved/signed by licensed clinical professional; and i) Place of evaluation, date of evaluation, start stop times, signature and credentials of evaluator.
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Additional Service Criteria:

1. The assessments are evaluative or standardized testing instruments.
2. Staff must have a minimum of a master's degree, bachelor's degree in a field of human services, or a registered nurse. Supervision and oversight by an individual with a minimum of a master's degree is required (See Clinical Supervision). Staff must be properly credentialed by the agency's internal credentialing committee.

T1023 HE Screening by Licensed Psychologist

Definition: Brief psychological evaluation with written report by a licensed psychologist to determine the appropriateness of consideration of an individual for participation/placement in a specified program, project or treatment protocol. Code 96101 or 90791 should be used when a more in depth assessment is indicated.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth:	Available
Initial Authorization	1 unit/ per member/per 184 days Unit = Event/Session
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after 184 days by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of one (1) session/per member/per 184 days. 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	<ol style="list-style-type: none"> 1. The member has a known or suspected behavioral health diagnosis, -and- 2. The initial screening/intake information indicates a need for additional information, -or- 3. Member's situation/functioning require evaluation for participating in a specialized treatment group or program.
Continuing Stay Criteria	None.
Discharge Criteria	Each evaluation is intended to be a discreet time-limited service, which is utilized to direct the member to the appropriate level and type of care.
Service Exclusions	96101 or 90791 should be used when a more in-depth assessment is indicated.
Clinical Exclusions	None.
Documentation	<p>Documentation must contain the following:</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Purpose of Evaluation • Start/Stop Times • Practitioner signature and credentials • Appropriate recommendations based on clinical data gathered in the evaluation

Additional Service Criteria: Must be performed by a West Virginia Licensed psychologist or Supervised Psychologist in good standing with WV Board of Examiners of Psychology.

96101 Psychological Testing with Interpretation and Report

Definition: Evaluation by a psychologist including psychological testing with interpretation and report. Psychological testing includes, but is not limited to psychodiagnostic assessment of personality, psychopathology, emotionality, and intellectual abilities. 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. 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously interpreted, completed and reported technician-and computer-administered tests.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Adult & Child (A&C)
Program Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Not Available
Initial Authorization	4 units/per member/per year Unit = One hour
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after a year by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is 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.
Admission Criteria	<ol style="list-style-type: none"> 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	None.
Discharge Criteria	Each evaluation is intended to be a discreet time-limited service, which is utilized to direct the member to the appropriate level and type of care.
Service Exclusions	<ol style="list-style-type: none"> 1. 96110 should be utilized for developmental testing and evaluation. 2. Interpretation and report of technician and computer-based tests may not be completed using this service. It is intended for the integration of previously interpreted and reported technician and computer-based tests. 3. Service cannot be used for work completed by the psychometrician/technician, scoring of computer based tests and self-administered assessments.
Clinical Exclusions	None
Documentation Requirement	<p>Documentation/Report must contain the following and be completed in 15 calendar days from the date of service:</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Time Spent (Start/Stop Times) • Signature with Credentials

	<ul style="list-style-type: none"> • Purpose of the Evaluation • Documentation that Medicaid Member was present for the evaluation • Report must contain results (score and category) of the administered tests/evaluations • Report must contain interpretation of the administered tests/evaluations • Report must contain documentation of mental status exam • Report must contain a rendering of the Medicaid Member's diagnosis within the current DSM or ICD methodology. • Report must contain recommendations consistent with the findings of administered test/evaluation
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Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. Must be performed by a West Virginia licensed psychologist in good standing with WV Board of Examiners of Psychology or a Supervised Psychologist under supervision of a Board approved Supervisor.

96110 Developmental Testing: Limited

Definition: This is limited to developmental testing (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report.

Service Tier	Core-Tier 1
Target Population	Mental Health (MH), Substance Abuse (SA), Intellectual Disability/Developmental Disability (ID/DD), Adult & Child (A&C)
Program Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Not Available
Initial Authorization	2 units/per member/per 184 days Unit = Event
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after 184 days by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed the limit of two (2) units per member/per 184 days. 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.
Admission Criteria	<ol style="list-style-type: none"> 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	None.
Discharge Criteria	Each evaluation is intended to be a discreet time-limited service, which is utilized to direct the member to the appropriate level and type of care.
Service Exclusions	<ol style="list-style-type: none"> 1. Extensive and general psychological testing should be provided utilizing 96101 Psychological Testing. 2. This service cannot be billed if Psychological Testing with Interpretation and Report (procedure code 96101) has been billed in the last six months.
Clinical Exclusions	None
Documentation Requirement	Documentation shall be a completed evaluation, including scoring and interpretation of testing and a written report of findings and recommendations (including evidence of provision of results to appropriate parties), signed by a licensed psychologist. The documentation must include the place of the evaluation and the date of service.

Additional Service Criteria:

1. Testing is for evaluative purpose(s) and purpose(s) is stated in the report.
2. Must be performed by a West Virginia Licensed Psychologist in good standing with WV Board of Examiners of Psychology, a Psychologist who is under the supervision of a Board approved Supervisor, a physician or physician extender.

90791 Psychiatric Diagnostic Examination

Definition: Initial or reassessment evaluation by a psychiatrist or psychologist. An integrated bi-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	MH, SA, ID/DD, A&C
Option	Clinic & Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	2 sessions/per member/per year Unit = Session/Event
Re-Authorization	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	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 of member's Individualized Service Plan have been substantially met.
Service Exclusions	<ol style="list-style-type: none"> 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.
Clinical Exclusions	None
Documentation	<p>Documentation must contain the following and be completed in 15 calendar days from the date of service.</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Purpose of Evaluation • Psychiatrist's/Psychologist's 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 • Members diagnosis per current DSM or ICD methodology

	<ul style="list-style-type: none">• Medicaid Member's prognosis and rationale• 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 psychologist in good standing with WV Board of Examiners of Psychology, a Supervised Psychologist who is supervised by Board approved Supervisor, a Physician, or a Physician Extender.

90792 Psychiatric Diagnostic Evaluations with Medical Services

Definition: An integrated bio-psychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. The evaluation may include communication with family and 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), Adult & Child (A&C)
Option	Clinic & Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	2 sessions/per member/per year Unit = Session/Event
Re-Authorization	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	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 of member's Individualized Service Plan have been substantially met.
Service Exclusions	<ol style="list-style-type: none"> 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.
Clinical Exclusions	None
Documentation	<p>Documentation must contain the following and be completed 15 calendar days from the date of service.</p> <ul style="list-style-type: none"> • Date of Service • Location of Service • Psychiatrist's signature with credentials • Purpose of the evaluation • Documentation that Medicaid Member was present for the evaluation • Documentation that Medical Evaluation was completed • Presenting Problem • History of the Medicaid Member's presenting illness • Duration and Frequency of symptoms • Current and Past Medication including efficacy and compliance

	<ul style="list-style-type: none">• Psychiatric history up to present day• Medical History related to behavioral health condition• Documentation of Mental Status Exam• Medicaid Member's diagnosis per current DSM and ICD Methodology• Medicaid Member's prognosis and rationale• Appropriate recommendations consistent with the findings of the evaluation
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Additional Service Criteria:

1. Must be completed by a physician or a physician extender.

H2010 Comprehensive Medication Services: Mental Health

Definition: Comprehensive Medication Services: Mental Health is utilized for Clozaril Case Management or other scheduled, face-to-face assessment of medication compliance or efficacy which includes any necessary blood work and obtaining laboratory results for a recipient by a registered nurse and subsequent evaluation of the results by the physician necessary for the medical management of the drug Clozaril/Clozapine or other psychotropic medications which require consistent and intensive monitoring. Because this is a physician directed service, a physician must be on site and available for direct service as needed. Recipients may be served individually or by a group/clinic model. Methadone is not a covered medication.

Service Tier	Core-Tier 1
Target Population	MH, A & C, SA, ID/DD
Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	Core-Tier 1 submission required for 24 units/per member/per 92 days 24 units/per member/per 92 days Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after 92 days by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of 24 units per member/per 92 days. This level of data is required to exceed initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. Additionally, the total number of additional units being requested must be specified in the free-text field, otherwise a maximum of 8 additional units will be authorized.
Admission Criteria	<ol style="list-style-type: none"> 1. Member with severe and persistent behavioral health diagnosis, -and- 2. Clozaril or other medication requiring intensive monitoring is prescribed and ordered by a licensed physician, -and- 3. Clozaril Management or other comprehensive medication services are adjunctive to primary behavioral health services.
Continuing Stay Criteria	Continues to meet admission criteria.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member refuses Clozaril/Clozapine or medication requiring intensive monitoring. 2. Physician discontinues order for Clozaril/Clozapine or medication requiring intensive monitoring.

Service Exclusions	<ol style="list-style-type: none"> 1. Provider must not bill Procedure Code H0036 Community Psychiatric Supportive Treatment, Pharmacologic Management (E&M codes) or H0040 Assertive Community Treatment on the same day as Mental Health Comprehensive Medication Services (H2010) since these services include all of the physician and nurse oversight expected from those clinicians for the Medical Case Management of Clozaril/Clozapine and other medications. As such they cannot be billed separately. 2. Members can still receive the following services on the same day as long as the actual time frames do not overlap: Targeted Case Management (T1017); Therapy or Counseling Service (H0004 HO, H004 HO HQ, H0004 and H0004 HQ); Skills Training and Development (H2014 HN U4, H2014 HN U1, H2014 U4, H2014 U1); or Day Treatment (H2012). Mental Health Comprehensive Medication Services whose time frames are identical or overlapping with these or other services will be considered duplicate services.
Clinical Exclusions	None.
Documentation	Documentation must contain a written note of the assessment results as completed by the registered nurse, and other laboratory results, and current psychotropic medication dosage with authorized pharmacy name. The documentation must include: place of service, start/stop time and date of service, and signature of qualified staff providing the service.

Additional Service Criteria:

1. There must be a physician's order for the medication and the order must be in the members' chart.
2. Documentation must support that the member has been informed of the risk and benefits of the medications, which are being administered, and that the person administering the medication is monitoring symptoms.

H0032 Mental Health Service Plan Development by Non-Physician

Definition: An individual service plan is required for all members receiving services through *Coordinated Care*. The treatment team consists of the member and/or guardian, and/or member's representative (if requested), the member's case manager, representatives of each professional discipline, and provider and/or program providing services to that person (inter- and intra-agency). If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session. All members of the team must receive adequate notice of the treatment team meeting. If a member of the team does not come, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances. A physician extender may serve on the committee in place of the physician.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A&C
Option	Clinic & Rehabilitation, BBHHF Charity Care
Telehealth	Available
Initial Authorization	sixteen (16) units/ per 90 days/per member Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after initial 90-day authorization by any provider previously utilizing the benefit for the same member. 2. Tier 2 information/data required to exceed limit of 16 units/ per member/per 90 days. This level of data is required to exceed initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. Additionally, the total number of additional units being requested must be specified in the free-text field, otherwise a maximum of 4 additional units will be authorized.
Admission Criteria	Member has a behavioral health condition that requires treatment services.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis and is in need of treatment services, -or- 2. Ninety (90) days has elapsed since the service plan was completed and the service plan must be reviewed, -or- 3. Member has reached a critical treatment juncture as necessitated by the member needs.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member has withdrawn or been discharged from service. 2. Goals of member's Individualized Service Plan have been substantially met.
Service Exclusions	<ol style="list-style-type: none"> 1. T1017 may not be billed during the same time period as H0032. 2. Individual program plans for Day Treatment, Children's Residential Services, and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services. 3. If Medicaid Member is in <i>Focused Care</i> H0032 cannot be billed.
Clinical Exclusions	None

<p>Documentation</p>	<p>All service plans (including updates) must be reviewed, signed, and approved by a physician within 72 hours of the service plan meeting and prior to implementing services.</p> <p>Mental Health Service Plan Development reimburses for team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.</p> <p>The following documentation is required for substantiation of Mental Health Service Plan Development:</p> <ul style="list-style-type: none"> • A service plan signature page is required. This document is to be placed in the member's clinical record along with the completed service plan or service plan update. <ul style="list-style-type: none"> ○ There must be signatures of all participating members of the treatment team (including the member, their guardian, or the member's requested representative). ○ All signatures must be original, must include the title and credentials of the individual, must be dated by the treatment team member, and must include the actual time spent providing the service by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process. • If a staff person from another agency participates in the service planning session, he/she must: <ul style="list-style-type: none"> ○ Meet the previously listed requirements of the service plan signature page. This includes signing the signature page along with listing the agency they are representing. ○ Write an activity note (which must be included in their agency's clinical record) that states their purpose for participating in the meeting, their signature and credentials, the location of the session, date of session, and the actual time spent participating in the session by listing their start-and-stop times. <p>Documentation must contain the physician's signature or that of the psychologist or physician extender on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.</p> <p>If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within 7 calendar days by the member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.</p>
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Additional Service Criteria:

1. An Initial Service Plan is developed based on intake information within seven days of intake; a Master Service Plan is developed within 30 days of intake and must be updated at least every 90 days. It must be updated more frequently, at critical treatment junctures, if necessitated by the member's needs.
2. Providers must make the proper distinction between service planning and other activities related to case management for the member. The case manager may be involved in the development of individual program plans, such as residential plans, day service plans, work training plans, educational plans, etc. as called for by the member's Master Service Plan. These types of activities may constitute billable time for case management services; however, when the case manager participates in a treatment team meeting he/she must bill Mental Health Service Plan Development rather than Targeted Case Management.
3. The case manager is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictate. Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the inclusion of the member. The agency providing services to the member may bill for participation by any of their staff necessary for the service planning process. Participation by staff from other agencies is not billable by the agency coordinating the service planning session. Participation by family members is not billable. It is important to remember that, although coordination of the service planning process is the responsibility of the case manager, development of the service plan is the responsibility of the treatment team.

REHABILITATION SERVICES

The physician, designated physician extender, licensed or supervised psychologist must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician or physician extender has been specifically requested by the case manager or the member.

CLINIC SERVICES:

The physician or designated physician extender must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the physician or physician extender has been specifically requested by the case manager or the member.

H0032 AH Mental Health Service Plan Development by Non-Physician- PSYCHOLOGIST PARTICIPATION

Definition: These are activities by a licensed psychologist directly related to service planning which includes participation in treatment team meeting as required and/or review and approval of service plans.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A & C
Option	Rehabilitation, BBHF Charity Care
Telehealth	Available
Initial Authorization	One unit/ per 30 days/per member Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after initial 30-day authorization by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of 1 unit/ per member/per 30 days. This level of data is required to exceed initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field. Additionally, the total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	<ol style="list-style-type: none"> 1. Member is receiving Coordinated Care services-and- 2. The licensed or supervised psychologist must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria: <ul style="list-style-type: none"> • Receive psychotropic medications prescribed by the agency • Have a diagnosis of major psychosis or major affective disorder • Have an I/D Diagnosis • Have an Autism Diagnosis • Have major medical problems in addition to major psychosis and medications • The presence of the licensed or supervised psychologist has been specifically requested by the case manager or the member.
Continuing Stay Criteria	Licensed Psychologist will continue to participate in the treatment team process.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuses treatment. 2. Goals of the member's service plan have been substantially met. 3. Member has progressed to move to Focused Care services.
Service Exclusions	H0032 AH PP; G9008; G9008PP may not be billed for the same treatment planning session.
Clinical Exclusions	None
Documentation	Documentation must contain the licensed psychologist's signature, in ink or in an electronic documentation system, on the completed service plan or service plan update, the date, and the actual time spent providing the service by listing the start-and stop times of his/her participation. A psychologist under

	supervision of a Licensed Psychologist may perform this service with oversight of their Supervising Licensed Psychologist. The Supervising Licensed Psychologist must indicate their oversight by their signature and the date.
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Additional Service Criteria:

1. Service plans must be reviewed, signed and approved by Licensed Psychologist under the Rehabilitation within 72 hours of service plan meetings.

G9008 Physician Coordinated Care Oversight Services

Definition: These are activities by a physician or physician extender directly related to service planning which includes participation in treatment team meeting as required and/or review and approval of service plans.

Service Tier	Core-Tier 1
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Telehealth	Available
Initial Authorization	Two units/ per 90 days/per member Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core-Tier 1 data submission is required for additional units after initial 90-day prior authorization by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of 2 units/ per member/per 90 days. This level of data is required to exceed initial authorization limit and demonstrate medical necessity. The need for these additional units should be described in the free-text field, including any criteria that require the physician to be physically present at the treatment team meeting.
Admission Criteria	<ol style="list-style-type: none"> 1. Member is receiving Coordinated Care services-and- 2. The physician or designated physician extender must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria: <ul style="list-style-type: none"> • Receive psychotropic medications prescribed by the agency • Have a diagnosis of major psychosis or major affective disorder • Have an I/D Diagnosis • Have an Autism Diagnosis • Have major medical problems in addition to major psychosis and medications • The presence of the physician or physician extender has been specifically requested by the case manager or the member.
Continuing Stay Criteria	Physician will continue to participate in the treatment team process.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuses treatment. 2. Goals of the member's service plan have been substantially met. 3. Member has progressed to move to Focused Care services.
Service Exclusions	H0032 AH; H0032 AH PP; G9008PP may not be billed for the same treatment planning session.
Clinical Exclusions	None
Documentation	Documentation must contain the physician or physician extender's signature, date of signature, and the actual time spent providing the service by listing the start-and-stop times of his/her participation.

Additional Service Criteria:

1. Service plans must be reviewed, signed and approved by a Physician under the Rehabilitation/Clinic options within 72 hours of service plan meetings.

H0004 HO Behavioral Health Counseling, Professional, Individual

Definition: Behavioral Health Counseling, Professional, Individual, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service.

Often by necessity, Behavioral Health Counseling of children will involve work with parents as the agent of change in maladaptive behavior of children. Structured behavior therapies designed to provide parents with therapeutic tools to control and modify inappropriate behavior and promote adaptive coping behaviors are considered to be appropriate use of this service.

This service must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Service Tier	Core-Tier 1, Tier 2 (continued stay)
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	60 units/per member/per year Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core – Tier 1 data submission required after the one-year authorization period, by any provider previously utilizing the benefit for the same member, if initial 60 units have not been exceeded within the year, 2. Tier 2 data submission is required for a provider to exceed the limit of sixty (60) 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 sixty (60) (e.g., 30, 35, etc.) must be specified in the free-text field, otherwise a maximum of twenty (20) 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, -and- 2. Member demonstrates emotional and behavioral disturbances causing functional impairments directly related to the established behavioral health condition, -and- 3. The specific impairment(s) to be addressed can be delineated, -and- 4. Intervention is to focus on the dynamics of members' problems, -and- 5. Interventions are based in generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. -and- 6. The members' evaluation reflects the need for the service.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's need as identified related to the behavioral health condition. 2. Progress notes document member's progress relative to goals identified although goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or member refuses treatment. 2. Symptoms and functional impairments related to the behavioral health condition have improved to level no longer requiring this service. 3. Transfer to another service is warranted by change in member's condition. 4. There is no outlook for improvement with the continuation of this service.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a lack of social support systems so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes provision of the service on an outpatient basis. 4. The member is unable to generalize concepts utilized in therapy to other environments. 5. The focus of this service is currently being addressed by another behavioral health service or program.
Documentation	<p>Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the Plan. 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.</p> <p>The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.</p>

Additional Service Criteria:

1. When this service is provided as part of a "focused care" service group a treatment strategy is sufficient to replace the master service plan (MSP). This strategy describes what the clinician

and/or member will do/achieve, at a minimum, prior to the next session or at some time in the future related to the focus of treatment. This is typically found as an addendum to the intake, part of the clinical summary, or the concluding section of documentation of member contact (progress note). The Bureau for Medical Services, the Office of Health Facility Licensure and Certification and KEPRO have approved and trained to this issue.

2. Under this procedure code, conjoint or family therapy may occur with other individuals with a significant relationship to the member (e.g. spouse, parent, child, sibling, etc.). These individuals may participate in therapy to the extent it is helpful to the progress of the member; however, such participation by significant others is not reimbursable as a separate activity.

H0004 HO HQ Behavioral Health Counseling, Professional, Group

Definition: Behavioral Health Counseling, Professional, Group, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member in a group setting.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Group so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

Service Tier	Core-Tier 1, Tier 2 (Continued Stay)
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Telehealth	Available
Initial Authorization	Core – Tier 1 data submission required for 50 units/per member/per year from start date of initial service Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Core – Tier 1 data submission required after the one-year authorization period by any provider previously utilizing the benefit for the same member, if initial 50 units have not been exceeded within the year 2. Tier 2 data submission is required for a provider to exceed the limit of fifty (50) 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 fifty (50) (e.g., 20, 25 etc.) must be specified in the free-text field, otherwise a maximum of twenty (20) 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, -and- 2. Member demonstrates emotional and behavioral disturbances causing functional impairments directly related to the established behavioral health condition, -and- 3. The specific impairment(s) to be addressed can be delineated, -and- 4. Intervention is to focus on the dynamics of members' problems, -and- 5. Interventions are based in generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. -and- 6. The members' evaluation reflects the need for the service.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's need as identified related to the behavioral health condition. 2. Progress notes document member's progress relative to goals identified although goals have not yet been achieved.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or member refuses treatment. 2. Symptoms and functional impairments related to the behavioral health condition have improved to level no longer requiring this service. 3. Transfer to another service is warranted by change in member's condition. 4. There is no outlook for improvement with the continuation of this service.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a lack of social support systems so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes provision of the service on an outpatient basis. 4. The member is unable to generalize concepts utilized in therapy to other environments. 5. The focus of this service is currently being addressed by another behavioral health service or program.
Documentation	<p>Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal on the Plan. 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.</p> <p>The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.</p>

Additional Service Criteria:

1. Group size must be limited to a maximum of twelve (12) persons per group.
2. When this service is provided as part of a “focused care” service group a treatment strategy is sufficient to replace the master service plan (MSP). This strategy describes what the clinician and/or member will do/achieve, at a minimum, prior to the next session or at some time in the future related to the focus of treatment. This is typically found as an addendum to the intake, part of the clinical summary, or the concluding section of documentation of member contact (progress note). The Bureau for Medical Services, the Office of Health Facility Licensure and Certification and KEPRO have approved and trained to this issue.

H0004 Behavioral Health Counseling, Supportive, Individual

Definition: Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another Behavioral Health service to meet service definition and medical necessity. The supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Individual, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

Supportive counseling should:

- 1) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
- 2) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	20 units/per member/per year Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Tier 2 data submission is required for additional units after the one year authorization period by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required for a provider to exceed the limit of twenty (20) 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 twenty (20) (e.g., 20, 25 etc.) must be specified in the free-text field, otherwise a maximum of twenty (20) 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, -and- 2. Member has a need to be assisted with day-to-day behavioral and emotional functioning to help them maintain progress toward identified goals, -and- 3. Member's service plan reflects the need for the service -and- 4. Member is currently receiving another Medicaid behavioral health service and needs a supplemental service to meet treatment goals.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Service continues to be needed to assist with day-to-day behavioral and emotional functioning -or- 2. Activity notes document the member's progress relative to the objective on the service plan but treatment goals have not yet been achieved – and- 3. Continued supplement to an existing Medicaid behavioral health service is needed for treatment of the behavioral health condition.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuse treatment. 2. Goals of the member's treatment plan have been substantially met. 3. Transfer to another service is warranted by change in member's condition. 4. Member has progressed and no longer requires another Medicaid behavioral health service.
Service Exclusion	No other Medicaid Clinic or Rehabilitation service is being provided.
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a lack of social support system so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes the provision of service at this level of care.
Documentation	<p>This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.</p> <p>There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the supportive intervention and the member's response to the intervention including any improvement or exacerbation of symptoms.</p>

Additional Service Criteria:

1. All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

H0004 HQ Behavioral Health Counseling, Supportive, Group

Definition: Behavioral Health Counseling, Supportive, Group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning. Behavioral Health Counseling, Supportive, Group, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

Supportive counseling should:

- 1.) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
- 2.) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	40 units/per member/per year Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Tier 2 data submission is required for additional units after the initial authorization period by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required for a provider to exceed the limit of forty (40) 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 forty (40) (e.g., 20, 25 etc.) must be specified in the free-text field, otherwise a maximum of twenty (20) additional units will be granted for the remainder of the authorization period. 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, -and- 2. Member has a need to be assisted with day-to-day behavioral and emotional functioning to help them maintain progress toward identified goals, -and- 3. Member's service plan reflects the need for the service -and- 4. Member is currently receiving another Medicaid behavioral health service and needs a supplemental service to meet treatment goals.

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Service continues to be needed to assist with day-to-day behavioral and emotional functioning -or- 2. Activity notes document the member's progress relative to the objective on the service plan but treatment goals have not yet been achieved –and- 3. Continued supplement to an existing Medicaid behavioral health service is needed for treatment of the behavioral health condition.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals and objectives of member's individualized service plan have been substantially met. 2. Member requests discharge. 3. Transfer to another service is warranted by change in member condition. 4. Member has progressed and no longer requires another Medicaid behavioral health service.
Service Exclusions	No other Medicaid Clinic or Rehabilitation service is being provided.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of impairment precludes provision of services in this level of care. 2. There is a lack of social support systems so that a more intensive level of service is needed. 3. There is no outlook for improvement with this level of service.
Documentation	<p>This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.</p> <p>There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the supportive intervention and the member's response to the intervention including any improvement or exacerbation of symptoms.</p>

Additional Service Criteria:

1. Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.
2. All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.

H0032 AH PP Mental Health Service Plan Development by Non-Physician- PSYCHOLOGIST PARTICIPATION

Definition: These are activities by a psychologist directly related to service planning which includes intensive participation and review including but not limited to required participation in treatment team meeting because a condition is met which requires the psychologist to be physically present for the service planning meeting and/or review and approval of the service plan(s) requires more than minimal review.

Licensed or supervised psychologist must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria and receiving rehabilitation services:

- Receive psychotropic medications prescribed by the agency
- Have a diagnosis of major psychosis or major affective disorder
- Have an I/D Diagnosis
- Have an Autism Diagnosis
- Have major medical problems in addition to major psychosis and medications
- The presence of the licensed or supervised psychologist has been specifically requested by the case manager or the member.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Rehabilitation, BBHCF Charity Care
Telehealth	Available
Initial Authorization	4 units/per member/per 30 days Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Tier 2 data submission is required for additional units after initial 30-day authorization by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of 4 units/ per member/per 30 days. The need for these additional units should be described in the free-text field. Additionally, the total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	<ol style="list-style-type: none"> 1. Member is receiving Coordinated Care services-and- 2. Due to the member's complex behavioral health needs, the psychologist requires additional time for review/participation/approval of the service plan than allowed in the H0032 AH code. 3. The member meets at least one of the following criteria and is receiving services from the WV Medicaid Rehabilitation manual: <ul style="list-style-type: none"> • Receive psychotropic medications prescribed by the agency • Has a diagnosis of major psychosis or major affective disorder • Has an I/D Diagnosis • Has an Autism Diagnosis • Has major medical problems in addition to major psychosis and medications • The presence of the licensed or supervised psychologist has been specifically requested by the case manager or the

	member.
Continuing Stay Criteria	Licensed Psychologist will continue to participate in the treatment team process including 90 day updates.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuses treatment. 2. Goals of the member's service plan have been substantially met. 3. Member has progressed to move to Focused Care services.
Service Exclusions	H0032 AH; G9008; G9008PP may not be billed for the same treatment planning session.
Clinical Exclusions	None
Documentation	For service planning meetings and the review and approval of service plans, the psychologists' signature on the completed service plan or 90 day update with the date and duration of participation constitute adequate documentation.

Additional Service Criteria:

1. Supervised Psychologist may perform this service with oversight of the supervising Licensed Psychologist.
2. Service plans must be reviewed, signed, and approved by a Licensed Psychologist under the Rehabilitation within 72 hours of service plan meetings.
3. PP indicates psychologist participation.

G9008 PP Physician Coordinated Care Oversight Services

Definition: These are activities by a physician or physician extender directly related to service planning which includes intensive participation and review including but not limited to required participation in treatment team meeting because a condition is met which requires the physician to be physically present for the service planning meeting and/or review and approval of the service plan(s) requires more than minimal review.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Telehealth	Available
Initial Authorization	4 units/ per 90 days/per member Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Tier 2 data submission is required for additional units after initial 90-day authorization by any provider previously utilizing the benefit for the same member. 2. Tier 2 data submission is required to exceed limit of 4 units/ per member/per 90 days. The need for these additional units should be described in the free-text field. Additionally, the total number of additional units/sessions being requested must be specified in the free-text field, otherwise a maximum of one (1) additional unit/session will be granted.
Admission Criteria	<ol style="list-style-type: none"> 3. Member is receiving Coordinated Care services-and- 4. The physician or designated physician extender must be present physically or by telehealth and participate in all service planning sessions for members who meet any of the following criteria: <ul style="list-style-type: none"> • Receive psychotropic medications prescribed by the agency • Have a diagnosis of major psychosis or major affective disorder • Have an I/D Diagnosis • Have an Autism Diagnosis • Have major medical problems in addition to major psychosis and medications • The presence of the physician or physician extender has been specifically requested by the case manager or the member.
Continuing Stay Criteria	Physician will continue to participate in the treatment team process including 90 day updates.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family requests discharge or refuse treatment. 2. Goals of the member's service plan have been substantially met. 3. Member has progressed to move to Focused Care services.
Service Exclusions	H0032 AH; H0032 AH PP; G9008; may not be billed for the same service planning session.
Clinical Exclusions	None
Documentation	For service planning meetings and the review and approval of service plans, the physicians' signature on the completed treatment plan or 90 day update with the date and duration of participation constitute adequate documentation.

Additional Service Criteria:

1. Service plans must be reviewed, signed, and approved by a Physician under the Rehabilitation/Clinic options within 72 hours of service plan meetings.
2. PP indicates psychiatrist participation.

90887 CASE CONSULTATION

Definition: A Case Consultation Service is an interpretation or explanation of results of psychiatric, and other medical examinations and procedures through the requesting clinician to family or other responsible persons. These are services provided at the request of a professional requiring the opinion, recommendation, suggestion and/or expertise of another professional for a specific purpose regarding services and/or activities of a member relevant to the particular area of expertise of the consulting professional. The consulting professional must be licensed or certified in the needed area of expertise.

Case Consultation may not be used during service planning. The member's case manager cannot be a case consultant. Professional staff persons who participated in the current member's service plan within the current 90 day period, or were directed to provide treatment, cannot bill for case consultation.

Only the consulting professional's time may be billed for this service. Any other professional(s) involved in the case consultation may not bill case consultation for their time. The consulting professional whose services are being billed must currently be an enrolled Medicaid provider if he/she is not an employee (either directly or under contract) of the agency seeking consultation.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHF Charity Care
Initial Authorization	Event/per member/per 90days Unit = Event
Re-Authorization	Tier 2 data submission required for 1 Unit per member/per 90 days Unit =Event
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis, -and- 2. The consultant's specialized expertise is needed for the development and monitoring of treatment interventions and/or outcomes, -or- 3. Consultant is needed to review the member's progress and make recommendations, -or- 4. Discussion of the progress of the member with regards to outcomes, functional limitation, and compliance with treatment and/or symptomology is necessary and the consulting professional's area of expertise is required.
Continuing Stay Criteria	None
Discharge Criteria	The consultant offers recommendations or suggestions, which are relevant to the activities that are being carried out with the member by the requesting professional and assist in the development/continuation of appropriate service for the member.
Service Exclusions	<ol style="list-style-type: none"> 1. Case consultation may not be used during service planning. 2. Professional staff that participated in the member's service plan within the current 90-day period or who was directed to provide treatment cannot bill for case consultation.
Clinical Exclusions	The case consultant cannot be the member's case manager.

Documentation	The consulting professional must document a summary of the consultation that includes: purpose, activities/services discussed, recommendations with desired outcomes, the relationship of the consultation to a specific objective(s) in the service plan, date of service, location, signature and credentials of the consulting professional, and the actual time spent providing the service by listing the start-and-stop times of the consultation..
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Additional Service Criteria:

1. Training and supervision of clinical staff, caseload review and review of medications are not considered case consultation.

T1017 TARGETED CASE MANAGEMENT SERVICE

Definition: Targeted Case Management services are federally defined as “those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational, and other services.” Targeted Case Management is to be provided at a level of intensity required by the recipient. Services must be provided in settings accessible to the recipient.

The individual must be given the option of whether or not to utilize Targeted Case Management services. If the individual chooses Targeted Case Management services, he/she must also be given a choice of state approved providers. The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. It should be respectful of cultural differences and enhance and coordinate care between other providers and medical, educational, or other services which are supportive, effective, and cost efficient without duplicating services. Targeted case management is not a direct service.

NOTE: To receive Targeted Case Management at Tier 2 (36 units) the data associated with this Tier is required. To receive Targeted Case Management at Tier 3 (96 units) Tier 3 data is required.

Service Tier	Tier 2
Target Population	Children with Mental Illness, Children with Substance-Related Disorders, Children with developmental disabilities not enrolled in the ID/DD Waiver Program, Adults with Mental Illness, Adults with Substance-Related Disorders, and Adults with Developmental Disabilities not enrolled in the ID/DD Waiver program.
Option	Targeted Case Management, BBHCF Charity Care
Initial Authorization	Tier 2 only service(s) 36 units/per member/per 92 days Unit = 15 minutes
Re-Authorization	Tier 2 service if no additional units requested after initial authorization 36 units/per member/per 92 days Unit = 15 minutes Tier 3 required if additional units exceeding thirty-six have been authorized. 36 units/per member/per 92 days Unit = 15 minutes
Admission Criteria	<u>Child Admission Criteria:</u> 1. Documentation indicates that a child member is eligible for TCM because: a. The child is between the ages of 3 through 17, and b. The child demonstrates a serious and persistent emotional, behavioral, developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current DSM or ICD manual; and

	<p>c. By virtue of age and effects of the emotional and/or developmental impairments, the child is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting.</p> <p>OR</p> <p>2. Documentation indicates that the Child is eligible due to actual or pending removal from placement and:</p> <ul style="list-style-type: none"> a. The child is between the ages of 3 and through the day before their 22nd birthday inclusively and/or is in the custody of the DHHR; and b. The child is removed or is pending removal from placement due to allegations of abuse and neglect. <p><u>Adult Admission Criteria:</u></p> <p>1. Documentation indicates that an adult member is eligible for TCM because:</p> <ul style="list-style-type: none"> a. The adult is age 22 or older; b. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance use disorder as exemplified by a valid diagnosis as described in the language of the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; and/or the current International Classification of Disease and Related Health Problems (ICD); and c. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting. <p>OR</p> <p>2. Documentation indicates the adult is currently and temporarily residing in a licensed domestic violence shelter.</p>
<p>Continuing Stay Criteria</p>	<ul style="list-style-type: none"> 1. Member continues to meet admission criteria. 2. Member continues to choose Targeted Case Management. 3. For continued eligibility for TCM services, a Medicaid member must meet face to face with an individual providing a Behavioral Health service to them every 30 days. The documentation of such contact must be completed by the targeted case manager or an individual with the minimum of a bachelor’s degree such as a physician, nurse practitioner, physician’s assistant, therapist, counselor, or case manager. The Bachelor’s degree must be in one of the eligible areas described under the section entitled “Staff Qualifications.” 4. The case manager must have at least one face-to-face contact for a valid Targeted Case Management activity with the member every 90 days. 5. Any TCM service may be conducted via Tele-medicine with the exception of the 90 day Face to Face encounter with the Targeted

	Case Manager.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member no longer meets admission criteria and does not have continued need for Targeted Case Management services. 2. Member no longer desires Targeted Case Management. 3. Member has social supports that can perform the functions necessary for the member to gain access to needed services.
Service Exclusions	<p><u>Exclusions For Children:</u></p> <ol style="list-style-type: none"> 1. The child is currently eligible for case management services Through one of the following: <ul style="list-style-type: none"> • The West Virginia Birth to Three Program • A Psychiatric Residential Treatment Facility (PRTF) • Long-Term Care Facility • Receiving acute and/or sub-acute psychiatric care • Enrolled through the ID/DD Waiver program • Residing in an Intermediate Care Facility for Intellectual Disabilities (ICF/IDD). <p>Note: A community-based provider may supply discharge planning services through Targeted Case Management for eligible children 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a long- term care program.</p> <ol style="list-style-type: none"> 2. The child is receiving TCM services from another entity including a county school system. <p><u>Exclusions for Adults:</u></p> <ol style="list-style-type: none"> 1. The adult is currently receiving services through: <ul style="list-style-type: none"> • an acute psychiatric care facility; or • a state-operated psychiatric facility; or • a long-term care facility; or • is enrolled through the I/DD Waiver program; or • is an active recipient of Assertive Community Treatment (ACT); or • Is residing in an ICF/IDD facility. <p>Note: A community-based provider may supply discharge planning services through Targeted Case Management for eligible individuals 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a longer term care program.</p> <p>OR</p> <ol style="list-style-type: none"> 2. The adult is receiving TCM services from another entity.
Clinical Exclusions	Member's needs do not indicate the need for Level II or Level III TCM services.
Documentation	<p>An agency approved by the Bureau for Medical Services for provision of Targeted Case Management Service for Medicaid reimbursement must maintain the following:</p> <ol style="list-style-type: none"> 1. An individual permanent clinical record for each member receiving Targeted Case Management Services.

	<p>2. Evidence in each clinical record that the member is shown to be in a targeted population.</p> <p>3. An individualized service plan detailing the need for Targeted Case Management Services which is updated at 90-day intervals or more frequently if indicated by member need.</p> <p>4. A clinical record that must include documentation specific to services/activities reimbursed as Medicaid Targeted Case Management. This includes a specific note for each individual case management service/activity provided and billed.</p> <p>Each case note must:</p> <ul style="list-style-type: none"> - Be dated and signed by the case manager along with a listing of the case manager's credentials, e.g. LSW, MA; - Have relevance to a goal or objective in the individual's plan of service; - Include the purpose and content of the activity as well as the outcome achieved; - Include a description of the type of contact provided (e.g., face-toface, correspondence, telephone, e-mail contacts); - Detail the TCM component of the valid activity provided; (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan evaluation and monitoring/follow-up); - List the location the activity occurred; and - List the actual time spent providing each activity by itemizing the start - and - stop time. <p>-The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member.</p> <p>In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:</p> <ol style="list-style-type: none"> 1. Because of inability to process and comprehend information, the individual is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting; 2. Because of interpersonal problems or psychiatric symptomatology, the individual is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.
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Additional Service Criteria:

523.12 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

1. Within Targeted Case Management are a number of activities federally recognized as components of case management. These components are:

- **Needs Assessment and Reassessment:** Reviewing of the member's current and potential strengths, resources, deficits, and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social

workers, and educators (if necessary) to form a complete assessment of the eligible member, his or her parent(s) and/or guardian and the case manager to determine whether services are needed and, if so, to develop a service plan. At a minimum, an annual face to face reassessment shall be conducted to determine if the member's needs or preferences have changed.

- Development and Revision of the TCM Service Plan: Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the member, his or her parent(s) or legal guardian and the case manager. Development (and periodic revision) of the TCM Service Plan which will specify the goals and actions to address the medical, social, educational, and other services needed by eligible member's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually.
- Referral and Related Activities: Facilitating the member's access to the care; services; and resources through linkage; coordination; referral; consultation; and monitoring. This is accomplished through in-person and telephone contacts with the member, his or her parent(s), or legal guardian, and with service providers and other collaterals on behalf of the member. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the member, his or her parent(s) or legal guardian and the case manager and between the member, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the member in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific member. This may also include acquainting the member, his or her parent(s), or legal guardian with resources in the community and providing information for obtaining services through community programs.
- Monitoring and Follow-up Activities: The case manager shall conduct regular monitoring and follow-up activities with the member, the member's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the member's TCM Service Plan. Periodic review of the progress the member has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the member and other involved parties. The periodic reviews will be conducted as necessary but at least annually. To bill the monitoring and follow-up component 1 of the first 3 TCM components must have been rendered for the Targeted Case Manager to monitor or follow up on.

Note: These components do not constitute separate services and cannot be billed as separate services, but are identified and defined here to assist case managers in understanding their roles and responsibilities.

523.4 STAFF QUALIFICATIONS

Targeted Case Management providers must assure that all staff that provides Targeted Case Management Services to members possesses one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
 - Psychology
 - Criminal Justice
 - Board of Regents with health specialization
 - Recreational Therapy
 - Political Science
 - Nursing
 - Sociology
 - Social Work
 - Counseling
 - Teacher Education
 - Behavioral Health
 - Liberal Arts or;
 - Other Degrees approved by the West Virginia Board of Social Work.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

Targeted Case Management providers must have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

Targeted Case Management providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

Targeted Case Management providers must credential their staff by an internal curriculum specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.

Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and Targeted Case Management Training must be maintained in staff personnel files.

T1017 CM TARGETED CASE MANAGEMENT SERVICE

Definition: Targeted Case Management services are federally defined as “those services which assist Medicaid eligible recipients in the target group to gain access to needed medical, behavioral health, social, educational, and other services.” Targeted Case Management is to be provided at a level of intensity required by the recipient. Services must be provided in settings accessible to the recipient. The individual must be given the option of whether or not to utilize Targeted Case Management services. If the individual chooses Targeted Case Management services, he/she must also be given a choice of state approved providers.

The relationship of the targeted case manager with a Medicaid member and his or her family should be one of a partnership. It should be respectful of cultural differences and enhance and coordinate care between other providers and medical, educational, or other services which are supportive, effective, and cost efficient without duplicating services. Targeted case management is not a direct service.

Service Tier	Tier 3
Target Population	Children with Mental Illness, Children with Substance–Related Disorders, Children with developmental disabilities not enrolled in the ID/DD Waiver Program, Adults with Mental Illness, Adults with Substance-Related Disorders, and Adults with Developmental Disabilities not enrolled in the ID/DD Waiver program.
Option	Targeted Case Management, BBHCF Charity Care
Initial Authorization	Tier 3 only service(s) or Intensive Targeted Case Management only: 96 units/per member/per 92 days Unit = 15 minutes
Re-Authorization	Tier 3 only service or Intensive Targeted Case Management only: 96 units/per member/per 92 days Unit = 15 minutes Tier 3 request to exceed 96 units before existing authorization lapses. 96 units/per member/per 92 days Unit = 15 minutes
Admission Criteria	<p>Child Admission Criteria:</p> <p>1. Documentation indicates that a child member is eligible for TCM because:</p> <ul style="list-style-type: none"> a. The child is between the ages of 3 through 17, and b. The child demonstrates a serious and persistent emotional, behavioral, developmental and/or substance abuse or dependence disturbance as exemplified by a valid and documented Axis I diagnosis and/or diagnosis of developmental disability as described in the language of the current DSM or ICD manual; and c. By virtue of age and effects of the emotional and/or developmental impairments, the child is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting. <p style="text-align: center;">OR</p>

	<p>2. Documentation indicates that the Child is eligible due to actual or pending removal from placement and:</p> <ul style="list-style-type: none"> a. The child is between the ages of 3 and 17 inclusively and/or is in the custody of the DHHR and; b. The child is removed or is pending removal from placement due to allegations of abuse and neglect; and c. The appointed foster care entity is not able or qualified to perform the case management task in question. <p><u>Adult Admission Criteria:</u></p> <p>1. Documentation indicates that an adult member is eligible for TCM because:</p> <ul style="list-style-type: none"> a. The adult is age 22 or older; and b. The adult demonstrates a serious and persistent emotional, behavioral, developmental and/or substance use disorder as exemplified by a valid diagnosis as described in the language of the current Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association; and/or the current International Classification of Disease and Related Health Problems (ICD); and c. By virtue of age and effects of the emotional and/or developmental impairments, the adult is unable to perform age-appropriate activities of daily living (ADL) without assistance and/or prompting; <p style="text-align: center;">OR</p> <p>2. The adult is currently and temporarily residing in a licensed domestic violence shelter.</p>
<p>Continuing Stay Criteria</p>	<p>1. Member continues to meet admission criteria.</p> <p>2. Member continues to choose Targeted Case Management.</p> <p>3. For continued eligibility for TCM services, a Medicaid member must meet face to face with an individual providing a Behavioral Health service to them every 30 days. The documentation of such contact must be completed by the targeted case manager or an individual with the minimum of a bachelor's degree such as a physician, nurse practitioner, physician's assistant, therapist, counselor, or case manager. The Bachelor's degree must be in one of the eligible areas described under the section entitled "Staff Qualifications."</p> <p>4. The case manager must have at least one face-to-face contact for a valid Targeted Case Management activity with the member every 90 days.</p> <p>5. Any TCM service may be conducted via Tele-medicine with the exception of the 90 day Face to Face encounter with the Targeted Case Manager.</p>

<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Member no longer meets admission criteria and does not have continued need for Targeted Case Management services. 2. Member no longer desires Targeted Case Management. 3. Member has found social supports that can perform the functions necessary for the member to gain access to needed services.
<p>Service Exclusions</p>	<p><u>Exclusions For Children:</u></p> <ol style="list-style-type: none"> 1. The child is currently eligible for case management services through one of the following: <ul style="list-style-type: none"> • The West Virginia Birth to Three Program • A Psychiatric Residential Treatment Facility (PRTF) • A Long-Term Care Facility • Receiving acute or sub-acute psychiatric care • Enrolled through the I/DD Waiver program • Residing in an Intermediate Care Facility for Intellectual Disabilities (ICF/IDD) <p>Note: A community-based provider may supply discharge planning services through Targeted Case Management for eligible children 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a long- term care program.</p> <ol style="list-style-type: none"> 2. The child is receiving TCM services from another entity including a county school system. <p><u>Exclusions For Adults:</u></p> <ol style="list-style-type: none"> 1. The adult is currently receiving services through an acute psychiatric care facility; a state-operated psychiatric facility; or a long term care facility; is enrolled through the I/DD Waiver program; or is an active recipient of Assertive Community Treatment (ACT); Provided that the community-based provider may supply discharge planning services through Targeted Case Management for eligible individuals 10 days prior to discharge from acute psychiatric care and 30 days prior to discharge from a longer term care program. 2. The adult is receiving TCM services from another entity.
<p>Clinical Exclusions</p>	<p>Member's needs do not indicate the need for Level II or Level III TCM services.</p>
<p>Documentation</p>	<p>An agency approved by the Bureau for Medical Services for provision of Targeted Case Management Service for Medicaid reimbursement must maintain the following:</p> <ol style="list-style-type: none"> 1. An individual permanent clinical record for each member receiving Targeted Case Management Services. 2. Evidence in each clinical record that the member is shown to be in a targeted population. 3. An individualized service plan detailing the need for Targeted Case Management Services which is updated at 90-day intervals

	<p>or more frequently if indicated by member need.</p> <p>4. A clinical record that must include documentation specific to services/activities reimbursed as Medicaid Targeted Case Management. This includes a specific note for each individual case management service/activity provided and billed.</p> <p>Each case note must:</p> <ul style="list-style-type: none"> - Be dated and signed by the case manager along with a listing of the case manager's credentials, e.g. LSW, MA; - Have relevance to a goal or objective in the individual's plan of service; - Include the purpose and content of the activity as well as the outcome achieved; - Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone, e-mail contacts); - Detail the TCM component of the valid activity provided; (i.e., assessment, service planning, linkage/referral, advocacy, crisis response planning, service plan evaluation and monitoring/follow-up); - List the location the activity occurred; and - List the actual time spent providing each activity by itemizing the start - and - stop time. <p>-The documentation must demonstrate that only one staff person's time is billed for any specific activity provided to the member.</p> <p>In order to demonstrate the linkage between emotional/behavioral/developmental disability and functional impairment, the provider's documentation must reflect one or both of the following:</p> <ol style="list-style-type: none"> 1. Because of inability to process and comprehend information, the individual is unable to properly act upon documents or utilize processes regarding benefit eligibility, medication management, budgeting, or otherwise performing activities required to continue to live in a community based setting; 2. Because of interpersonal problems or psychiatric symptomatology, the individual is unable to cooperate with others in order to achieve goals and obtain services necessary for community living.
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Additional Service Criteria:

523.12 COMPONENTS OF TARGETED CASE MANAGEMENT SERVICES

1. Within Targeted Case Management are a number of activities federally recognized as components of case management. These components are:

- Needs Assessment and Reassessment: Reviewing of the member's current and potential strengths, resources, deficits, and need for medical, social, educational and other services. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible member, his or her parent(s) and/or guardian and the case manager to determine whether services are

needed and, if so, to develop a service plan. At a minimum, an annual face to face reassessment shall be conducted to determine if the member's needs or preferences have changed.

- Development and Revision of the TCM Service Plan: Developing a written plan based on the assessment of strengths and needs, which identifies the activities and assistance needed to accomplish the goals collaboratively developed by the member, his or her parent(s) or legal guardian and the case manager. Development (and periodic revision) of the TCM Service Plan which will specify the goals and actions to address the medical, social, educational, and other services needed by eligible member's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually.
- Referral and Related Activities: Facilitating the member's access to the care; services; and resources through linkage; coordination; referral; consultation; and monitoring. This is accomplished through in-person and telephone contacts with the member, his or her parent(s), or legal guardian, and with service providers and other collaterals on behalf of the member. This will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the member, his or her parent(s) or legal guardian and the case manager and between the member, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes advocating for the member in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific member. This may also include acquainting the member, his or her parent(s), or legal guardian with resources in the community and providing information for obtaining services through community programs.
- Monitoring and Follow-up Activities: The case manager shall conduct regular monitoring and follow-up activities with the member, the member's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the member's TCM Service Plan. Periodic review of the progress the member has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of TCM services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the member and other involved parties. The periodic reviews will be conducted as necessary but at least annually. To bill the monitoring and follow-up component 1 of the first 3 TCM components must have been rendered for the Targeted Case Manager to monitor or follow up on.

Note: These components do not constitute separate services and cannot be billed as separate services, but are identified and defined here to assist case managers in understanding their roles and responsibilities.

523.4 STAFF QUALIFICATIONS

Targeted Case Management providers must assure that all staff that provides Targeted Case Management Services to members possesses one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
 - Psychology
 - Criminal Justice
 - Board of Regents with health specialization
 - Recreational Therapy
 - Political Science
 - Nursing
 - Sociology
 - Social Work
 - Counseling
 - Teacher Education
 - Behavioral Health
 - Liberal Arts or;
 - Other Degrees approved by the West Virginia Board of Social Work.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to: transcripts, licenses, and certificates.

Targeted Case Management providers must have a review process to ensure that employees providing Targeted Case Management Services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

Targeted Case Management providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

Targeted Case Management providers must credential their staff by an internal curriculum specific to Targeted Case Management prior to the staff assuming their Targeted Case Management duties.

Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and Targeted Case Management Training must be maintained in staff personnel files.

H2015 Comprehensive Community Support Services

Definition: Comprehensive Community Support Services is a long-term rehabilitation service designed to serve clients with a severe and persistent mental illness whose quality of life and level of functioning would be negatively impacted without structured ongoing skill maintenance and/or enhancement activities. Provision of this service may occur in either a 1:12 or a 1:8 ratio. The respective modifier should be included in the provider's remittance to the claims payer as follows:

- H2015 U1 = ratio of 1:12
- H2015 U2 = ratio of 1:8

This is a structured program of ongoing regularly scheduled day activities designed to enhance or maintain a client's level of functioning and to prevent a client's deterioration, which could result in the need for institutionalization. This may be accomplished through skill maintenance and/or development and behavioral programming designed to maintain or improve adaptive functioning. This service emphasizes community-based activities.

This service is to be provided in accordance with the member's interests and potential as reflected in the master treatment/service plan. The intensity, frequency and type of comprehensive Community Support activities must be appropriate to the age and functional level of the member, and individualized to meet their own specific needs and future plans. Critical skills identified as essential to maintain placement in the community and preventing hospitalization will also be targeted for skill maintenance/enhancement.

Examples of skill areas include:

- a) Health Education- first aid, pedestrian and passenger safety, home safety
- b) Meal preparation- nutrition, menu planning, cooking
- c) Personal Hygiene- grooming, oral and general body care
- d) Utilization of Community Resources- church groups, clubs, volunteer work, getting and keeping entitlements, learning to access recreational opportunities, job search etc.
- e) Interpersonal skills
- f) Problem Solving
- g) Communications- assertiveness, correspondence, initiating conversation, giving and taking compliments and criticism, body language, active listening, etc.
- h) Stress Reduction- relaxation techniques, biofeedback, etc.
- i) Interpersonal Relationships- with peers, caregivers, family, etc.
- j) Interactions with Strangers
- k) Social Skill Development and Coping Skills
- l) Social Competence- social skill training, presenting opportunities for social interaction
- m) Understanding Mental Illness- medication usage, course of the illness, symptom management, coping mechanisms, normalization, etc.

This service has a maximum staff-to-member ratio of one staff person per 12 members when provided at a licensed site; and a maximum staff-to-member ratio of one staff person to eight members when provided in a community setting.

The amount of Comprehensive Community Support provided is individually determined and should not automatically reflect the program's operating hours. Members eligible for Comprehensive Community Support do not meet medical necessity for Day Treatment services.

Comprehensive Community Support services must be based at a site listed on the agency's behavioral health license. Training may occur onsite or in community settings.

Service Tier	Tier 3
Target Population	MH, A&C
Option	Rehabilitation, BBHHF Charity Care
Telehealth	Not Available
Initial Authorization	Tier 3 data submission required for 1056 units/per member/per 92 days Unit= 15 minutes
Re-authorization	1056 units/per member/per 92 days Unit=15 minutes
Admission Criteria	<ol style="list-style-type: none"> 1. Member must have a severe and persistent mental health diagnosis, -and- 2. The member's symptomatology or functional impairment is mild to moderate, -and- 3. The member needs a level of structure for activities of daily living that cannot be met in the community with natural support, or the member does not have a means for the acquisition or maintenance of skills through the natural support system or community resources, -and- 4. The member does not require more intensive Day Treatment services, -and- 5. The individualized service plan delineates goals that are flexible, relevant to the member's identified needs and futures planning, tailored to the individual, and attempt to utilize community resources and natural supports.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Client progress is documented relative to program objectives and futures planning, -and- 2. Efforts to link to natural supports/activities/services in the community are documented, -and- 3. New areas of need are identified on the service plan to be addressed in the program as needed.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals of the member's individualized service plan have been substantially met, -or- 2. Member/family request discharge or refuses treatment, -or- 3. Transfer to another service/level is warranted by change in the member's condition (e.g. the level of supervision in Comprehensive Community Support Services are no longer adequate to meet safety and/or supervision needs), -or- 4. There is no participation in treatment or cooperation with the program rules and regulations. The lack of participation is such that treatment is rendered ineffective despite multiple attempts to address the lack of participation; -or- 5. The member has been integrated into the community to the degree that community resources and natural supports are sufficient to maintain the member in the community/current living setting.

Service Exclusions	<ol style="list-style-type: none"> 1. Day Treatment. 2. No other Clinic or Rehabilitation Service may be billed during the hours Comprehensive Community Support Services are provided and billed.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Current physical or mental impairments prevent participation in the program. 2. Intensity, frequency and type of activities are not appropriate to the age and functional level of the participant. 3. Member has a Substance Abuse or Intellectual Disability /Developmental Disability Diagnosis and the focus of treatment is on reduction/management or improved functioning related to this condition and not the mental health condition. 4. Member has not received previous outpatient services with the purpose of addressing the symptoms and functional impairments related to their mental health condition.
Documentation	<ol style="list-style-type: none"> 1. <u>Daily Notes</u>: Documentation for each daily episode of Comprehensive Community Support Services including date of attendance, description of the type of service/activity provided the relationship of the service/activity to objectives in the service plan and relative progress. Documentation shall include place of service, date of service, start/stop time for the service, and participation level of the member in each specified activity. 2. <u>90 Day Review</u>: Comprehensive Community Support Services must be reviewed at 90 day intervals and the Treatment/ Service Plan goals and objectives relevant to Comprehensive Community Support Services must be adjusted to the changing needs of the recipient. There is not a requirement for a separate treatment/service plan for Comprehensive Community Support Services. 3. <u>Daily Attendance Roster</u>: reflecting participants in the service. The roster must be signed and dated by participating staff, reflect adequate staff/member ratios, require start/stop times and be maintained on site and not in the individual member records.

Additional Service Criteria

1. May be a long-term service with activities provided on or off site.
2. Staff to client ratio is maximum 1:8 for H2015 U2 and a ratio of 1:12 for the H2015 U1.
3. Services must be age and functionally appropriate and be delivered at the level that best meets the needs of the individual participant.
4. Supervisor Requirement: Qualified Mental Health Professional (QMHP) with a minimum of BA degree and experience working with individuals with serious and persistent mental illness. FTE equivalent of the supervisor must reflect the actual number of hours spent on site and supervisor responsibility as part of direct care ratios (if any).
5. Paraprofessional Staff: Be at least 18 years old; high school diploma or G.E.D.; experience and skills in working with individuals with serious and persistent mental illness (this should be documented in the personnel file) Professionals or paraprofessionals who are otherwise qualified may provide Comprehensive Community Support Services as a ‘peer’.

6. Comprehensive Community Support Services Treatment Program Certification: all programs must be certified by the Bureau for Medical Services. Any changes from an approved original certification must be submitted and approved.

H2012 DAY TREATMENT

Definitions: Rehabilitation Services: Day Treatment – A structured program of ongoing regularly scheduled therapeutic activities to increase a member’s skill level, produce behavioral change which improves adaptive functioning and/or which facilitates progress towards more independent living (and/or employment) in accordance with the member’s potential and interests as reflected in the master treatment/service plan. This service has a maximum staff to member ratio of 1:5-7 members. Services must be available for 5 days a week for a minimum of four hours each day. Services must be provided at a site listed on the agency’s behavioral health license. However, off-site training related to the areas of skill development can be incorporated into the program. Skill development areas for adults and adolescent include:

- a) daily living skills;
- b) interpersonal skills;
- c) leisure & social skill development;
- d) prevocational skills; and
- e) disability coping skills.

For children under age 5, the maximum ratio is one staff per 4 children. This service must not be utilized to provide therapeutic activities for children under the age of five in a group setting for more than 4 hours per day or more than 4 days per week (see guidelines below for young children).

Guidelines for Young Children (0-5):

- a. The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual child.
- b. These therapeutic activities for young children should promote the following skill acquisitions, including necessary adaptations and modifications, and be based upon developmentally appropriate practice. These services must also be provided in a way that supports the daily activities and interaction within the family’s routine. Skill acquisitions include, but are not limited to:
 - a. adaptive, self-help, safety, and nutritional skills
 - b. parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
 - c. interpersonal and communication skills
 - d. problem-solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

Service Tier	Tier 3
Target population	MH, SA, A & C
Option	Rehabilitation, BBHCF Charity Care
Telehealth	Not Available
Initial Authorization	Tier 3 data submission required for 396 units*/per member/per 92 days Unit = 60 minutes
Re-Authorization	396 units/per member/per 92 days
Admission Criteria	<p><u>Rehabilitation Service:</u></p> <ol style="list-style-type: none"> 1. Member must have a severe and persistent mental health or substance abuse diagnosis and require intensive services, -and- 2. The member’s symptomatology or functional impairment indicates a need for intensive services, -and- 3. The member needs a level of structure for activities of daily living that cannot be met at a lower level, -and-

	<ol style="list-style-type: none"> 4. The member has previously demonstrated capability of mastering more complex personal and interpersonal life skills (e.g., problem solving, assertiveness, self-advocacy, shopping, meal preparation, development of leisure skills, and the use of community resources), -and- 5. There is reasonable expectation that the member can improve demonstrably within 3 months (6 months for children & adolescents), -and- 6. The individualized service plan delineates specific day treatment goals which are flexible, tailored to the individual, and attempt to utilize community and natural supports.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Progress is clearly evident and notes document the progress relative to day treatment objectives identified in the Master Service Plan. Continuation of remaining objectives to achieve goal are appropriate. 2. New areas of need are identified on the service plan to be addressed in the day treatment program.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals of member's individualized service plan have been substantially met. 2. Member/family request discharge or refuses treatment. 3. Transfer to another service/level of care is warranted by change in member's condition. 4. There is no participation in treatment or cooperation with the program rules & regulations. The lack of participation is such that treatment is rendered ineffective despite multiple documented attempts to address the lack of participation. 5. The member is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.
Service Exclusions	H2014 U4, H2014 U1, H2014 HN U4; H2014 HN U1; H2019, H0004; H0004 HQ during the hours Day Treatment is provided.
Clinical Exclusions	Current physical or mental impairments prevent participation in the program.
Documentation	<ol style="list-style-type: none"> 1. <u>Daily Notes</u>: Documentation for each daily episode of day treatment including total time in attendance at the day program, describing the type of service/activity provided, and the relationship of the service/activity to objectives in the service plan. Documentation shall include place of service, date of service, actual time spent providing the service, staff/member ratio, and participation of the member in each daily activity. This documentation is not required to be stored in the main clinical record but must be maintained and be available for review. 2. <u>Monthly Summary</u>: This summarizes progress on the objectives specified in the member's treatment or day service plan. This documentation must be placed in the member's master clinical record 3. <u>Daily Attendance Roster</u>: reflecting participants in the service that is signed and dated by participating staff. This also easily reflects

	adequate staff/member ratios were met for the day.
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Additional Service Criteria:

1. Day treatment is not considered a long-term maintenance program but an active treatment program with progression and outcomes.
2. Activities provided either off or on-site for the purpose of leisure, or recreation, are not billable services.
3. Any objective that results in no progress (or desired change) after two consecutive 90 day intervals must be discontinued or modified.
4. Services must be age and functionally appropriate and be delivered at a level that best meets the needs of the individual participant.
5. The recommended ratio for mental health and substance abuse members is 1:5, although the Rehabilitation Manual allows up to 1:7.
6. Supervisor Requirement: BA Degree with 1 yr. Supervised experience. 15 hours every 2 yrs. of continued education relevant to targeted population served.
7. Paraprofessional Staff: Be at least 18 yrs. old; high school diploma or G.E.D; Certified in Red Cross CPR & First Aid; and successfully complete behavioral health agency training or equivalent. Documentation of training and qualification must be maintained by the Provider Agency.
8. Day Treatment Program Certification Process: Every two years all day treatment programs require the completion of the Day Treatment Re-Certification Form that is then reviewed and approved by the Bureau for Medical Services. After approval of this form, the Utilization Review Team will conduct an on-site review. New programs must submit the Day Treatment Certification Form to the Bureau for Medical Services for approval. All programs must be located on the Provider Behavioral Health License and may commence billing once the application is submitted to BMS. After approval of the application, the UR Team will conduct an on-site review.

H2012 MR: DAY TREATMENT

Definitions: Clinic Services: Day Treatment – (For ID/DD Members) - A day treatment program for persons with Intellectual Disability/Development Disabilities **only** that has a maximum participation ratio of 1:5. Areas of intervention include but are not limited to:

- a. self-care skills
- b. emergency skills
- c. mobility skills
- d. nutritional skills
- e. social skills
- f. communication & speech instruction
- g. carryover of physical and/or occupational therapy objectives
- h. interpersonal skills instruction
- i. functional community skills
- j. volunteering in community service settings
- k. citizenship, rights & responsibilities, self-advocacy
- l. other services necessary for an individual to participate in the community setting of his/her choice.

Services must be provided at a site listed on the agency's behavioral health license. For children under age 5, the maximum staff ratio is 1 staff per 4 children (see guidelines below for young children).

Guidelines for Young Children (0-5):

1. The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual child.
2. These therapeutic activities for young children should promote the following skill acquisitions, including necessary adaptations and modifications, and be based upon developmentally appropriate practice. These services must also be provided in a way that supports the daily activities and interaction within the family's routine. Skill acquisitions include, but are not limited to:
 - a) adaptive, self-help, safety, and nutritional skills
 - b) parent-child interactions, peer interactions, coping mechanisms, social competence, and adult-child interactions
 - c) interpersonal and communication skills
 - d) problem-solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

Service Tier	Tier 3
Target population	ID/DD, A & C
Option	Clinic, BBHCF Charity Care
Initial Authorization	Tier 3 data submission required for 396 units*/per member/per 92 days Unit = 60 minutes
Re-Authorization	396 units/per member/per 92 days
Admission Criteria	<u>Clinic Service:</u> 1. Member must have an Axis I diagnosis of severe DD and need intensive services or have an Axis II diagnosis of ID/DD and need intensive services, -and- 2. The member's clinical & behavioral issues are unmanageable in traditional outpatient treatment & require intensive, coordinated

	<p>multidisciplinary intervention within a therapeutic milieu, -and-</p> <ol style="list-style-type: none"> 3. The member's level of functioning precludes provision of services in a less restrictive level of care & exhibits substantial deficits in daily living and 1 or more of the following areas: <ol style="list-style-type: none"> a. social skills b. vocational/academic skills c. community/family integration, -and- 4. There is expectation that the member will demonstrate progress related to specific day treatment objectives within 3 months (6 months for children & adolescent) -and- 5. Day treatment goals are to be specific, flexible, & tailored to the individual with attempts to utilize community & natural supports whenever possible to augment treatment.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Progress is clearly evident and notes document the progress relative to day treatment objectives identified in the Master Service Plan. Continuation of remaining objectives to achieve goal are appropriate. 2. New areas of need are identified on the service plan to be addressed in the day treatment program.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals of member's individualized service plan have been substantially met. 2. Member/family request discharge or refuses treatment. 3. Transfer to another service/level of care is warranted by change in member's condition. 4. There is no participation in treatment or cooperation with the program rules & regulations. The lack of participation is such that treatment is rendered ineffective despite multiple documented attempts to address the lack of participation. 5. The member is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care.
Service Exclusions	Basic Living Skills, Behavioral Management Implementation Services, Supportive Individual Counseling & Supportive Group Counseling during the hours Day Treatment is provided.
Clinical Exclusions	Current physical or mental impairments prevent participation in the program.
Documentation	<ol style="list-style-type: none"> 1. <u>Daily Notes</u>: Documentation for each daily episode of day treatment including total time in attendance at the day program, describing the type of service/activity provided, and the relationship of the service/activity to objectives in the service plan. Documentation shall include place of service, date of service, actual time spent providing the service, staff/member ratio, and participation of the member in each daily activity. This documentation is not required to be stored in the main clinical record but must be maintained and be available for review. 2. <u>Monthly Summary</u>: This summarizes progress on the objectives specified in the member's treatment or day service plan. This documentation must be placed in the member's master clinical record. 3. <u>Daily Attendance Roster</u>: reflecting participants in the service that is

	signed and dated by participating staff. This also easily reflects adequate staff/member ratios were met for the day.
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Additional Service Criteria:

1. Day treatment is not considered a long-term maintenance program but an active treatment program with progression and outcomes.
2. Activities provided either off or on-site for the purpose of leisure, or recreation, are not billable services.
3. Any objective that results in no progress (or desired change) after two consecutive 90 day intervals must be discontinued or modified.
4. Services must be age and functionally appropriate and be delivered at a level that best meets the needs of the individual participant.
5. Supervisor Requirement: BA Degree with 1 yr. Supervised experience. 15 hours every 2 yrs. of continued education relevant to targeted population served.
6. Paraprofessional Staff: Be at least 18 yrs. old; high school diploma or G.E.D; Certified in Red Cross CPR & First Aid; and successfully complete behavioral health agency training or equivalent. Documentation of training and qualification must be maintained by the Provider Agency.
7. Day Treatment Program Certification Process: Every two years all day treatment programs require the completion of the Day Treatment Re-Certification Form that is then reviewed and approved by the Bureau for Medical Services. After approval of this form, the Utilization Review Team will conduct an on-site review. New programs must submit the Day Treatment Certification Form to the Bureau for Medical Services for approval. All programs must be located on the Provider Behavioral Health License and may commence billing once the application is submitted to BMS. After approval of the application, the UR Team will conduct an on-site review.

H0040 Assertive Community Treatment (ACT)

Definition: ACT is an inclusive array of community-based rehabilitative mental health services for members with serious and persistent mental illness who have a history of high use of psychiatric hospitalization and/or crisis stabilization and therefore, require a well-coordinated and integrated package of services, provided over an extended duration, in order to live successfully in the community of their choice. Eligible members will have a primary mental health diagnosis and may have co-occurring conditions including mental health and substance use or mental health and mild intellectual disability. ACT is a very specialized model of treatment/service delivery in which a multidisciplinary team assumes ultimate accountability for a small, defined caseload of individuals. ACT is a unique treatment model in which the majority of direct services are provided by the ACT team members in the member's community environment.

ACT combines clinical, rehabilitation, supportive, and case management services, providing direct assistance for symptom management, as well as facilitating a more supportive environment with direct assistance in meeting basic needs and improving social, family, and environmental functioning.

Only qualified teams, certified by the Bureau of Behavioral Health and Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification of the team must be renewed, following initial approval, at Bureau-designated intervals, or with any changes in personnel. All currently certified ACT Teams must submit for recertification by January 1, 2015.

Purpose: ACT is a service designed to achieve the following treatment goals:

- To reduce psychiatric hospitalization for members with serious and persistent mental illnesses;
- To provide an established clinical relationship with the member and his or her natural support system in order to promote continuity of care;
- To compose and implement a mutually agreed service plan promoting success and satisfaction in the community;
- To increase the cognizance of the member to the need for medication compliance, the nature of his or her disease, and early warning signs of psychiatric difficulty so as to maximize his or her functioning and independence in the community;
- To improve successful integration into the larger community through non-traditional approaches to broadening a member's social support base;
- To ensure that the member's basic needs for sustaining community living are addressed, promoting acquisition of independent levels of adult living skills whenever possible; and
- To maintain member engagement in treatment by providing supportive behavioral health and skill development services in a community environment so as to maximize generalization of learning.

Member Participation Criteria: Members eligible to become a recipient of ACT services must meet one of the following criteria:

- Three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months;
- Five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months; or
- 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months.

The Bureau for Medical Services may authorize ACT services for members within other specific target populations who exhibit medical necessity for the service (e.g., persons who are homeless and who have a severe and persistent mental illness, members with a mental illness who have frequent contact with law enforcement or the criminal justice system, or members with co-occurring mental illness and chemical addiction who require consistent monitoring).

A member must be an adult, eighteen (18) years of age or older, have an eligible diagnosis as determined by BMS' contracted authorization agent and be in an eligible disability group of Serious and Persistent Mental Health Disorders or co-occurring Mental Health and Substance Abuse Disorders or co-occurring Mental Health Disorders and Mild Intellectual Disability.

An ACT Team may serve members on an on-going basis following authorization/re-authorization of eligibility based upon continuing need and clinical appropriateness of ACT services. Billing for ACT services is permissible only when active treatment is occurring based on a current service plan. No billing may be submitted for a member enrolled in ACT who has not received services from ACT Team staff for a period of seven days or more. When services resume, billing may resume.

Service Tier	Tier 3
Target Population	MH, MH & SA, MH & ID/DD
Option	Rehabilitation, BBHMF Charity Care
Telehealth	Available for the following services as part of ACT: Behavioral Health, Supportive, Individual and Group; Behavioral Health Counseling, Professional, Individual and Group; Mental Health Assessment by Non-Physician; Psychiatric Diagnostic Evaluation (No Medical Services); Psychiatric Diagnostic Evaluation with Medical Services; medication management via E/M codes; and Screening by a Licensed Psychologist.
Initial Authorization	Tier 3 data submission required for 365 units/per member/per 365 days Unit=1day (calendar day)
Re-authorization	365 units/per member/per 365 days
Admission Criteria	<ol style="list-style-type: none"> 1. Member must have a severe and persistent mental health diagnosis, -and- 2. The member requires an array of services to remain in a community based setting and prevent further hospitalization, -and- 3. The member has had previous mental health treatment services and/or is currently receiving services, -and- 4. The member has had three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months, -or- the member has had five or more hospitalizations in a psychiatric inpatient unit , psychiatric hospital, or crisis stabilization program in the past 24 months, -or- 180 days total length of stay in a psychiatric unit or psychiatric hospital within the past 12 months.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Member continues to require an array of services to preserve community placement, -and- 2. Progress/stability is documented and efforts to link to natural supports/activities/services in the community are documented, -and/or-

	<p>3. Symptoms, functional impairments and new areas of need are identified on the service plan to be addressed in the program as needed.</p>
Discharge Criteria	<p>A provider may discharge an ACT recipient of services for the following reasons:</p> <ol style="list-style-type: none"> 1. The member no longer meets eligibility criteria; 2. The member has met all program goals and is at maximum level of functioning; 3. The member has moved outside of the ACT team's geographic area; 4. The member is no longer participating or refuses services regardless of the ACT team's efforts at engagement; and/or 5. By virtue of diagnosis or intensity of service needs, the member would be better served by an alternative program of care. <p>The team must document at least weekly attempts to locate the member for 30 days before a discharge should be considered. Attempts should not consist solely of telephone calls but should include at least weekly visits to the location the member was last known to live and telephone calls or visits to significant others for the member.</p> <p>If a member consistently refuses to participate or cannot be located, the provider has the option to place the member on an "inactive roster" after 30 days of no contact, preserving the authorization for service. Providers must not bill ACT services for members on an inactive roster. This option should be utilized primarily when the member is familiar to the team and has a history of being unavailable or noncompliant for periods of time, but returning to service regularly. At 30 days of lack of contact or refusal to participate, the provider must make a decision as to whether to place the individual on the inactive roster, or discharge him or her. If the member is on the inactive roster for 60 days with no contact and/or continued refusal of services, the agency must discharge the member from ACT.</p> <p>The provider is required to notify the Contracted Agent within 72 hours of discharge of an ACT participant in order to terminate the authorization for services.</p>
Service Exclusions	<ol style="list-style-type: none"> 1. Targeted Case Management 2. 90887 Case Consultation may be billed when a client has approved eligibility for Assertive Community Treatment. 3. No Psychiatric CPT codes (other than "J" codes for psychotropic injections) may be billed for a member receiving ACT services. 4. No Personal Care codes other than T1001, T1002 or T1019 may be billed. 5. Mileage A0160HE may be billed. 6. H0036 Community Psychiatric Supportive Treatment may be authorized up to 84 hours (336 units) during the one year ACT authorization period.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Current physical or mental impairments prevent participation in the

	<p>program.</p> <ol style="list-style-type: none"> 2. Intensity, frequency and type of activities are not appropriate to the age and functional level of the participant. 3. Member has not received previous outpatient services with the purpose of addressing the symptoms and functional impairments related to their mental health condition and/or the member has not had psychiatric inpatient admissions.
<p>Clinical Exceptions</p>	<ol style="list-style-type: none"> 1. Homeless persons with severe and persistent mental illness 2. Individuals with a severe and persistent mental illness who have frequent contact with law enforcement or the criminal justice system (a single serious offense may be evaluated on a case by case basis) 3. Individuals with co-occurring mental illness and chemical addiction who require frequent monitoring.
<p>Documentation</p>	<ul style="list-style-type: none"> • The program must have a valid authorization for service from the Bureau for Medical Services to bill for ACT services. • At entry into the program, there must be documentation of a comprehensive assessment and a recommendation by a qualified professional that ACT services are necessary and appropriate. • The team must develop an initial service plan for the ACT member within seven days of admission into the program. The initial plan must authorize the services to be provided to the member until the comprehensive plan for the member is completed. • The ACT Team, including the member, must amend or develop a comprehensive service plan for the member within 30 days. The plan must describe goals and specific objectives the member hopes to achieve with the assistance of ACT. The comprehensive plan must identify the services to be provided under ACT and must be approved by the member, as signified by his or her signature. • The team may elect to create a comprehensive plan upon admission into the program without completing an initial and subsequent comprehensive plan; however the on-going plan must reflect amendments made in services, goals and/or objectives as the team moves forward. The service plan is a fluid document which must be amended as the needs of the member change or are newly recognized. • The record must sufficiently document assessments, service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT Team can identify the member's treatment needs and services rendered. • The comprehensive plan must identify the Qualified Team that is providing ACT to the member. The certification of the team and a roster of members assigned to an ACT Team must be available for review. • All staff contacts with members of the ACT team must be documented. Each entry needs to include date and place of the contact, the purpose, content and outcome of the contact, the start and stop times of the contact, and the signature, credentials, and title of the individual providing the service.

	<ul style="list-style-type: none"> • At minimum the documentation must include the following: <ol style="list-style-type: none"> 1. A log documenting the discussion of each member in the daily team meeting; 2. A weekly summary of member status; 3. 90 day reviews of the comprehensive plan and/or documentation of team meetings and revisions of comprehensive plans at the time of critical treatment junctures; 4. Documentation of each member contact as described above. • Each member enrolled in ACT must receive a minimum of two face-to-face contacts with one or more ACT team members per week. Documentation must provide evidence of the delivery of at least four separate ACT services per week (e.g., four days of medication delivery is inappropriate and insufficient to meet this standard), but so long as the requirement for two face to face contacts is met, the service may be indirect, telephonic, collateral, etc. It is permissible for a member to receive more than one service during one member contact; however the documentation must clearly describe the two or more services provided. • The 90 day review required for each ACT participant must summarize progress towards achieving the service objectives and describe problems that impeded progress towards meeting objectives. If a member is clearly not making progress toward achieving an objective after 90 days, the team must either amend the objective or describe why the objective was not amended. An objective on an ACT plan may include activities designed to preserve stability in the community, rather than requiring active progress towards meeting an objective.
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Additional Service Criteria:

1. Only qualified teams, certified by the Bureau of Behavioral Health and Health Facilities and the Bureau for Medical Services, may provide ACT services. Certification of the team must be renewed, following initial approval, at Bureau-designated intervals, or with any changes in personnel. All currently certified ACT Teams must submit for recertification by January 1, 2015.
2. Each member enrolled in ACT must receive a minimum of two face-to-face contacts with one or more ACT team members per week.
3. Medication Delivery And Monitoring: If a provider delivers medications to a member on a regular basis, the provider must have a policy that ensures that:
 - Delivery date, time, person receiving and name of medication delivered is documented, including amount delivered (the list of medications and dosages may be contained in the member record however each delivery must be logged either in the member record or in a central location);
 - If there are children or other incapacitated adults in the home, medications are at least initially stored properly in a secure location;

- If medications are delivered to a member at a location other than the home, the medications must be delivered in a manner that ensures the confidentiality of the member and shields the nature of the items delivered; and
 - A system of monitoring the member's compliance with consumption of medications is created with the agreement and participation of the member. The nature of the monitoring system will be individualized and designed by the clinical team in conjunction with the member. This system may consist of the member logging consumption of his or her own medications. The member has the right to refuse participation in a monitoring system however the provider may then refuse to deliver medications to the member's residence and/or make alternative arrangements for the provision of medications if clinically appropriate.
4. Because ACT is a community focused treatment modality, a minimum of 75 percent of service must be delivered outside of program offices.
 5. ACT Team Composition and Staff Qualifications: The ACT Team must include a multidisciplinary staff mix, including mental health professionals and substance abuse treatment professionals. The team is composed at a minimum of a psychiatrist or board certified physician with behavioral health experience and five other staff persons. The additional five (minimum) staff composing the ACT Team must include:
 - a. One full time Team Leader/Supervisor with three (3) years' experience in behavioral health services, two (2) of which must be in a supervisory capacity, and a master's degree and valid West Virginia license in Counseling, Social Work, Psychology, a Supervised Psychologist.
 - b. A registered nurse may serve as a team leader if the team has an additional full time registered nurse.
 - c. One full time Registered nurse with one year of psychiatric experience;
 - d. Two (2) full time staff at the Master's level in Counseling, Social Work, or Psychology and two (2) years' experience in behavioral health services. At least one of these individuals must have experience in substance abuse assessment/treatment and/or vocational rehabilitation; and
 - e. One full time staff with a Bachelor's degree in Social Work or an alternative Behavioral Science, with one year of behavioral health experience.
 6. ACT Weekend and Holiday Requirements: Staff working as weekend and holiday coverage may be on a rotating basis. Staff must be sufficient to meet ACT Members' needs including, but not limited to, medication delivery, crisis response – via phone or face to face, therapeutic services to promote stability. The ACT staff individual on call must review each member with the ACT Team Leader or the team leader's designee, which must be a master's level staff or RN on the certified ACT Team each weekend day and holiday. The physician or physician extender must be accessible for medication adjustments or any issues that arise that would indicate the need for a physician or physician extender to be involved.
 7. Role of The Physician: The physician must be actively involved with members and the team. He/she must participate in the daily ACT Team meetings, though he or she may do so by means of tele-video conferencing when unable to be physically present. A suitably trained and experienced physician extender (Advanced Practice Registered Nurse or Physician's Assistant) under the direct supervision of the team physician may participate on the team in lieu of the physician; however the substitution on team meetings must be documented. The physician and/or physician extender must physically attend at least one team meeting per week.
 8. The physician must physically participate in the annual service planning session, and must demonstrate direct and on-going involvement with the ACT team and ACT members. The physician

or physician extender must be actively involved with the team and the members for a minimum of 16 hours per week.

9. Caseload Mix and Ratios: The certified ACT Team must always have the required minimum staffing unless temporary approval is obtained from the Bureau for Medical Services to operate the team in the absence of a member. The maximum number of members served by an approved ACT Team is 120. The team must preserve a staff/member ratio of at least 1:10 (i.e., one staff person to ten members, not counting the Physician or physician extender) when the number of ACT members served by the team exceeds 50.

With the exception of the team physician and physician extender, if any, the ACT Team cannot serve non-ACT members.

10. ACT Service Elements: ACT is a Recovery oriented program. ““Recovery is a process of change whereby individuals work to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their full potential “(SAMHSA, 2012).

The ACT Team is required to directly provide the following combination of case management and rehabilitation services:

- Assertive outreach designed to identify and engage individuals that meet clinical guidelines and could benefit from the program;
- Sustained effort to engage the member in treatment, medication education and prompting, and skill development activities in order to facilitate more integrated and successful community living;
- Comprehensive and appropriate assessment of medical, environmental and social needs;
- Maintenance of on-going involvement with the member during stays in environments such as inpatient care, convalescent care facilities, community care hospitals, or rehabilitation centers in order to assist in transition back to a community placement;
- Member-specific advocacy;
- Assistance with securing basic necessities (e.g., food, income, safe and stable housing, medical and dental care, other social, educational, vocational, and recreational services);
- Facilitation of maintenance of living arrangements during periods of institutional care. The member and his/her support system remains responsible for these expenses;
- Counseling, problem solving, and personal support;
- Psychiatric services and medication management;
- Assistance in obtaining necessary primary care services;
- Facilitation and improvement of daily living/community living skills;
- Behavior management as necessary and appropriate;
- 24-hour crisis response for ACT members;
- Transportation or facilitation of transportation to necessary community and Medicaid services as specified on the service plan;
- Representative payee-ship or facilitation of representative payee-ship when needed;
- Collaboration with family/personal support network; and
- Assistance with preparation of advanced psychiatric directives.

11. ACT Fidelity Indicators:

- The team works with a small caseload (10 to one preferred when caseloads exceed 50);
- The team is cooperative and collaborative. Team members are familiar with and work with all clients;
- Program meeting occurs daily other than federally recognized holidays;
- The team leader is a practicing clinician providing services at least 50% of the time;
- Program staff remain consistent over time; turnover is low;
- The program operates at 95% or more of full staffing on average over a 12 month period;
- The physician/physician extender works at least 16 hours per week on teams with 50 clients, proportionally more on larger teams;
- Each team has one full time registered nurse in a program of 50 clients;
- At least one staff member has training or certification in working with members with substance abuse issues;
- The program is of sufficient size to provide consistently the necessary staffing, diversity, and coverage (minimum 6 members);
- The program has explicitly defined admission criteria that address a clearly defined population;
- No more than 6 new members are admitted per month on average;
- The program is required to have available the following five services: medication management, counseling/psychotherapy, housing support, substance abuse treatment, and employment/rehabilitative services;
- The program provides 24 hour services for crisis intervention;
- The team is actively involved in admission in 95% or more of hospital admissions. Admission involvement must become active as soon as the team becomes aware that the member is at risk of being admitted or has been admitted without the team's prior knowledge to an institutional environment, including Crisis Stabilization Units. Active involvement is demonstrated by regular contact with the institutional treatment team, exchange of information as necessary, contact with the member as possible and appropriate, and interaction with family members as necessary and desired by the member;
- The team participates in discharge planning for 95% of members, providing assistance to the institutional team with housing, benefits, medication appointments, etc.;
- All members are served on a time-unlimited basis with fewer than 5% of the population expected to graduate annually;
- 75% of member contacts occur outside the clinic setting;
- The team actively pursues engagement of treatment resistant members as described in the policy described below under "Discharge Criteria";
- The program is aggressive in assuring engagement and uses outreach and contacts with corrections and homeless programs to engage members;
- Each member receives an average of two hours of face to face contact with a team member per week;
- Each member receives at least four contacts per week of any type;
- With or without the member present, the team provides support and skills for the member's support network: family, landlords, employers, etc.;

- One or more team members provides direct treatment and substance abuse treatment for members with substance use disorders;
- The program uses group modalities as a treatment strategy for people with substance use disorders;
- The program uses a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse and has gradual expectations of abstinence; and
- Stable recovering members may be involved as members of the team providing direct services.

12. ACT Team Certification Process:

- All ACT Teams require initial approval through the completion of the ACT Team Certification form. The certification form is reviewed and subject to approval by the Bureau for Medical Services (BMS) and the Bureau of Behavioral Health and Health Facilities (BHHF). Certification is specific to the individuals in a team, the team composition, and qualifications submitted. Specific certification elements are described in the BMS application form for the ACT Certification.
- Certification packet may be requested from BMS and will be sent electronically or through postal service at the request of the provider.
- Certification is valid for 2 years from the approval date stated on the certification letter issued by BMS.
- BMS will issue a denial or acceptance of a certification team within 30 days of receipt of completed certification packet
- A provider must apply for certification of each ACT Team.
- No ACT services may be billed for a member without written certification of the ACT Team by BMS.
- Re-certification shall occur each two years through a process developed by BMS in conjunction with BHHF.
- All teams must be based at a site listed on the provider's Behavioral Health License. Administrative support must be provided by the parent agency sufficient to meet scheduling and support needs of the ACT Team.
- Billing may commence after receiving approval from BMS. After initial approval, a site review will be conducted to validate the approval.
- BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program. Programs not receiving approval may appeal the decision as per the policy contained in Chapter 800, Medicaid regulations.
- Variations from the original certification must be submitted with corresponding rationale for changes.
- When a team member resigns or is no longer associated with the Certified ACT Team, the ACT Team must replace the team member within 30 days of the team member's last day. The provider is responsible for notification of the BMS in writing within two working days of the resignation of the team member. A team is considered then to be provisionally certified until the team member is replaced. The provisional is in place until the team member is replaced. The provider may apply for extended provisional certification if an appropriately credentialed individual cannot be found within the original 30 day period. The BMS will notify the provider in writing of the acceptability of the proposed replacement team member after review of the individual's credentials as submitted by the provider. If more than one team member resigns or is terminated, the 30 day provisional status will be reinitiated at the loss of the subsequent team member.

H2014 U4 SKILLS TRAINING AND DEVELOPMENT (1:1 BY PARAPROFESSIONAL)
H2014 U1 SKILLS TRAINING AND DEVELOPMENT (1:4 BY PARAPROFESSIONAL)
H2014 HN U4 SKILLS TRAINING AND DEVELOPMENT (1:1 BY PROFESSIONAL)
H2014 HN U1 SKILLS TRAINING AND DEVELOPMENT (1:4 BY PROFESSIONAL)

Definition: Skills Training and Development is a combination of structured group activities and individual support offered to members who have basic skill deficits. These skill deficits may be due to several factors such as history of abuse or neglect or years spent in institutional settings or supervised living arrangements that did not allow growth and development in the areas of daily living that are acquired during the formative years. The purpose of this service is to provide therapeutic activities focused upon basic living designed to improve or preserve a member's level of functioning. Therapeutic activities include, but are not limited to, learning and demonstrating personal hygiene skills, parenting skills, managing living space, manners, sexuality, and social appropriateness and teaching daily living skills. These same services may be provided to an individual in his/her natural environment through a structured program as identified in the goals and objectives described in the service plan.

Skill acquisitions include, but are not limited to:

- A. adaptive, self-help, safety, and nutritional skills
- B. parent-child interactions, coping mechanisms, social competence, and adult-child interactions
- C. interpersonal and communication skills
- D. mobility problem-solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills.

GUIDELINES FOR YOUNG CHILDREN:

1. The service must be age and functionally appropriate and be delivered at the intensity and duration that best meets the needs of individual children.
2. The service should not be utilized to provide therapeutic activities for children under the age of five in a group setting for more than 4 hours per day or more than 4 days per week.
3. These therapeutic activities for young children should promote the following skill acquisitions:
 - a) adaptive, self-help, safety
 - b) coping mechanisms, social competence
 - c) age appropriate interpersonal and communication skills
 - d) mobility problem-solving, causal relationships, spatial relationships, sensorimotor, sensory integration, and cognitive skills
 - e) necessary adaptations and modifications based upon developmentally appropriate practice.

These services must be provided in a way that supports the daily activities and interactions with the family's routine.

Service Tier	Tier 3
Target Population	MH, SA, A & C
Option	Rehabilitation, BBHCF Charity Care
Telehealth	Not Available
Initial Authorization	Tier 3 data submission required for 600 Units*/per member/per 92 days Unit=15 minutes

Re-Authorization	Maximum 600 Units/per member/per 92 days Unit=15 minutes
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a known persistent MH or SA Diagnosis and requires intensive services, -and- 2. The member has measurable, identified skills deficits related to the MH/SA diagnosis and reflects skills that the member once held and then lost due to neglect, abuse, institutionalization, etc., -and- 3. Reasonable expectations that the member can demonstrate improvement in 3 months, -and- 4. The member, by history, has required periodic hospitalizations and exhibits symptoms or functional impairments that are severe enough to require hospitalization, -or- 5. Member has a mood or thought disorder which interferes with her/his ability to resume work, family, or school responsibilities unless psychiatric/social/rehabilitative services are provided and Skills Training and Development is the appropriate intervention to remediate skill deficits that are related to the symptoms of the illness, -or- 6. Member has stabilized during acute hospital or partial hospitalization care but would benefit from transitional services to reestablish their role in the community, -or- 7. Member does not have adequate family support and therefore is in need of assistance to improve or preserve ADL's in order to remain stable and prevent likely admission to an inpatient environment if the targeted skills are not remediated, or to transition to independent living from a more restrictive setting when this is the specific discharge plan
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Progress is evident and noted in the documentation related to goals and objectives identified on the Individual Service Plan with date to discontinue. 2. If progress indicates that Skills Training and Development objectives are used to preserve functioning and the condition is stable, there must be documentation of need to continue the objective. 3. Service Plan Review documentation reflects there is a history of symptoms & functional impairments that indicate a need for continued Skills Training and Development Service.
Discharge Criteria	<ol style="list-style-type: none"> 1. Goals and objectives of the member's service plan have been substantially met. 2. Member/family request discharge or refuses treatment. 3. There is no participation in treatment or cooperation with the program rules and regulations. The lack of participation is such that treatment is rendered ineffective despite multiple documented attempts to address lack of participation. 4. The member is not making progress toward treatment goals and there are no reasonable expectations of progress at this level of care. 5. Functioning has been restored or maintained for a sufficient period of time to warrant discontinuation of the service.

Service Exclusions	<ol style="list-style-type: none"> 1. Members participating in this service shall not access any Day Treatment Service during the hours in which Skills Training and Development are being provided. 2. There is a combined service limit of 600 units in 92 days for H2014 U4, H2014 U1, H2014 HN U4, H2014 HN U1, and H2019.
Clinical Exclusions	Current physical or mental impairments prevent participating in the program.
Documentation	<ol style="list-style-type: none"> 1. There shall be an activity note describing the type of service/activity provided, and the relationship of the service/activity to objectives in the service plan. 2. Documentation shall include place of service, date of service, and the actual time spent providing the service with the total number of billable units identified on each page of documentation. 3. Attendance Roster: Must reflect a listing of all participants. It must be signed and dated by participating staff.

Additional Service Criteria:

1. Only the support services, which are essential to maintain the member in the community, are allowable under this code. These include:
 - a. Medical appointments
 - b. Pharmacy
 - c. Grocery Shopping
 - d. Other essential appointments to maintain entitlements (i.e., Social Security Office, DHHR).

In order to include essential support services as part of Skills Training and Development, the member must meet admission criteria for Skills Training and Development services and the member's level of support (as measured by the functional assessment) must be documented on the member's service plan and reevaluated every 90 days.

Alternative methods of obtaining the necessary support were explored and documentation must be made in the case notes.

2. The alternative resources that were explored must be documented and continued alternatives must be sought within the 90 day service period.
3. Where Skills Training and Development Services are provided in a group context, the group must be limited to four members to each staff member. In any setting, these services target members who require direct prompting or direct intervention by a provider.
4. Recreational trips, visits to the mall, recreational/leisure time activities, and social events are not essential support services and cannot be billed under this code.
5. Skills Training and Development is a rehabilitation service only and must be medically necessary for the member. The member must meet diagnostic eligibility and meet criteria for Level III service as well as specifically requiring Skills Training and Development services. Medical necessity for Skills Training and Development includes identified skill deficits that relate to the behavioral health condition, were developmentally not achieved due to abuse, neglect or institutionalization or where there is not adequate support and the person is likely to be institutionalized if skill deficits are not remediated. The member's plan must be individualized, age and developmentally appropriate, and relate to the specific criteria above that are applicable to that member.

*A maximum of 600 units in 92 days for H2014 U4, H2014 U1, H2014 HN U4, H2014 HN U1, and H2019 is permitted for service combinations for automatic authorization. No more than 1800 units authorized for a period of 92 days may be allowed.

H2019 HO Therapeutic Behavioral Services- Development

Therapeutic Behavioral Services refers to specific activities which have been planned and tailored to eliminate maladaptive behaviors and/or to increase or develop desired adaptive behaviors for an individual member. These services result from areas of need identified on the individual's service plan. Therapeutic Behavioral Services are time-limited services which should end when the desired outcomes have been achieved, (i.e., targeted behaviors have been acquired or eliminated). If plan implementation fails to achieve goals or specified levels, within specified time frames, then the therapeutic behavioral services plan must be reviewed, and subsequently modified, continued and/or terminated.

Therapeutic Behavioral Services- Development – Includes four major components: 1) Behavior Assessment, 2) Plan Development, 3) Implementation Training and 4) Data Analysis and Review of the behavior management plan once implementation has begun. The required documentation must exist to justify billing for Behavior Management Plan Development.

Behavior Assessment Component – is a process of data collection, behavior and skill assessments functional analysis, and observation that describes behaviors and the circumstances under which they occur. Prior to the development of the Behavior Management Plan, behavior assessment activities must culminate in the identification of target behavior(s) (those behaviors which the plan proposes to increase, decrease, shape, or eliminate). The target behaviors must be described in specific terms beyond the developmental and they must be stated in terms of an objective, quantifiable measurement. The target behaviors must address symptoms of the diagnosed behavioral health condition that negatively impacts the member's overall functioning. The target behavior(s) is causing a functional deficit and is related to the behavioral health condition. Baseline data (quantified measurements which describe the intensity, frequency and duration of the targeted behaviors) must be collected on each target behavior. Baseline data are then reviewed to determine if the data justifies or supports the development of a Behavior Management Plan.

Following implementation of the Behavior Management Plan, behavior assessment must occur to determine objectively whether to continue, modify, or terminate the plan.

Plan Development Component

Plan Development refers to those activities required for the formal development of a Behavior Management Plan. It should be noted that a formal plan is developed only if objective baseline data supports and demonstrates the need for such a plan. A Behavior Management Plan for which there is no documentation of behavior management implementation activity must be considered invalid for billing purposes except for those activities related to assessment where a decision was made based on assessment data that it was not appropriate to proceed.

In those instances when baseline data indicate an occurrence of the target behavior(s) at a frequency or duration not sufficient to warrant the development of a complete Behavior Management Plan and its implementation training and on-going data analysis and review, the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Protocol**. A Behavior Protocol is a document that describes a consistent response(s) upon the occurrence/reoccurrence of the target behavior(s) as a means to maintain the rate of behavior(s) at a low rate. No more than two units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Protocol. Following the development of a Behavior Protocol, no further Therapeutic Behavioral Services billing must occur unless a new problem behavior is discovered. If this occurs,

behavior assessment on the new behavior must follow, and the process should start anew.

When a Behavior Management Plan has achieved the criteria for success (the objective, quantified amount of behavior change has been maintained for the time period specified in the plan), the Behavior Management Specialist or the Behavior Management Assistant may develop a **Behavior Management Maintenance Plan**. A Behavior Management Maintenance Plan is a document that describes a consistent response(s) to the target behavior(s) as a means to maintain target level performance. No more than four units of Therapeutic Behavioral Services – Development (H2019HO) may be billed for the development of the Behavior Management Maintenance Plan. Following the implementation of the Behavior Management Maintenance Plan (which is not to exceed 90 days), the Behavior Management Specialist or the Behavior Management Assistant may conduct data analysis and review on no more than three occasions (a maximum of one unit each occasion) to assure that behavior levels are maintained.

Implementation Training Component

Implementation training is the process by which the Behavior Management Specialist or the Behavior Management Assistant provides the rationale for the plan, defines the behavior(s) that are targeted for change and instructs the individual(s) responsible in the specific steps necessary for implementation of the plan. All individuals who will be involved in providing Therapeutic Behavioral Services – Implementation (procedure code H2019) must receive implementation training prior to implementation of the plan. This includes agency employees and/or significant others (e.g., parents, teachers, foster care providers, etc.).

Data Analysis and Review Component

Data Analysis and Review is the process by which the Behavior Management Specialist or the Behavior Management Assistant evaluates plan effectiveness. Plan effectiveness is determined through a comparison of the baseline data for the target behavior(s) with objective, quantified implementation data to determine whether the plan is leading to achievement of the criteria for success. Any necessary direct observation of member *behavior* is included in this category. This analysis and review result in the determination of continuation, modification, or termination of the Behavior Management Plan.

Staff Qualifications: The Behavior Management Specialist must be an individual with a minimum education at the Master's level in psychology, psychiatry, education, social work or counseling. This individual's training must include successful completion of course work and documented training in behavioral theory. The Behavior Management Specialist is responsible for all aspects of Behavior Management Services provided by Behavior Management Assistants and must sign all documentation of those services.

The Behavior Management Assistant must be an individual with a minimum education of a bachelor's degree in a human services field who has been certified by the agency as having training specific to behavior management which is consistent with documented training in behavioral theory. Behavior Management Services provided by Behavior Management Assistants are subject to review and approval by the Behavior Management Specialist. A copy of the provider's training program for its Behavioral Health Assistant staff must be retained and filed by the provider. (The Behavior Management Assistant must use the HO modifier when providing Therapeutic Behavioral Services – Development, procedure code H2019HO, since their documentation must be reviewed and signed by the Behavior Management Specialist. Otherwise, the wrong service, Therapeutic Behavioral Services – Implementation, procedure code H2019, would be billed).

Service Tier	Tier 3
Target Population	MH, SA, ID/DD, C & A
Options	Clinic & Rehabilitation, BBHCF Charity Care
Initial Authorization	Tier 3 data submission required for 120 units*/per member/per 92 days Unit=15 minutes
Re-Authorization	120 units/per member/per 92 days
Admission Criteria	<ol style="list-style-type: none"> 1. The member has a behavioral health diagnosis, -and- 2. The member demonstrates moderate to severe symptoms and /or functional impairments and exhibits specific behaviors which interfere with age appropriate adaptive and psychological functioning, -and- 3. Specific targeted behaviors can be identified and interventions to modify these behaviors can be developed -and- 4. Progress can be quantified and documented, -and- 5. Member demonstrates problematic or high risk behaviors that impact social problem solving and the ability to form or sustain a relationship with family or other significant persons in the member's life, -or- 6. The member's behaviors are such that structured behavioral management is indicated to assist the member to remain in the community, school, living setting, or to maintain other activities of daily living.
Continuing Stay Criteria	Data Analysis & Review indicates continuation or modification of the therapeutic behavioral services plan.
Discharge Criteria	<ol style="list-style-type: none"> 1. A therapeutic behavioral services plan has been developed and success has been achieved. 2. Plan Implementation fails to achieve goals or specified levels, within specified time frames. 3. Member or family request discharge or refuses treatment.
Service Exclusions	None
Clinical Exclusions	<ol style="list-style-type: none"> 1. The member's symptoms and/or functional impairment do not indicate the need for such an intensive level of service. 2. Therapeutic Behavioral Services is not a recommended intervention for the member's diagnosis and/or symptoms. 3. The Therapeutic Behavioral Services Plan is not developmentally appropriate for the targeted member.
Documentation	<p>There are four types of Therapeutic Behavioral Services - Development documentation:</p> <ol style="list-style-type: none"> 1. Activity notes 2. Behavior Management Plan 3. Behavior Protocol 4. Behavior Management Maintenance Plan. <p>Standard Activity Notes Documentation Requirements</p> <p>Activity Notes identify the specific component of Therapeutic Behavioral Services - Development (i.e., Behavior Assessment, Plan Development, Implementation Training, Data Analysis and Review) that was performed, place of service, date of service, the</p>

amount of time spent by listing the start-and-stop times, and the signature (with credential initials) of the staff person who provided the service.

Behavior Assessment documentation must be present prior to the development of the Behavior Management Plan. In addition to the standard activity notes documentation requirements, behavior assessment documentation must reflect that the following activities have occurred in this order:

- Identification of the target behavior(s).
- Specific description of each target behavior in terms capable of objective, quantified measurement.
- Collection of baseline data on each target behavior to obtain an objective, quantifiable determination of its occurrence/nonoccurrence.
- Review and analysis of baseline data to determine objectively if a need for further Behavior Management Services exists.

Following implementation of the therapeutic behavioral services plan, behavior management assessment must include the place of service; the actual time spent providing the service. The actual time must list the start and stop times. It must also include the rationale for such assessment, which may take one of two forms:

- a. Identification of a new target behavior. Should this occur, behavior assessment must meet the requirements outlined in steps above to provide objective documentation of the need to modify the plan.
- b. Objective determination through data analysis and review that the plan is not effective. If this occurs, behavior assessment should be conducted to determine if the plan is being implemented correctly. If not, implementation training must reoccur. If the plan is being implemented correctly further data based assessment to determine whether to modify the plan will occur. Documentation of the latter must reflect the specific components of the plan addressed and modified to obtain the desired behavior (e.g., methods of behavioral intervention, schedules of reinforcements, methods of reinforcements, etc.).

Activity notes documenting **Plan Development** must include the specific components of the plan itself that were developed in addition to the standard activity notes documentation requirements.

Activity notes for **Implementation Training** must document the training of implementation staff (and/or unpaid support staff) as defined by the plan, the definitions of the behavior(s) targeted for change, and the specific steps necessary for implementation of the

plan. It must also include the standard activity notes documentation requirements.

Activity notes for **Data Analysis and Review** must document a measured amount of each target behavior, a comparison of that amount to a previously documented amount and, based on that measured amount, a determination of continuation, modification, or termination of the plan. It must also include the standard activity notes documentation requirements.

Behavior Management Plan Documentation Requirements

The second type of documentation is a separate, freestanding document labeled Behavior Management Plan. The Behavior Management Plan must contain, at a minimum, the following components within the body of the plan itself, regardless of their presence anywhere else in the member's record.

- The Name and Agency Identification Number of the member for whom the plan has been developed
- Implementation Date - the date the plan is implemented
- Target Behaviors/Specific Descriptions.
- Baseline data including the actual dates the baseline data was collected.
- The criteria for success – (A generic statement such as “The member will obey the rules more frequently” is not acceptable, as it does not state a quantified amount that can be compared to baseline data).
- Methods of Behavioral Intervention includes the following:
 - Method - A description of the behavioral intervention that implementation staff (and/or unpaid support staff) will employ given the occurrence/nonoccurrence of the target behavior(s).
 - Method and Schedule of Reinforcement - The method statement must specify and describe the method of reinforcement, the type of reinforcers to be used, when the reinforcers will be provided (i.e., the schedule of reinforcement), by whom, and whether reinforcers are delivered upon occurrence/reoccurrence of the target behavior(s), or upon the occurrence of behavior(s) incompatible with the target behavior(s).
 - Data Collection - A description of the quantified information that will be collected during the implementation of the Behavior Management Plan. This must include who collects the information and what type of quantified information is recorded, such as frequency or duration of behavior. This information must be of the same type as that collected during baseline so that comparisons can occur.
- Responsible person - a designated Behavior Management Specialist is responsible for the Behavior Management Plan in terms of its appropriateness in clinical practice and for financial reimbursement, and for identifying staff and/or others and their

	<p>respective responsibility relative to the plan. It should be noted that implementation staff do not have to be named individually, but they must have received the required implementation training <u>prior</u> to implementing the plan. The Behavior Management Specialist must sign and date all plans prior to their implementation (or review and co-sign plans signed and dated by a Behavior Management Assistant). The signature of any individual(s) who participated in the development of the written plan must also be included in the plan (and the date of their participation), along with the degree, and other credentials (license type and number) of each individual.</p> <p>Behavior Protocol Documentation The behavioral protocol consists of a summary of objective, quantified baseline data, a rationale for the development of the protocol, and recommendations for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s). The date the protocol was developed, time spent (including start and stop times) and the signature and credentials of the person preparing the protocol must be present.</p> <p>Therapeutic Behavioral Services Maintenance Plan Documentation Consists of a summary of objective, quantified implementation data (collected during the implementation of the plan), a rationale for the development of a maintenance plan (i.e., the criteria for success has been achieved), and recommendation for consistent response(s) upon the occurrence/nonoccurrence of the target behavior(s). The date the maintenance plan was developed, time spent (including start and stop times) and the signature and credentials of the person preparing the maintenance plan must be present.</p>
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Additional Service Criteria: None.

H2019 Therapeutic Behavioral Services- Implementation

Definition: Therapeutic Behavioral Services- Implementation means a face-to-face, hands on encounter where the actual time is spent in the delivery of a behavioral service to a specific member (i.e., any delivery of the service must be on a strictly one staff to one client basis). Such encounters are interventions or scheduled reinforcements, which have been previously described in the Therapeutic Behavioral Services Plan and are measured and recorded. Any and all therapeutic behavioral services implementation activity under this procedure will be considered non-reimbursable if it is not supported by a Therapeutic Behavioral Services Plan that meets the documentation detailed under procedure code H2019 HO. Anyone providing Therapeutic Behavioral Services Implementation must be specifically trained on the particular intervention, schedule of reinforcement, and data collection of the behavioral plan for this individual.

General observation, data collection and/or monitoring are not considered billable implementation activities. Activity provided for the purpose of leisure or recreation is not a billable service.

Service Tier	Tier 3
Options	Rehabilitation and Clinic, BBHCF Charity Care
Target Population	MH, SA, ID/DD, A & C
Initial Authorization	Tier 3 data submission required for 600 units*/per member/per 92 days Unit=15 minutes Service must be requested with (H2019 HO) Therapeutic Behavioral Services- Development.
Re-Authorization	Maximum 600 units/per member/per 92 days Service must be requested with (H2019 HO) Therapeutic Behavioral Services- Development.
Admission Criteria	<ol style="list-style-type: none"> 1. The member has a behavioral health diagnosis, -and- 2. Member demonstrates maladaptive behaviors that are resistant to verbally oriented treatments (individual, group, or day services), -and- 3. Admission criteria for Therapeutic Behavioral Services- Development have been met, -and- 4. There is a valid Therapeutic Behavioral Services Plan to be implemented.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Target problem behaviors, which are addressed in the Therapeutic Behavioral Services Plan, persist at the level documented, -and/or- 2. New problem behaviors have appeared which have been incorporated into the Therapeutic Behavioral Services Plan and resubmitted for authorization, -or- 3. Relevant member progress towards management of the targeted behavior has been observed and documented but behavioral goals have not been reached.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member is placed in a more intensive level of care resulting in the inability to implement the plan in a community-based program, -or- 2. Criteria for success have been achieved, -or- 3. Plan implementation fails to achieve goals or specified levels within specified time frames, -or-

	<p>4. Therapeutic Behavioral Services Maintenance Plan has been developed.</p> <p>5. Natural supports are able to perform implementation services.</p>
Service Exclusions	<p>1. There is not a Therapeutic Behavioral Services Plan provided for the member.</p> <p>2. Implementation is not provided by persons trained on the plan.</p> <p>3. The activity is considered leisure or recreation.</p>
Clinical Exclusions	<p>1. The Therapeutic Behavioral Services Plan does not identify a specific behavior to be addressed.</p> <p>2. There is a combined service limit of 600 units in 92 days for H2014 U4, H2014 U1, H2014 HN U4, H2014 HN U1, and H2019.</p>
Documentation	<p>1. Documentation must contain the intervention used (which is individualized to meet the needs of the member), methods, measurements, delivery of service, outcome of the implementation, place of service, date of service, signature of implementing staff (with credential initials), and the actual time spent by listing the start-and-stop times.</p> <p>2. Only trained, qualified staff can provide billable Therapeutic Behavioral Services - Implementation Services. Activities provided by a non-staff person may be considered as a valid part of the service if there is documentation of the role and specific activities by such individuals in both the description of the methods of intervention in the Behavior Management Plan and in the data which describes the encounters by non-staff persons as they implement the plan. Activity by non-staff persons as described above, however, will not be considered billable under neither Therapeutic Behavioral Services – Development (procedure code H2019HO), nor Therapeutic Behavioral Services – Implementation (procedure code H2019).</p>

Additional Criteria *There is a combined service limit of 600 units in 92 days for H2014 U4, H2014 U1, H2014 HN U4, H2014 HN U1, and H2019 for an automatic authorization. No more than 1800 units in 92 days may be authorized

H0019 U1 RESIDENTIAL CHILDREN'S SERVICES LEVEL I

Definition: Residential Children's Services, Level I is a structured 24-hour therapeutic group care setting that targets youth with a confirmed current DSM or ICD diagnosis that manifests itself through adjustment difficulties in school, home, and/or community. This level of service is designed for children or youth whose needs can best be met in a community-based setting where the child can remain involved in community-based school and recreational activities. These youths usually can function in public school and in a group residential setting with a minimal amount of supportive services and behavioral interventions. The goal of supportive residential programs is to enable children to overcome their problems to the degree that they may move to a less restrictive community placement or independent living situation. This service level is appropriate for members:

- Whose relationship with their families or whose family situations, level of development, and social or emotional problems are such that they cannot accept family ties or establish and maintain relationships in a less restrictive environment, or
- Who are in transition from a more intensive form of care.

Members in need of this level of service display impaired abilities in the social, communication, or daily living skills domains. Life threatening symptoms are generally absent. They generally are able to interact appropriately in social settings with a minimal amount of adjustment problems. Although they may display emotional problems such as anxiety, depression, avoidance, etc., these are not part of a persistent, long term pattern nor do they preclude normal social functioning in most school or community settings. Where aggressive acting out behaviors are present, they are not of a degree or at a frequency to require ongoing measures of control (restraint, hospitalization, and chemical interventions) and generally respond to logical/natural consequences and supportive counseling interventions.

Program Requirement:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling, Supportive
- Skills Training and Development

These services must be provided in accordance with the minimum standards established by the Bureau for Medical Services in this chapter of the Provider Manual, and with the certification standards established by the WVDHHR for children's group residential services. This service can only be reimbursed to agencies dually licensed as behavioral health services and as childcare group residential facilities, and only for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

Service Tier	Tier 3
Target Population	SA, MH, ID/DD, A & C
Initial Authorization	Tier 3 data submission required for 184 units/per member/per 184 days Unit = 1 Day
Re-Authorization	184 units/per member/per 184 days
Admission Criteria	<ol style="list-style-type: none"> 1. The child's age range is from eight (8) years of age up to but not including eighteen (18) years of age. EXCEPTION: When there is individualized clinical justification documented in the member's case record as to why it is considered appropriate beyond the age of 18 or prior to the age of 8 or to 21 if youth is in DHHR custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age requirements -and- 2. A behavioral health diagnosis that meets medical necessity for Level I Residential Children's Service, -and- 3. The child demonstrates low to moderate symptoms or functional impairment which interfere with age appropriate adaptive and psychological functioning and social problem solving that prohibit a relationship with a family, or whose family situation and functioning are such that the child cannot accept family ties or establish relationships in a less restrictive setting, -and- 4. The child's symptoms and functional impairment are such that the treatment needs are best met in a community-based structured setting where the client can remain involved in the community, school, and recreational activities, and cannot be successfully provided in a less intensive level of care, -and- 5. The child will have a CAFAS score indicating a level of functioning in the mild to moderate range, which indicates that this is an appropriate level of service, and a more appropriate living arrangement is not available, -and- 6. Admission is not used solely for providing special education, housing, and supervision or meeting other needs that are not medically necessary, -or- 7. The child is in need of a "step down" from a more restrictive level of care as part of a transitional discharge plan.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The child's age range is eight (8) years of age up to the age of 18 or to 21 if youth is in DHHR custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age requirements), -and- 2. The continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, -and- 3. The child continues to exhibit symptoms and/or functional impairment such that treatment needs are best met in community-based setting where the child can remain involved in the community

	<p>school and recreational activities, -or-</p> <ol style="list-style-type: none"> 4. The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, -or- 5. The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, -or- 6. The child demonstrates new symptoms or functional impairment in adaptive and/or psychological functioning, and/or psychological functioning and problem solving, which met the criteria for admission, -or- 7. The child's symptoms have diminished and functional impairment has improved, but there are continuing symptoms and functional impairment in the child's adaptive and or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, -or- 8. The child demonstrates an inability to sustain gains without the therapeutic service provided by the residential Children's Service-Level 1 program.
Discharge Criteria	<ol style="list-style-type: none"> 1. The child has attained the age of eighteen (18) years of age (or 21 years of age if he remains in State custody). 2. The child or family has attained goals as identified in the service plan or symptoms have abated to the point where the child may be served in a less intensive treatment service. 3. The child demonstrates functional impairment and symptoms, which cannot be treated safely or effectively at this level of treatment, and the child requires a higher level of care. 4. The child has been on runaway status/away from supervision for a period of 5 days or more. 5. The child has refused treatment against medical advice for a period of five (5) days or more. 6. Care appears to be custodial.
Service Exclusions	<ol style="list-style-type: none"> 1. H0031 Mental Health Assessment by non-physician 2. H0032 Mental Health Service Plan Development by a non-physician 3. T1017 Targeted Case Management 4. H0004 Supportive Individual Counseling 5. H0004 HQ Supportive Group Counseling 6. H2014 HN U4; H2014 HN U1; H2014 U4; H2014 H1 Skills Training and Development 7. H2012 Day Treatment 8. H2019 Therapeutic Behavioral Services Implementation (if there is a Therapeutic Behavioral Services Plan prepared by a qualified Behavioral Management Specialist and authorized by KEPRO).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Clearly documented evidence that the child is exhibiting an acute psychiatric episode. 2. Severity of child's issues precludes provision of services in this level of care. 3. The child can effectively and safely be treated at a lower level of

	care.
Documentation	<ol style="list-style-type: none"> 1. There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and agency record keeping policies. 2. The member's record must contain a Behavior Health Clinic/Rehabilitation Services Authorization for Services form signed by a physician or psychologist and indicating the need for Level I Children's Residential Services, results of the evaluation which establishes medical necessity for the level of service, and the members individualized service plan. 3. Documentation must also include: <ol style="list-style-type: none"> a. behavioral observations of the child b. identification of the service components provided c. record of the child's program participation including specific times of program participation d. medication administration records e. A sign-in/sign-out sheet in each member's record that indicates the date and time a youth departs from the site and the date and time they return to the site. The reason for the absence must be noted and the notation must be signed and dated by an agency staff.

Additional Service Criteria: The child must be receiving medically necessary services as indicated by an Individualized Service Plan and the program must include the following elements:

1. Within 30 days of admission and every 90 days thereafter, continued interdisciplinary, individualized service planning based on multidisciplinary assessments and that is designed to restore an acceptable level of adaptive and or psychological functioning and problem solving.
2. The child is receiving continued appropriate and timely evaluation of treatment needs, goals, and impediments; aftercare treatment needs; and active disposition planning.
3. The child is receiving continued multidisciplinary assessment of the social, physiological/biological, and developmental/cognitive processes and evaluation indicating their relevance for a plan of treatment.
4. The child is receiving skilled therapeutic milieu services provided by trained staff and supervised by licensed professional staff.
5. A West Virginia licensed professional with at least a Bachelor's degree in a human services field with a minimum of one year of experience serving children and or families will provide the child case management and all other treatment services are provided by staff who meet licensing/credentialing standards for the specific service as defined in Chapter 503 of the Rehabilitation Service Manual.
6. The family system is receiving continued assessment and evaluation relevant to aftercare needs, services, and disposition planning.
7. Service which may be provided and billed separately:
 - a. H0004 HO Behavioral Health Counseling, Professional, Individual
 - b. H0004 HO HQ Behavioral Health Counseling, Professional, Group
 - c. H2019 HO Therapeutic Behavioral Services- Development
 - d. G9008 Physician Coordinated Care Oversight Services
 - e. H0032 AH Mental Health Service Planning by non-Physician (Psychologist)
 - f. 96101 Comprehensive evaluation by a Psychologist
 - g. 90791 Psychiatric Diagnostic Examination
 - h. 90792 Psychiatric Diagnostic Examination with Medical Service

- i. J1630 Injection Haldol
- j. J2680 Injection Prolixin
- k. H2010 Mental Health Comprehensive Medication Services
- l. T1023 HE Screening by Licensed Psychologist
- m. H2011 Crisis Intervention

PROGRAM SERVICE ELEMENTS

(All elements will always be met)

1. A West Virginia licensed professional with at least a Bachelor's degree in a human services field with two years experience serving children or families will recommend the need for services to the physician or licensed psychologist who is to evaluate and to certify whether the youth meets the medical necessity criteria for this level of service.
2. A West Virginia licensed professional with at least a Master's degree in a human services field and two years post graduate experience serving children or families will provide clinical supervision to staff, and will review and sign off on all documentation of treatment as necessary.
3. Provide appropriate and timely evaluation of treatment needs, goals, and strengths; aftercare needs; and active disposition planning. The interdisciplinary team establishes clearly defined treatment issues and measurable objectives. The service plan must, at a minimum, meet OHFLAC licensing standards.
4. All components of Residential Children's service-Level 1 must be available on a 24-hour basis. Focus of treatment is on the client's resources and strengths.

H0019 U2 RESIDENTIAL CHILDREN'S SERVICES – LEVEL II

Definition: Residential Children's Services, Level II is a structured group-care setting targeting youth with a confirmed current DSM or ICD Diagnosis that manifests itself in the form of moderate to severe adjustment difficulties in school, home, and/or community. These youths cannot function in a public school setting without significant psychosocial and psycho-educational support. In the residential care setting they require substantial professional level treatment services and behavioral interventions that normally require a multidisciplinary team. The goals of intermediate residential treatment programs are to develop interpersonal skills and remediate social skill deficits and disruptive behavior patterns that preclude living in a less restrictive environment.

Children served at this level are characterized by persistent patterns of disruptive behavior and exhibit disturbances in age-appropriate adaptive functioning and social problem solving. Disturbance in psychological functioning is common and may present some risk of causing harm to themselves or others. This population generally displays emotional problems and/or persistent behavior patterns challenging enough to preclude socially appropriate functioning in family, school, and community contacts without behavior management and additional structure and support.

Most often the children display multi-agency needs that require interagency planning and interventions including behavioral health, education, child welfare, juvenile justice, and others. In this target population, children display a persistent pattern of challenging behavior that has been present for at least 1 year and is not a reaction to a single precipitating event.

Children in Level II have a current ICD or DSM diagnosis usually in the disruptive behavior disorders, mood disorders, or in the psychoactive substance use disorder categories. Their social functioning limitations are significant to a degree that they require up to 24 hours of supervision, structure and support upon admission. Generally, they respond well to structure and treatment, and the level of supervision required initially can be gradually withdrawn. From time-to-time, they can present a danger to themselves or others, but this is not a routine issue in treatment.

They possess cognitive capacity and can participate in academic and vocational education, but often require specialized instruction and a modified learning environment within a public or alternative secondary or primary school setting.

PROGRAM REQUIREMENTS:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certifications standards as established by the WVDHHR for children’s group residential services.

This service can only be reimbursed to providers who are dually licensed as behavioral health services and childcare facilities and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member’s residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

Service Tier	Tier 3
Target Population	SA, MH, ID/DD, A&C
Option	Rehabilitation
Initial Authorization	Tier 3 data submission required for 184 units/per member/per 184 days (Unit = 1 day)
Re-Authorization	184 units/per member/per 184 days
Admission Criteria Elements (1-7 will always be met)	<ol style="list-style-type: none"> 1. The child’s age range is from eight (8) years of age up to but not including eighteen (18) years of age custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age requirements) -and- 2. A behavioral health diagnosis that meets medical necessity for Level II Residential Children’s Services, -and- 3. The child demonstrates moderate to severe symptoms or functional impairment which interfere with age-appropriate adaptive and psychological functioning and social problem solving that prohibit a relationship with a family, or whose family situation and functioning level are such that the child can not accept family ties or establish relationships in a less restrictive setting, -and- 4. The child’s symptoms or functional impairment are such that treatment can not be successfully provided in a less intensive level of care, -and- 5. The child’s symptoms or functional impairments have existed for duration of six (6) months or longer, and are part of an established <u>and persistent</u> pattern of disruptive behavior at home, in school, or in the community, -and- 6. The child will have a CAFAS score indicating moderate to severe functional impairment and this is the appropriate level of service, -and- 7. Admission is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The child’s age range is eight (8) years of age up to the age of 18 (or 21 for individuals who remain in DHHR custody) custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age

	<p>requirements), -and-</p> <ol style="list-style-type: none"> 2. Continuing Stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, -and- 3. The child continues to exhibit symptoms and functional impairment such that treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, -or- 4. The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, -or- 5. The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, -or- 6. The child demonstrates new symptoms and functional impairments in the child's adaptive and/or psychological functioning, and/or psychological functioning and problem solving, which meet the criteria for admission, -or- 7. The child's symptoms and functional impairments have diminished, but there are continuing symptoms and functional impairment in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, -or- 8. The child demonstrates an inability to sustain gains without the therapeutic services provided by the Residential Children's Service – Level II program.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. The child has attained the age of eighteen (18) years of age (or 21 if remained in DHHR custody) custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age requirements). 2. The child or family has attained goals as identified in the service plan or symptoms and functional impairment have abated to the point where the child may be served in a less intensive treatment service. 3. The child demonstrated symptoms and functional impairment, which cannot be treated safely or effectively at this level of treatment, and the child requires a higher level of care. 4. The child has been on runaway status/away from supervision for a period of five (5) days or more. 5. The child has refused treatment against medical advice for a period of five (5) days or more. 6. Care appears to be custodial.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. H0031 Mental Health Assessment by a non-physician 2. T1023 HE Screening by Licensed Psychologist 3. H0004 Behavioral Health Counseling, Supportive, Individual 4. H0004 HQ Behavioral Health Counseling, Supportive, Group 5. H2014 HN U4; H2014 HN U1; H2014 U4; H2014 U1 Skills Training and Development

	6. H2012 Day Treatment 7. H2011 Crisis Intervention 8. H0004 HO Behavioral Health Counseling, Professional, Individual 9. H0004 HO HQ Behavioral Health Counseling, Professional, Group 10. H2019 HO Therapeutic Behavioral Services Development 11. H2019 Therapeutic Behavioral Services Implementation 12. T1017 Targeted Case Management
Clinical Exclusions	1. Clearly documented evidence that the child is exhibiting an acute psychiatric episode. 2. Severity of child's issues precludes provision of services in this level of care. 3. The child can effectively and safely be treated at a lower level of care.
Documentation	1. There must be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and the agency's record-keeping policies. The child's record must contain a written physician's order authorizing Residential Children's Services and the member's individualized service plan. Documentation must also include: <ul style="list-style-type: none"> • Behavioral observations of the child • There must be a daily summary of the child's program participation, which includes identification of the supportive and therapeutic services received by the member, the start and stop times of each service, and a summary of the member's participation in the services. The attending staff must sign, list their credentials, and date this summary. • Medication administration records. • Each member must have a sign-in/sign-out sheet to be filled out if the member exits the residential site. The list must note the actual time the child departs the site and returns to the site. The reason for absence must be noted on the sheet. Each notation must be signed and dated by the agency staff.

Additional Service Criteria:

The child must be receiving medically necessary services as indicated by an Individualized Service Plan and the program must include the following elements:

1. Within 30 days of admission and every 90 days thereafter, continued interdisciplinary, individualized service plan based on multidisciplinary assessments designed to restore an acceptable level of adaptive and/or psychological functioning and problem solving.
2. The child is receiving continued appropriate and timely evaluation of treatment needs, goals, and impediments; aftercare treatment needs; and active disposition planning. The service plan must, at a minimum, meet OHFLAC licensing standards.
3. The child is receiving continued multidisciplinary assessment of the social, physiological/biological, and developmental/cognitive processes and evaluation indicating their relevance for a plan of treatment.
4. The child is receiving skilled therapeutic milieu services provided by trained staff and supervised by licensed professional staff.
5. A West Virginia licensed professional with at least a Master's degree in a human services field with two years post graduate professional experience serving children and/or families will provide the child individual, family, and group therapy and behavior management plan development as indicated on the Individualized Service Plan.

6. A West Virginia licensed professional with at least a Bachelor's degree in a human services field with a minimum of one year of experience serving children and/or families will provide the child case management and all other treatment services are provided by staff who meet licensing/credentialing standards for the specific service as defined in Chapter 503 of the Rehabilitation Service Manual.
7. Therapeutic Behavioral Services and/or adjunctive therapies which have been selected as part of the individualized treatment program are being provided, and are designed to assist the child in achieving treatment goals and objectives.
8. Services that may be provided and billed separately:
 - J1630 Haldol Injection
 - J2680 Prolixin Injection
 - H2010 Mental health Comprehensive Medication Services
 - G9008 Physician Coordinated Care Oversight Services
 - 96101 Comprehensive Evaluation by Psychologist
 - 90791 Psychiatric Diagnostic Examination
 - 90792 Psychiatric Diagnostic Examination with Medical Services
 - 90887 Case Consultation
 - H0032 AH Mental Health Service Plan Development by a non-physician (Psychologist)

H0019 U3 RESIDENTIAL CHILDREN'S SERVICES – LEVEL III

Definition: Residential Children's Services, Level III is a highly-structured, intensively-staffed, 24-hour group care setting targeting youth with a confirmed current DSM or ICD diagnosis which manifests itself in severe disturbances in conduct and emotions. As a result, they are unable to function in multiple areas of their lives. Residential treatment facilities provide a highly structured program with formalized behavioral programs and therapeutic interventions designed to create a therapeutic environment where all planned activities and applied interventions are designed with the goal of stabilizing the child's serious mental condition.

The service plan is implemented in all aspects of the child's daily living routine. The focus of intensive residential treatment is on psycho-social rehabilitation aimed at returning the child to an adequate level of functioning. In the case of children and adolescents, this includes rehabilitation in instances where psychiatric or substance abuse disorders have significantly disrupted the achievement of the expected development level.

This service level is comprised of children who display seriously disordered behaviors with sufficient frequency to be considered an established pattern of long duration, or are so intense that they preclude social interaction in school, family, or community environments. Often, they exhibit persistent or unpredictable aggression, serious sexual acting-out behavior, and marked withdrawal and depression.

Symptoms of thought disorder are often present. They routinely present a significant danger to themselves or others.

Children in Level III have a current ICD or DSM diagnoses that include major depression, bipolar disorders, posttraumatic stress disorders, other anxiety disorders, thought disorders, and personality disorders. Where the focus of care has been on antisocial and dangerous behavior patterns, an initial diagnosis of Conduct Disorder, Severe may be present. However, in many of these cases, underlying significant psychiatric disturbance will reveal itself during the course of treatment.

Substantial social, academic, and vocational functional limitations are characteristics of the population's behavior pattern, and as a result they require substantial environmental structure and controls including 24-hour awake supervision, verbal crisis response, medical management, chemical interventions, physical restraint, and alternative learning environments. The key element is that these children present behaviors so intense, severe, and unpredictable to be seriously detrimental to their growth, development, welfare, or to the safety of others.

PROGRAM REQUIREMENTS:

Providers of this program must be able to provide a comprehensive array of treatment/intervention modalities in accordance with the service description for which they are certified, and to provide them for the type of child population as clinically described. This comprehensive array of services includes, but is not limited to, the following services:

- Assessment Services
- Service Planning
- Targeted Case Management
- Behavioral Health Counseling
- Skills Training and Development
- Crisis Intervention 24-hour availability
- Therapeutic Behavioral Services

- Any needed Behavioral Health Service including psychiatric and medication management services
- On-campus schooling

These services must be provided in accordance with the minimum standards established by BMS in this chapter of the Provider Manual, and with the certification standards established by the DHHR for children’s group residential services.

This service can be reimbursed only to providers who are dually licensed to provide behavioral health services and as childcare group residential facilities, and for those programs which meet the certification standards noted above.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member’s residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

Service Tier	Tier 3
Target Population	SA, MH, ID/DD, A & C
Option	Rehabilitation
Initial Authorization	Tier 3 data submission required for 184 units/per member/per 184 days Unit = 1 day
Re-Authorization	184 units/per member/per 184 days
Admission Criteria (Elements 1-7 will always be met)	<ol style="list-style-type: none"> 1. The child’s age range is from ten (10) years of age up to but not including eighteen (18) years of age custody (or the provider has a specific contract to provide services for children below the age of eight (8) or above the age of eighteen (18) or has received a waiver to serve a child who does not meet the age requirements), -and- 2. A behavioral health diagnosis that meets medical necessity for Level III Residential Children’s Services, -and- 3. The child has severe symptoms and functional impairments which interfere with age-appropriate adaptive and psychological functioning and social problem solving, -and- 4. The child’s symptoms or functional impairment are such that treatment can not be successfully provided in a less intensive level of care, -and- 5. The child’s symptoms and functional impairments have existed for a duration of one year or longer, and are a part of an established pattern of disruptive behavior at home, in school, or in the community, -and- 6. The child will have a CAFAS score indicating severe functional impairment and this is the appropriate level of care, -and- 7. The admission is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, -or- 8. The child is in need of a “step down” from a more restrictive level of care as part of a transitional discharge plan (e.g., symptoms or functional impairments remain at a level that requires out-of-home treatment, but not at a level that would require continued psychiatric

	hospitalization).
Continuing Stay Criteria (Elements 1-2 will always be met as well as two additional elements from 3-8)	<ol style="list-style-type: none"> 1. The child's age range is ten (10) years of age up to age 18 (unless remains in DHHR custody until age 21), -and- 2. The continued stay is not used solely for providing special education, housing, supervision or meeting other needs that are not medically necessary, -and- 3. The child continues to exhibit an inability to sustain gains without the comprehensive program of therapeutic services provided by the Residential Children's Service—Level III program, -or- 4. The child continues to exhibit symptoms and functional impairments so severe and complex that treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, -or- 5. The child's symptoms and functional impairments which warranted admission to this level of service have been observed and documented, but treatment goals have not been reached and a less intensive level of care would not adequately meet the child's needs, -or- 6. The child demonstrates new symptoms and functional impairments which interfere with age appropriate adaptive and/or psychological functioning, and/or psychological functioning and problem solving, which meet the criteria for admission, -or- 7. The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, -or- 8. The child's symptoms and functional impairments have diminished, but there are continuing disturbances/behaviors/symptoms in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions.
Discharge Criteria (Any element may result in discharge or transfer)	<ol style="list-style-type: none"> 1. The child has attained the age of eighteen (18) years of age (or 21 if remained in DHHR custody). 2. The child or family has attained goals as identified in the service plan or symptoms and functional impairments have abated to the point where the child may be served in a less intensive treatment service. 3. The child demonstrates symptoms or functional impairments which cannot be treated safely or effectively at this level of treatment, and the child requires a higher level of care. 4. The child has been on runaway status/away from supervision for a period of five (5) days or more. 5. The child has refused treatment against medical advice for a period of five (5) days or more. 6. Care appears to be custodial.
Service Exclusions	No individual fee for service code under Clinic, Rehabilitation or targeted case management may be billed while this code is being utilized.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Clearly documented evidence that the child is exhibiting an acute psychiatric episode that requires Psychiatric Residential Treatment Facility (PRTF) or Inpatient Psychiatric Treatment.

	<ol style="list-style-type: none"> 2. Severity of child's issues precludes provision of services in this level of care. 3. The child can effectively and safely be treated at a lower level of care.
<p>Documentation Requirement</p>	<ol style="list-style-type: none"> 1. There must always be a permanent clinical record maintained in a manner consistent with applicable licensing regulations and agency record keeping policies. 2. The member's record must contain a Behavior Health Clinic/Rehabilitation Services Authorization for Services form signed by a physician or psychologist and indicating the need for Level III Children's Residential Services, results of the evaluation which establishes medical necessity for the level of service and the members individualized service plan. 3. Documentation must also include: <ol style="list-style-type: none"> a. Behavioral observations of the youth b. Identification of the treatment service components provided c. Record of the child's program participation including specific times of program participation d. Medication administration records e. Specific documentation of physical, chemical, or mechanical restraints, and crisis intervention f. a sign-in/sign-out sheet in each member's record that indicates the date and time a youth departs from the site and the date and time they return to the site. The reason for the absence must be noted and the notation must be signed and dated by an agency staff.

Additional Service Criteria:

The child must be receiving medically necessary services as indicated by an Individualized Service Plan and the program must include the following elements:

1. Within 30 days of admission and every 90 days thereafter continued interdisciplinary, individualized service plan based on multidisciplinary assessments designed to restore an acceptable level of adaptive and/or psychological functioning and problem solving.
2. The child is receiving continued appropriate and timely evaluation of treatment needs, goals, and impediments; aftercare treatment needs; and active disposition planning. The service plan must, at a minimum, meet OHFLAC licensing standards.
3. The child is receiving continued multidisciplinary assessment of the social, physiological/biological, and developmental/cognitive processes and evaluation indicating their relevance for a plan of treatment.
4. The child is receiving skilled therapeutic milieu services provided by trained staff and supervised by licensed professional staff. All components of Residential Children's Service-Level III must be available on a 24-hour basis including 24-hour awake staff and highly structured programs with formalized behavioral programs and therapeutic interventions.
5. A West Virginia licensed professional with at least a Master's degree in a human services field with two years post graduate professional experience serving children and/or families will provide clinical supervision to staff and will review and sign off on all documentation of treatment as necessary.
6. A West Virginia licensed professional with at least a Bachelor's degree in a human services field with a minimum of one year of experience serving children and/or families will provide the child case management and all other treatment services are provided by staff who meet

licensing/credentialing standards for the specific service as defined in Chapter 503 of the Rehabilitation Service Manual.

7. Focus of this intensive treatment program is on psychosocial rehabilitation aimed at returning the client to an adequate level of functioning. Focus of treatment is on the client's strengths and resources.
8. Therapeutic Behavioral Services and/or adjunctive therapies which have been selected as part of the individualized treatment program are being provided, and are designed to assist the child in achieving treatment goals and objectives.
9. The family system is receiving assessments and evaluations relevant to aftercare needs and disposition planning.

H0019 U4 SHORT TERM RESIDENTIAL CHILDREN'S SERVICES – LEVEL IV

Definition: Short-Term Residential (formerly known as Crisis Support) is a structured crisis service for children up to age 21, which is provided in a community-based small group residential setting. Short-Term Residential must be provided in a site licensed as a Children's Emergency Shelter by the West Virginia Department of Health and Human Resources. The service is delivered in an environment, which is safe, supportive and therapeutic. The purpose of this service is to provide a supportive environment designed to minimize stress and emotional instability which may have resulted from family dysfunction, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of a child from a failed placement or other current living situation. Crisis support involves a comprehensive array of supportive and therapeutic services including but not limited to individual and small group counseling, crisis intervention, behavior monitoring, clinical evaluation, and service planning, and enhancement of daily living skills. Some child activities such as sleep time, home visits, schools hours or other time periods in which the child is not directly receiving crisis support is not considered part of services covered, and thus is not reimbursable and must not be billed.

A member day (one service unit) is defined as eight continuous hours in residence in the facility in a twenty-four hour period. (However, only one unit of service is billable during each 24 hour period.) Since the daily census time starts at noon, the eight continuous hours must occur between the start and end of the census period. On each day of the member's residence, he/she must receive Behavioral Health Rehabilitation Services (other than transportation services).

Service Tier	Tier 3
Option	Rehabilitation
Target Population	Children and adolescents up to age 18 (or 21 if youth remains in DHHR custody)
Initial Authorization	Tier 3 data submission required for 45 units*/per member/per 45 days Unit = 1 day
Re-Authorization	45 units*/per member/per 45 days
Admission Criteria	<ol style="list-style-type: none"> 1. Child is experiencing a crisis due to a mental condition and/ or impairment in functioning due to a problematic family setting. The child may be displaying behaviors and or impairments ranging from impaired abilities in the social, communication, or daily living skills domains to severe disturbances in conduct and emotion. The crisis results in symptoms and impaired functioning which may be caused by family dysfunction, a serious mental disturbance, transient situational disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of the child from a failed placement or other current living situation, -and- 2. Child is in need of 24-hour treatment intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the child's needs based on the documented response to prior treatment and/ or intervention, -or- 3. Child is in need of 24 hour treatment/intervention to prevent hospitalization; (e.g., the child engages in self-injurious behavior but not at a level of severity that would require psychiatric hospitalization, the child is currently physically aggressive and

	<p>communicates verbal threats but not at a level that would require hospitalization) -or-</p> <p>4. The child is in need of step-down from a more restrictive level of care as part of a transitional discharge plan (e.g., behaviors/symptoms remain at a level which requires out of home care but the placement plan has not been fully implemented.)</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The psychiatric symptoms and level of functioning, which necessitated the admission, persist at the level documented. A modified care plan has been developed which documents treatment methods and projected discharge date based on the change in the care plan. 2. New symptoms and/ or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and or maladaptive behaviors may be treated safely in the crisis support setting and a less intensive level of care would not adequately meet the client's needs. 3. There has been relevant member and family progress toward crisis resolution and progress clearly and directly related to resolving the factors, which warranted admission to crisis support, have been observed and documented, but treatment goals have not been reached. 4. It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care) but the care plan has been modified to introduce further evaluation of member needs and other appropriate interventions and treatment options.
Discharge Criteria	<ol style="list-style-type: none"> 1. Appropriate placement has been located which meets the child's treatment and care needs as outlined in the service plan. 2. The crisis, which necessitated placement, has abated, and the child has returned to a level of functioning that allows reintegration into their previous care setting. 3. The child exhibits symptoms and functional impairment that cannot be treated safely and effectively in the crisis support setting and which necessitates more restrictive care (e.g. inpatient).
Service Exclusions	<ol style="list-style-type: none"> 1. The member is over 18 years of age (or 21 years of age if remained in DHHR custody). 2. No individual fee for Clinic or Rehabilitation service may be billed while this code is being utilized. As of 1/1/2018, Targeted Case Management is included within the Shelter services.

Clinical Exclusions	<ol style="list-style-type: none"> 1. The member is considered a danger to himself or others. 2. The severity of the clinical issues/symptoms precludes provision of services in this level of care.
Documentation	<ol style="list-style-type: none"> 1. There must be a permanent clinical record maintained; 2. The record must contain a Behavior Health Clinic/Rehabilitation Services Authorization for Services form signed by a physician within three (3) business days of admission, and indicating the need for Crisis Support; 3. The record must contain the client's individual service plan; 4. Documentation must include the following: behavioral observations of the child, record of the child's participation including specific times of program participation, identification of the crisis support service components provided, and medication administration records. 5. A sign-in/sign-out sheet in each member's record that indicates the date and time a youth departs from the site and the date and time they return to the site. The reason for the absence must be noted and the notation must be signed and dated by an agency staff.

Additional Service Criteria:

1. *Service still subject to edits which limit length of stay to 90 days (no more than two (2) consecutive authorizations.)

H0004 HO IS Behavioral Health Counseling, Professional, Individual

Definition: Behavioral Health Counseling, Professional, Individual, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development as part of an intensive service. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service.

Often by necessity, Behavioral Health Counseling of children will involve work with parents as the agent of change in maladaptive behavior of children. Structured behavior therapies designed to provide parents with therapeutic tools to control and modify inappropriate behavior and promote adaptive coping behaviors are considered to be appropriate use of this service.

This service must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Individual, so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

NOTE: Providers who have an approved intensive service description may only utilize this procedure code. The number of units approved for this service within a specified time period for the approved provider will be authorized when the member meets medical necessity criteria.

Service Tier	Tier 3
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Telehealth	Available
Initial Authorization	Tier 3 data submission required. Units determined by individual intensive service program approved by KEPRO. Unit = 15 minutes NOTE: The name and county of the specific Intensive service description must be included in the KEPRO CareConnection® so appropriate units may be assigned.
Re-Authorization	Tier 3 data submission is required for additional units during or after the initial authorization period by any provider previously utilizing the benefit for the same member. Units determined by intensive services description approved by KEPRO. Unit = 15 minutes

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis, -and- 2. Member demonstrates emotional and behavioral disturbances causing functional impairments directly related to the established behavioral health condition, -and- 3. The specific impairment(s) to be addressed can be delineated, -and- 4. Intervention is to focus on the dynamics of members' problems, -and- 5. Interventions are based in generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. -and- 6. The members' evaluation reflects the need for the service -and- 7. The member requires a combination of specific services addressing the behavioral health condition on a frequent basis for a limited period of time.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's need as identified related to the behavioral health condition. 2. Progress notes document member's progress relative to goals identified although goals have not yet been achieved.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Member/ family request discharge or member refuses treatment. 2. Symptoms and functional impairments related to the behavioral health condition have improved to level no longer requiring this service. 3. Transfer to another service is warranted by change in member's condition. 4. There is no outlook for improvement with the continuation of this service.
<p>Service Exclusions</p>	<p>None</p>
<p>Clinical Exclusions</p>	<ol style="list-style-type: none"> 1. There is a lack of social support systems so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes provision of the service on an outpatient basis. 4. The member is unable to generalize concepts utilized in therapy to other environments. 5. The focus of this service is currently being addressed by another behavioral health service or program.
<p>Documentation</p>	<p>Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal and/or objective on the Plan. 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.</p>

	The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.
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Additional Service Criteria:

1. The provider must have an approved intensive service description per the protocol developed by KEPRO and the member must meet the identified target population and admission/continued stay criteria.
2. Under this procedure code, conjoint or family therapy may occur with other individuals with a significant relationship to the member (e.g. spouse, parent, child, sibling, etc.). These individuals may participate in therapy to the extent it is helpful to the progress of the member; however, such participation by significant others is not reimbursable as a separate activity.

H0004 HO HQ IS Behavioral Health Counseling, Professional, Group

Definition: Behavioral Health Counseling, Professional, Group, is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourages personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member in a group setting and as part of an intensive service.

Any therapeutic interventions applied must be performed by a minimum of a Master's level therapist using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. Alcohol and Drug Counselors (ADCs) are considered to be credentialed to provide Behavioral Health Counseling, Group so long as they have a master's degree in a clinical field, but only when directly addressing Substance Abuse treatment issues.

To provide therapy in other treatment areas, the ADCs must be credentialed by the applicable accrediting bodies of their respective professional disciplines. All individuals with an ADC hired after July 1, 2014 must have a Master's Degree. All current individuals employed with an ADC must only address substance abuse treatment issues.

NOTE: Providers who have an approved intensive services description may only utilize this procedure code. The number of units approved for this service within a specified time period for the approved provider will be authorized when the member meets medical necessity criteria.

Service Tier	Tier 3
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Initial Authorization	Tier 3 data submission required. Units determined the intensive service description approved by KEPRO. Unit = 15 minutes NOTE: The name and county of the specific Intensive service description must be included in the KEPRO CareConnection® so appropriate units may be assigned.
Re-Authorization	Tier 3 data submission is required for additional units during or after the initial authorization period by any provider previously utilizing the benefit for the same member. Units determined by individual intensive service description approved by KEPRO. Unit = 15 minutes

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis, -and- 2. Member demonstrates emotional and behavioral disturbances causing functional impairments directly related to the established behavioral health condition, -and- 3. The specific impairment(s) to be addressed can be delineated, -and- 4. Intervention is to focus on the dynamics of members' problems, -and- 5. Interventions are based in generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work. -and- 6. The members' evaluation reflects the need for the service –and- 7. The member requires a combination of specific services addressing the behavioral health condition on a frequent basis for a limited period of time.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The service is necessary and appropriate to meet the member's need as identified related to the behavioral health condition. 2. Progress notes document member's progress relative to goals identified although goals have not yet been achieved.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. Member/ family request discharge or member refuses treatment. 2. Symptoms and functional impairments related to the behavioral health condition have improved to level no longer requiring this service. 3. Transfer to another service is warranted by change in member's condition. 4. There is no outlook for improvement with the continuation of this service.
<p>Service Exclusions</p>	<p>None</p>
<p>Clinical Exclusions</p>	<ol style="list-style-type: none"> 1. There is a lack of social support systems so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes provision of the service on an outpatient basis. 4. The member is unable to generalize concepts utilized in therapy to other environments. 5. The focus of this service is currently being addressed by another behavioral health service or program.
<p>Documentation</p>	<p>Documentation must indicate how often this service is to be provided. There must be an activity note describing each service/activity provided, the relationship of the service/activity to the identified behavioral health treatment needs, and the member's response to the service. If there is a Master Service Plan, the intervention should be reflective of a goal on the Plan. 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.</p> <p>The documentation must include the signature and credentials of</p>

	the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times.
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Additional Service Criteria:

1. It is expected that the service will be provided at a frequency of no less than twice a month or as indicated on the service plan as a part of an approved plan of phasing out this service (may be less than twice a month).
2. Group size must be limited to a maximum of twelve (12) persons per group.
3. The provider must have an approved intensive description per the protocol developed by KEPRO and the member must meet the identified target population and admission/continued stay criteria.

H0004 IS Behavioral Health Counseling, Supportive, Individual

Definition: Behavioral Health Counseling, Supportive, Individual is a face-to-face intervention provided to a member receiving coordinated care. It must directly support another Behavioral Health service to meet service definition and medical necessity. The supportive intervention is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning as part of an intensive service. Behavioral Health Counseling, Supportive, Individual, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

Supportive counseling should:

- 1) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
- 2) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

NOTE: Providers who have an approved intensive services description may only utilize this procedure code. The number of units approved for this service within a specified time period for the approved provider will be authorized when the member meets medical necessity.

Service Tier	Tier 2
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHMF Charity Care
Telehealth	Available
Initial Authorization	Tier 3 data submission required. Units determined by individual intensive service description approved by KEPRO. Unit = 15 minutes NOTE: The name and county of the specific Intensive Services description must be included on the KEPRO CareConnection® so appropriate units may be assigned.
Re-Authorization	Tier 3 data submission is required for additional units during or after the initial authorization period by any provider previously utilizing the benefit for the same member. Units determined by individual intensive service description approved by KEPRO. Unit = 15 minutes
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis, -and- 2. Member has a need to be assisted with day-to-day behavioral and emotional functioning to help them maintain progress toward identified goals, -and- 3. Member's service plan reflects the need for the service -and- 4. Member is currently receiving another Medicaid behavioral health

	service and needs a supplemental service to meet treatment goals.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Service continues to be needed to assist with day-to-day behavioral and emotional functioning -or- 2. Activity notes document the member's progress relative to the objective on the service plan but treatment goals have not yet been achieved – and- 3. Continued supplement to an existing Medicaid behavioral health service is needed for treatment of the behavioral health condition.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuse treatment. 2. Goals of the member's treatment plan have been substantially met. 3. Transfer to another service is warranted by change in member's condition. 4. Member has progressed and no longer requires another Medicaid behavioral health service.
Service Exclusion	No other Medicaid Clinic or Rehabilitation service is being provided.
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a lack of social support system so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes the provision of service at this level of care.
Documentation	<p>This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.</p> <p>There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the supportive intervention and the member's response to the intervention including any improvement or exacerbation of symptoms.</p>

Additional Service Criteria:

1. All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.
2. The provider must have an approved intensive service description per the protocol developed by KEPRO and the member must meet the identified target population and admission/continued stay criteria.

H0004 HQ IS Behavioral Health Counseling, Supportive, Group

Definition Behavioral Health Counseling, Supportive, Group is a face-to-face coordinated care intervention that is directly related to the individual's behavioral health condition. The service is intended to promote continued progress toward identified goals and to assist members in their day-to-day behavioral and emotional functioning as part of an intensive service. Behavioral Health Counseling, Supportive, Group, is not a professional therapy service, but must supplement another Medicaid service that is addressing the individual's identified behavioral health needs.

Supportive counseling should:

- 1.) Promote application and generalization of age appropriate skills such as problem solving, interpersonal relationships, anger management, relaxation, and emotional control as it impacts daily functioning as related to their behavioral health condition; and/or
- 2.) The interventions will assist the individual as he or she explores newly developing skills as well as identifying barriers to implementing those skills that are related to achieving the objectives listed on the service plan.

Supportive counseling should consistently augment other coordinated care services being provided by the agency and if possible, services being provided to the member by other agencies.

NOTE: Providers who have an approved intensive services description may only utilize this procedure code. The number of units approved for this service within a specified time period for the approved provider will be authorized when the member meets medical necessity criteria.

Service Tier	Tier 3
Target Population	MH, SA, ID/DD, A & C
Option	Clinic/Rehabilitation, BBHHF Charity Care
Telehealth	Available
Initial Authorization	Tier 3 data submission required. Units determined by individual intensive service description approved by KEPRO. Unit = 15 minutes NOTE: The name and county of the specific Intensive Services description must be included on the KEPRO CareConnection® so appropriate units may be assigned.
Re-Authorization	Tier 3 data submission is required for additional units during or after the initial authorization period by any provider previously utilizing the benefit for the same member. Units determined by individual intensive service description approved by KEPRO. Unit = 15 minutes
Admission Criteria	<ol style="list-style-type: none"> 1. Member has a behavioral health diagnosis, -and- 2. Member has a need to be assisted with day-to-day behavioral and emotional functioning to help them maintain progress toward identified goals, -and- 3. Member's service plan reflects the need for the service -and- 4. Member is currently receiving another Medicaid behavioral

	health service and needs a supplemental service to meet treatment goals.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Service continues to be needed to assist with day-to-day behavioral and emotional functioning -or- 2. Activity notes document the member's progress relative to the objective on the service plan but treatment goals have not yet been achieved –and- 3. Continued supplement to an existing Medicaid behavioral health service is needed for treatment of the behavioral health condition.
Discharge Criteria	<ol style="list-style-type: none"> 1. Member/ family request discharge or refuse treatment. 2. Goals of the member's treatment plan have been substantially met. 3. Transfer to another service is warranted by change in member's condition. 4. Member has progressed and no longer requires another Medicaid behavioral health service.
Service Exclusions	No other Medicaid Clinic or Rehabilitation service is being provided.
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a lack of social support system so that a more intensive level of service is needed. 2. There is no outlook for improvement with this level of service. 3. Severity of impairment precludes the provision of service at this level of care.
Documentation	<p>This service must be included in the member's service plan. The objectives of the service must be clearly identified, and reviewed at a minimum of each 90 days and at every critical treatment juncture.</p> <p>There must be an activity note describing each service provided, the relationship of the service to a specific objective(s) in the service plan, the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. The activity note should describe the supportive intervention and the member's response to the intervention including any improvement or exacerbation of symptoms.</p>

Additional Service Criteria:

1. Behavioral Health Counseling, Supportive, Group sessions are limited in size to a maximum of 12 persons per group session.
2. All new employees hired as of July 1, 2014, must have a bachelor's degree in an approved human services field (see definition of human services degree). Current employees hired before July 1, 2014, and providing supportive counseling must obtain an approved bachelor's degree by July 1, 2018. Staff must be properly supervised according to BMS policy on clinical supervision. The service may be provided in a variety of settings, by appropriately designated, trained and supervised staff.
3. The provider must have an approved intensive service description per the protocol developed by KEPRO and the member must meet the identified target population and admission/continued stay criteria.

H0036 Community Psychiatric Supportive Treatment

Definition: Community Psychiatric Supportive Treatment is an organized program of services designed to stabilize the conditions of a person immediately following a crisis episode. An episode is defined as the brief time period of days in which a person exhibits acute or severe psychiatric signs and symptoms. (If a Medicaid member experiences more than one crisis, each crisis is considered a separate crisis episode). This physician driven service is intended for persons whose condition can be stabilized with short-term, intensive services immediately following a crisis without the need for a hospital setting and who, given appropriate supportive care, can be maintained in the community.

Due to the comprehensive nature of this service, no other services (other than Targeted Case Management) may be reimbursed when Community Psychiatric Supportive Treatment is on-going. These services are not intended for use as an emergency response to situations such as members running out of medication, or loss of housing. Any such activities will be considered as non-reimbursable activities. Since this service is intended to address an episode, it must be rendered on consecutive days of service. Community Psychiatric Supportive Treatment cannot be rendered on alternate days such as Tuesday and Thursday or only on Mondays, Wednesdays, and Fridays; with other days of non-service (such as holidays or weekends) or other intervening services interrupting the episode. Community Psychiatric Supportive Treatment is an acute and short-term service.

Community Psychiatric Supportive Treatment Programs must be available seven days a week to anyone who meets the admission criteria. Availability may include mornings, afternoons, evenings, etc. There must be a minimum of two staff present onsite at all times Community Psychiatric Supportive Treatment is provided, one of which must have at least high school degree or equivalency, trained in systematic de-escalation, and must have training related to the targeted population being treated (i.e. substance abuse, mental health). The other staff must have an LPN or higher degree in the medical field (See Definitions for further clarifications). Additional staff must be added as necessary to meet the needs of increased utilization and/or increased level of need. Staffing must be sufficient to assure that each member receives appropriate individual attention, as well as assure the safety and welfare of all members.

The program must have access to a psychiatrist/physician/physician extender to provide psychiatric evaluations and medication orders at all times.

The following elements are required components of Community Psychiatric Supportive Treatment:

- Comprehensive Psychiatric Evaluation at intake to contain documentation of:
 - Daily psychiatric review and examination
 - Ongoing psychotropic medication evaluation and administration
 - Intensive one-on-one supervision, when ordered by a physician/psychiatrist
 - Individual and small group problem solving/support as needed
 - Therapeutic activities consistent with the member's readiness, capacities, and the service plan
 - Disability-specific interdisciplinary team evaluation and service planning before discharge from Community Psychiatric Supportive Treatment. Discharge service planning must include consideration of the antecedent condition that led to admission to Community Psychiatric Supportive Treatment.
 - Psychological/functional evaluations specific to the disability population where appropriate and;
 - Family intervention must be made available to the families of members as appropriate
- Community Psychiatric Supportive Treatment must be provided at a site licensed by WVDHHR for the delivery of Behavioral Health Rehabilitation Services.

The criteria for prior authorization for Community Psychiatric Supportive Treatment Services are organized around three primary areas that determine the need for this service:

- Acute Psychiatric signs and symptoms
- Danger to self/others
- Medication management/active drug or alcohol withdrawal

Additionally, criteria for continued stay have been devised so that those members who still require Community Psychiatric Supportive Treatment Services can be authorized to continue services.

To receive or continue to receive Community Psychiatric Supportive Treatment Services, the following corresponding criteria must be satisfied.

Service Tier	High Intensity Services/Tier 4
Target Population	MH, SA, A & C, ID/DD BBHHF Members*
Option	Clinic/Rehabilitation, BBHHF Charity Care
Telehealth	Available – for medical services provided physician or physician extender only. Daily face to face meeting with physician must be in person.
Initial Authorization	288 units/per member/per 10 days Unit = 15 minutes
Re-Authorization	<ol style="list-style-type: none"> 1. Tier 4 data submission is required for additional units after the 10-day authorization period by any provider previously utilizing the benefit for the same member. <i>NOTE: No more than 288 units may be provided in a six (6) month period and no more than 48 units may be provided in a 24 hour period (24 hour period begins at 12 AM) Each crisis admission within a 184 day period is considered a separate crisis episode.</i> 2. Tier 4 data submission is required for a provider to exceed the limit of 288 units/per member in a six month period. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over 288 units must be specified in the free-text field, otherwise a maximum of 192 additional units in 10 calendar days will be granted. The need for additional units must be described in the free-text field, as well as listing the continued stay criteria relevant to the member's continued need for the service.
Admission Criteria	<p>These criteria are to be used for both the initial and continued stay authorizations:</p> <p><u>A. PSYCHIATRIC SIGNS AND SYMPTOMS:</u> (Both criteria must be met)</p> <ol style="list-style-type: none"> 1. The member is experiencing a crisis due to a mental health condition or impairment in functioning due to acute psychiatric signs and symptoms. The member may be displaying behaviors and/or impairments ranging from impaired abilities in the daily living skills domains to severe disturbances in conduct and emotions. The crisis results in emotional and/or behavioral instability that may be exacerbated by family dysfunction,

	<p>transient situational disturbance, physical or emotional abuse, failed placement, or other current living situation; - and-</p> <p>2. The member is in need of a structured, intensive intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the member's needs based on the documented response to prior treatment and/or interventions.</p> <p><u>B. DANGER TO SELF/OTHERS</u></p> <p>1. The member is in need of an intensive treatment intervention to prevent hospitalization (e.g. the member engages in self-injurious behavior but not at a level of severity that would require inpatient care, the member is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization).</p> <p><u>C. MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL (Either criteria must be met)</u></p> <p>1. The member is in need of a medication regimen that requires intensive monitoring/medical supervision or is being evaluated for a medication regimen that requires titration to reach optimum therapeutic effect. -or-</p> <p>2. There is evidence that the member is using drugs, which have produced a physical dependency as evidenced by clinically significant withdrawal symptoms, which require medical supervision.</p>
<p>Continuing Stay Criteria</p>	<p><u>A. PSYCHIATRIC SIGNS AND SYMPTOMS: (One of the three criteria must be met)</u></p> <p>1. The acute psychiatric signs and symptoms and/or behaviors that necessitated the admission persist at the level documented at admission and the treatments and interventions tried are documented. A modified care plan must be developed which documents treatment methods and projected discharge date based on the change in the care plan.-or-</p> <p>2. New symptoms and/or functional impairments have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or functional impairments may be treated safely in the Community Psychiatric Supportive Treatment setting and a less intensive level of care would not adequately meet the member's needs. -or-</p> <p>3. Relevant member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission for Community Psychiatric Supportive Treatment have been observed and documented, but treatment goals have not been reached.</p> <p><u>B. DANGER TO SELF/OTHERS</u></p> <p>1. Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to crisis stabilization have been observed and</p>

	<p>documented, but treatment goals have not been reached. -or-</p> <ol style="list-style-type: none"> 2. It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care) but the care plan has been modified to introduce further evaluation of member needs and other appropriate interventions and treatment options. -or- 3. New symptoms and functional impairments have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or functional behaviors may be treated safely in the crisis stabilization setting and a less intensive level of care would not adequately meet the member's needs. <p><u>C. MEDICATION MANAGEMENT/ACTIVE DRUG OR ALCOHOL WITHDRAWAL (One of three must be met)</u></p> <ol style="list-style-type: none"> 1. Member progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to Community Psychiatric Supportive Treatment have been observed and documented, but treatment goals have not been reached. 2. It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement (less restrictive or more restrictive care), but the care plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and treatment options. 3. New symptoms and/or maladaptive behaviors have appeared which have been incorporated into the care plan and modified the discharge date of the member. These new symptoms and/or maladaptive behaviors can be treated safely in the Community Psychiatric Supportive Treatment setting, and a less intensive level of care would not adequately meet the member's needs.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. The crisis which necessitated placement has abated and the member has returned to a level of functioning that allows reintegration into their previous living arrangement and/or use of a less intensive service than Community Psychiatric Supportive Treatment. 2. The member exhibits symptoms and functional impairment that cannot be treated safely and effectively in the Community Psychiatric Supportive Treatment setting and which necessitate more restrictive care, e.g. inpatient.
<p>Service Exclusions</p>	<ol style="list-style-type: none"> 1. No other service codes may be billed, with the exception of Targeted Case Management, while Community Psychiatric Supportive Treatment is being provided. 2. Community Psychiatric Supportive Treatment is not a planned, scheduled service. (e.g., it is not a respite service.) 3. As Community Psychiatric Supportive Treatment is intended to address a crisis episode, it must be rendered on consecutive

	<p>days of service. (It cannot be rendered on alternate days, such as, Tuesdays and Thursdays, or only on Mondays with other days of non-service or other intervening services interrupting the episode.)</p>
Clinical Exclusions	<ol style="list-style-type: none"> 1. The member's presenting situation is dangerous to self or others and cannot be managed in a crisis stabilization environment. 2. The severity of the clinical issues precludes provision of services in this setting. 3. Community Psychiatric Supportive Treatment is not intended to be utilized for physical health conditions.
Documentation	<ol style="list-style-type: none"> 1. The Comprehensive Psychiatric Evaluation at intake must contain: <ol style="list-style-type: none"> a. Reason for admission/presenting problems: Purpose of evaluation is to assess symptoms in order to determine need for crisis stabilization services, determine need for changes to medication regimen, and develops an initial plan of care as appropriate. b. Presenting problems/reason for the evaluation including list of any collateral interviews conducted. c. History and description of present illness d. Past psychiatric history including description of any past suicidal or homicidal behavior or threats e. History of alcohol and other substance use including longest period of sobriety, history of prior treatment attempts, and medical risks associated with detoxification as appropriate f. General medical history including list of current medications, current medical providers, and past treatment attempts (may be completed by ancillary staff person) g. Developmental, psychosocial and sociocultural history (may be completed by ancillary staff person) h. Occupational and military history (may be completed by ancillary staff person) i. Legal history (may be completed by ancillary staff person) j. Family history (may be completed by ancillary staff person) k. Review of systems (sleep, appetite, pain levels, other systems directly linked to the patient's psychiatric symptoms) l. Focused Physical examination including appearance and vital signs, musculoskeletal review of gait and station and description of any specific physical anomalies and allergies m. Mental status examination including assessment of insight, judgment, and general cognitive functioning n. Assessment of daily functionality and ADLs (may be completed by ancillary staff person) o. Diagnostic conclusions and prognosis p. Treatment recommendations including clear statement of justification for recommendation for admission to CSU and

reasoning for elimination of lesser level of care.

2. There must be a permanent clinical record consistent with licensing regulations and agency records/policies for each member provided Community Psychiatric Supportive Treatment services. These services shall be documented in each member's clinical record. Items to be included in the clinical record are written orders for each crisis episode from the physician/psychiatrist for the Community Psychiatric Supportive Treatment program, medication orders, medication administration records and the member's individual service plan.

See below for further documentation requirements:

Daily Documentation criteria:

- Number of treatment hours per day
- Summary of the member's status – need for continued CSU
- Member's Service participation
- Symptoms related to the crisis that are being addressed
- If admitted for detox; vitals and use of nationally recognized withdrawal protocol
- Services Provided:
 - **Individual Therapy** – notes at a minimum need to contain:
 - Addressed specifics of admission criteria to substantiate appropriate level of care
 - Substantiation of daily/appropriate treatment services
 - Intervention
 - Relate back to treatment plan
 - Member's response
 - **Group Therapy** – notes at a minimum need to contain:
 - Addresses specifics of admission criteria to substantiate appropriate level of care
 - Substantiation of daily/appropriate treatment services
 - Intervention
 - Relate back to treatment plan
 - Member's response
 - **Family Therapy** – notes at a minimum need to contain:
 - Addresses specifics of admission criteria to substantiate appropriate level of care.
 - Substantiation of daily/appropriate treatment services.
 - Intervention
 - Relate back to treatment plan.
 - Member's response
 - **Individual Supportive Counseling** - notes at a minimum need to contain:
 - Addresses specifics of admission criteria to

	<ul style="list-style-type: none"> substantiate appropriate level of care. ▪ Substantiation of daily/appropriate treatment services. ▪ Intervention ▪ Relate back to treatment plan. ▪ Member's response ○ Group Supportive Counseling - notes at a minimum need to contain: <ul style="list-style-type: none"> ▪ Addresses specifics of admission criteria to substantiate appropriate level of care. ▪ Substantiation of daily/appropriate treatment services. ▪ Intervention ▪ Relate back to treatment plan ▪ Member's response
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Additional Service Criteria:

1. Community Psychiatric Supportive Treatment is an acute and relatively short-term service.
2. Community Psychiatric Supportive Treatment must be provided in a site licensed for the delivery of behavioral health services by the West Virginia Department of Health and Human Resources.
3. Billing for Community Psychiatric Supportive Treatment services cannot exceed 12 hours (48 units) in a twenty-four (24) hour period.
4. Much of the structured, staff-directed activity or face-to-face activity which has been documented in an activity note can be considered billable time. Some examples of billable versus non-billable time are as follows:

Billable activities:

- Structured, staff-directed activities such as therapies and counseling
- Time spent by staff in the process of interviewing/assessing members whether for social history, discharge planning, psychological reports, etc.
- Time spent in treatment team meetings or staff consultation
- Time spent by staff monitoring one member when specifically ordered by the physician/psychiatrist for reasons of clinical necessity (The physician/psychiatrist's order must state the frequency and duration of the time to be spent monitoring.)
- Routine observation/monitoring by staff ordered by physician/psychiatrist limited to 10 minutes per hour (can include member's sleep, meal, grooming time). Routine observation time cannot exceed two hours per day. The physician must document the need for the observation as related to the Medicaid Member's qualifying behavioral health condition/crisis episode.

Non-billable activities:

- Activity which is recreation or leisure in nature, such as basketball, exercise, reading a newspaper, watching television and or videos
 - Social activity such as talking with other members, visiting with family members or significant others, releasing the member from the program on pass
 - Time in which the member is sleeping, eating, grooming (except as outlined above).
5. Community Psychiatric Supportive Treatment services are not intended for use as an emergency response to situations such a member running out of medication or the loss of housing.
 6. Billing for any other approved service authorizations, except T1017, may not occur while a member is in a Community Psychiatric Supportive Treatment program. BBHFF follows the same

utilization management guidelines as Medicaid for data submission and prior authorization of this service.

7. Physician Assistant may perform the service if it is specifically within their defined scope of work. Permissions granted to Physician Assistants can be found in the West Virginia Code 30-3-16 [(b) and (o)] and legislative rule 11 CSR 1B. Program Instruction MA-01-06 issued January 6, 2001 allows the Physician Assistant to be reimbursed for services rendered to Medicaid eligible individuals as outlined in their job description submitted to the West Virginia Board of Medicine.
8. A Nurse Practitioner with a Psychiatric Certification may perform this service. Any other Nurse Practitioner may perform this service provided it is within their scope of practice as defined by their Licensing Board and their contract with the Bureau for Medical Services and under the supervision of a psychiatrist.

APPENDIX I

Medical Necessity Guidelines for Young Children (0-5)

The Bureau for Medical Services allows access to Rehabilitation Services for young children (0-5) utilizing an expanded criterion that does not require a current DSM or ICD diagnosis, but allows children with significant developmental delays that interfere with the ability to perform age appropriate tasks to qualify for services. This eligibility criteria was initiated in 1996 and remains in force. The criteria are included in Appendix I for reference.

To qualify for services, young children must meet the medical necessity criteria, but must also meet the specific requirements for the service(s) requested. Children (0-3) who are determined eligible for the Birth to Three Program by the Office of Maternal, Child and Family Health do not require prior authorization to access rehabilitation services. For these children, the IFSP should reflect the services to be provided and the specific providers who will deliver the services. The Office of Maternal, Child and Family Health informs the Bureau for Medical Services of eligible children and this notification serves as the exemption from the Prior Authorization requirement. For children 3-5 years of age, or for those children 0-3 who meet medical necessity but are not Birth to Three eligible (these children are few since the eligibility guidelines for Birth to Three are broad), the KEPRO CareConnection® data is required. Requests for authorization for those services the child will be receiving are also required.

When completing the KEPRO CareConnection® data the disability group (Field #44) should be Early Childhood/Intervention (Value=8) and the results of the appropriate Early Childhood Instrument utilized to determine developmental delays and/or diagnosis should be coded in the free text field #208. The response for all other instruments on the form (unless the PECFAS was used, in this case code the scores in the appropriate fields for CAFAS/PECFAS) should be the appropriate value to indicate, "This Assessment was not required". All required fields on the KEPRO CareConnection® must be completed, but for young children many of the responses will be "this does not apply", "Never" or "Not Present". In cases of rehabilitation services for young children, the prior authorization review system is set to require that these requests be subject to KEPRO Care Manager review. The KEPRO Care Manager may request additional clarification or information from the clinician/provider making the service request.

It is also important to note that once young children meet medical necessity criteria for access to rehabilitation services, they must also meet the Utilization Management requirements (contained in this document for each service) for the specific service(s) requested. There have been significant problems with qualifying young children for Skills Training and Development since it is difficult to establish that skill deficits are the result of "skill loss" or the "inability to acquire a developmentally appropriate skill due to abuse, neglect, institutionalization or lack of family support". An outline for determining medical necessity for Skills Training and Development for this group is included in Appendix I.

Determining Diagnostic Eligibility and Functional Impairment for Children Birth through Five Years of Age for Medicaid Behavioral Health Clinic and Rehabilitation Services

Issues unique to diagnosing and determining functional impairment in young children:

Diagnostic Eligibility

There are stirring arguments against assigning diagnostic labels to children five years of age and younger. First, the instruments and tools, which are used to measure typical and atypical development and behavior in young children, show little correlation, if any to long term delays and disabilities.

Second, children experience enormous fluctuations in growth and development in the first five years. With appropriate intervention, many of the delays and/or atypical behaviors that children exhibit at young ages will not be as significant or, at times, even discernable by the time a child is elementary age. A label, however, may follow a child for a lifetime. Therefore, in the birth to five age group, it is suggested that delays in development and other relevant factors be acceptable diagnostic criteria in the absence of specific disability diagnosis.

Assessment of Functional Impairment

No one instrument can be considered the “instrument” for identifying functional limitations in young children. Rather, at least two instruments, combined with more thorough and holistic information gathering techniques, should be used to determine functional impairments. The instruments should be from an approved list. However, the instruments should be unique to the child’s strengths and areas of concern.

Medical Necessity

In identifying medical necessity in young children, it is important to note that medical and what has been defined traditionally as educational needs in older children overlap. Education for the young child does not consist of reading, math, career development and science. Development in, as well as education of, young children encompasses motor, social/ emotional, coping, maturation, adaptive, and health. Therefore, the definition of medical necessity must be different for young children as opposed to older children and adults. Services which enhance a child’s basic living skills and adaptive behavior may be medically necessary under Behavioral Services. For the child under five, these may be also considered educational.

Data Gathering

In order to provide appropriate and cost effective medically necessary services to young children and their families, it is necessary to gather information which will be useful in determining effective service parameters and delivery models. This will be extremely difficult as a multitude of child and family factors influence the identification of needed services and the effectiveness of those services. As such, one cannot rely on a correlation between services provided, diagnostic category, and functional impairment scores on specific testing instruments to predict needed services and to develop service packages for specific populations. The services which an individual receives are influenced by geographic constraints and agency priorities; therefore, these services may not best fit or the identified “produce” the greatest long-term impact on the individual’s functioning.

TABLE OF DIAGNOSTIC ELIGIBILITY AND FUNCTIONAL IMPAIRMENT

CHILD POPULATIONS AND MEDICALLY NECESSARY SERVICES	DIAGNOSTIC ELIGIBILITY- ELIGIBLE DIAGNOSES	FUNCTIONAL IMPAIRMENT- FUNCTIONAL ASSESSMENT INSTRUMENTS
<i>Child Population: Significant Medical Risk and Delay</i>		
A. 0-3 Years of Age Services: Early Intervention Service Codes plus Treatment Planning, Physician Participation, Treatment Planning, Therapeutic Behavioral Services, Crisis Intervention, Interpretation or	A. 0-3 Years of Age This includes children identified as eligible for Part H of the Individuals with Disabilities Education Act services through an agency under contract with DHHR/BPH/OMCH.	A. 0-3 Years of Age This includes those areas of concern or priority identified through the use of an approved evaluation/assessment process under Part H of the Individuals with Disabilities Education Act and administered through an agency

<p>Explanation and Skills Training and Development</p> <p>B. 3-5 Years of Age Services: Same as Mental Health 3-5 years of age.</p> <p>C. 3-5 Years of Age Services: Same as Mental Health 3-5 years of age. NOTE: The child requires treatment services as defined in the Medicaid rehabilitation and clinic manuals, which are medically necessary and not educational in nature.</p>	<p>B. 3-5 Years of Age The child is identified as experiencing four risk factors and is functioning at, or lower than, 75% of the normal rate of development in one of the following areas: Cognition, fine motor, gross motor, communication, social/emotional/affective, or self-help skills.</p> <ul style="list-style-type: none"> ◆ Physical or sexual child abuse ◆ Maternal prenatal and post natal substance abuse behavior ◆ Chronic illness of the child ◆ Maternal age under 18 years old ◆ Maternal educational level less than 9th grade ◆ Single parent status ◆ Very low birth weight (meets medical definition – less than 1200 g.) ◆ Socioeconomic status (meets financial eligibility guidelines for Medicaid) ◆ Parental disability or chronic illness ◆ Failure to thrive (meets medical definition) <p>C. 3-5 Years of Age The child is functioning at, or lower than, 75% of the normal rate of development in two or more of the following areas: Cognition, fine motor, gross motor, communication, social/emotional/affective, or self-help skills The child meets the definition of ID/DD as articulated by state statute.</p>	<p>under contract with DHHR/BPH/OMCH.</p> <p>B. 3-5 Years of Age The child demonstrates functional impairment in one area as measured by at least two norm or criterion referenced instruments which may include, but are not limited to, those listed in Section C below.</p> <p>C. 3-5 Years of Age The child demonstrated functional impairment in two or more areas as measured by at least two norm or criterion referenced instruments which may include, but are not limited to, those listed below. Each instrument has significant limitations as a comprehensive tool; however, they may be used to augment one's information or picture of a child in one or more specific area.</p> <ul style="list-style-type: none"> ◆ Batalle Developmental Inventory ◆ Children's Adaptive Behavior Scale ◆ Coping Inventory, A Measure of Adaptive Behavior ◆ Burks' Behavior Rating Scales (BBRS) (Preschool and Kindergarten Edition) ◆ Childhood Autism Rating Scale ◆ Child Behavior Checklist (CBCL) ◆ Kaufman Assessment Battery for Children ◆ Personality Inventory for Children ◆ Child Development Inventory ◆ Pediatric Evaluation of Disabilities Inventory ◆ Vineland Adaptive Behavior Scales ◆ Test of Socioemotional Development (TOSED) ◆ Brigance Inventory of Early Development ◆ Hawaii Early Learning Profile for Preschoolers
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		◆ Social Skills Rating System
Child Population: Mental Health		
0-3 Years of Age Services: Refer to 0-3 years of age under Significant Risk and Delay 3-5 Years of Age Services: Same as for children 6-21 years of age	0-3 Years of Age Refer to Part H eligibility 3-5 Years of Age Same as children 6-21 years of age – an approved DSM or ICD diagnosis	0-3 Years of Age Refer to Part H guidelines and definitions regarding functional impairments. 3-5 Years of Age PECFAS BPRS-C
Child Population: Child Welfare		
0-5 Years of Age Services: Same as Mental Health 3-5 years of age	0-5 Years of Age Same as children 6 through 21 years of age – An approved DSM or ICD diagnosis	0-5 Years of Age Open Child Protective Services case plus a score of 25 on the Child at Risk Field or a safety plan PECFAS

APPENDIX II
Determining Medical Necessity for Skills Training & Development
for Young Children
(0-5)

Diagnosis, Symptom, and Functional Impairment

- Current DSM or ICD diagnosis -or- four risk factors and one significant developmental delay as measured by an accepted assessment instrument for young children –or- two significant developmental delays as measured by an accepted assessment instrument for young children - and-
- Symptoms and areas of impairment identified through assessment must be identified

Requesting Skills Training & Development for Young Children

- Child must meet medical necessity as defined above -and-
- Symptom and/or functional impairment must be moderate to severe -and-
- There must be identified skill deficits that are related to the identified behavioral health condition or were developmentally not achieved due to abuse, neglect or years spent in institutional environment -and-
- There is a reasonable expectation that the child can improve in three months -or-
- Child must meet medical necessity as defined above -and-
- Symptom and/or functional impairment must be moderate to severe -and-
- The child does not have adequate family support and without assistance to improve the identified deficits is likely to be institutionalized or placed out of the home (this criteria is generally applied to children receiving in-home services, those already out-of-home would need to meet the criteria outlined above). -and-
- There is a reasonable expectation that the child can improve in three months

Documentation:

Interventions must be documented and include the place of service, date of service, actual time spent and the number of units billed. The documentation must also include the type of activity or intervention and the relationship of the activity to the deficits identified to establish medical necessity and identified in the treatment plan and/or Skills Training & Development Plan.

Continued Stay Criteria:

There is documentation of progress and review of progress, there is documentation of continued symptoms and impairment that requires Skills Training & Development –or- if Skills Training & Development is used to preserve functioning there is documentation as to the reason, Skills Training & Development continues to be required to preserve the skill.

APPENDIX III

Medical Necessity Guidelines for Children and Youth (0-18) in the Child Welfare System

The Bureau for Medical Services has worked in conjunction with the Bureau for Children and Families to develop an expanded list of eligible diagnoses for children and youth in the Child Welfare system to increase access to Medicaid Behavioral Health Rehabilitation Services. The rationale for creating an expanded diagnostic eligibility is to improve outcomes for children with a behavioral health need who are experiencing significant problems or disruption related to their family situation. Family problems or lack of available support can significantly impact the efficacy of therapeutic interventions, and when the disruption is related to physical, sexual, emotional abuse or neglect, the youth may require a more intensive intervention. These interventions should target the reduction of the symptoms of the diagnosed behavioral health condition or the symptoms and behaviors manifested as a result of the abuse or neglect, and the required intervention may be more intensive than would normally be indicated for a youth with similar symptoms or behaviors who has adequate family support.

Youth in custody, or youth involved with Child Protective Services, as indicated on the KEPRO CareConnection® are included in this expanded eligibility. A list of those diagnoses included has been published by the Office of Behavioral Health Services (last update 06/30/99). It is important to note that once children involved in the Child Welfare system meet medical necessity criteria for access to rehabilitation services, they must also meet the Utilization Management requirements (contained in this document for each service) for the specific service(s) requested. There have been significant problems identified related to utilization of Skills Training & Development for youth in the Child Welfare system, particularly with respect to the required Phillip Roy Independent Living Skills curriculum required by the Bureau for Children and Families. Only those deficits which are determined to be a “skill loss” or those skills which are developmentally appropriate but have not been acquired due to the symptoms of the diagnosed behavioral health conditions or due to abuse, neglect or institutionalization are appropriate to be targeted under Skills Training & Development. Skills that are age and developmentally appropriate and which the child should be acquiring during the current developmental stage (such as learning banking, member, and job seeking skills between age 14-18) while appropriate to be addressed do not meet medical necessity requirements for Skills Training & Development. An outline for determining medical necessity for Skills Training & Development for this group is included in Appendix II.

For those youth who remain in custody until age 21 and remain in dependent settings, providers may request evaluation as a juvenile. In these instances the provider should be prepared to establish to the KEPRO Care Manager that the youth is functionally an adolescent (e.g. in a dependent living setting, still in school and dealing with adolescent developmental issues). Youth in independent living settings, married youth or emancipated minors do not generally meet these criteria. Field #267 on the KEPRO CareConnection® may be utilized to indicate the young adult is “functionally adolescent”. The appropriate assessment should be utilized, in most instances the CAFAS continues to be used since it better represents the youth’s functional status, but the West Virginia Functional Assessment Instrument or Addiction Severity Index may be utilized if these are more appropriate.

Determining Medical Necessity for Skills Training & Development for Children and Youth In the Child Welfare System (0-18)

Diagnosis, Symptoms, and Functional Impairment

- Current DSM or ICD diagnosis on Child MH, Child SA or Child Welfare listing if in custody or CPS referred—**or-**
- For children (0-5) four risk factors and one significant developmental delay as measured by an accepted assessment instrument for young children—**or-**
- Two significant developmental delays as measured by an accepted assessment instrument for young children -**and-**
- Symptoms and areas of impairment identified through assessment must be identified

Requesting Skills Training & Development for Children

- Child must meet medical necessity as defined above -**and-**
- Identified symptoms and functional impairment must be moderate to severe -**and-**
- There must be identified skill deficits that are related to the identified behavioral health condition or were developmentally not achieved at the appropriate age due to abuse, neglect or years spent in institutional environment -**and-**
- There is a reasonable expectation that the child can improve in three months -**or-**
- Child must meet medical necessity as defined above -**and-**
- Identified symptoms and/or functional impairment must be moderate to severe -**and-**
- The child does not have adequate family support and without assistance to improve the identified deficits is likely to be institutionalized or placed out of the home (this criteria is generally applied to children receiving in-home services, those already out-of-home would need to meet the criteria outlined above).-**and-**
- There is a reasonable expectation that the child can improve within three months

Documentation:

Interventions must be documented and include the place of service, date of service, actual time spent and the number of units billed. The documentation must also include the type of activity or intervention and the relationship of the activity to the deficits identified to establish medical necessity and identified in the treatment plan and/or Skills Training & Development Plan.

Continued Stay Criteria:

There is documentation of progress and review of progress, there is documentation of continued symptoms and impairment that requires Skills Training & Development —**or-** if Skills Training & Development is used to preserve functioning there is documentation as to the reason Skills Training & Development continues to be required to preserve the skill.

APPENDIX IV

NON-METHADONE MEDICATION ASSISTED TREATMENT

Non-Methadone Medication Assisted Treatment Guidelines:

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 (See Attachment A) 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.

Physician Requirements: The physician responsible for prescribing and monitoring the member's treatment must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider.

Therapy Services: Therapy for Non-Methadone Assisted Treatment Patients is the treatment of behavioral health conditions in which the qualified health care professional through definitive therapeutic communication attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. This process includes ongoing assessment and adjustment of psychotherapeutic interventions and may include involvement of family members or others in the treatment process. Behavioral Health Counseling, Professional, is a face to face medically necessary service provided to the member and/or family member however the member must be present for some or all of the service (See Program Guidelines for Professional Therapy Requirements).

Any therapeutic intervention applied must be performed by a minimum of a Master's Level Therapist using the generally accepted practice of therapies recognized by national accrediting bodies of:

- Psychology plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Psychiatry plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,

- Counseling plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions,
- Social work plus possessing 2 years documented experience in the substance abuse field or an Alcohol Drug Counselor (ADC) or higher level accreditation in addictions

Physician and Professional Therapy services will be provided for individuals utilizing Buprenorphine, Suboxone strips or Vivitrol®. Agencies should be aware that West Virginia law forbids the use of Buprenorphine/Naltrexone in tablet form for the treatment of substance use disorders.

Documentation: Documentation for a coordinated care member must include a Master Service Plan that includes individual therapeutic interventions. The plan must also include a schedule detailing the frequency for which therapy services are to be provided.

A member receiving focused care (Physician and Professional Therapy only) will require a treatment strategy in lieu of a Master Service Plan.

The documentation must include the signature and credentials of the staff providing the service, place of service, date of service, and the objectives utilizing individual therapeutic interventions.

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.

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 professional therapeutic services per month. The four hours must contain a **minimum** of one (1) hour individual professional therapy 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 professional therapeutic services per month individual, family, or group. 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 must be maintained in the member's record. 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. The Physician must work with another physician that has a DEA-X. The physician taking responsibility for prescribing and monitoring the member's treatment while the primary physician is unavailable must have a degree as a Medical Doctor and/or Doctor of Osteopathic Medicine. Must be licensed, board certified and in good standing in the state of West Virginia. Requirements for the Drug Addiction Treatment Act of 2000 (DATA 2000) must be met by the physician unless indicated by Substance Abuse Mental Health Services Administration (SAMHSA). The physician must be an enrolled WV Medicaid provider so that treatment is not interrupted for any reason for Medicaid Members participating in this service. If a physician fails to have a plan in place **a hold will be placed on all Rx authorizations**. At no time is a Nurse Practitioner or a Physician's Assistant to prescribe Suboxone.