KEPRO
Utilization Management Guidelines for the WV Children's Health Insurance Program (WVCHIP)

KEPRO
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Service Utilization Management Guidelines
for the
WV Children's Health Insurance Program

These Service Utilization Management (UM) Guidelines are organized to provide an overview of the WVCHIP services that require prior authorization through KEPRO. Each service listing provides:

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

In addition, the service listing provides:

- member-specific criteria, which discusses the conditions for:
  - admission,
  - continuing stay,
  - discharge,
- clinical exclusions

The elements of these service listings will be the basis for utilization reviews and management by KEPRO. Additional detail regarding service definitions and documentation requirements can be found in the American Medical Association Current Procedural Terminology (CPT) Manual. Specific information regarding the WVCHIP benefit can be found in the Summary Plan Description (SPD) located at: https://chip.wv.gov/Pages/default.aspx

Request for Prior Authorization

All behavioral health prior authorization requests must be submitted electronically using the KEPRO Behavioral Health CareConnection®. This web based data system allows providers to submit service authorization requests and receive response information including authorization numbers (when authorized) and communication from KEPRO staff regarding requests. WVCHIP services remain intact along with the requirement for a prior authorization after 26 visits have been reached. Requests to exceed the initial 26 visits will require data submission including demographics, diagnostic, symptom acuity, and functional information.

Status of Request for Prior Authorization

When a prior authorization for service is required, the service provider submits the required information to KEPRO. The provider will be notified if the request is authorized,

pended (additional information is needed to make the decision), or closed or denied and/or what alternative services may be recommended. Providers must access the submitted record to obtain an authorization number to be used for reimbursement.

Provider requests for service authorizations failing to meet the medical necessity guidelines are subject to negotiations between the provider and KEPRO. KEPRO strives to assist the provider in developing an appropriate plan of care for each member. Typically, the vast majority of discrepancies between the request for service and final status are resolved through discussion and mutual agreement. In the event that a member truly does not have a demonstrated behavioral health or ID/DD diagnosis and/or need that meet the guidelines for care, the request will be denied. In this event, both the provider and member will receive notification of the denial. Please see the KEPRO Provider Manual and WVCHIP Summary Plan Description for additional information regarding the denial and appeals process.

Multiple Service Providers

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

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

Medical Necessity

Prior authorization does not guarantee payment for services. Prior authorization is an initial determination that medical necessity requirements are met for the requested service. The state of West Virginia utilizes the following definition of medical necessity: "services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis or treatment of an illness; (2) provided for the diagnosis or direct care of an illness; (3) within the standards of good practice; (4) not for the convenience of the plan member or provider; and (5) the most appropriate level of care that can be safely provided."

The CPT code services rendered WV CHIP providers more clearly define the services and criteria utilized to meet parts (1) and (2) of the definition above. In determining the

appropriateness and necessity of services for the treatment of specific individuals, the diagnosis, level of functioning, clinical symptoms, stability, and availability of the member's support system are evaluated. KEPRO's role is to devise clinical rules and review processes that evaluate these characteristics of individuals, ensure that psychiatric services requested are medically necessary, and to enforce the policies WV WVCHIP.

The Utilization Management Guidelines published by KEPRO serve to outline the requirements for diagnosis, level of functional impairment and clinical symptoms of individuals who require the specific services.

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

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

Additional Information

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

90791 Psychiatric Diagnostic Evaluation

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

Service Tier	Tier 2
Provider Qualifications	This service may be provided by: • Physician/Psychiatrist • Licensed Psychologist • LICSW's, LPC's and LGSW
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 required for additional 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	Tier 2 data submission required to exceed limit of 26 units per member/per year. This level of data is required to exceed the initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition, **-or-** 2. Member is entering or reentering the service system, **-or-** 3. Member has need of an assessment due to a change in clinical/functional status, **-or-** 4. Evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status.

Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Codes 90791 and 90792 may be reported once per day and not on the same day as an evaluation and management service performed by the same individual for the same patient. 2. Psychotherapy, including for crisis, may not be reported on the same day as 90791 or 90792.
Clinical Exclusions	None

90792 Psychiatric Diagnostic Evaluation with Medical Services

Definition: Initial or reassessment evaluation by a psychiatrist. Psychiatric Diagnostic Examination includes an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. This evaluation may include communication with family or other sources, prescription of medications, and review and ordering of laboratory or other diagnostic studies.

Service Tier	Core-Tier 2
Provider Qualifications	• Physician/Psychiatrist • Nurse Practitioners and Physician Assistants
Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 required for additional 2 sessions/per member/per year from start date of initial service Unit = Session/Event
Re-Authorization	Tier 2 data submission required to exceed limit of 26 units per member/per year This level of data is required to exceed initial authorization limit and demonstrate medical necessity. Only one unit (session) can be approved and the need for the additional unit should be described in the free-text field.
Admission Criteria	1. Member has a known or suspected behavioral health diagnosis, **-and-** 2. Member is entering or reentering the service system, **-or** 3. Member has need of an assessment due to a change in clinical/functional status.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals of member's Individualized Treatment Plan have been substantially met.
Service Exclusions	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

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

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

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

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

Service Tier	Core-Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW, LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need

	for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 2. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 3. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous

	ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

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

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

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Assistant • Nurse Practitioner
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 30 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need

	for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90791 and 90792 Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Evaluation and 90836 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 45 minutes may not be billed *on the same day as* 90833 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 30 minutes.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

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

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW, LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 45 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/ per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g. 15, 20 etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text

	field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -and- 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment needs. 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	1. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 2. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 3. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance

	therapy and is not considered a covered benefit with WVCHIP.

90836 Psychotherapy, 45 min. with Patient and/or Family Member with Evaluation and Management Service

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

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Assistant • Nurse Practitioner
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 45 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need

	for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90791 and 90792 Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Evaluation and 90836 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 45 minutes may not be billed *on the same day as* 90833 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 30 minutes.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

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

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW , LCSW, LGSW • LPC
Program Option	Psychological Services-CPT codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 60 minutes NOTE: Tier 2 data submission required for a provider to exceed the limit of ten (10) additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for

	additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. Psychotherapy provided to a patient in a crisis state is reported with codes 90839 and 90840 and cannot be reported in addition to psychotherapy codes 90832, 90834 and 90837. 2. Some psychiatric patients receive medical evaluation and management (E/M) service on the same day as psychotherapy by the same physician or other health care provider. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using codes specific for psychotherapy with E/M services (90833 and 90836). 3. Psychotherapy, including for crisis, may not be reported on the same day as the 90791 or 90792. 4. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

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

90838 Psychotherapy, 60 min. with Patient and/or Family Member with Evaluation and Management Service

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

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Assistant • Nurse Practitioner
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 60 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text

	field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change, **-and-** 5. Medical evaluation and/or management services are required.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Services 90791 and 90792 Psychiatric Diagnostic Evaluation and Psychiatric Diagnostic Evaluation with Medical Evaluation and 90836 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 45 minutes may not be billed *on the same day as* 90833 Psychotherapy with Patient and/or Family Member with Evaluation and Management Service 30 minutes.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

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

90839 Psychotherapy for Crisis; First 60 Minutes

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

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

Code 90839 should be used to report the first 30-74 minutes of psychotherapy for crisis on a given date. It should be used only once per date even if the time spent by the physician is not continuous.

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW, LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per 30 calendar days/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Another request for prior authorization is required for any provider to exceed the limit of 2 units/per member/ per 30 calendar days for utilization review purposes – or- if this is a new crisis episode. If the crisis episode has continued for more than 74 minutes, the 90840 code should be requested to address the additional time. 2 additional units/per member/30 calendar days Unit = 60 minutes

Admission Criteria	1. Member has a behavioral health diagnosis -and- 2. The member presents the need for an urgent assessment of their crisis state – and- 3. Member demonstrates severe to acute psychiatric symptoms, impaired functional abilities due to the crisis – and – 4. Requires the immediate, direct attention of the physician to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.
Continuing Stay Criteria	This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.
Discharge Criteria	Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.
Service Exclusions	• Not to be used as an emergency response to a member running out of medications or housing problems. • Psychotherapy for a crisis of less than 30 minutes total duration on a given date should be reported with the 90832 or 90833 (when provided with an E/M service). • Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. • No other psychiatric service may be provided and billed during this service. • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	None.

90840 Psychotherapy for Crisis; Additional 30 Minutes

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

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

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW, LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per 30 calendar days/per member from start date of initial service Unit = 30 minutes An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.
Re-Authorization	2 units/per member/ per 30 calendar days for utilization review purposes Unit = 30 minutes Another request for prior authorization is required for any provider to exceed the limit of 74 minutes for a crisis response on a specific date. An authorization must exist for the 90839 service by the same provider for the same member for the same date of service.

Admission Criteria	1. Member has a behavioral health diagnosis -and- 2. The member presents the need for an urgent assessment of their crisis state – and- 3. Member demonstrates severe to acute psychiatric symptoms, impaired functional abilities due to the crisis – and – 4. Requires the immediate, direct attention of the physician to address the presenting problem which is typically life threatening or complex and requires immediate attention to a patient in high distress.— and- 5. The 74 minutes of 90839 have been exhausted for this date of service.
Continuing Stay Criteria	This service may be required at different points in the member's course of treatment. Each intervention is designed to be a time-limited service which stabilizes the member and evaluates their level of care.
Discharge Criteria	Crisis episode which triggered the need for this service has been sufficiently managed to promote the well-being of the member.
Service Exclusions	• Not to be used as an emergency response to a member running out of medications or housing problems. • Psychotherapy for a crisis of less than 74 minutes total duration on a given date should be reported with the 90839 service. • Psychotherapy for crisis should not be used in conjunction with 90791 or 90792. • No other psychiatric service may be provided and billed during this service. • Response to a Domestic Violence Situation • Admission to a Hospital • Admission to a Crisis Stabilization Unit • Time awaiting for Transportation or the transportation itself • Removal of a minor or an incapacitated adult from an abusive or neglectful household. • Completion of certification for involuntary commitment.
Clinical Exclusions	None

90847 Family Psychotherapy (with patient present)

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

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 45-50 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/per year Unit = 45-50 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The total number of units requested over ten (10) (e.g., 15, 20, etc.) must be specified in the free-text field, otherwise a maximum of ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or

	interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	N/A
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

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

90849 Multiple Family Group Psychotherapy

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a multiple family group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual members.

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW LGSW, LCSW • LPC
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 10 units/per year/per member from start date of initial service Unit = 50 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.

Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -**and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -**and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

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

90853 Group Psychotherapy

Definition: Face-to-face structured intervention by a psychiatrist to improve an individual's cognitive processing, reduce psychiatric symptoms, reverse or change maladaptive patterns of behavior and/or improve functional abilities. This includes insight oriented, behavior modifying and/or the use of behavior modification techniques, supportive interactions, the use of cognitive discussion of reality or any combination of these techniques to provide therapeutic change in an outpatient setting. These activities are carried out within a group context where the therapist engages the group dynamics in terms of relationships, common problems focus, and mutual support to promote progress for individual members. This code may not be utilized for multiple family group therapy.

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner • Licensed Psychologist • LPC, LICSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional units/per year/per member from start date of initial service Unit = Event
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = 75-80 minutes **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.

Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, -**and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, -**and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	None
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

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

90785 Psychotherapy Complex Interactive

Definition: Add on code for interactive complexity to be reported in conjunction with codes for diagnostic psychiatric evaluation (90791, 90792), psychotherapy (90832, 90834, 90837), psychotherapy when preformed with an evaluation and management service (90833, 90836, 90838), and group psychotherapy. Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have other individuals legally responsible for their care, such as minors or adults with guardians, interpreters, language translators, agencies, court official or schools. . Interactive complexity is commonly present during visits by children and adolescents, but may apply to visits by adults, as well.

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Extender (Physician Assistant, Nurse Practitioner) • Licensed Psychologist • LICSW , LCSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional units/per year/per member from start date of initial service Unit = Event/add-on to the timed service code being provided in conjunction to.
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = add-on to timed service code being provided in conjunction with **NOTE:** Tier 2 data submission required for a provider to exceed the limit of ten additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-

	text field.
Admission Criteria	When at least one of the following communication factors is present during the visit: 1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care. 2. Caregiver emotions or behaviors that interfere with implementation of the treatment plan. 3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants. 4. Use of play equipment, physical devices, interpreter or translator to overcome barriers to diagnostic or therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	May not report with Psychotherapy for crisis (90839, 90840); E/M alone, i.e., E/M service not reported in conjunction with a psychotherapy add-on service; Family psychotherapy (90847, 90849)
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

Additional Service Criteria:

1. Per the Center for Medicare and Medicaid Services (CMS), "90785 generally should

not be billed solely for the purpose of translation or interpretation services" as that may be a violation of federal statute.

90863 Pharmacologic Management w/ Psychotherapy

Definition: Pharmacologic management including prescription and review of medication, when performed with a psychotherapy service. This is an add-on service provided in conjunction with 90832, 90834, and 90837.

Service Tier	Tier 2
Provider Qualifications	• Physician/Psychiatrist • Physician Assistant • Nurse Practitioner
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional unit/per year/per member from start date of initial service Unit = Event/add on to timed service code being provided in conjunction with (90832, 90834, 90837)
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. 10 additional units/per member/ per year Unit = event performed as add on to psychotherapy service. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity and the total number of units requested over ten (10) (e.g., 15, 20, etc.) should be specified in the free-text field, otherwise ten (10) additional units will be granted. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has a behavioral health diagnosis which qualifies for WVCHIP behavioral health services, **-and-** 2. Member demonstrates intrapsychic or interpersonal conflicts and/or need to change behavior patterns, **-and-** 3. The specific impairments to be addressed can be delineated and/or the intervention is for purposes of focusing on the dynamics of the member's problem, **-and-** 4. Interventions are grounded in a specific and identifiable theoretical base, which provides a

	framework for assessing change.
Continuing Stay Criteria	1. The service is necessary and appropriate to meet the member's identified treatment need(s). 2. Progress notes document member's progress relative to goals identified for treatment, but goals have not yet been achieved.
Discharge Criteria	1. Member has withdrawn or been discharged from service. 2. Goals for member's treatment have been substantially met.
Service Exclusions	Do not count time spent on providing pharmacologic management service in the time used for selection of psychotherapy service. For pharmacologic management w/ psychotherapy services performed by a physician or other qualified health care provider who may report evaluation and management codes, use the appropriate evaluation and management codes and the appropriate evaluation and management service.
Clinical Exclusions	1. There is no outlook for improvement with this level of service. 2. Severity of symptoms and impairment preclude provision of service at this level of care. 3. When further clinical improvement cannot reasonably be expected from continuous ongoing care, the therapy would be considered maintenance therapy and is not considered a covered benefit with WVCHIP.

90865 Narcosynthesis for psychiatric diagnostic and therapeutic purposes

Definition: Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g. Sodium amobarbial interview). Treatments which involve using the treatment of narcotics to stimulate traumas experienced by patients are classed under narcosynthetic therapies.

Service Tier	Tier 2
Provider Qualifications	Physician/Psychiatrist
Program Option	WV Children's Health Insurance Program
Initial Authorization	Initial 26 visits, prior authorization not required. Tier 2 for additional 2 units/per 30 calendar days/per member from start date of initial service Unit = Event
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None

96105 Assessment Aphasia with Interpretation and Report

Definition: Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia examination with interpretation and report per hour.

Service Tier	Tier 2
Provider Qualifications	Licensed Psychologist
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 4 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	• Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** • Member requires testing or evaluation for a specific purpose, **-or-** • Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None

96116 Neurobehavioral Status Exam

Definition: Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment,e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to face time with the patient and time interpreting test results and preparing the report.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Neuropsychologist
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, -or 2. Member requires testing or evaluation for a specific purpose, -or 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.

Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96121 Neurobehavioral status exam, both face to face time with patient and time interpreting report; each additional hour

Definition: Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to face time with the patient and time interpreting test results and preparing the report.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Neuropsychologist
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, -or 2. Member requires testing or evaluation for a specific purpose, -or 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from

	service.
Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • • Computer – Interpretation
Clinical Exclusions	None

96125 Standardized Cognitive Performance Testing

Definition: Standardized cognitive performance testing (e.g. Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face to face time administrating tests to the patient and time interpreting test results and preparing the report.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 1 unit/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, -or 2. Member requires testing or evaluation for a specific purpose, -or 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None

96127 Brief Emotional/Behavioral Assessment

Definition: Brief emotional/behavioral assessment (e.g. depression inventory, ADHD scale), with scoring and documentation per standardized instrument.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Physician or a Physician Extender • LPC, LICSW, LGSW • LPC
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional unit/per year/per member from start date of initial service Unit=Event
Re-Authorization	Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, -or 2. Member requires testing or evaluation for a specific purpose, -or 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None

96130 Psychological Testing Evaluation by Professional, first hour

Definition: Psychological testing evaluation services by physician or other qualified health professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 1 unit/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having a behavioral health diagnosis, -or 2. Member requires psychological testing or evaluation for a specific purpose, -or 3. Psychological testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	This service is not intended for:

	• Test Administration and Scoring by Professional (96136,96137) • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96131 Psychological Testing Evaluation by Professional, additional hour

Definition: Psychological testing evaluation services by physician or other qualified health professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour..

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having a behavioral health diagnosis, -or 2. Member requires psychological testing or evaluation for a specific purpose, -or 3. Psychological testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	This service is not intended for:

	• Test Administration and Scoring by Professional (96136,96137) • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation This service includes the provision of results to appropriate parties.
Clinical Exclusions	None

96132 Neuropsychological Testing Evaluation by Professional, first hour

Definition: Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s), caregiver(s), when performed; first hour.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist/ Neuropsychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 1 unit/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from

	service.
Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96133 Neuropsychological Testing Evaluation by Professional, additional hour

Definition: Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s), caregiver(s), when performed; first hour.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist/ Neuropsychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 9 units/per year/per member from start date of initial service Unit = 60 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has received one hour of 96136 and requires additional time and, 2. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 3. Member requires testing or evaluation for a specific purpose, **-or-** 4. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.

Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	This service is not intended for: • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96136 Psychological or Neuropsychological Test Administration and Scoring by Physician or Other Health Professional, first 30 minutes

Definition: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist/ Neuropsychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 1 unit/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	Member has, or is seeking psychological or neuropsychological testing and evaluation that includes test administration and scoring by professional.
Continuing Stay Criteria	Continued test administration and scoring must be requested under the 96137 code.
Discharge Criteria	Member has withdrawn or been discharged from service
Service Exclusions	This service is not intended for: • Time for evaluation services (e.g., integration of patient data or interpretation of test results • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation • Administration of single test
Clinical Exclusions	None

96137 Psychological or Neuropsychological Test Administration and Scoring by Physician or Other Health Professional, additional 30 minutes

Definition: Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; additional 30 minutes.

Service Tier	Tier 2
Provider Qualifications	• Licensed Psychologist/ Neuropsychologist • Physician or a Physician Extender
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Tier 2 for additional 2 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	Member has, or is seeking psychological or neuropsychological testing and evaluation that includes test administration and scoring by professional for greater than 30 minutes in duration.
Continuing Stay Criteria	Additional test administration and scoring is required to complete psychological or neuropsychological testing evaluation by professional.
Discharge Criteria	Member has withdrawn or been discharged from service
Service Exclusions	This service is not intended for: • Time for evaluation services (e.g., integration of patient data or interpretation of test results • Psychometrician/Technician Work • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation • Administration of Single Test

Clinical Exclusions	None

96138 Psychological or Neuropsychological Test Administration and Scoring by Technician, first 30 minutes

Definition: Psychological or Neuropsychological testing administration and scoring services by technician, first 30 minutes

Service Tier	Core-Tier 2
Provider Qualifications	Psychometrician * Document signed off and billed by Licensed Psychologists. Technicians cannot enroll with WVCHIP
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional 1 unit/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	This service is not intended for: • Computer - Scoring

	• Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96139 Psychological or Neuropsychological Test Administration and Scoring by Technician, each additional 30 minutes

Definition: Psychological or Neuropsychological testing administration and scoring services, two or more tests, any method, by technician, each additional 30 minutes. List separately in addition to code for primary procedure.

Service Tier	Core-Tier 2
Provider Qualifications	Psychometrician/Technician * Document signed off and billed by Licensed Psychologists. Technicians cannot enroll with WVCHIP
Program Option	WV Children's Health Insurance Program CPT Codes
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional 4 units/per year/per member from start date of initial service Unit = 30 minutes
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.

Service Exclusions	This service is not intended for: • Computer - Scoring • Self-Administered Assessments • Computer – Interpretation
Clinical Exclusions	None

96146 Psychological or Neuropsychological Automated Testing and Results

Definition: Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated results only.

Service Tier	Core-Tier 2
Provider Qualifications	Automated Testing If test is administered by physician, other qualified health professional, technician, do not report 96146.
Program Option	WV Children's Health Insurance Program
Telehealth	Not Available
Initial Authorization	Initial 26 visits, prior authorization not required Core-Tier 2 for additional 4 units/per year/per member from start date of initial service Unit = Event
Re-Authorization	1. Tier 2 data submission required for additional units within the one-year authorization period by any provider previously utilizing the benefit for the same member or continuing the service after one year. **NOTE:** Tier 2 data submission required for a provider to exceed the limit/additional units/per member/per year. This level of data is required to exceed the authorization limits and demonstrate medical necessity. The need for additional units must be described in the free-text field.
Admission Criteria	1. Member has, or is suspected of having, a behavioral health condition with an organic component or etiology, **-or-** 2. Member requires testing or evaluation for a specific purpose, **-or-** 3. Neurobehavioral testing/evaluation is required to make specific recommendations regarding additional treatment or services required by the individual.
Continuing Stay Criteria	1. Member has a need for further assessment due to findings of initial evaluation and/or changes in functional status. 2. Reassessment is needed to update/evaluate the current treatment plan.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	

	96136, 96137 should not be billed for the same tests or services performed under neuropsychological test by computer code 96146. This service should not be performed for multiple tests. This is for a single automated test. This service is not intended for: • Psychometrician/Technician Work • Psychologist test administration and scoring • Self-Administered Assessments
Clinical Exclusions	None

Additional Service Criteria: When testing is administered by the computer, interpretation and report is included in the 96132/96133.

C0124 Acute Inpatient Psychiatric Hospitalization

Definition: This service offers the highest level of physical security and most intensive psychiatric and nursing intervention. Inpatient psychiatric units located in a licensed general hospital or freestanding behavioral health facility are generally locked and equipped to restrain or seclude patients if necessary and staffed by nurses 24 hours per day, seven (7) days per week. Inpatient psychiatric hospitalization consists of a full range of diagnostic and therapeutic services offered with capability for emergency implementation of medical and psychiatric interventions. Admission is the result of a behavioral health condition that requires rapid stabilization of psychiatric symptoms. This service is required to provide intensive evaluation, medication titration, symptom stabilization and intensive brief treatment. Inpatient care must be medically necessary for the diagnosis and/or treatment of a behavioral health condition.

Service Tier	High Intensity Services
Provider Qualifications	Multi-disciplinary treatment team consists of the following professionals at a minimum: • Board certified/board eligible psychiatrist (attending physician) • Registered nurse (certified psychiatric nurse preferred) • Psychologist (consultative) • Licensed clinical social worker/counselor • Activities therapist
Program Option	WV Children's Health Insurance Program
Initial Authorization	5 units Unit = 1 day
Re-Authorization	Re-Authorization 5 units/days
Admission Criteria	1. Individual with a known behavioral health condition – and 2. Imminent risk for self-injury, with an inability to guarantee safety, as manifested by any one of the following: a. Recent, serious, and dangerous suicide attempt, indicated by degree of lethal intent, impulsivity, and/or concurrent intoxication b. Current suicidal ideation with intent, realistic plan, and/or available means. c. Recent self-mutilation that is severe and dangerous d. Recent verbalization or behavior indicating high risk for severe injury.-or

	3. Imminent risk for injury to others as manifested by any of the following: a. Active plan, means, and lethal intent to inflict seriously injury to other(s). –or b. Recent assaultive behaviors that indicate a high risk for recurrent an serious injury to others –or c. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others. –or d. Active hallucinations, bizarre or delusional behavior resulting in danger to self or others. – or e. Acute dysfunction – rapid deterioration of ADL's to the point the member cannot perform daily living activities (safety, nutrition, shelter) due to psychiatric condition. The ability to function is so disorganized or bizarre it would be unsafe to be treated in a less intensive level of care. – or f. A need for acute psychiatric interventions (e.g., ECT) with a high probability of serious and acute deterioration of general medical and/or mental health.- or g. Requiring detoxification from alcohol and/or drugs and is at significant risk for acute withdrawal symptoms **and one of the following**: i. Failed OP treatment • Hallucinations (auditory, visual, tactile, or olfactory) or delusions. ii. Homicidal or suicidal attempt or ideation w/ a plan • Chronic medical conditions (e.g., epilepsy, cardiomyopathy, or diabetes) or pregnancy iii. Delirium tremens (or history of DTs
Continuing Stay Criteria	1. Current involvement and cooperation with treatment process **and one of the following**: a) Continued admitting symptoms/behaviors are present or new and/or previously unidentified symptoms/behaviors have emerged –or b) Symptoms continue despite treatment or a reaction to treatment efforts (psychosocial or medication) has caused a regression or unexpected response –or c) Symptoms and functional impairments continue despite best efforts and modifications to

	treatment plan. – or d) Progress toward treatment goals have occurred, as evidenced by measurable decline in signs, symptoms, and/or behaviors indicating a positive response to treatment 2. And, treatment goals are realistic, measurable, achievable and directed toward stabilization to allow treatment to continue in a less restrictive environment.-and 3. Family members are encouraged to participate in treatment unless documented their participation is contraindicated.
Discharge Criteria	1. Goals for treatment have been substantially met as evidenced by abatement of admission symptoms and the patient has returned to a level of functioning that allows reintegration into their previous living arrangement and/or use of a less intensive outpatient service. 2. The member exhibits symptoms and functional impairment that requires a longer length of stay in a restrictive setting (e.g. State Psychiatric Hosp.) 3. An individualized discharge plan with appropriate, realistic, and timely follow-up care is in place. 4. The member becomes medically unstable and requires treatment related to their physical health condition.
Service Exclusions	1. Admissions other than emergency to out-of-state facilities for services which are available in-state or in border area facilities 2. Admissions for experimental or investigational procedures 3. Admissions and/or continued stays which are strictly for patient or guardian's convenience and not related to the care and treatment of a patient 4. No outpatient service may be billed. 5. Court ordered treatment is not a WVCHIP benefit. Refer to Medicaid or BCF for transfer.
Clinical Exclusions	1. Inpatient admission for services which could be performed in an outpatient setting 2. Unstable medical condition that requires intensive medical management. 3. Primary diagnosis/presenting problem related to Pervasive Developmental Disorders, Mental Retardation or Traumatic Brain Injury.

Additional Service Criteria:

1) Retrospective review is available for admissions occurring on weekends and holidays, or at times when the utilization management review process is unavailable. Additionally, retrospective review is permitted for admissions of members whose eligibility has been determined retroactively. Retrospective review must be requested within 6 months of discharge date.
2) Nursing and other related services, such as use of hospital facilities, medical and social services, and transportation furnished by the hospital during an inpatient stay are included in the rate of reimbursement.
3) A multi-disciplinary treatment team consists of the following professionals at a minimum: a. Board certified/board eligible psychiatrist (attending physician) b. Registered nurse (certified psychiatric nurse preferred) c. Psychologist (consultative) d. Licensed clinical social worker e. Activities therapist
4) Behavioral health services are provided by qualified behavioral health staff that meet WVCHIP requirements for individual professional providers.
5) Progress notes should document the course of treatment including a description of the interventions implemented including medication(s) and efficacy, member's response, and interpretation of the effectiveness of the intervention; date, length and type of therapy provided.
6) All clinical entries should be legible, sequential, signed and dated.

Applied Behavior Analysis Allowable Services and Coding Guide:

Required Documentation Checklist Faxed to 866-473-2354
Please visit http://wvaso.kepro.com/wvchip/behavioral-health-services/
for reference documents.

- A qualifying diagnostic assessment establishing an Autism Spectrum Disorder (ASD) diagnosis prior to age eight. A licensed physician (e.g., a neurologist, pediatric neurologist, developmental pediatrician, and psychiatrist) or a licensed psychologist must complete the diagnostic assessment.

- A qualified provider must complete comprehensive diagnostic assessment within the past 24 months addressing areas of: 1) Current ICD or DSM diagnosis of ASD, 2) Indication of Diagnostic Severity Level including level of communication; and restricted repetitive behaviors, and 3) Specifiers of the ASD diagnosis, including underlying medical causes, if identified. A licensed physician (e.g., a neurologist, pediatric neurologist, developmental pediatrician, and psychiatrist) or a licensed psychologist must complete the diagnostic assessment.

- Annual physician's order for ABA services.

- EPSDT referral for ABA services completed by the Pediatrician. ASD experienced physician must provide the Physician's Orders.

- Copy of the "Consent to Release Information and Bill WVCHIP" form (Part of the IEP documentation) or the "Statement of Assurances" form signed and dated.

- A copy of a specific functional assessment (ABAS II or III) is required upon initial PA request and 1 year intervals showing information such as complete medical history; measurements specific to language skills, communication skills, social skills, and adaptive functioning; no risk of imminent danger to self or others; and current or baseline level of functioning.

- Initial treatment plan including behaviors to be addressed; instructional methods to be used; description of data collection procedures; measurable short-term, intermediate and long-term goals; and desired outcomes for discharge.

- Copy of the Individualized Education Plan to assure that ABA Services are consistent and coordinated with the instructional plan, not in conflict with the IEP and is not replicating or supplanting responsibilities of I.D.E.A

H0031*CH Mental Health assessment by a non-physician

BCBA/BCaBA level assessment. Completed in order to submit the initial ABA treatment plan for Prior Authorization submission.

Level of Service	Core-Tier 2
Provider Qualifications	BCBA/BCaBA
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	1 Unit/Event
Re-Authorization	1 per year without prior authorization Additional "event" will require Prior Authorization Maximum of 2 events annually
Service Description	• Professional level assessments; • Development of the ABA plan per professional guidelines as outlined by the BACB; • Limited: non-face to face service: analyzing past data submitted to the current BCBA or BCaBA to incorporate successful and unsuccessful behavior protocols
Maximum Units	2 events annually
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97151 Behavior Identification Assessment

Definition: Administered by a physician or other qualified health care professional, each 15 minutes of the provider's time face to face with patient and or guardian/caregiver administering assessments and discussing findings and recommendations, and non-face to face analyzing past data, scoring/interpreting the assessment and preparing the report/treatment plan.

Level of Service	Core-Tier 2
Provider Qualifications	• Board Certified Behavior Analyst (BCBA); • Board Certified Behavior Analyst –Doctoral (BCBA-D) • Board Certified Assistant Behavior Analyst (BCaBA); • Registered Behavior Technician (RBT)
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. •Service authorizations are issued for a duration of 90 days. •Include units requested for each service in the free text field
Service Description	• Professional level assessments; • Development of the ABA plan per professional guidelines as outlined by the BACB; • Limited: non-face to face service: analyzing past data submitted to the current BCBA or BCaBA to incorporate successful and unsuccessful behavior protocols
Maximum Units	32 units units/ day-(8 hours/day) -160 units/ week (40 hours/week) in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97152, 97153, 97154, 97155, 97156, 97158

Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97152 Behavior Identification Supporting Assessment

Definition: Administered by one technician under the direction of a physician or other qualified health care professional, face to face with the patient, each 15 minutes.

Level of Service	Core-Tier 2
Provider Qualifications	• Registered Behavior Technician (RBT)/BAT
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Service Description	• Basic assessments administered by a technician working under the direction and supervision of a BCBA/BCaBA • Face to Face with the patient • Technician only • Face to Face • 1:1 Service
Maximum Units	*32 units units/ day-(8 hours/day) and/or 160 units/ week (40 hours/week) in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97153, 97154, 97155, 97156, 97158
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97153 Adaptive behavior treatment by protocol by an RBT/BAT (Paraprofessional)

Definition: Administered by technician under the direction of a physician or other qualified health care professional, face to face with the patient, each 15 minutes.

Level of Service	Core-Tier 2
Provider Qualifications	• Registered Behavior Technician (RBT)/BAT
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Service Description	• Basic assessments administered by a technician working under the direction and supervision of a BCBA/BCaBA • Face to Face with the patient • Technician only • Face to Face, 1:1
Maximum Units	*32 units units/ day-(8 hours/day) and/or 160 units/ week or 40 hours/week in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97152, 97154, 97155, 97156, 97158
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97154 Group Adaptive Behavior Treatment

Definition: Administered by technician under the direction of a physician or other qualified health care professional, face to face with two or more patients, each 15 minutes.

Level of Service	Core-Tier 2
Provider Qualifications	• Registered Behavior Technician (RBT)/BAT
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Service Description	• Direct ABA treatment implementation, by protocol per the prior authorized ABA Plan by qualified technician (RBT/BAT) • Technician must be under the supervision of a BCBA/BCaBA • Code is for paraprofessional work only • Group Code 1:2-3 patients
Maximum Units	*32 units units/ day-(8 hours/day) and/or 160 units/ week or 40 hours/week in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97152, 97154, 97155, 97156, 97158
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	Do not report 97154 if the group has more than 8 patients.
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97155 Adaptive Behavior Treatment

Definition: Adaptive Behavior Treatment with protocol modification, administered by physician or other qualified health care professional (with or without the patient present), face to face with guardian or caregiver, each 15 minutes

Level of Service	Core-Tier 2
Provider Qualifications	• BCBA/BCaBA
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Service Description	• ABA Treatment with protocol modification; resolves one or more problems with the protocol • Includes simultaneous direction of technician • Face to Face, 1:1 with patient
Maximum Units	*32 units units/ day-(8 hours/day) and/or 160 units/ week or 40 hours/week in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97152, 97153, 97154, 97156, 97158
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97156 Family Adaptive Behavior Treatment Guidance

Definition: Administered by physician or other qualified health care professional (with or without the patient present), face to face with guardian or caregiver, each 15 minutes

Level of Service	Core-Tier 2
Provider Qualifications	• BCBA/BCaBA
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit •Service authorizations are issued for a duration of 90 days. •Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. •Service authorizations are issued for a duration of 90 days. •Include units requested for each service in the free text field
Service Description	• Guidance provided to the family to continue implementation at home with patient present identifying potential treatment targets (elimination of maladaptive behaviors • Face to Face with parent/guardian and/or primary caregiver training • One Professionals service provided to One Patient Family
Maximum Units	32 units units/day (8 hours/day) -160 units/ week (40 hours/week) in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97152, 97153, 97154, 97155, 97158
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist

97158 Group Treatment – Adaptive Behavior Treatment

Definition: Administered by physician or other qualified health care professional (with or without the patient present), face to face with guardian or caregiver, each 15 minutes

Level of Service	Core-Tier 2
Provider Qualifications	• BCBA/BCaBA
WVCHIP Option	WV Children's Health Insurance Program CPT Codes
Initial Authorization	Prior authorization must be obtained before initiation of services. 15 minutes = unit • Service authorizations are issued for a duration of 90 days. • Include units requested for each service in the free text field
Re-Authorization	Tier 2 data submission required for continued stay requests. •Service authorizations are issued for a duration of 90 days. •Include units requested for each service in the free text field
Service Description	ABA Treatment with protocol modification; such as adjusts the treatment techniques during group sessions; protocol adjustments are being made in real time.
Maximum Units	32 units units/day (8 hours/day) -160 units/ week (40 hours/week) in combination with all other ABA designated codes except H0031 Other ABA Designated codes = 97151, 97152, 97153,97154, 97155, 97156.
Discharge Criteria	Member has withdrawn or been discharged from service.
Service Exclusions	None
Clinical Exclusions	None
Documentation Requirements	See Above Required Documentation Checklist