Chapter 16

Mental Health Services

Minnesota’s publicly provided mental health system, as reflected in the Minnesota Comprehensive Mental Health Acts, is Minnesota Department of Human Services (DHS)-supervised and county-administered. Counties act as the local mental health authority. Review mental health provider requirements in Chapter 1, Requirements for Providers, for information about criteria to be an eligible Minnesota Health Care Programs (MHCP) and PrimeWest Health mental health provider.

Definitions

Child with Emotional Disturbance (ED): A child with an organic disorder of the brain, or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:
1. Is listed in the clinical manual of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), code range 290.0 – 302.99 or 306.0 – 316.0 or the corresponding code in the Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), Axes I, II, or III; and
2. Seriously limits a child’s capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

ED is a general term and intended to reflect all categories of disorder described in the DSM-MD, as usually first evident in childhood or adolescence.

Clinical Supervision: Clinical supervision is the documented time a clinical supervisor and supervisee spend together to discuss the supervisee’s work, to review individual member cases, and for the supervisee’s professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a member’s mental health treatment.

Evaluation and Management (E/M): E/M codes are used to report services provided in a physician’s office or outpatient setting or other ambulatory facility, or services provided to an individual who is an inpatient in a hospital. For mental health services, providers must follow the Current Procedural Terminology (CPT) guidelines when using these codes unless otherwise specified in the coverage text for a mental health service.

Hour: A 60-minute session of mental health service. At least 45 minutes of the period must be spent in face-to-face contact with the member. The other 15 minutes may be spent in member-related activities, such as scheduling, maintaining clinical records, consulting with others about the member’s mental health status, preparing reports, receiving the clinical supervision directly related to the member’s psychotherapy session, and revising the member’s individual treatment plan (ITP).

If the period of service is longer or shorter than one hour, up to one-fourth of the time may be spent on member-related activities.

Individual Community Support Plan (ICSP): A written plan developed by a case manager on the basis of a diagnostic assessment (DA) and functional assessment (FA) that identifies specific services needed by an adult with Serious and Persistent Mental Illness (SPMI) to develop independence or improved functioning in daily living, health and medication management, and social skills.

Individual Treatment Plan (ITP): A written plan developed by a mental health professional or mental health practitioner of intervention, treatment, and services for a member.
**Mental Health Crisis:** A behavioral, emotional, or psychiatric situation that would likely result in significantly reduced levels of functioning in primary activities of daily living (ADL) or in the placement of the member in a more restrictive setting (e.g., inpatient hospitalization).

**Mental Health Emergency:** A behavioral, emotional, or psychiatric situation that causes an immediate need for mental health services (e.g., 911 call, emergency department visit, or inpatient hospitalization).

**Mental Illness:** An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the *ICD-10-CM*.

**Psychotherapy Session:** A planned and structured face-to-face treatment episode between the provider of psychotherapy and one or more individuals. A psychotherapy session may be individual psychotherapy, family psychotherapy, or group psychotherapy.

**Rehabilitative Services:** Day treatment, partial hospitalization, Adult Rehabilitative Mental Health Services (ARMHS), Children’s Therapeutic Services and Supports (CTSS), and crisis response.

**Serious and Persistent Mental Illness (SPMI):** Case management services may continue to be provided for a child with a Severe Emotional Disturbance (SED) who is over age 18, but under age 21.

For purposes of case management and community support services, a “person with serious and persistent mental illness [SPMI]” means an adult who has a mental illness and meets at least one of the following criteria:

1. The adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months
2. The adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months’ duration within the preceding 12 months
3. The adult has been treated by a crisis team two or more times within the preceding 24 months
4. The adult:
   a. Has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;
   b. Indicates a significant impairment in functioning; and
   c. Has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause 1 or 2, unless ongoing case management or community support services are provided.
5. The adult has, in the last three years, been committed by a court as a person who is mentally ill under *MN Stat. Chap. 253B*, or the adult’s commitment has been stayed or continued
6. The adult:
   a. Was eligible under clauses 1 – 5, but the specified time period has expired or the adult was eligible as a child under *MN Stat. sec. 245.4871, subd. 6*; and
   b. Has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause 1 or 2, unless ongoing case management or community support services are provided.

**Severe Emotional Disturbance (SED):** Case management services may continue to be provided for a child with SED who is over age 18, but under age 21.
For purposes of eligibility for case management and family community support services, “child with Severe Emotional Disturbance [SED]” means a child who has an emotional disturbance and who meets at least one of the following criteria:

1. The child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an ED; or
2. The child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an ED through the interstate compact; or
3. The child has one of the following as determined by a mental health professional:
   a. Psychosis or a clinical depression or
   b. Risk of harming self or others as a result of an ED; or
   c. Psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or
4. The child, as a result of an ED, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

**Mental Health Covered Services**

The following are covered mental health services:

1. Crisis services
2. Adult crisis services
3. Greater Minnesota Prepaid Medical Assistance Program (PMAP) and MinnesotaCare Contact Grid for Mental Health and Chemical Health Services (DHS-4484)
4. Children’s Mental Health Crisis Response Services
5. DA
6. Mental Health Targeted Case Management (MH-TCM)
7. Mental health provider travel time
8. Outpatient mental health services
9. Explanation of findings
10. Mental health medication management
11. Neuropsychological services
12. Psychotherapy
13. Psychological testing
14. Rehabilitative mental health services
15. Assertive Community Treatment (ACT)
16. Adult Day Treatment
17. ARMHS
18. Children’s Day Treatment
19. Children’s Mental Health Crisis Response Services
20. Children’s mental health residential treatment services
21. CTSS
22. Early Intensive Developmental and Behavioral Intervention (EIDBI)
23. Intensive Treatment in Foster Care
24. Intensive Residential Treatment Services (IRTS)
25. Youth Assertive Community Treatment (Youth ACT)
26. Partial hospitalization program
27. Physician mental health services
28. Health and behavior assessment/intervention
29. Inpatient visits
30. Psychiatric consultations to primary care providers
31. Physician consultation, evaluation, and management
32. Behavioral Health Home

**Mental Health Service Continuum**

The service continuum for mental health is composed of the following six key components:
1. DA
2. FA
3. Level of care utilization system (LOCUS)
4. ITP
5. Service delivery
6. Reassessment

![Mental Health Service Continuum Diagram]

**Clinical Infrastructure Components**

**Diagnostic Assessment (DA)**

A DA is a written evaluation conducted by a mental health professional that includes different criteria as defined in the DA areas below.

**Functional Assessment (FA)**

An FA is a key eligibility requirement for the following services:
1. Adult Mental Health Targeted Case Management (AMH-TCM)
2. ARMHS
3. ACT
4. Adult Day Treatment
5. Dialectical Behavior Therapy (DBT) Intensive Outpatient Program (IOP)
6. IRTS
The purpose and intent of an FA is:
1. To use the defined domains to clearly and concisely describe in narrative:
   a. The individual’s current status within that domain
   b. The individual’s current level of functioning (strengths of function and/or impairment of functioning) within that domain
   c. When applicable and present, making the link to the individual’s mental illness and his/her status and level of functioning within that specific domain
2. To describe only current status and level of functioning within each domain:
   a. History of status and functioning (strengths of function and/or impairment of functioning) may be included on the initial assessment for selected domains if the history and description of past status and/or past functioning gives context to the individual’s current status and/or functioning
3. To assess and identify functional strengths and/or impairments to do the following:
   a. Help the individual articulate his/her recovery life vision or goal, service goals, needs, and priorities
   b. Prioritize needs based on the individual’s preferences and posed risk
   c. Formulate service planning based on the individual’s recovery vision or goal, service goals, priorities, and best practice interventions
   d. Utilize the individual’s strengths of functioning and resources in any domain to build, restore, and enhance functioning that is currently impaired in that same or another domain
   e. Demonstrate medical necessity and establish a “golden thread” documenting that necessity throughout the individual’s service record
   f. Inform other assessments (i.e., LOCUS)
   g. Guide the documentation for all services and interventions
   h. Justify reimbursement/payment for services

Cultural and social mores of the individual member must be considered in the assessment of all domains.

**Instructions for Completing a Functional Assessment (FA)**

**Completing the Initial Assessment**
1. Review the definitions and related components for each domain.
2. Determine how you will use the domain definitions and parameters to ensure you document the most salient and pertinent status and functional descriptions for that domain without being repetitive from domain to domain.
3. Within, and specific to each domain, assess the individual’s current status (stating facts: “has a job” [vocational], “does not have contact with family of origin” [interpersonal]).
4. State in detail the current level of functioning (using descriptions of the actual observable, objective, behavioral, purposeful activity) including both strengths of functioning and functional impairments whenever and wherever present.
5. If there is truly not a functional impairment in a particular domain, the term “no problem” should still not be used in documentation. The term “no problem” would seem to indicate a positive status and/or functional description of related strengths in the domain. If there is not a functional impairment in a particular domain, the narrative should focus on the individual’s functional strengths. Functional strengths are the cornerstone of person-centered planning and strength-based interventions. Functional strengths can be adapted across domains and, therefore, must be detailed within the domains in which they exist.
6. For each domain, determine if there is a link to the individual’s level of functioning (usually, but not always, related to an impairment in functioning) and the individual’s mental illness and the unique way he/she experiences his/her mental illness (signs and symptoms that are distinctive to the individual).
7. Document in a clear, concise, informative, narrative manner the individual’s status, functional description (strengths of functions and/or impairments of functions), and the link (if there is one) to the mental illness for each domain.
8. Each domain must be assessed and documented as being assessed. There will be a status and detailed functional description (strengths and/or impairments) for every domain. There may or may not be a link to the mental illness for each domain.

9. It should be noted that to meet medical necessity and eligibility for reimbursement/payment, all mental health clinical and all mental health rehabilitation service interventions must be focused on those domains where there is a functional impairment and the impairment is directly linked to the individual’s mental illness.

10. If this is an initial FA for this individual or an initial FA for a particular service, you may include historical status and functioning if you determine it is relevant to current status and functioning. Historical status and functioning can also be added at a later time if the information is just becoming available to the provider completing the assessment.

### Updating/Reassessing the Initial Functional Assessment (FA)

1. If this is an updated FA, document only current status and current functioning. “Current” time frame is defined by your service type and the time between updates.

2. Any significant changes in functioning or in an individual’s life situation and/or status, in any domain/life area, should generate a reassessment of the functional domains regardless of the due date for the of next FA update.

3. Every time you do an update or reassessment, each domain must be reassessed and current status and functional description documented.

4. When routinely updating an FA, there may be a limited number of domains for which there is minimal or no change between assessments. In these domains you may indicate and use the term “no change” for your FA updates provided the following conditions are met:
   a. The status and functioning of this domain is not affecting the individual’s life or other domains; and
   b. Does not pose risk for the individual; or
   c. Is not a priority for the individual; and
   d. Is not incorporated into service planning; and
   e. Is not represented by a service goal or objective; and
   f. Is not included or expected to be impacted by a clinical or rehabilitative intervention.

5. The term “no change” cannot be used for those functional impairments that have been prioritized; are deemed to pose risk; are part of service planning, service goals, and objectives, and for which clinical and rehabilitative interventions have been provided. If there truly is no change, then a written narrative detailing current status and functional description must be included in these domains.

6. The term “no change” should be used very cautiously, even in the above conditions. Likewise, staff should be judicious about indicating in their narrative there is no change in domain status and functionality where they have provided ongoing intervention to build, restore, improve, or enhance functioning as it indicates ineffective interventions have not been assessed and changed in a timely manner.

### Functional Assessment (FA) Definitions

**Mental Health Symptoms:** This domain refers to whether or not the individual experiences current behavioral health diagnosis/diagnoses. Describe the current diagnosis/diagnoses, the specific signs and symptoms related to the diagnosis/diagnoses, and the unique ways the individual experiences the diagnosis/diagnoses. Include descriptors of which symptoms affect his/her life, including those he/she is managing well and those which have negative impact on functionality, in the specific domains listed below.

**Note:** In order to substantiate a link to impairment in the life domains below, the diagnoses/related signs and symptoms must be included in this category. The individual’s past mental health history should be included in initial assessment only if it gives context to current functioning.
Mental Health Services: This domain refers to what behavioral health services the individual participates in and what additional services he/she may need to support function. Include descriptors of how well the individual is able to access, engage, attend, connect, and participate in medically necessary services needed to restore and improve functionality in the life domains below. The individual’s past history securing, participating in, and benefiting from mental health services can be included in the initial assessment only if it gives context to current functioning.

Use of Drugs and Alcohol: This domain refers to whether or not the individual currently uses/misuses drugs and/or alcohol; what he/she uses; how much, how often, and under what circumstances; and to what extent the use of drugs and/or alcohol affects the individual’s functioning in the other life domains. Include descriptors as to how usage affects the individual’s mental health and related signs and symptoms and to what extent the individual’s mental health and related signs and symptoms affect his/her use of drugs and alcohol. History of use/misuse, nonuse, episodes of sobriety, and recovery may be included in initial FA for individuals for whom use/misuse of drugs and alcohol has been an issue in the past to give context to current functioning. If applicable, identify how the individual’s mental health symptoms interfere with the individual’s ability to participate, access, engage, and attend treatment for drug and/or alcohol abuse or dependence.

Vocational: This domain refers to the individual’s participation in purposeful activity and/or meaningful work. Purposeful activity or meaningful work may include full and part-time employment or volunteer work on a regular or periodic basis or production of a product or provision of a service through engagement in a structured activity that can be either externally directed by other(s) or self-directed. Structured activities may include gardening for a local farmer’s market, knitting caps for cancer patients, building bird houses for charity, reading to visually impaired, etc. Include descriptors as to the individual’s current abilities in all phases of participation in purposeful activity/meaningful work including engaging in the work, contributing to the work, and/or completing or fulfilling the goal of the activity/work.

Educational: This domain refers to the individual’s participation in any relevant educational activity in multiple learning environments. These may include, but are not limited to, school settings; scholastic, trade, classroom, or hands-on experiences; formal enrollment; or auditing related to skill or knowledge acquisition. This domain also includes informal learning experiences related to skill or knowledge acquisition including the individual’s ability to participate in group learning situations or other informal settings. Education activities do not need to be goal directed (degree, job) or long-term but do need to be structured (by others or the individual). Include descriptors as to individual’s current abilities to engage, participate, benefit, and/or complete related educational activities.

Social (including the use of leisure time): This domain refers to two major functional components: social interactions and use of leisure time. Social interactions refer to the individual’s participation (active or passive interactions and interfaces) with known or unknown individuals or groups of individuals in numerous social or community settings. The individual’s social network may include casual friends, acquaintances, colleagues, peers, providers, neighbors, contacts made using technology (blogs, Facebook, YouTube, Twitter, etc.), wait staff in restaurants, people driving or riding public transportation, shopkeepers, support group participants, staff at food banks or shelters, members of the individual’s church/synagogue/temple/mosque, etc. Social contacts may be known to the individual through ongoing interactions, may be known by name or sight, or may be unknown strangers. The key is the interaction or interface in a social, non-intimate, non-one-to-one context or in a larger group setting involving multi-personal interactions. Include descriptors as to the individual’s current abilities to read and respond to social cues and to engage, respond to, and interact in social contact situations.

Leisure time is defined as “free time in which the individual is free to engage in enjoyable activities with no obligations or work responsibilities.” Include descriptors as to the individual’s current abilities to identify leisure interests, plan for, engage in, and participate in leisure activities.
Interpersonal (including relationships with family): This domain refers to the individual’s participation (active or passive interactions and interfaces) with family (as is defined by community and the individual), close friends, and the individual’s self-defined inner circle of trusted associates. These relationships are well known to the individual through past and current contacts, ongoing one-to-one interactions, and small group interactions. Include descriptions of the individual’s current abilities to read and respond to interpersonal cues, to engage, respond, interact, and to participate in structured and unstructured activities as a part of these relationships.

Self-Care and Independent Living Capacity: This domain refers to the individual’s participation in self-care and independent living activities. These activities may include, but are not limited to, ADLs such as meeting nutrition needs through eating regularly, selecting, securing, preparing, and safely storing nutritious food; meeting hygiene needs by regular bathing, hair washing, and oral hygiene; and meeting resource needs to maintain independent living. Independent living may also include the individual’s ability to keep him/herself safe from imminent risk for harm by self or others and the ability to assess and mitigate that risk while living independently. Include descriptions of the individual’s ability to care for him/herself and to live independently based on activities detailed above (shelter, food, hygiene, risk).

Medical: This domain refers to the individual’s participation in his/her medical care activities. These activities may include but are not limited to: preventive activities, determining when and how to access medical care services, making and keeping appointments, ability to engage as an active participant in medical health management (including making needs and opinions known to the health care provider), and the ability to self-direct and follow medical care interventions in order to maintain or improve physical health and/or manage known medical conditions and/or diseases. This may include monitoring blood pressure; maintaining a low sugar, low fat diet; exercising; maintaining weight; etc. Include descriptors of the individual’s ability to perform the related activities above in regards to medical care (identifying need, making and keeping appointments, following through on recommendations, participating in self-directed care and activities, etc.). This domain may also include the individual’s ability to navigate the health care system, regarding both access to providers and access to health care benefits.

Dental: This domain refers to the individual’s participation in his/her dental care activities. These activities may include, but are not limited to, preventive activities; determining when and how to access dental care; making and keeping appointments; ability to engage as an active participant in dental health management including making needs and opinions known to the dental health care provider; and the ability to self-direct and follow dental care interventions to meet needs, to maintain, or improve dental health, and/or to manage known dental conditions and/or diseases. Include descriptions of the individual’s ability to perform the related activities above in regards to dental care (identifying need, making and keeping appointments, following through on recommendations, participating in self-directed care and activities, etc.).

This domain may also include the individual’s ability to maintain access to dental health care including the individual’s ability to navigate the dental health care system both regarding access to providers and access to dental health care benefits.

Financial: This domain refers to the individual’s participation in personal finance-related activities. These activities include, but are not limited to, identifying financial resources and securing entitlements or payee functions. This domain also encompasses the much broader category of financial management and the abilities needed to manage finances independently. This can include: whether the individual is currently managing his/her own financial resources, what abilities he/she has for self-management in having sufficient financial resources, and in managing resources independently. Include necessary budgeting skills not included in self-care/independently domain.
Housing: This domain refers to the individual’s participation in housing-related activities. These activities include, but are not limited to, identification of lack of housing resources and the securing of housing by others for the individual. Information about the individual’s current housing status such as housing needs and resources and housing (non-housing) preferences may be identified. Descriptors that identify the individual’s challenges related to stable housing, how or whether the individual is currently managing his/her own housing resources, and what abilities he/she has for self-management in having sufficient housing resources and in managing those resources independently should be included. Descriptors may also include the individual’s challenges related to maintaining housing arrangements where the individual might otherwise have access to housing with others (examples include: communication skills or lack thereof, anger management issues, relationship problems, trust issues.) Include functioning descriptors around necessary independent living skills that affect potential loss of housing; meeting needs for safe and adequate shelter through securing, organizing, and maintaining that shelter; and/or safety and security risk with current housing setting not included in self-care/independently domain.

Transportation: This domain refers to the individual’s participation in transportation activities. These activities may include, but are not limited to: knowledge and ability related to general access to and availability of public and private transportation in his/her community, determining modes of transportation available, identifying and securing resources (financial, tokens, people) needed to use transportation, accessing specific types of transportation (bus, train, car, taxi, and/or van service, private car driven by friend or volunteer), and the activities and skills needed to do so (e.g., reading and following a bus/train schedule; calling taxi/van transportation dispatch; contacting a friend, neighbor, or volunteer). Include descriptors of the individual’s ability to perform the related activities above as well as level of functioning in following schedules; making, being ready, and keeping transportation appointments; interacting and interfacing with those providing transportation and, in the case of public transportation, interacting and interfacing with those using transportation while waiting in bus/train queues, riding as passenger, etc. Descriptors may also include the individual’s challenges related to group transportation methods, which may include interpersonal skills, hygiene skills, social skills, and symptom management in group or public settings. Descriptions may also include the individual’s judgment around transportation safety.

Other: This is an optional domain. Suggested topics for this domain may include, but are not limited to: legal, risk for harm (self/others) including self-injurious behaviors, spirituality, language, immigration acclamation, transition to adulthood, cognitive abilities, additional co-occurring issues (besides chemical use and physical health), etc. As in all domains, it is expected the domain be clearly defined and include the individual’s current functioning, strengths and/or impairments. History of function may be included in the initial assessment, or as information is obtained, if it lends context to current functioning.

Level of Care Utilization System (LOCUS)

Overview
LOCUS is a level of care tool designed to help determine the resource intensity needs of individuals being served within the adult mental health system and is a key eligibility requirement for these services. The mental health provider must complete the LOCUS Recording Form (DHS-6249) prior to delivering the following PrimeWest Health services:
1. Adult Day Treatment – Level 3
2. ARMHS – Level 3 or Level 2
3. ACT – Level 4
4. Intensive Community Rehabilitative Services (ICRS) – Level 4 or Level 3
5. IRTS – Level 5
6. Partial hospitalization – Level 4
LOCUS Levels
After the provider completes the LOCUS assessment, the resulting number indicates the level of care needs. The LOCUS levels above indicate the appropriate level for an individual to be admitted into a specific program.

1. Clearly document clinical justification of service provision outside of the LOCUS level prescribed to a service type. The written clinical justification must include how the member’s resource intensity needs would be or are being met through the proposed service.
2. Include a brief description of the variance on the LOCUS Recording Form (DHS-6249) and a separate, more in-depth description within the member’s medical record. This can be on a separate form, as part of a clinical summary, and/or a part of the interpretive summary (if completed by the mental health professional).

Complete the LOCUS Assessment
1. As part of the FA
2. Within the same timelines indicated for the specific rehabilitative mental health service that is currently in place for completing the FA. A LOCUS assessment is required every 180 days (six months). The period of time starts from the time the LOCUS is completed and signed by the mental health professional.
3. Within ten days of discharge. If the member ends services without notice and leaves before a discharge, the LOCUS can be completed. In a discharge summary, document the reason the LOCUS was unable to be completed.

If a significant change in a member’s functioning and/or significant life event occurs, reassess the member using the LOCUS tool.

LOCUS Assessment Steps
1. Use the LOCUS Recording Form (DHS-6249).
2. Keep the completed LOCUS tool in the member’s medical record.
3. Have the clinical supervisor sign the form.

Eligible Providers
Refer to the above programs to determine if you are eligible to provide these services and complete the LOCUS Recording Form (DHS-6249).

A mental health professional can complete a LOCUS Recording Form (DHS-6249) without needing the assessment to be reviewed and signed by another professional.

Clinical Supervision
1. A mental health professional can review and sign the completed LOCUS Recording Form (DHS-6249) if he/she is acting as the clinical supervisor.
2. As is true with all assessment information needing the review of a clinical supervisor, the LOCUS Recording Form (DHS-6249) is not technically valid until all necessary signatures have been obtained.

Adult Mental Health Targeted Case Management (AMH-TCM)
Adult members receiving MH-TCM are required to have a completed LOCUS assessment as it pertains to the case manager’s responsibilities of: assessment, ICSP planning, referral, coordination, and monitoring of services.

Clinical Justification for Exceptions
PrimeWest Health may allow for exceptions for other proposed services, but exceptions will require documented clinical justification. The written clinical justification must include how the individual’s resource intensity needs would be or are being met through the proposed service. Include a brief description of the
variance in the *Reason for Variance* field of the *LOCUS Recording Form (DHS-6249)*, and include a more in-depth description in the member’s medical record. This can be on a separate form, as part of a clinical summary, and/or a part of the interpretive summary (if completed by the mental health professional).

**Time Frames for a LOCUS to be “Current”**

You may use a current LOCUS assessment completed by another provider/agency/county at the time of admission into the program if:

1. You receive appropriate permissions from the member
2. The LOCUS has been completed within 30 days from admission; and
3. The clinical supervisor has reviewed the LOCUS and determined that there are no changes in the clinical picture of the individual seeking admission since the original LOCUS was completed.

The clinical supervisor can make the decision to complete another LOCUS.

Completion of the LOCUS needs to follow the same timelines, dictated per service type, that are currently in place for completing the FA). The longest a LOCUS form can be valid is for 180 days (six months). However, depending on the requirements per service, the LOCUS will need to be completed more often to be valid. Beyond the referral process, a LOCUS assessment will be considered “current” as it relates to the amount of time each service has to update the FA and LOCUS. The period of time starts from the time the LOCUS is completed and signed by the mental health professional. For example, AMH-TCM service providers have six months between updates for the FA and LOCUS. If the LOCUS is completed and signed on October 1, 2012, then it is no longer current after March 31, 2013.

1. Complete a LOCUS within 10 days of discharge. If the member ends services without notice and leaves before a discharge LOCUS can be completed, indicate in the discharge summary or elsewhere why the discharge LOCUS was unable to be completed.
2. As is true for the FA, if there has been a significant change in an individual’s functioning and/or significant life events have occurred, the LOCUS should be reassessed.

**Additional Resources**

1. DHS Bulletins 09-53-04 and 09-53-04C
2. *American Association of Community Psychiatrists*
3. *LOCUS Questionnaire booklet*

**Individual Treatment Plan (ITP)**

PrimeWest Health only covers services in accordance with the member’s ITP, except DAs and in cases of emergency. The member’s ITP must be all of the following:

1. Based on the information and outcome of the DA
2. Involve the member in the development, review, and revision of the ITP
3. Developed by the mental health professional who provides the psychotherapy, no later than the end of the first psychotherapy session, or five days, if the member is in a day treatment program
4. Signed by the member (including revisions), unless the request is not appropriate to the member’s mental health status. In the case of a child, the child’s parent, primary caregiver, or other authorized person must sign the ITP. If a member refuses to sign the ITP or his/her mental health status contraindicates the request, the mental health professional must document the circumstances in the ITP.
5. Reviewed at least once every 90 days and, if necessary, revised. **Exception:** ARMHS allows review at least once every 180 days and allows the ICSP to be used instead of an ITP if a mental health case manager is involved and with the member’s approval. The ICSP must include the criteria in *MN Stat. sec. 256B.0623, subd. 10.2.*
Telemedicine Delivery of Mental Health Services

PrimeWest Health covers delivery of mental health services through telemedicine.

Telemedicine does all of the following:
1. Delivers mental health services using two-way interactive video that can:
   a. Extend limited resources
   b. Expand the geographical area over which a mental health provider can offer direct service
   c. Save time and energy without compromising quality
2. Allows providers and the member greater flexibility and increased access when delivering/receiving services
3. Allows members to receive needed services without having to travel long distances

Eligible Members

Members are eligible to receive their mental health services via telemedicine when:
1. Telemedicine is determined medically appropriate
2. The member has provided his/her consent before receiving services via telemedicine
3. The member is present to receive service through the telemedicine method

Eligible Providers

Providers currently authorized to provide mental health services may conduct the same services via telemedicine, except for the following services:
- Day treatment
- Partial hospitalization programs
- Residential treatment services
- Case management, face-to-face contact

Providers providing telemedicine services must do all of the following:
1. Conduct a risk analysis
2. Develop a risk management plan
3. Employ strategies to minimize vulnerabilities in technological equipment and systems
4. Create safe and private accommodations for members receiving services by telemedicine
5. Ensure procedures are in place to prevent system failures that could lead to a breach in privacy or cause exposure of member mental health records to unauthorized persons
6. Use high quality interactive video and audio communications systems and equipment
7. Be prepared administratively, operationally, and technologically

Interactive telemedicine systems must be compliant with Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements and regulations.

Billing

Refer to the following when billing for services provided through telemedicine:
1. Services provided via telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face.
2. Bill for mental health services delivered via telemedicine with POS 02 for the distant site.
3. Use the place of service code that identifies the location of the member when the service was provided. The servicing facility location or receiving site should be included on the claim along with the service facility
NPI. If the servicing facility is a PrimeWest Health network provider, no additional authorization is required.

4. PrimeWest Health will reimburse the receiving site/servicing facility a facility charge. Bill Q3014 for the facility charge.

**Eligible Mental Health Providers**

Mental health providers include agencies and individuals (professionals and practitioners). Each mental health agency must have at least one mental health professional on staff. Providers may be eligible to enroll as PrimeWest Health providers (mental health professionals) or may be eligible to provide services but not eligible to enroll as PrimeWest Health providers.

When qualified State staff provides adult mental health services, they are considered part of the certified local provider entity and their services may be billed in accordance with typical billing practices as appropriate to the specific service.

**Enrollable Mental Health Agencies**

1. Adult Day Treatment
2. Billing entity for mental health
3. County-contracted mental health rehabilitation service
4. Community Mental Health Center (CMHC)
5. County human service agency
6. Indian Health Service (IHS)
7. Outpatient hospital
8. Physician-directed clinic
9. School district

**Enrollable Mental Health Professionals**

1. Clinical Nurse Specialist (CNS)
2. Licensed Independent Clinical Social Worker (LICSW)
3. Licensed Marriage and Family Therapist (LMFT)
4. Licensed Professional Clinical Counselor (LPCC)
5. Licensed Psychologist (LP)
6. Mental health rehabilitative professional
7. Psychiatric nurse practitioner (NP)
8. Psychiatrist
9. Osteopathic physician
10. Tribal-certified professional

**Who Can Conduct Mental Health Diagnostic Assessments (DAs) and Psychotherapy?**

Select mental health practitioners may provide specific mental health services under limited conditions (MHCP Professional Certification & Enrollment Requirements).

**Non-Enrollable Mental Health Providers**

1. Adult mental health rehabilitation worker
2. Certified peer specialist (CPS)
3. Mental health behavioral aide (CTSS only)
4. Mental health practitioners
5. Mental health practitioner clinical trainee
6. Mental Health Targeted Case Manager/Case Manager Associate (CMA)

**Clinical Supervision Requirements**

**Definition**

Clinical supervision is the documented time a clinical supervisor and supervisee spend together to discuss the supervisee’s work, to review individual member cases, and for the supervisee’s professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a member’s mental health treatment.

**Coverage Requirements**

All mental health practitioners must receive clinical supervision. Clinical supervision must be based on each supervisee’s written supervision plan and must do all of the following:

1. Promote professional knowledge, skills, and values development
2. Model ethical standards of practice
3. Promote cultural competency by:
   a. Developing the supervisee’s knowledge of cultural norms of behavior for individual members and generally for the members served by the supervisee regarding the member’s cultural influences, age, class, gender, sexual orientation, literacy, and mental or physical disability;
   b. Addressing how the supervisor’s and supervisee’s own cultures and privileges affect service delivery;
   c. Developing the supervisee’s ability to assess his/her own cultural competence and to identify when consultation or referral of the member to another provider is needed; and
   d. Emphasizing the supervisee’s commitment to maintaining cultural competence as an ongoing process.
4. Recognize that the member’s family has knowledge about the member and will continue to play a role in the member’s life and encourage participation among the member, member’s family, and providers as treatment is planned and implemented
5. Monitor, evaluate, and document the supervisee’s performance of assessment, treatment planning, and service delivery

Clinical supervision must be conducted by a qualified supervisor using individual and/or group supervision. Individual and/or group face-to-face supervision may be conducted via electronic communications that utilize interactive telecommunications equipment that includes, at a minimum, audio and video equipment for two-way, real-time, interactive communication between the supervisor and supervisee, and meet the equipment and connection standards of telemedicine.

1. Individual supervision means one or more designated clinical supervisors and one supervisee.
2. Group supervision means one clinical supervisor and two – six supervisees in face-to-face supervision.

Clinical supervision must be recorded in the supervisee’s supervision record. The documentation must include the following:

1. Date and duration of supervision
2. Identification of supervision type as individual or group supervision
3. Name of the clinical supervisor
4. Subsequent actions that the supervisee must take
5. Date and signature of the clinical supervisor

Clinical supervision pertinent to member treatment changes must be recorded by a case notation in the member record after supervision occurs.
Clinical Trainees

Medical Assistance (Medicaid) covers DA, explanation of findings, and psychotherapy performed by a mental health practitioner working as a clinical trainee when:

1. The mental health practitioner is:
   a. Complying with requirements for licensure or board certification as a mental health professional (does not include mental health rehabilitative professional), including supervised practice in the delivery of mental health services for the treatment of mental illness; or
   b. A student in a bona fide field placement or internship under a program (the individual is only considered a clinical trainee while at his/her internship/field placement, not at any other employment he/she may hold at that time) leading to completion of the requirements for licensure as a mental health professional; and

2. The mental health practitioner’s clinical supervision experience is helping the practitioner gain knowledge and skills necessary to practice effectively and independently. This may include supervision of the following:
   a. Direct practice
   b. Treatment team collaboration
   c. Continued professional learning
   d. Job management

Clinical Supervisor

A clinical supervisor must:

1. Be a licensed mental health professional;
2. Hold a license without restrictions that has been in good standing for at least one year while having performed at least 1,000 hours of clinical practice;
3. Be approved, certified, or in some other manner recognized as a qualified clinical supervisor by the person’s professional licensing board, when this is a board requirement;
4. Be competent as demonstrated by experience and graduate-level training in the area of practice and the activities being supervised;
5. Not be the supervisee’s blood or legal relative or cohabitant, or someone who has acted as the supervisee’s therapist within the past two years;
6. Have experience and skills that are informed by advanced training, years of experience, and mastery of a range of competencies that demonstrate the following:
   a. Capacity to provide services that incorporate best practice;
   b. Ability to recognize and evaluate competencies in supervisees;
   c. Ability to review assessments and treatment plans for accuracy and appropriateness;
   d. Ability to give clear direction to mental health staff related to alternative strategies when a recipient is struggling with moving towards recovery; and
   e. Ability to coach, teach, and practice skills with supervisees;
7. Accept full professional liability for a supervisee’s direction of a member’s mental health services;
8. Instruct a supervisee in the supervisee’s work, and oversee the quality and outcome of the supervisee’s work with members;
9. Review, approve, and sign the DA, ITPs, and treatment plan reviews of members treated by a supervisee;
10. Review and approve the progress notes of members treated by the supervisee according to the supervisee's supervision plan (MN Rules 9505.0371);
11. Apply evidence-based practices and research-informed models to treat members;
12. Be employed by or under contract with the same agency as the supervisee;
13. Develop a clinical supervision plan for each supervisee;
14. Ensure that each supervisee receives the guidance and support needed to provide treatment services in areas where the supervisee practices;
15. Establish an evaluation process that identifies the performance and competence of each supervisee; and
16. Document clinical supervision of each supervisee and securely maintain the documentation record.

Clinical supervisors who supervise clinical trainees must complete the *Qualified Mental Health Professional Clinical Supervision Assurance Statement (DHS-6330)* in order for the clinical trainee’s time spent conducting DAs, psychotherapy, or explanation of findings to be billed.

**Clinical Supervision Plan**

The supervision plan must be developed by the supervisor and the supervisee. The plan must be reviewed and updated at least annually. For new staff, the plan must be completed and implemented within 30 days of the new staff person’s employment. The supervision plan must include the following:
1. The name and qualifications of the supervisee and the name of the agency in which the supervisee is being supervised
2. The name, licensure, and qualifications of the supervisor
3. The number of hours of individual and group supervision to be completed by the supervisee including whether supervision will be in person or by some other method approved by the commissioner
4. The policy and method that the supervisee must use to contact the clinical supervisor during service provision to a supervisee
5. Procedures that the supervisee must use to respond to member emergencies
6. Authorized scope of practices, including the following:
   a. Description of the supervisee’s service responsibilities
   b. Description of recipient population
   c. Treatment methods and modalities

**Eligible Members**

All PrimeWest Health members are eligible. Refer to *Benefits* section for coverage determination.

A resident of an Institution for Mental Disease (IMD) is eligible to receive Medical Assistance (Medicaid) services only if the member is receiving inpatient psychiatric care in a Joint Commission of Accreditation of Healthcare Organizations (JCAHO)-accredited psychiatric facility and meets one of the following criteria:
1. Is under age 21
2. Is age 21 but less than age 22 and has been receiving inpatient psychiatric care in the IMD continuously since the resident’s twenty-first birthday
3. Is at least age 65

**Non-Covered Services**

The following mental health services are not covered:
1. Mental health services provided by a non-psychiatrist, except psychological testing, to a member who is inpatient and has a mental illness diagnosis (these services are included in the hospital’s payment)
2. Mileage (provider travel time is not the same as mileage)
3. Transporting a member
4. Telephone calls
5. Written communication between provider and member
6. Reporting, charting, and record keeping
7. Community planning or consultation, program consultation/monitoring/evaluation, public information, training and education activities, and resource development
8. Fundraising
9. Court-ordered services for legal purposes
10. Mental health service not related to the member’s diagnosis or treatment for mental illness
11. Services dealing with external, social, or environmental factors not directly addressing the member’s physical or mental health
12. Staff training
13. Mental health case management for members receiving similar services through the Veterans Administration (VA)
14. Duplicate services (for example, mental health case management for members receiving case management services through Home and Community Based Services [HCBS])
15. Mental health services provided by a school or local education agency, unless the school or agency is a PrimeWest Health-enrolled provider and the services are medically necessary and prescribed in the child’s ITP
16. Mental health services provided by an entity whose purpose is not health service related (for example, services provided by the Division of Vocational Rehabilitation or Jobs and Training)
17. Legal services, including legal advocacy, for the member
18. Information and referral services included in the county’s community social service plan
19. Outreach services through the community support services program
20. CTSS provided to a child who has not had a DA, except the first 30 hours provided to a child who later is assessed and diagnosed with SED at the time the services were initiated
21. CTSS concurrently provided by more than one mental health professional or practitioner (two providers may not provide services during the same time, for example, 9 – 9:15 a.m.)
22. Assistance in locating respite care, special needs day care, and assistance in obtaining financial resources, except when these services are provided as part of case management
23. Member outreach
24. Recreational services, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack times, trips to community activities, etc.

**PrimeWest Health-Specific Mental Health Billing Guidelines – General**

1. Member-related activities, such as documentation, are not separately billable.
2. At least 75 percent of each unit of billable time must be spent providing direct service to the member.
3. Not more than 25 percent of a billed unit may be spent on documentation or other member-related activities.
4. However, if a member receives more than one hour of direct service in a day, the time spent on member-related activities cannot increase proportionately. For example: if you provide three hours of direct service, you cannot bill one hour of member-related activity.

If you provide direct service and member-related activity on different days:
1. Do not combine the times into a single unit of service
2. Bill only the direct service time
3. Do not bill time spent on member-related activity
Right to Appeal Denial of Certification or County Contract

Providers required to be certified by or contracted with a county as part of the criteria to become an authorized provider of mental health services under Medicaid rules may Appeal to the commissioner a county refusal to grant the necessary contract or certification. A member may initiate an Appeal on behalf of a provider denied certification. A request for a review of the county decision may be sent/faxed to the Adult or Children’s Mental Health Division at:

DHS Mental Health Division – Appeal Review
PO Box 64981
444 Lafayette Rd
Saint Paul, MN 55164-0981

Or

For adults, fax to: **1-651-431-7418** (Attn: Mental Health Appeal Review)

For children, fax to: **1-651-431-2321** (Attn: Mental Health Appeal Review)

Adult Crisis Response

Adult crisis response services are community-based services provided by a county or county-contracted crisis team to adults age 18 and over.

Eligible Adult Crisis Providers

A crisis response provider must be a county or county-contracted mental health professional, practitioner, or rehabilitation worker; or a mobile crisis intervention team.

A mobile crisis intervention team must consist of the following:
1. Two or more mental health professionals; or
2. At least one mental health professional and one mental health practitioner.

Certified peer specialists may provide certified peer specialist services during all phases of crisis response.

Mental health practitioners and rehabilitation workers must:
1. Have completed at least 30 hours of crisis intervention and stabilization training during the past two years
2. Be consulted by the clinical supervisor, in person or by phone, during the first three hours the practitioner provides on-site services
3. Be under clinical supervision by a mental health professional who:
   a. Is employed by or under contract with the crisis response provider
   b. Accepts full responsibility for the services provided. The clinical supervisor must:
      i. Be immediately available to staff by phone or in person
      ii. Document consultations
      iii. Review, approve, and sign the crisis assessment and treatment plan performed by mental health practitioners within one day
      iv. Document on-site observations in the member’s record
Crisis response providers must be experienced in and/or have knowledge of the following:
1. Mental health assessment
2. Treatment engagement strategies
3. How to work with families and others in the member’s support system
4. Crisis intervention techniques
5. Emergency clinical decision-making abilities
6. Local services and resources

MHCP strongly encourages crisis services providers to contract with PrimeWest Health.

The PrimeWest Health Mental Health and Chemical Dependency Services contact table is available as Greater Minnesota PMAP and MinnesotaCare Contact Grid for Mental Health and Chemical Health Services (DHS-4484).

**Crisis Residential Settings**

When Crisis Stabilization services are provided in any residential setting, the following requirements apply:
1. All staff must have immediate access to a qualified mental health professional or practitioner, 24-hours per day. The access can be direct or by telephone.
2. A qualified mental health professional or practitioner must provide face-to-face contact with the recipient every day.

When Crisis Stabilization services are provided in a residential setting that serves four or fewer adults, the setting must be licensed as an adult foster care home.

If more than two individuals are receiving crisis response services, one of the following providers must be on site at least 8 hours per day:
1. Mental health professional
2. Crisis-trained mental health practitioner
3. Crisis-trained rehabilitation worker
4. Crisis-trained certified peer specialist

When Crisis Stabilization services are provided in a residential setting that serves more than four adults, the setting must be licensed under Rule 36 with a Crisis Stabilization variance.

One of the following providers must be present 24 hours per day:
1. Mental health professional
2. Crisis-trained mental health practitioner
3. Crisis-trained rehabilitation worker
4. During the first 48 hours a recipient receives Crisis Stabilization services, at least two staff must be present 24 hours per day. Only one staff is required to be trained in providing crisis services.

**Eligibility for Residential Crisis Stabilization Services**

In addition to the requirements listed under Eligible Recipients, recipients must:
1. Need residential crisis stabilization services to avoid hospitalization or loss of independent living
2. Be referred by a mental health crisis team, an Emergency Department physician or a mental health professional
Authorization Requirements for Residential Crisis Stabilization

Authorization is needed to exceed the maximum threshold of 10 days in a calendar month. To request authorization, submit an MHCP Authorization Form (DHS-4695) with the following documentation:
1. Crisis Assessment, completed before intake by any of the following:
   a. Crisis team
   b. Mental health professional
   c. Emergency department physician
2. Progress notes from the time of intake
3. Crisis Stabilization plan
4. Discharge plan or plans for transitioning to the community, including referrals to other service providers (services are coordinated after the recipient leaves the facility)
5. Identify symptoms that have not returned to the recipient’s baseline level
6. Other options considered, including hospitalization and community crisis stabilization
7. Written explanation of why the recipient needs more time and the anticipated outcome

Authorization is not required for crisis assessment, stabilization, and intervention

Eligible Members

To be eligible for PrimeWest Health adult crisis response services, a member must be all of the following:
1. Eligible for Medical Assistance (Medicaid), MinnesotaCare (check the Evidence of Coverage [EOC] for coverage), PrimeWest Senior Health Complete (HMO SNP), Minnesota Senior Care Plus (MSC+), Prime Health Complete (HMO SNP) or Special Needs BasicCare (SNBC)
2. Age 18 or over
3. Experiencing a mental health crisis or emergency

Covered Services

Mental health crisis response services are covered and reimbursed through PrimeWest Health. This coverage is effective for all PrimeWest Health eligible members.

Crisis response services include the following:
1. Crisis assessment
2. Crisis intervention
3. Crisis stabilization
4. Community intervention

Certified peer specialists may provide certified peer specialist services during all phases of the crisis response.

Crisis Assessment

A crisis assessment:
1. Is an immediate, face-to-face evaluation by a physician, mental health professional, or practitioner to determine the member’s presenting situation and identify any immediate need for emergency services
2. Provides immediate intervention to provide relief of distress based on a determination that the member’s behavior is a serious deviation from his/her baseline level of functioning
3. Evaluates, in a culturally appropriate way and as time permits, the member’s current:
   a. Life situation and sources of stress
   b. Symptoms, risk behaviors, and mental health problems
   c. Strengths and vulnerabilities
d. Cultural considerations  

 e. Support network  

 f. Functioning  

Conduct the crisis assessment in the member’s home, the home of a family member, or another community location. Determine the need for crisis intervention services or referrals to other resources based on the assessment.

If the services continue into a second calendar day, a mental health professional must contact the member face-to-face on the second day to provide services and update the crisis treatment plan. For this service, “second calendar day” means 24 hours from the beginning of the face-to-face intervention. The mental health professional is not restricted to only the professional who was supervising the service when the face-to-face crisis intervention began.

**Crisis Intervention**

Mobile crisis interventions are face-to-face, short-term intensive mental health services started during a mental health crisis or emergency to help the member do the following:

1. Cope with immediate stressors and lessen his/her suffering  
2. Identify and use available resources and member’s strengths  
3. Avoid unnecessary hospitalization and loss of independent living  
4. Develop action plans  
5. Begin to return to his/her baseline level of functioning

Mobile crisis intervention services must be:

1. Available 24 hours per day, seven days per week, 365 days per year  
2. Provided on-site by a mobile team in a community setting  
3. Provided promptly

Mobile crisis response providers do not have to provide services 24 hours per day if they have requested and received a waiver of the 24-hour requirement from DHS. To receive a waiver, they must show that the services cannot be provided 24 hours per day due to inability to hire qualified staff or because of sparse population and wide geographic area to be served.

**Crisis Intervention Treatment Plan**

With the member, develop, document, and implement an initial crisis intervention treatment plan within 24 hours after the initial face-to-face intervention to reduce or eliminate the crisis.

A crisis intervention treatment plan should do the following:

1. List the member’s needs and problems identified in the crisis assessment  
2. Identify the following:  
   a. Frequency and type of services to be provided  
   b. Measurable short-term goals  
3. Specify objectives directed toward the achievement of each goal  
4. Note cultural considerations  
5. Recommend needed services, including crisis stabilization  
6. Refer to appropriate local resources, such as the county social services agency, mental health services, local law enforcement  
7. Contain clear progress notes of the outcome of goals and frequency and type of services to be provided to achieve the goals and reduce or eliminate the crisis  
8. If the member has a case manager, coordinate the planning of other services with the case manager
Update the crisis intervention treatment plan as needed to reflect current goals and services.

If the member shows positive change in a baseline of functioning or a decrease in personal distress:
1. Make (and document) a referral to less intensive mental health services; or
2. Document short-term goals that have been met and when no further crisis intervention services will be needed.

If the recipient is unable to follow-up with a referral, the crisis response provider must link the recipient to the service and follow-up to ensure that the recipient is receiving the service.

The member must sign the treatment plan. If the member refuses to approve and sign the plan, the team must note the refusal and the reason(s) for the refusal in the treatment plan. A mental health professional must approve and sign the treatment plan. Give a copy of the treatment plan to the member.

If the services continue into a second calendar day, a mental health professional must contact the member face-to-face on the second day to provide services and update the crisis treatment plan.

**Crisis Stabilization**

Crisis stabilization services are mental health services provided to a member after crisis intervention to help the member obtain his/her functional level as it was before the crisis.

1. Provide stabilization services
   a. In the community
   b. Based on the crisis assessment and intervention treatment plan
2. Consider the need for further assessment and referrals.
3. Update the crisis stabilization treatment plan
4. Provide supportive counseling
5. Conduct skills training
6. Collaborate with other service providers in the community
7. Provide education to members family and significant others regarding mental illness and how to support the member

**Crisis Stabilization Treatment Plan**

With the participation of the member, develop a crisis stabilization treatment plan within 24 hours of beginning services. The crisis stabilization treatment plan, at a minimum, must include the following:

1. Problems identified in the assessment
2. Concrete, measurable short-term goals and tasks to be achieved, including time frames for achievement
3. Specific objectives directed toward achieving each goal
4. Clear progress notes about outcomes of goals
5. List of member’s strengths and resources
6. Documentation of participants involved and a crisis response action plan, if another crisis should occur
7. Frequency and type of services initiated, including a list of providers, as applicable

The member must sign the treatment plan. If the member refuses to approve and sign the plan, the team must note the refusal and the reason(s) for the refusal. A mental health professional must approve and sign the crisis stabilization treatment plan. Give a copy of the plan to the member.

**Community Intervention**

Community intervention is a service of strategies provided on behalf of a member to do the following:
1. Alleviate or reduce a member’s barriers to community integration or independent living; or
2. Minimize the risk of hospitalization or placement in a more restrictive living arrangement.
Community intervention may be conducted with an agency, institution, employer, landlord, or member’s family and may require the involvement of the member’s relatives, guardians, friends, employer, landlord, treatment providers, or other significant people, to change situations and allow the member to function more independently.

Community intervention:
1. Must be directed exclusively to the treatment of the member;
2. Must be provided on an individual basis only (cannot be provided in a group);
3. May be conducted in person or by telephone, if the intervention strategy warrants it (document accordingly); and
4. Can be conducted without the member present when the intervention strategy warrants it (document why the strategy is more effective without the member present).

Community intervention may not be billed for the following:
1. Routine communication between members of a treatment team, a routine staffing, or a care conference
2. Telephone contacts that do not conform to the definition of this service or that are not properly documented
3. Clinical supervision or consultation with other professionals
4. Treatment plan development

Non-Covered Services

The following services are not covered as crisis response services:
1. Member transporting services
2. Crisis response services performed by volunteers
3. Provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the member’s household, housekeeping, and grocery shopping for the member
4. Time spent “on call” and not delivering services to members
5. Activities primarily social or recreational in nature, rather than rehabilitative
6. Job-specific skills services such as on-the-job training
7. Case management
8. Outreach services to potential members
9. Crisis response services provided by a hospital, board and lodging, or residential facility to a member at that facility
10. Room and board

Billing for Adult Crisis Services

1. Bill for direct, face-to-face service(s) provided to an eligible member by a qualified staff person.
2. Use the 837P claim format.
3. Enter the actual place of service (POS) code.
4. Enter the individual treating provider number.
5. When an off-site team member (professional) works with an on-site team member, the professional may bill for time spent working directly with the on-site member.
6. Two team members who are providing services on-site may bill for time spent providing service.

<table>
<thead>
<tr>
<th>Code</th>
<th>Minnesota Health Care Programs (MHCP) Service</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9484</td>
<td>Adult crisis assessment, intervention, and stabilization – individual – professional</td>
<td>60 minutes</td>
</tr>
<tr>
<td>S9484 HN</td>
<td>Adult crisis assessment, intervention, and stabilization – individual – practitioner</td>
<td>60 minutes</td>
</tr>
<tr>
<td>S9484 HM</td>
<td>Adult crisis assessment, intervention, and stabilization – individual – rehabilitation worker</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>
### Code | Minnesota Health Care Programs (MHCP) Service | Unit
---|---|---
S9484 HQ | Adult crisis stabilization | 60 minutes

The changes above do not apply to the coverage, coding, or authorization thresholds for residential crisis stabilization (H0018) or community intervention (90882).

### Code | Minnesota Health Care Programs (MHCP) Service | Unit
---|---|---
H0018 | Crisis stabilization, residential | 1 day
90882 HK | Community intervention – professional or practitioner or mental health rehabilitation agency | 1 session
90882 HK HM | Community intervention – rehabilitation worker or agency | 1 session

### Diagnostic Assessment (DA)

A DA is a written report that documents clinical and functional face-to-face evaluation of a member’s mental health, including the nature, severity, and impact of behavioral difficulties, functional impairment, and subjective distress of the member, and identifies the member’s strengths and resources. A DA is necessary to determine a member’s eligibility for mental health services.

An interactive DA is usually performed with children and uses physical aids and nonverbal communication to overcome communication barriers because the member:

1. Has lost or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment;
2. Does not possess the receptive communication skills to understand the mental health professional if he/she were to use ordinary adult language for communication; or
3. Needs an interpreter, whether due to hearing impairment or the member and the provider speaking a different language, in order to participate in the DA.

### Eligible Providers

1. Licensed mental health professionals, except allied mental health professionals and adult mental health rehabilitation professionals
2. An individual certified by tribal council as a mental health professional serving a Federally recognized tribe
3. Mental health practitioners who qualify as clinical trainees and are clinically supervised by a mental health professional who is enrolled with the clinical supervisor specialty

Clinical supervision pertinent to member treatment changes must be recorded by a case notation in the member record after supervision occurs.

### Eligible Members

All PrimeWest Health members are eligible. Refer to Benefits section for coverage determination.

### Covered Diagnostic Assessment (DA) Services

PrimeWest Health covers four types of DAs when they are provided in accordance with the requirements as explained in each type.
To be eligible for PrimeWest Health payment, a DA must:
1. Identify a mental health diagnosis and recommended mental health services that are the factual basis to develop the members’ mental health services and treatment plan or include a finding that the member does not meet the criteria for a mental health disorder
2. Be a face-to-face interview with the member and a written evaluation
3. Meet the conditions of one of the following four types of DA. Include a description of which of these types of DA is used in the written report:
   a. Brief DA
   b. Standard DA
   c. Extended DA
   d. Adult DA Update

DAs may be conducted using telemedicine technology when appropriate.

**Brief Diagnostic Assessment (DA)**

A brief DA includes the following:
1. Sufficient information to apply a provisional clinical hypothesis – the clinical hypothesis may be used to address the recipient’s immediate needs or presenting problem
2. The member’s current life situation, including the following:
   a. Age
   b. Current living situation (including household membership and housing status)
   c. Basic needs status including economic status
   d. Education level and employment status
   e. Significant personal relationships (including member’s evaluation of relationship quality)
   f. Strengths and resources (including extent and quality of social networks)
   g. Belief system
   h. Contextual non-personal factors contributing to the member’s presenting concerns
   i. General physical health and relationship to member’s culture
   j. Current medications
3. Member’s description of symptoms (including reason for referral)
4. A mental status exam
5. Screenings used to determine a member’s substance use, abuse, or dependency, and other standardized screening instruments
6. A clinical summary that explains the provisional diagnostic hypothesis

A brief DA may be used for the following:
1. A new member
2. An existing member who had less than 10 sessions of psychotherapy in previous 12 months and is projected to need ten or fewer psychotherapy session in the next 12 months
3. An existing member who only needs medication management
4. An annual assessment, if the member’s treatment history and provider’s clinical judgment suggest the member will need ten or fewer mental health sessions in the next 12 months

A brief DA must not be used:
1. When a member or member’s family requires a language interpreter to participate, unless the member:
   a. Had fewer than 10 sessions of psychotherapy in the previous 12 months and is projected to need fewer than 10 sessions in the following 12 months
   b. Receives only medication management
2. When a member is expected to need more than 10 sessions of mental health services in a 12-month period.
Standard Diagnostic Assessment (DA)
A standard DA must include the following:
1. Be conducted in the member’s cultural context
2. The member’s current life situation including the following:
   a. Age
   b. Current living situation (including household membership and housing status)
   c. Basic needs status including economic status
   d. Education level and employment status
   e. Significant personal relationships (including member’s evaluation of relationship quality)
   f. Strengths and resources (including extent and quality of social networks)
   g. Belief system
   h. Contextual non-personal factors contributing to the member’s presenting concerns
   i. General physical health and relationship to member’s culture
   j. Current medications
3. The reason for the assessment, including the member’s:
   a. Perceptions of his/her condition
   b. Description of symptoms (including reason for referral)
   c. History of mental health treatment (including review of member’s records)
   d. Important developmental incidents
   e. Maltreatment, trauma, or abuse issues
   f. History of alcohol and drug usage and treatment
   g. Health history and family health history, including physical, chemical, and mental health history
   h. Cultural influences and their impact on the member
4. A mental status exam
5. An assessment of the member’s needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, and safety
6. Screenings used to determine a member’s substance use, abuse, or dependency and other standardized screenings instruments required by the Commissioner
7. Assessment methods and use of standardized assessment tools, clinical summary, recommendations, and prioritization of needed mental health, ancillary, or other services
8. Involvement of the member and member’s family in assessment and service preferences and referrals to services
9. Sufficient member data to support findings on all axes of the current edition of the DSM-MD, and any differential diagnosis

A new standard DA must be completed for a child:
1. When a child does not meet the criteria for a brief DA
2. At least annually following the initial DA if additional services are needed and the child does not meet the criteria for a brief or extended assessment
3. When the child’s mental health condition has changed markedly since the child’s most recent DA
4. When the child’s current mental health condition does not meet criteria of the child’s current diagnosis

A new standard DA may be used for an adult:
1. When the adult does not meet the criteria for a brief DA or an adult update at least every three years following the initial standard or extended DA for an adult who receives services
2. When the adult’s mental health condition has changed markedly since the adult’s most recent DA
3. When the adult’s current mental health condition does not meet criteria of the adult’s current diagnosis

Extended DA
1. An extended DA must include all components of a standard DA, gathered over three or more appointments due to the member’s complex needs that necessitate significant additional assessment time.
2. Complex needs are those caused by the following:
   a. Acuity of psychotic disorder
   b. Cognitive or neurocognitive impairment
   c. A need to consider past diagnoses and determine their current applicability
   d. Co-occurring substance abuse use disorder
   e. Disruptive or changing environments
   f. Communication barriers
   g. Cultural considerations

3. Children:
   a. Appointments may be conducted outside the diagnostician’s office for face-to-face consultation and information gathering with family members, doctors, caregivers, teachers, and other providers with or without the child present
   b. May involve directly observing the child in various settings that the child frequents (home, school, care settings)

4. Children under age 5:
   a. Utilize the DC: 0-3R diagnostic system for young children
   b. Utilize an early childhood mental status exam that assesses the child’s developmental, social, and emotional functioning and style both within the family and with the examiner and includes the following:
      i. Physical appearance including dysmorphic features
      ii. Reaction to new setting and people and adaptation during evaluation
      iii. Self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, frustration tolerance
      iv. Physical aspects including motor function, muscle tone, coordination, tics, abnormal movements, seizure activity
      v. Vocalization and speech production including expressive and receptive language
      vi. Thought including fears, nightmares, dissociative states, hallucinations
      vii. Affect and mood including modes of expression, range, responsiveness, duration, intensity
      viii. Play including structure, content, symbolic functioning, modulation of aggression
      ix. Cognitive functioning
      x. Relatedness to parents, other caregivers, examiner
   c. Other assessment tools as determined and periodically revised by the commissioner

5. Children ages 5 – 18:
      i. At least annually following the initial DA if additional services are needed
      ii. When a child does not meet the criteria for a brief or standard DA
      iii. When the child’s mental health condition has changed markedly since the child’s most recent DA
      iv. When the child’s current mental health condition does not meet criteria of the child’s current diagnosis

6. Adults:
   a. Appointments may be conducted outside the diagnostician’s office for face-to-face assessment with the adult
   b. May involve directly observing the adult in various settings that the adult frequents (home, school, job, service settings, community settings)
   c. May include face-to-face meetings the adult and family members, doctors, caregivers, teachers, social support network members, recovery support resource representatives, and other providers for consultation and information gathering
   d. Completion of other assessment standards for adults

7. A new extended DA must be completed for a child at the following times:
   a. When a child does not meet the criteria for a brief DA
b. At least annually following the initial DA if additional services are needed and the child does not meet the criteria for a brief DA

c. When the child’s mental health condition has changed markedly since the child’s most recent DA

d. When the child’s current mental health condition does not meet criteria of the child’s current diagnosis

8. A new extended DA must be completed for an adult at the following times:
   a. When the adult does not meet the criteria for a brief DA
   b. When the adult has complex needs and requires at least 3 DAs to complete the assessment, which allows further mental health services for one year
   c. When the adult’s mental health condition has changed markedly since the adult’s most recent DA
   d. When the adult’s current mental health condition does not meet criteria of the adult’s current diagnosis

**Adult DA Update**

1. Adults ages 18 and over
2. Updates the most recent DA
3. Reviews members life situation: updates significant new or changed information, documents where there has not been significant change
4. Screens for substance use, abuse, or dependency
5. Mental status exam
6. Assesses member’s needs based on baseline measurements, symptoms, behavior, skills, abilities, resources, vulnerabilities, safety needs
7. Includes a clinical summary
8. Includes recommendations and prioritization of needed mental health, ancillary, or other services
9. Includes involvement of member and member’s family in assessment and service preferences and referrals to services
10. Includes diagnosis on all axes of the current edition of the *DSM-MD*

An adult DA update can only be an update of a standard or extended DA. An adult DA update must be an update of a standard or extended DA that has occurred within the past 12 months or must be an update of a standard or extended DA that has occurred within the past 24 months and an adult DA that has occurred within the past 12 months.

CTSS requires an annual DA for children up to age 18 (CTSS annual DA exception). For adolescents ages 18 – 21, only annual updating is required, unless the mental health status has changed.

**Release of Member Information**

If the mental health professional conducting the DA is not the provider who referred the member or conducts psychotherapy, the provider:

1. Must request that the member authorize release of information to the provider who referred the member and the provider conducting psychotherapy; and
2. Must inform the member that any other mental health professional providing mental health services to the member will need access to the DA in order to develop an ITP and receive payment from PrimeWest Health.

**Annual Review of DA**

The DA must be reviewed once every 12 months for all mental health services except MH-TCM to determine the member’s continued diagnosis of mental illness or ED. If the member’s mental health status has not changed markedly since the most recent DA or within the last 12 months, only an update of a DA is necessary. An update is a written summary by a mental health professional of the member’s current mental health status and service needs.
Complete a new DA only if the member’s mental health status has changed markedly since the member’s most recent DA.

**Note:** CTSS requires an annual DA for children up to age 18. For adolescents ages 18 – 21, only annual updating is required, unless the mental health status has changed.

**Billing**

1. Bill a DA online using the 837P claim format.
2. Enter the date the DA was completed as the date of service (DOS) (do not bill a span of or multiple dates).
3. Use procedure code 90791 or 90792.
4. Indicate the individual treating provider National Provider Identifier (NPI).
5. If a DA does not result in a diagnosis of mental illness or ED, the provider is allowed to provide and bill for the following:
   a. Explanation of findings (90887)
   b. Psychological testing (96101, 96102, 96103)
   c. One psychotherapy session (9080X)
6. Do not bill for updating a DA.
7. Complete all Diagnostic Assessment (DA) Report components before billing a DA.

**Diagnostic Assessment (DA) Report Components**

<table>
<thead>
<tr>
<th>Diagnostic Assessment (DA) Report Components</th>
<th>Brief</th>
<th>Standard</th>
<th>Extended</th>
<th>Adult Update: for areas marked in this section there must be a review and written update of those parts where significant new or changed information exists and document where there have been no significant changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client's current life situation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Current living situation, including household membership and housing status</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Basic needs status including economic status</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Education level and employment status</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Significant personal relationships, including the client's evaluation of relationship quality</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Strengths and resources, including the extent and quality of social networks</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Belief systems</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Contextual non-personal factors contributing to the client’s presenting concerns</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>General physical health and relationship to client's culture</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Current medications</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Reason for the assessment</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of symptoms, including reason for referral</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
## Diagnostic Assessment (DA) Report Components

<table>
<thead>
<tr>
<th></th>
<th>Brief</th>
<th>Standard</th>
<th>Extended</th>
<th>Adult Update: for areas marked in this section there must be a review and written update of those parts where significant new or changed information exists and document where there have been no significant changes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of his or her condition</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>History of mental health treatment, including review of records</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Developmental incidents</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maltreatment or abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>History of alcohol and/or drug abuse</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health history and family health history</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cultural influences and impact</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental status exam</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assessment of client needs based on baseline measurements, symptoms, behaviors, skills, abilities, resources, vulnerabilities, and safety needs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

## Screenings used to determine substance abuse, and other standardized screening instruments

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGE-AID, GAIN-SS</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</table>

## Assessment methods

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>CASII, ECSII, SDQ (children's assessments)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCUS (not required at this time)</td>
<td></td>
<td></td>
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<td></td>
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</table>

## Clinical summary

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Recommendations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prioritization of needed mental health, ancillary, or other services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Client and family participation in assessment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Referrals to services required by statute or rule</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Service preferences</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Cause, prognosis, and likely consequences of symptoms</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>How diagnosis criteria are met: symptom descriptions, including, at a minimum, frequency, intensity, duration, impact, and functional impairment</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Strengths, cultural influences, life situations, relationships, health concerns, and how diagnosis interacts/impacts with client's life</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Explain R/O, other provisional diagnosis, and why alternative diagnoses that were considered were ruled out.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

## Diagnosis
## Diagnostic Assessment (DA) Report Components

<table>
<thead>
<tr>
<th>Brief</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Complete diagnosis using non-axial system as defined in DSM-5 *

For children under age 5, use the five-axial system defined in DC: 0-3R

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td></td>
<td>Diagnostic Assessment – standard</td>
<td>1 session</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Diagnostic Assessment – standard, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>52</td>
<td>Diagnostic Assessment – brief</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>52 HN</td>
<td>Diagnostic Assessment – brief, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>TG</td>
<td>Diagnostic Assessment – extended</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TG HN</td>
<td>Diagnostic Assessment – extended, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90791</td>
<td>TS</td>
<td>Adult Diagnostic Assessment – update</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TS HN</td>
<td>Adult Diagnostic Assessment – update, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90792</td>
<td></td>
<td>Diagnostic Assessment (with medical service) – standard</td>
<td>1 session</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Diagnostic Assessment (with medical service) – standard, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90792</td>
<td>52</td>
<td>Diagnostic Assessment (with medical service) – brief</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>52 HN</td>
<td>Diagnostic Assessment (with medical service) – brief, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td>TG HN</td>
<td>Diagnostic Assessment (with medical service) – extended, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90792</td>
<td>TS</td>
<td>Adult Diagnostic Assessment (with medical service) – update</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TS HN</td>
<td>Adult Diagnostic Assessment (with medical service) – update, by clinical trainee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90785</td>
<td></td>
<td>Interactive Complexity (add on code)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90887</td>
<td></td>
<td>Explanation of Findings</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Explanation of Findings, by a clinical trainee</td>
<td>1 session</td>
<td></td>
</tr>
</tbody>
</table>

Teaching hospitals may enter the GC modifier for services performed under the direction of a supervising physician.
Requirements for Standardized Outcome Measures for Children’s Mental Health

1. Mental health targeted case managers need to ensure that all 11 domains of functioning are in the member’s record. This can be accomplished through several options: the mental health targeted case manager can complete an FA for the member (there are two FA options that the case manager may utilize) or can use a combination of the DA and Child and Adolescent Service Intensity Instrument/Early Childhood Service Intensity Instrument (CASII/ECSII) and additionally assess the medical/dental health, financial needs, housing, and transportation needs of the member.

2. If the county is completing the CASII/ECSII, the county clinical supervisor must be involved in the scoring and interpretation of the results. This can be indicated by the clinical supervisor signing the document.

3. The county clinical supervisor is required to attend the DHS training sessions on the CASII and/or ECSII.

4. If a community mental health provider is providing services to the child, he/she is required to complete the CASII every six months and at discharge and is required to complete the ECSII every six months and at discharge.
   a. Counties should request the CASII/ECSII from the mental health professional and document this request in the child’s record. The mental health targeted case manager will need to assess the additional areas identified in 1 above. If the mental health targeted case manager has difficulty obtaining copies of CASII/ESCII from the provider, please complete a full FA.

Mental Health Targeted Case Management (MH-TCM)

Adults

Overview
AMH-TCM services help adults with SPMI gain access to needed medical, social, educational, vocational, and other necessary services as they relate to the member’s mental health needs. AMH-TCM services include developing an FA and an ICSP, referring and assisting the member in obtaining needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

Eligible MH-TCM Providers

Eligible case management service providers must be employed by a county or under contract with a county agency, PrimeWest Health, or a tribe to provide MH-TCM services, and be:
1. CMAs
2. Case management mentors
3. Case management supervisors
4. Case managers
5. Immigrant case managers

A case management mentor is a qualified, practicing case manager or case manager supervisor who teaches or advises and provides intensive training and clinical supervision to one or more CMAs.

A case management supervisor must be a mental health professional.

A CMA must be at least age 21, have at least a high school diploma or its equivalent, work under the direction of a case manager or case management supervisor, and:
1. Have an associate of arts degree in one of the behavioral sciences or human services; or
2. Be a registered nurse (RN) without bachelor’s degree; or
3. Within the previous 10 years, had:
   a. Three years’ life experience with SPMI; or
b. SED as a child; or  
c. Three years life experience as a primary caregiver to an adult with SPMI, if providing case management to adults; or three years life experience as a primary caregiver to a child with SED if providing case management to children.

4. Have 6,000 hours of work experience as a State hospital technician (no degree); or

5. Be a mental health practitioner.

CMAs may qualify as a case manager after four years of supervised work experience as a CMA.

Mental health practitioners may qualify as a case manager after three years of supervised experience as a CMA.

A case manager must have a bachelor’s degree in one of the behavioral sciences or related fields, including, but not limited to, social work, psychology, or nursing from an accredited college or university; or, if without a degree, must:

1. Have three or four years’ experience as a CMA;
2. Be an RN without a bachelor’s degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or
3. Be a person who qualified as a case manager under the 1998 DHS waiver provision and meet the continuing education and mentoring requirements.

An immigrant case manager, who does not meet the qualifications as stated above, may provide case management services to members with SPMI or SED who are immigrants if he/she is a member of the same ethnic group as the member and:

1. Is currently enrolled in and actively pursuing credits to complete a bachelor’s degree in one of the behavioral sciences or related field from an accredited college or university;
2. Completes 40 hours of training approved by DHS in case management skills and in the characteristics and needs of adults with SPMI or children with SED; and
3. Receives clinical supervision at least once per week until the requirements of obtaining a bachelor’s degree and 2,000 hours of supervised experience are met.

**Case Manager Supervision and Continuing Education Requirements**

Case managers with 2,000 hours or more of supervised experience in the delivery of mental health services must receive 38 hours per year of ongoing supervision and clinical supervision, as follows:

1. At least one hour per month must be under clinical supervision in individual service delivery with a case management supervisor
2. The remaining 26 hours of clinical supervision may be provided by a case manager with two years of experience

Case manager without 2,000 hours of supervised experience in delivery of mental health services must receive the following:

1. 40 hours training approved by DHS in case management skills and in the characteristics and needs of adults with SPMI or children with SED; and
2. One hour per week of clinical supervision in individual service delivery from a mental health professional until 2,000 hours of experience are met

A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in mental illness and mental health services every two years.
Group supervision may not constitute more than one-half of the required supervision hours.

Clinical supervision related to a member must be documented in the member’s record.

**CMA Supervision and Continuing Education Requirements**

CMAs must:
1. Receive 40 hours training approved by DHS in case management skills and in the characteristics and needs of adults with SPMI or children with SED;
2. Annually receive at least 40 hours of continuing education in SMPI/SED and mental health; and
3. Receive at least five hours of mentoring per week from a case management mentor, of which at least two hours must be individual and face-to-face.

**Eligible Members**

*Adults* meeting the following:
1. Is a person with SPMI and is determined eligible by county mental health authority (or tribal authority if tribal authority is an AMH-TCM provider); or
2. Is determined by a county or tribe to appear to be eligible for case management but due to the member’s initial refusal to participate in the DA process, the eligibility determination cannot be completed (eligibility limited to 90 days); or
3. Is an adolescent who has received children’s MH-TCM services within 90 days prior to reaching age 18, and upon turning age 18 seeks AMH-TCM services.

*Children* meeting the following:
1. Is a child under the age of 21 with SED

**Covered Services**

The MH-TCM service has the following four core components:
1. Assessment
2. Planning
3. Referral and linkage
4. Monitoring and coordination
Mental Health Targeted Case Management (MH-TCM)

Core Service Components and Process

“Gaining access to needed medical, social, educational, vocational, and other necessary services”

The MH-TCM components often overlap and may be provided concurrently. The member and case manager are constantly doing the following:

1. Assessing the member’s needs and goals and impact of mental illness, utilizing the member’s strengths and progress
2. Clarifying goal-related plans and steps and updating the ICSP/Individual Family Community Support Plan (IFCSP), thinking of new resources
3. Referring and linking to resources/supports/services, coordinating with partners in the member’s plan
4. Monitoring the effectiveness of the resources/supports/services being utilized
5. Reviewing the need for MH-TCM services
6. Discussing the member’s progress toward goals and recovery
Assessment

An MH-TCM assessment has the following five parts:
1. Review the DA
2. Assess member for strengths, resources, supports, needs, functioning, health problems and conditions, safety, vulnerability, and injury risk. Assessment should include family members, significant others, and providers as possible.
3. Screen for substance use/abuse
4. Review and update documentation of member’s status, cultural considerations, and functional description in all the FA domains specified in Minnesota Statute
5. Complete **LOCUS Recording Form (DHS-6249)** assessment to determine resources and resource intensity needs for adults

It is important that the FA, defined in **MN Stat. sec. 245.462, subd. 11a** and **MN Stat. sec. 245.4871, subd. 18**, includes the member’s health care coverage, access to preventative and routine health care, individual participation in recommended health care treatment, and individual health lifestyle.

The case manager must complete an FA within 30 days of the first meeting with the member, and at least every 180 days after the development of the ICSP/IFCSP. The FA must be developed with input from the member, and (with permission of member), service providers and significant members of the member’s support network. For children, the following comprises the FA:
1. Complete the CASII and Strength and Difficulties Questionnaire (SDQ) assessment for children ages 6 – 18
2. Complete the ECSII and SDQ assessment for children age 5 and under
3. Assess the following additional domains of function:
   a. Medical and dental health
   b. Financial assistance needs
   c. Housing and transportation needs
   d. Current living conditions

Planning

A case manager must develop, with the member, the member’s ICSP/IFCSP including the following:
1. Goals of member and the specific services
2. Activities for accomplishing each goal
3. Schedule for each activity
4. Frequency of face-to-face contact with case manager

The case manager must complete an ICSP/IFCSP within 30 days of the first meeting with the member, and at least every 180 days after the development of the member’s ICSP/IFCSP. The ICSP/IFCSP must be developed with input from the member, other service providers, and significant members of the member’s support network.

Referral and Linkage

Referral and linkage MH-TCM services are the implementation of parts of the ICSP/IFCSP that involve resource acquisition to help the member obtain planned goals.

A primary focus of referral and linkage is to break down the walls separating members from the community to replace segregation with true community integration. Case managers must be familiar with the community and key contact persons within particular agencies (housing, education, vocational, financial, health care services, and other providers) to assist the member.
Referral and linkage involves interactions with the member to do the following:
1. Connect the member with informal natural supports
2. Link the member with the local community, resources, and service providers
3. Refer the member to available health treatment and rehabilitation services

Monitoring and Coordination

A significant portion of the case manager’s monitoring and coordination activities are done over the phone with other providers, resources, and service representatives. Monitoring and coordination serves four global purposes:
1. Ensure service coordination by reviewing programs and services for accountability, verification that everyone is addressing the same purposes stated in the ICS/IFCSP so that the member is not exposed to discontinuous or conflicting interventions and services
2. Determine achievement of the goals/objectives in the member’s ICSP/IFCSP to see if goals are being achieved according to the ICSP/IFCSP’s projected timeline(s) and continue to fit the member’s needs
3. Determine service and support outcomes through ongoing observations that can trigger reconsideration of the plan and its recommended interventions when the ICSP/IFCSP is not accomplishing its desired effects
4. Identify emergence of new needs by staying in touch with the member to identify problems, modify plans, ensure the member has resources to complete goals, and track emerging needs

Additional Services Requirements

Limit on Size of Case Manager’s Caseload
The average caseload size of a full-time equivalent case manager must not exceed 30 adult clients or 15 children clients to one full-time equivalency case manager. This standard applies to the average caseload size of case managers across the provider agency.

Face-to-Face Contact between Client and Case Manager
For adults: The standard for face-to-face contact is at least monthly. Less than monthly face-to-face contact is not an acceptable standard for the large majority of case management clients. Although the Administrative Rule allows for some flexibility and less frequent contact, this flexibility is to be applied in certain limited and appropriate situations. For example, prior to terminating case management services, the client and case manager might plan for less than monthly face-to-face contact to help determine the client’s self-sufficiency and aptness of case closure planning.

For adult MH-TCM, interactive video may be used instead of a face-to-face contact if the member resides in a hospital, nursing facility, residential mental health facility, or an intermediate care facility for persons with developmental disabilities. The use of interactive video may substitute for no more than 50 percent of the required face-to-face contacts.

Reimbursement for qualifying services should not be interpreted as the service standard for face-to-face contact frequency. Monthly face-to-face contact is the standard.

For children: Monthly face-to-face contact is required.

Face-to-face contact of less than once per month must be supported by an evaluation of the client’s functioning and preferences, and planned in the ICSP.

MH-TCM (non-tribe-run provider agency) reimbursement is a monthly rate paid if at least one case management core service component is provided consistent with the ICSP/IFCSP in at least one face-to-face contact with the client during the month; or for adults at least a telephone contact with the client within which at
least one case management core service component is provided consistent with the ICSP, plus at least one qualifying face-to-face contact with the client within the preceding two months. However, reimbursement for qualifying services should not be interpreted as the service standard for face-to-face contact frequency. The client contact standard is at least monthly contact.

Tribe-run provider agency reimbursement is the “daily IHS encounter rate” for that tribe to each face-to-face contact with the member client during which a qualifying MH-TCM service is provided consistent with the ICSP/IFCSP (within other “encounter rate” rules).

**Arrangement of Standardized Assessment by a Physician for Members on Psychotropic Medications**
The case manager must arrange for a standardized assessment by a physician of the client’s choice of side effects related to the administration of the client’s psychotropic medications.

**Non-Covered Services**

MH-TCM services are not:
1. Treatment, therapy, or rehabilitation services
2. Other types of case management (for example, Community Alternative Care [CAC], Community Alternatives for Disabled Individuals [CADI], Brain Injury [BI], Developmental Disability [DD])
3. Legal advocacy
4. A DA
5. Determining eligibility for MH-TCM
6. Administration or management of a member’s medications
7. Services that are integral components of another service or direct delivery of an underlying medical, educational, social, or other service
8. Transportation services

**Documentation**

Minnesota must comply with Federal regulations in order to receive Federal Financial Participation (FFP) and documentation is crucial to compliance.

Documentation must support the qualifying MH-TCM services provided to an eligible member by a qualified provider.

All service records must:
1. Be legible to the individual providing care
2. Contain the member’s name must be on each page of the member’s record

Each entry in the health service record must contain:
1. The date on which the entry is made
2. The date(s) on which the health service is provided
3. The length of time spent with the member if the amount paid for the service depends on time spent
4. The signature and title of the person from whom the member received the service
5. Reportage of the member’s progress or response to treatment and the changes in the treatment or diagnosis
6. When applicable, the countersignature of the vendor or supervisor as required
7. Documentation of supervision by the supervisor

The record must state:
1. The member’s case history and health condition as determined by the vendor’s examination or assessment
2. The results of all diagnostic tests and examinations
3. The diagnosis resulting from the examination
The record must contain:
1. Reports of consultations that are ordered for the member
2. The client’s plan of care (ICSP), ITP, or individual program plan

Client File
The client file includes client information such as: name, address, phone, email, identification (ID) numbers, natural support contacts, other mental health provider contacts, health conditions, health care coverage and providers, other significant contacts (landlord, employer, etc.), emergency contacts, current medications, intake dates, relapse prevention plans, releases of information, referral materials, client rights materials, determination of SPMI, and information supporting the client’s eligibility for MH-TCM.

MH-TCM agencies must follow these additional requirements:
1. The member/client file must include:
   a. Releases of information
   b. DAs
   c. FAs
   d. Mandated screenings and level of care documentation
   e. ICSP/IFCSPs
   f. MH-TCM services provided to client – contact/progress entries
   g. Entries of any assessment/planning/referral/monitoring/coordination activities that the agency has engaged in on behalf of the client with family members, significant others, other providers of services, representatives of other community resources, and/or the client’s natural supports (with or without client; whether coordination/communication was initiated by case manager or another [e.g., calls from client family members])
2. Documentation must appear in the client’s record when the client’s case/plan/situation is reviewed by the agency team or with a clinical supervisor

The ICSP/IFCSP is the roadmap of MH-TCM services. It is governed by Federal and State regulations. At its heart, the ISCP/IFCSP is a straightforward plan to help the member utilize his/her current strengths and resources and gain access to additional services and resources to help the member accomplish his/her goals.

The ICSP/IFCSP documentation should include the following:
1. The development of the ISCP/IFCSP consistent with Statute and Rule
2. To the extent possible, the member, the member’s family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the ICSP/IFCSP

The ISCP/IFCSP must state the following:
1. The goals of each service
2. The activities/tasks of the member, case managers, and involved others for accomplishing each goal
3. A schedule for each activity/task
4. The frequency of face-to-face contacts by the case manager, as appropriate to member need and the implementation of the ICSP

The ISCP/IFCSP should reflect the prioritization of member goals, risk/vulnerability, and needs identified in the assessment process.

Identify the natural supports, services, programs, and resources to which the member is gaining access, who and how that access will be gained, and planned monitoring and coordination to assure member progress and value of supports, services, programs, and resources.
A written ICSP/IFCSP needs to be completed within 30 days of beginning AMH-TCM services, and a new FA completed at least every 180 days thereafter (more often, if the member requests). The ICSP/IFCSP needs to be written by a mental health professional or signed by the clinical supervisor of the case manager and include the member’s name; date of completion of the ICSP/IFCSP; and signatures of the member, case manager, and clinical supervisor (optional: signatures of others who participate in the development/implementation of the ICSP/IFCSP).

**Note for clarification:** There is contradictory language in Statute and Administrative Rule concerning the minimum frequency which FAs and ICSPs must be completed. The Administrative Rule for MH-TCM services notes that the FA and ICSP need to be reviewed and, if necessary, revised at least once every 90 calendar days after the development of the initial plan. Minnesota Statutes use an “at least every 180 days” standard. Documentation of the revision of the FA and ICSP/IFCSP must occur at least every 180 calendar days – Statute supersedes Rule.

**Member Contact/Progress Notes**

The note should answer primary questions to ensure good communication, planning, and billing support.

1. Which of the MH-TCM four core service components (assessment, planning, referral and linkage, monitoring and coordination) was being provided?
2. What goals were being addressed?
3. What was the service provided – what did the case manager do?
4. What was the member’s response to the service?
5. What is the plan for the next contact?
6. Any significant observation of the member’s situation or condition should also be included (situation/information/condition that is not necessarily related to planned services but that is important or out of the ordinary [e.g., major news in member’s life, changes of behavior]). These will not be present in every contact/note.

Often during a contact, a case manager will be providing more than one case management service component. Each service component should be documented.

Communication with the member’s family members, support system members, other providers, doctors, resource representatives, community representatives (employer, landlord, etc.), whether initiated by the case manager or not, must be documented in the member file.

Documentation is a basic element of case management services provision. It is not an add-on, it is not optional, it is not separate from service provision, and it is not “just paperwork.”

**Documenting Clinical Supervision**

Clinical supervision must be documented by the clinical supervisor.

1. Complete or cosign all member **FAs**.
2. Complete or cosign all member **LOCUS Recording Form (DHS-6249)** level of care assessments, CASII/ECSII.
3. Complete or cosign all ICSPs.
4. “Case reviews” by the case manager and the clinical supervisor should be summarized and signed in the member file.
5. Entries in the member’s record regarding record review and supervisory activities.
Clinical supervision of the case manager that is not specific to an individual member, but rather is for the benefit and professional growth of the case manager or CMA, must be documented in the case manager’s personnel file or related file.

Referrals (Prior Authorization Is Required for This Service)

Referrals can come from the following sources:
1. County case managers
2. Physicians
3. Mental health professionals and providers
4. Self-referral
5. Parent (if referring a minor child)
6. Legal guardian

Referrals can be made to the following entities:
1. PrimeWest Health – Utilization Management (UM) department: call 1-866-431-0803 (toll free) or fax 1-866-431-0804 (toll free)
2. County Social/Human Services of member’s residence

<table>
<thead>
<tr>
<th>County</th>
<th>Phone Number</th>
<th>County</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beltrami</td>
<td>1-218-333-8300</td>
<td>Meeker</td>
<td>1-320-693-5300</td>
</tr>
<tr>
<td>Big Stone</td>
<td>1-320-839-2555</td>
<td>Pipestone</td>
<td>1-888-632-4325 (toll free)</td>
</tr>
<tr>
<td>Clearwater</td>
<td>1-218-694-6512</td>
<td>Pope</td>
<td>1-320-634-5750</td>
</tr>
<tr>
<td>Douglas</td>
<td>1-320-762-2302</td>
<td>Renville</td>
<td>1-320-523-2202</td>
</tr>
<tr>
<td>Grant</td>
<td>1-218-685-8200</td>
<td>Stevens</td>
<td>1-320-208-6600</td>
</tr>
<tr>
<td>Hubbard</td>
<td>1-218-732-1451</td>
<td>Traverse</td>
<td>1-320-563-8255</td>
</tr>
<tr>
<td>McLeod</td>
<td>1-800-247-1756 (toll free)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Referrals must be made by completing the Mental Health Targeted Case Management (MH-TCM) Service Authorization Request Form located on the PrimeWest Health website.

MH-TCM Billing Procedures

1. Bill MH-TCM services online using the 837P claim format.
2. Counties and county-contracted vendors: Bill one claim per month.
3. Tribes and Federally Qualified Health Centers (FQHCs): Bill one claim per encounter.
4. Enter the DOS. Do not enter a treating provider NPI on each line item.
5. Submit appropriate diagnosis code(s) to indicate the patient’s condition with the most detailed level of specificity.

Since TCM service codes are indicated as “per month,” the “from” and “to” dates should be indicated as the first and last day of a calendar month when TCM services were provided to an eligible PrimeWest Health member, and the number of units for these should always be “1.” Billing a value greater than “1” for a monthly service may result in delayed processing or claim denial for incorrect billing.

For an adult member, a face-to-face contact is required in at least one month out of a quarter. MH-TCM claims will deny when a face-to-face contact occurs within the preceding two months prior to a change in eligibility status and the first contact under the new eligibility status is a telephone contact. Providers must resubmit the claim with case notes documenting the face-to-face contact using the Minnesota Administrative Uniform Committee (AUC) cover sheet.
<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2023</td>
<td>HE HA*</td>
<td>Face-to-face contact between case manager and member under age 18</td>
<td>1 unit per month</td>
</tr>
<tr>
<td></td>
<td>HE*</td>
<td>Face-to-face or ITV contact between case manager and member age 18 or over</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HE U4*</td>
<td>Telephone contact (member age 18 or over)</td>
<td></td>
</tr>
<tr>
<td>T1017 (For IHS/638 and FQHC billing only)</td>
<td>HE HA</td>
<td>Face-to-face encounter (member under age 18)</td>
<td>Per encounter</td>
</tr>
<tr>
<td></td>
<td>HE</td>
<td>Face-to-face encounter (member age 18 or over)</td>
<td></td>
</tr>
</tbody>
</table>

*HE: Mental health; HA: Child/adolescent program; U4: Case management via telephone

**Mental Health Provider Travel Time**

Mental health provider travel time allows providers to bill for traveling to the member to provide covered mental health services in a place other than the provider’s usual place of business.

All mental health providers except case managers, CMAs, and site-based programs are eligible to bill for mental health provider travel time.

**Eligible Members**

All PrimeWest Health members with an ITP specifying mental health services that are medically necessary and which necessitate the provider travel to the member’s home, place of work, or other setting to provide services.

**Mental Health Provider Travel Time Covered Services**

PrimeWest Health covers provider travel time when:
1. A member’s ITP indicates the need for mental health services to be provided outside the provider’s normal place of business; and
2. The service being provided to the member is a covered mental health service.

Provider travel time covers only the time the provider is in transit to and from the member.

In the progress notes on the DOS, clearly document the need for provider travel time.

**Non-Covered Services**

PrimeWest Health does not cover provider travel time for any of the following:
1. Member transport (even if to a covered service)
2. Site-based programs (such as day treatment)
3. MH-TCM travel time, which is included in the monthly rate
4. No shows
Billing

1. Bill mental health provider travel time online using the 837P claim format.
2. Bill the travel time on the same claim as the provided service. If the provided service was authorized, bill the travel time on a separate claim.
3. Enter the treating provider ID number for each line item. If the individual provider is a mental health practitioner, mental health behavioral aide (MHBA), or mental health rehabilitation worker, bill using the NPI of the supervising mental health professional.
4. Use the appropriate POS code. The POS may be a member’s home, the work place, or other setting as defined in the member’s treatment plan.
5. Use procedure code H0046 without any modifiers.
6. Enter the number of minutes of travel time in the units field.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
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</thead>
<tbody>
<tr>
<td>H0046</td>
<td></td>
<td>Mental health provider travel time (exclude county case management and children’s day treatment). Providers are required to maintain detailed travel logs that include origination and destination information and document the time leaving for and arriving at each site.</td>
<td>1 minute</td>
<td>None</td>
</tr>
</tbody>
</table>

Explanation of Findings

Overview

“Explanation of findings” means the explanation of a member’s DA, psychological testing, treatment program, and consultation with culturally informed mental health consultants as required under [MN Rules parts 9520.0900 – 9520.0926](#) or other accumulated data and recommendations to the member, member’s family, primary caregiver, or other responsible persons.

The purpose of explanation of findings is to discuss the results of the DA, psychological tests, and other accumulated data and make recommendations in regard to the member’s treatment plan.

Eligible Providers

1. All mental health professionals
2. All mental health practitioners under supervision and authorized to provide psychotherapy and conduct DAs

Eligible Members

All PrimeWest Health members are eligible. Refer to Benefits section for coverage determination.

Covered Services

Explanation of findings is a face-to-face meeting between the mental health professional and the member’s:

1. Family
2. Primary caregiver
3. Other responsible persons such as:
   a. Case manager
   b. Child protection worker
   c. Community corrections agency
   d. Guardian
   e. Health care provider
   f. Local education agency representative
   g. Qualified Developmental Disability Professional (QDDP)
   h. School
   i. Vulnerable adult worker

Non-Covered Services

Explanations of findings of services do not include the following:
1. Providing clinical direction of employees or students who provide mental health services under the clinical supervision of the mental health professional conducting the explanation of findings
2. Sharing information at regularly scheduled interagency coordination of care meetings where member care is discussed

Explanation of finding services are not paid separately when the results of the DA or psychological testing are explained as part of those services.

Billing


No more than one hour may be billed for the DOS unless the member meets the criteria for an extended DA.

If criteria for an extended DA exist, the provider may distribute the calendar year total of four hours in any manner necessary. PrimeWest Health covers the actual time spent, or four hours, whichever is less.

The mental health professional providing the service must obtain an authorization from the member or guardian to release member information.

Family Psychoeducation

Overview
Family psychoeducation services are planned, structured, and face-to-face interventions that involve presenting or demonstrating information. The goal of family psychoeducation is to help prevent relapse or development of comorbid disorders and to achieve optimal mental health and long-term resilience. It supports the member and family in understanding the following factors:
1. The member’s symptoms of mental illness
2. The effect on the member's development
3. Needed components of treatment
4. Skill development

In addition to the information in this section, refer to the Family Psychoeducation Frequently Asked Questions.
Eligible Providers
PrimeWest Health enrolled mental health professionals or their clinical trainee may provide family psychoeducation.

The following mental health professionals may enroll with PrimeWest Health:
1. Clinical nurse specialists (CNS) in mental health
2. Licensed independent clinical social workers (LICSW)
3. Licensed marriage and family therapists (LMFT)
4. Licensed professional clinical counselors (LPCC)
5. Licensed psychologists (LP)
6. Psychiatric nurse practitioners (NP)
7. Psychiatrists
8. Tribal certified professionals

The following providers are not eligible to enroll as PrimeWest Health providers:
1. Mental health practitioners who qualify as clinical trainees
2. Clinical supervisors

Providers must follow Clinical Supervision of Outpatient Mental Health Services (Rule 47) guidelines.

Eligible Recipients
Eligible members of family psychoeducation must have a diagnosis of emotional disturbance or mental illness as determined by a diagnostic assessment and be under age 21.

Covered Services
PrimeWest Health covers family psychoeducation services for any of the following in outpatient settings when directed toward meeting the identified treatment needs of each participating recipient as indicated in the member’s treatment plan:
1. The member (individual)
2. The member’s family (with or without the member present)
3. Groups of members (peer group)
4. Multiple families (family group)

If you believe the member’s absence from a family psychoeducation session is necessary, document the length of time and reason for the member to be absent. Family members or primary caregivers do not need to be eligible for PrimeWest Health to participate.

These services may be provided via telemedicine. Refer to the Telemedicine Delivery of Mental Health Services section of this chapter.

Family
The member’s family includes people the member, parent, or guardian identify as being important to the member’s mental health treatment. Family may include, but is not limited to, the following:
1. Parents or caregivers
2. Siblings
3. Children
4. People related by blood or adoption
5. People who are presently living together as a family unit

Do not consider shift staff members or other facility staff members at the recipient’s residence as family members.
Peer Group
A peer group must be comprised of at least three and no more than 12 members. The following criteria for groups applies:
1. For groups of three to eight members, at least one mental health professional or clinical trainee must conduct the group.
2. For groups of nine to 12 members, any combination of at least two mental health professionals or clinical trainees must co-conduct the group.

Family Group
The following criteria applies for family groups:
1. A family group must be comprised of at least two and no more than five families.
2. For groups of five to 10 families, any combination of at least two mental health professionals or clinical trainees must co-conduct the group

Documentation of Covered Services
Refer to the following sections for documentation requirements.

Medical Necessity
Document the medical necessity for family psychoeducation in the diagnostic assessment. The diagnostic assessment must describe how the child meets criteria for a mental health condition. You may include this description in the initial assessment, in an addendum to the diagnostic assessment, or within the narrative portion of the individualized treatment plan (ITP) review process. Submit this information with any request for authorization.

Individualized Treatment Plan
Document in the ITP the specific interventions, describing how the mental health professionals will use family psychoeducation to treat the child’s mental illness.

Progress Notes
Progress notes must be legible and must include the following information, at a minimum:
1. Type of service (recipient, family, peer group, or family group)
2. Date of service
3. Session start and stop times
4. Scope of service (nature of interventions)
5. Number of attendees
6. Role of attendees
7. Attendees’ responses or reactions to the interventions
8. Potential effect on eligible member
9. Name(s) and title(s) of provider(s) who delivered the service
10. Date documentation was made in the member’s record

For family psychoeducation performed by clinical trainees, the clinical supervisor must review and approve the member’s progress notes according to the clinical trainee’s supervision plan.

Non-covered Services
Family psychoeducation does not include the following:
1. Communication between the treating mental health professional and a person under the clinical supervision of the treating mental health professional
2. Written communication between providers
3. Reporting, charting, and record keeping (these activities are the responsibility of the provider)
4. Mental health services not related to the member’s diagnosis or treatment for mental illness
5. Communication provided while performing any of the following mental health services:
   a. Mental health case management
   b. In-reach services
   c. Youth ACT
   d. Intensive treatment services in foster care

Authorization Requirements
Refer to the Authorization section for general authorization policy and procedures.

Family psychoeducation units or sessions are subject to the same calendar year and cumulative limits as psychotherapy. These limits are as follows and are effective January 1, 2019:
1. 26 hours of individual psychoeducation per calendar year, cumulative
2. 26 sessions of family psychoeducation per calendar year, cumulative
3. 52 sessions of peer group psychoeducation per calendar year, cumulative
4. 10 sessions of family group psychoeducation per calendar year, cumulative
5. A maximum of 4 units of family psychoeducation, per individual in one day
6. A maximum of 1 session (or 4 units) of family psychoeducation, per family in one day
7. A maximum of 1 session (or 4 units) of family psychoeducation, per family in a multifamily group in one day
8. A maximum of 1 session (or 4 units) of family psychoeducation, per individual in a group setting in one day

Effective January 1, 2019, follow the authorization process for continuation of psychotherapy services once the limit has been reached. Include a diagnostic assessment, treatment plan goals, and any progress toward those treatment plan goals with the documentation submitted.

Billing
Submit claims only for the member who is the primary subject of the family psychoeducation sessions, regardless of the number of other family or group members in the session.

When more than one family member is a recipient (e.g., two or three siblings, each receiving treatment within a specific timeframe), bill only for the time spent conducting family psychoeducation with each member.

When two professionals render group family psychoeducation, submit only one claim for each recipient. Professionals must determine which recipient each will bill for, or one professional may claim for all recipients and reimburse the other professional.

When billing, use the following guidelines:
1. Enter the treating provider NPI number on each claim line
2. Use the HN modifier for services performed by a clinical trainee

Use the following table for billing services:

<table>
<thead>
<tr>
<th>Proc. Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2027</td>
<td>HQ</td>
<td>Family Psychoeducation Individual (with a single recipient)</td>
<td>15 min</td>
<td>None</td>
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<td></td>
<td></td>
<td>Family Psychoeducation Recipient Group (with multiple recipients)</td>
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<td>None</td>
</tr>
</tbody>
</table>
Family Psychoeducation Benefits for Children under age 21

<table>
<thead>
<tr>
<th>Proc. Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td></td>
<td>Family Psychoeducation Recipient and Family (with a single recipient and their family)</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>HS</td>
<td></td>
<td>Family Psychoeducation Family (with a single family individual not present)</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>HQ HR</td>
<td></td>
<td>Family Psychoeducation Family Group (with multiple families with individuals present)</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>HQ HS</td>
<td></td>
<td>Family Psychoeducation Family Group (with multiple families individuals not present)</td>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

Mental Health Medication Management

Medication management determines the need for or the effectiveness of the medication prescribed for the treatment of a member’s symptoms of mental illness.

Eligible Providers

PrimeWest Health covers medication management provided by the following:
1. Physician
2. Clinical Nurse Specialist – Mental Health (CNS-MH)
3. Psychiatric NP; or
4. RN (not authorized to prescribe) who is:
   a. Qualified as a mental health practitioner
   b. Under the supervision of a physician
   c. Employed by or under contract with the physician providing clinical supervision
   d. Eligible to bill for evaluation and management (E/M)

Eligible Members

All PrimeWest Health members are eligible. Refer to Benefits section for coverage determination.

Covered Mental Health Medication Management Services

Medication management is a service to determine a member’s need for a prescribed drug, or to evaluate the effectiveness of the prescribed drug as noted in the member’s ITP.

Billing

Bill mental health medication management services online using the 837P claim format. Use the individual treating provider NPI.
1. If you provide psychotherapy in addition to medication management, use the appropriate E/M with psychotherapy add-on code. Refer to Psychotherapy section for further details and add-on codes.
2. For concurrent provision of medication management or monitoring (M0064) with all other services, follow National Correct Coding Initiative (NCCI) and CPT guidelines.
3. Teaching hospitals may enter the GC modifier for services performed under the direction of a supervising physician.
4. Eligible providers must use the appropriate E/M codes to bill medication management. PrimeWest Health follows current procedural technology (CPT) guidelines for E/M services. Follow CPT guidelines for E/M services within the provider’s scope of practice for medication management.

5. Registered Nurses may only bill using E/M codes.

Use the following table for billing services with DOS on or after January 1, 2013:

<table>
<thead>
<tr>
<th>Code</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0064</td>
<td>Brief office visit for monitoring or changing drug prescriptions by physician, CNS-MH, or NP</td>
<td>1 session</td>
<td>Generally less than 10 minutes.</td>
</tr>
<tr>
<td>E/M</td>
<td>Evaluation and medication management by RN</td>
<td></td>
<td>For medication monitoring services only; do not use modifiers.</td>
</tr>
</tbody>
</table>

**Additional Resources**
1. Review the 2013 CPT Codebook for code changes and requirements
2. [CMS 1997 Evaluation and Management Guidelines](#)

**Neuropsychological Services**

Please review the CPT codes for psychological and neuropsychological testing that were changed as of January 1, 2006, to more accurately reflect the work value attributable to administering tests by a psychologist, technician, or computer.

**Overview**

Neuropsychological services:
1. Identify the internal and external restrictions of a member’s cognitive, emotional, behavioral, and social impairments; and
2. Are skills-based interventions provided to members with neurological disorders that result in cerebral dysfunction.

**Eligible Neuropsychological Providers**

Neuropsychological assessment, neuropsychological rehabilitation, and neuropsychological case/team consultation services must be conducted by an LP who is to provide clinical neuropsychological services. This requires a diploma in clinical neuropsychology from the American Board of Clinical Neuropsychology (ABCN) or the American Board of Professional Psychology (ABPP). Send a copy of your diploma to PrimeWest Health Provider Services with a cover letter requesting approval to bill for these services. For neuropsychological assessment, the provider must have declared a competency in neuropsychological rehabilitative services or a closely related competency to the Board of Psychology.

**Covered Neuropsychological Services**

**Neuropsychological Assessment**

Neuropsychological assessments are testing and clinical interviews integrated with data from medical records that are used to determine a member’s level of cognitive, emotional, and behavioral functioning as they relate to the organic integrity of the brain following an injury or disease. The following components are all-inclusive and cannot be billed separately:
1. Face-to-face interview
2. Administration
3. Scoring the test(s)
4. A written report documenting results of the test(s)

**Neuropsychological Rehabilitation**
Neuropsychological rehabilitation is a program to help a member:
1. Restore neuropsychological abilities; or
2. Acquire and use compensatory methods to improve post-injury adjustment and adaptive living skills.

**Cognitive Remediation Training**
Cognitive remediation training services are skills-based interventions provided to a member with a current diagnosis of neurological disorder resulting in cerebral dysfunction. Cognitive remediation training identifies the internal and external restrictions of the member’s cognitive, emotional, behavioral, and social impairments. Use this information to design and implement a rehabilitation program to help the member to either restore neuropsychological abilities, or to acquire and use compensatory methods to improve post-injury adjustment and adaptive living skills. Interventions must be authorized and provided by a doctoral prepared clinical neuropsychologist or a multidisciplinary rehabilitation team under the clinical supervision of a doctoral prepared clinical neuropsychologist. In addition to a recent DA, the recommendation for cognitive remediation training must be supported by the results of a recently conducted neuropsychological assessment. PrimeWest Health covers cognitive remediation training with the limitations that cognitive remediation training must meet the following criteria:
1. It must be supported by the DA and the results of a recently conducted neuropsychological assessment
2. It may be conducted on a one-on-one basis (for 1 – 3 people) or in a group (for 4 – 9 people)
3. It must be documented on a daily basis, by use of a checklist of available therapies in which the member participated, and on a weekly basis, by summary of the information required in the member’s record.

**Billing**

Bill neuropsychological services online using the 837P claim format.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>96116</td>
<td></td>
<td>Neuropsychological assessment – (neurobehavioral status exam)</td>
<td>1 hour</td>
<td>PrimeWest Health follows Medicaid Medically Unlikely Edits (MUEs) in allowing a limit of 6 units.</td>
</tr>
<tr>
<td>96118</td>
<td></td>
<td>Neuropsychological assessment (testing), DHS-approved LP, interpretation, analysis, report</td>
<td>1 hour</td>
<td>PrimeWest Health follows Medicaid MUEs in allowing a limit of 6 units.</td>
</tr>
<tr>
<td>96119</td>
<td></td>
<td>Neuropsychological testing, technician-administered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96120</td>
<td></td>
<td>Neuropsychological testing, computer-administered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2012 HK</td>
<td></td>
<td>Cognitive rehabilitative therapy</td>
<td>1 hour</td>
<td>None</td>
</tr>
</tbody>
</table>

Only PrimeWest Health-approved providers can provide and bill for neuropsychological services.
Psychotherapy

Psychotherapy is a planned and structured face-to-face treatment of a member’s mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the needs of the member according to current community standards of mental health practice; and is directed to accomplish measurable goals and objectives specified in the member’s ITP.

Eligible Providers

Individual or group psychotherapy may be provided by the following:
1. CNS-MH
2. LICSW
3. LMFT
4. LPCC
5. LP
6. Psychiatric NP
7. Psychiatrist

Eligible Members

Eligible members of psychotherapy must have a diagnosis of mental illness as determined by a DA.

Exception: A new member may receive up to three sessions of a combination of individual or family psychotherapy or family psychoeducation prior to completing the diagnostic assessment.

Covered Psychotherapy Services

Psychotherapy services include the following:
1. Individual psychotherapy (including interactive individual psychotherapy)
2. Hypnotherapy (conducted by a mental health professional trained in hypnotherapy)
3. Biofeedback training
4. Family psychotherapy
   a. For the member and one or more family members whose participation is necessary to accomplish the member’s treatment goal. Family members may be related to the member by blood, marriage, or adoption, or may be the member’s foster parent, primary caregiver, or significant other. Do not consider facility staff members at the member’s residence as family.
   b. If you believe the member’s absence from the family psychotherapy session is necessary to accomplish the treatment goal in the ITP, document the length of time and reason for the member’s absence; also document reason(s) for a family member’s exclusion from family psychotherapy.
   c. Family members or primary caregivers do not need to be eligible for PrimeWest Health.
5. Multiple family group psychotherapy
   a. Multiple family group psychotherapy is designed for at least three, but no more than five families, regardless of family members’ PrimeWest Health eligibility status or the number of family members who participate in the family psychotherapy session.
   b. Multiple family group psychotherapy is directed toward meeting the identified treatment needs of each member as indicated in the member’s treatment plan.
   c. If a member is excluded from a session, document the reason for and length of time of the exclusion.
   d. Document reasons why a family member is excluded.
6. Group psychotherapy, appropriate for individuals who, because of the nature of their emotional, behavioral, or social dysfunctions, can derive benefit from treatment in a group setting. Group size applies regardless of the number of PrimeWest Health members in one of the following groups:
a. Group psychotherapy provided by one mental health professional for 4 – 8 recipients
b. Group psychotherapy provided by two mental health professionals for 9 – 12 recipients, who because of
the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
interaction in a group setting.
c. Group size cannot ever exceed 12 recipients

7. Group psychotherapy for crisis intervention
   a. Group psychotherapy for crisis intervention is designed for a member who is experiencing acute social,
      interpersonal, or environmental stress that threatens the member’s current level of adjustment or causes
      significant subjective distress. Documentation must show how the group psychotherapy session applied
to the member’s treatment goals.
   b. May be used with the interactive complexity add-on

**Interactive Complexity**

Use the interactive complexity add-on code (90785) to designate a service with interactive complexity. Report
interactive complexity for services when any of the following exist during the visit:
1. Communication difficulties among participants that complicate care delivery, related to issues such as the
   following:
   a. High anxiety
   b. High reactivity
   c. Repeated questions
   d. Disagreement
2. Caregiver emotions or behaviors that interfere with implementing the treatment plan
3. Discovery or discussion of evidence relating to an event that must be reported to a third party. This may
   include events such as abuse or neglect that require a mandatory report to the State agency.
4. The mental health provider overcomes communication barriers by using play equipment, physical devices,
an interpreter, or a translator for members who meet one of the following criteria:
   a. Are not fluent in the same language as the mental health provider
   b. Have not developed or have lost the skills needed to use or understand typical language

**Documentation**

**Progress Notes**

A progress note must be legible. It serves as the documentation of treatment information and can be kept to a
minimum.

Progress notes include the following:
1. Type of service
2. DOS
3. Session start and stop times
4. Scope of service (nature of interventions or contacts including treatment modalities, phone contacts, etc.)
5. Member’s progress (or lack of) progress toward overall treatment plan goals and objectives
6. Member’s response or reaction to treatment intervention(s)
7. Formal or informal assessment of the member’s mental health status
8. Name and title of person who gave the service
9. Date documentation was made in the member record

The following are other elements that may be included:
1. Current risk factors the member may be experiencing
2. Emergency interventions
3. Consultations with or referrals to other professionals
4. Summary of effectiveness of treatment, prognosis, discharge planning, etc.
5. Test results and medications
6. Symptoms

For clinical trainees conducting psychotherapy, the clinical supervisor must review and approve the member’s progress notes in accordance with the clinical trainee’s supervision plan.

While providers need to keep progress notes in order to document treatment, it is at the discretion of the provider whether to keep additional psychotherapy notes. A psychotherapy note is the documentation or analysis of the contents of conversation during an individual, group, or family psychotherapy session. Psychotherapy notes are kept separate from the rest of the individual’s medical record and are protected from normal record release under HIPAA even when requesting an authorization or continued services.

**Clinical Supervision**
Clinical supervision pertinent to member treatment changes must be recorded by a case notation in the member record after supervision occurs.

**Authorization**

Refer to [Chapter 5, Service Authorization](#), for general authorization policy and procedures. Effective January 1, 2019, requests for psychotherapy services that exceed the following limits will require authorization for continued service:

1. 26 hours of psychotherapy (with patient and/or family member) (including biofeedback) per calendar year, cumulative
2. 26 sessions of family psychotherapy per calendar year, cumulative
3. 10 sessions of multiple family group psychotherapy per calendar year
4. 52 sessions of group psychotherapy per calendar year, cumulative

Submit the following as part of the provider appeal process for continuation of services:

1. Copy of the most current DA
2. Clinical summary (including justification for each diagnosis)
3. Individual treatment plan that includes the following:
   a. Measurable and observable goals
   b. Start and end dates
   c. No status statements
4. Progress notes that include the following:
   a. Type of service
   b. DOS
   c. Session start and stop times
   d. Scope of service (nature of interventions or contacts, treatment modalities, phone contacts, etc.)
   e. Member’s progress (or lack thereof) toward overall treatment plan goals and objectives
   f. Member’s response or reaction to treatment intervention(s)
   g. Formal or informal assessment of the member’s mental health status
   h. Name and title of person who gave the service
   i. Date documentation was made in the member record

1. Other elements that may apply, including the following:
   a. Current risk factors the member may be experiencing
   b. Emergency interventions
   c. Consultations with or referrals to other professionals
   d. Summary of effectiveness of treatment, prognosis, discharge planning, etc.
e. Test results and medications
f. Symptoms

When requesting services that are to be performed with interactive complexity, include the interactive complexity add-on code on the provider appeal request.

Billing

1. Submit claims only for the recipient who is the primary subject of the psychotherapy sessions, regardless of the number of other family/group members in the session.
2. When more than one family member is a recipient (such as two or three siblings, each receiving treatment within a specific time frame), bill only for the time spent conducting psychotherapy for each recipient.
3. When group psychotherapy is rendered by two professionals, the time billed can be:
   a. Split between the professionals (for example: each professional bills 30 minutes of a one hour group psychotherapy session); or
   b. Under one professional who will then reimburse the second professional.
4. Bill psychotherapy services online using the 837P claim format, using the individual treating provider’s NPI number.
5. Hypnotherapy is part of psychotherapy; do not bill separately.
6. Enter the treating provider NPI number on each claim line.
7. Teaching hospitals may enter the GC modifier for services performed under the direction of a supervising physician.

Use the following table for billing services with DOS on or after January 1, 2013:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Brief Description</th>
<th>Unit</th>
<th>(*Per CPT Time Rule)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>30</td>
<td>(16 – 37*) minutes</td>
</tr>
<tr>
<td>90834</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>45</td>
<td>(38 – 52*) minutes</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>60</td>
<td>(53+*) minutes</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged service code for psychotherapy services (add on to 90837)</td>
<td>60</td>
<td>(30 – 60) minutes</td>
</tr>
<tr>
<td>Appropriate E/M and 90833</td>
<td>E/M and psychotherapy (with patient and/or family member)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate E/M and 90836</td>
<td>E/M and psychotherapy (with patient and/or family member)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate E/M and 90838</td>
<td>E/M and psychotherapy (with patient and/or family member)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis</td>
<td>60</td>
<td>minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis (add on to 90839)</td>
<td>30</td>
<td>minutes</td>
</tr>
<tr>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback, with psychotherapy</td>
<td>30</td>
<td>(16 – 37*) minutes</td>
</tr>
<tr>
<td>90876</td>
<td>Individual psychophysiological therapy incorporating biofeedback, with psychotherapy</td>
<td>45</td>
<td>(38 – 52*) minutes</td>
</tr>
<tr>
<td>90846†</td>
<td>Family psychotherapy; without patient present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90847†</td>
<td>Family psychotherapy with patient present</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Mental Health Psychotherapy Benefits for Children under Age 21 and Adults

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Brief Description</th>
<th>Unit (*Per CPT Time Rule)</th>
</tr>
</thead>
<tbody>
<tr>
<td>90849†</td>
<td>Multiple family group psychotherapy</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>Group psychotherapy</td>
<td>1 session</td>
</tr>
</tbody>
</table>

†Service Limitations

Use the appropriate prolonged services code (99354) with 90847 to report family psychotherapy, face-to-face with the recipient present, of 80 minutes or longer.

Calendar year thresholds effective January 1, 2019 (see Authorization):
- 26 sessions of family psychotherapy
- 10 sessions of multiple family group psychotherapy

Codes 90846 – 90849 are used to report family psychotherapy. Billing for family psychotherapy may be separately reported for each patient in the family group; however, it should not be reported for each family member.

Refer to the Children’s Therapeutic Services and Supports (CTSS) for Children under Age 21 table for additional information about CTSS services.

Refer to Psychotherapy for information about billing services with DOS prior to January 1, 2013.

## Psychological Testing

Psychological tests and other psychometric instruments are used to determine the status of a member’s mental, intellectual, and emotional functioning. Tests are listed in the most recent Buros’ *Mental Assessments Handbook* edition. Tests must meet psychological standards for reliability and validity, and be suitable for the diagnostic purposes for which they are used.

### Eligible Providers

LPs with competence in psychological testing may conduct psychological testing.

Under clinical supervision of an LP, psychometrists or psychological assistants may administer or score psychological tests. Psychological testing may also be administered and scored as part of a computer assisted psychological testing program.

### Eligible Members

Members eligible for psychological testing must be:
- Eligible PrimeWest Health members; and
- Adults diagnosed with a mental illness; or
- Children diagnosed with an ED.

### Covered Services

The following components of psychological testing are *all-inclusive* and cannot be billed separately:
- A face-to-face interview to validate the test
2. Administration
3. Scoring the psychological test(s)
4. Interpretation of results
5. A written report to document results of the test(s)

The LP must conduct the face-to-face interview, interpret the test results, and sign the report that is then placed in the member’s record. The member’s record must be released, upon authorization from the member or guardian, to other persons responsible for providing services for the member.

**Billing Psychological Testing**

1. Use the 837P claim format.
2. Enter the test name(s) on the Claim Notes segment.
3. Abbreviate names of the tests, if necessary.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>96101</td>
<td>Psychological testing LP, or LP-clinically supervised clinical psychology trainee, administered tests, interpretation and report</td>
<td>1 hour</td>
</tr>
<tr>
<td>96102</td>
<td>Psychological testing Technician-administered tests, with LP or clinical psychology trainee interpretation and report</td>
<td></td>
</tr>
<tr>
<td>96103</td>
<td>Psychological testing Computer-administered, with LP or clinical psychology trainee interpretation and report</td>
<td>1 session</td>
</tr>
</tbody>
</table>

**Assertive Community Treatment (ACT)**

ACT is an intensive, comprehensive, non-residential treatment and rehabilitative mental health service provided according to the assertive community treatment model. Assertive community treatment provides a single, fixed point of responsibility for the treatment, rehabilitation, and support needs of members. Services are offered 24 hours per day, seven days per week in a community-based setting.

The team promptly and appropriately responds to emergent needs and makes necessary staffing adjustments to assure the health and safety of members.

**Eligible ACT Programs**

An eligible ACT program must have a contract with a host county and be certified by DHS.

An ACT team must have 4 – 10 full-time staff assigned exclusively to the team. The team should include the following:
- Team leader (licensed mental health professional)
- Psychiatrist (or provisionally, a psychiatric NP or CNS-MH)
- Licensed mental health professional
- Registered nurse
- Co-occurring disorder specialist
- Vocational specialist
• Mental health certified peer specialist
• Program administrative assistant

Eligible Members

Members eligible to receive ACT services must meet the following criteria:
1. Be eligible PrimeWest Health members
2. Be age 18 or over (members ages 16 and 17 may be eligible upon approval by PrimeWest Health)
3. Have a primary diagnosis of schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, other psychologic disorders or bipolar disorder
4. Have a significant functional impairment demonstrated by at least one of the following:
   a. No indication that other available community-based services would be equally or more effective as evidenced by consistent and extensive efforts to treat the individual
   b. Written opinion of a licensed mental health professional that the recipient has a need for mental health services that cannot be met with other available community based services, or is likely to experience a mental health crisis or require a more restrictive setting if assertive community treatment is not provided

Covered ACT Services

The ACT team must offer and have the capacity to provide the following services:
• Assertive engagement
• Benefits and finance support
• Co-occurring disorder treatment
• Crisis assessment and intervention
• Employment services
• Family psychoeducation and support
• Housing access support
• Medication assistance and support
• Medication education
• Mental health certified peer specialist services
• Physical health services
• Rehabilitative mental health services
• Symptom management
• Therapeutic interventions
• Wellness self-management and prevention
• Other services based on client needs as identified in a member’s assertive community treatment individual treatment plan

ACT teams must ensure the provision of all services necessary to meet a member’s needs as identified in the member's individual treatment plan.

Billing

1. PrimeWest Health reimburses ACT services:
   a. Based on one, all-inclusive daily rate
   b. To one provider, per day
2. Each claim must be for a face-to-face contact (ACT team member and member).
3. Only one agency may bill when team members are from more than one agency; the billing provider reimburses other contributing agencies.
4. Bill ACT program services online using the 837P claim format.
5. Enter one DOS per line (do not enter a span of days on a line).
6. Enter POS code 21 if ACT services were provided to a member who was in an inpatient hospital.
7. Do not enter a treating provider on a line item.

If PrimeWest Health denies your ACT services claim because ARMHS or day treatment claims without authorization were paid, contact PrimeWest Health to request a reversal of the ARMHS or day treatment claim. After the reversal, resubmit your ACT claim.

<table>
<thead>
<tr>
<th>Assertive Community Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>H0040</td>
</tr>
<tr>
<td>H0040</td>
</tr>
</tbody>
</table>

**Certified Peer Specialist Services (CPSS)**

CPSS are specific rehabilitative services emphasizing the acquisition, development, and enhancement of skills needed by an individual with a mental illness to move forward in his/her recovery. These services are self-directed and person-centered with a focus on recovery. CPSS are identified in a treatment plan or an Individualized Service Plan (ISP) and are characterized by a partnering approach between the CPS and the individual who receives the services (peer).

**The Role of the Certified Peer Specialist (CPS)**

As a member of the team, the CPS uses a non-clinical approach that assists the person to discover his/her strengths and develop his/her own unique recovery goals. The CPS models wellness, personal responsibility, self-advocacy, and hopefulness through appropriate sharing of his/her story.

**Eligible Providers**

CPS Level I or Level II are employed in agencies approved to provide CPSS within the following mental health rehabilitation services:
1. ACT providers
2. IRTS providers
3. ARMHS providers
4. Crisis stabilization service providers

**CPS Level I**

CPS Level I must:
1. Be at least age 21;
2. Have a high school diploma or pass the General Educational Development (GED) test or equivalent;
3. Have a primary diagnosis of mental illness;
4. Be a current or former consumer of mental health services; and
5. Have successfully completed the DHS-approved CPS training and certification exam.

**CPS Level II – meets all requirements of CPS Level I and meets one or more of the following:**
1. Is qualified as a mental health practitioner;
2. Has at least 6,000 hours of supervised experience in the delivery of peer services to persons with mental illness; and
3. Has at least 4,000 hours of supervised experience in the delivery of services to persons with mental illness and an additional 2,000 hours of supervised experience in the delivery of peer services to persons with mental illness.

Certification is valid for two years from the date of certification. To retain certification as CPS Level I and II, providers must complete and submit documentation of continuing education to DHS of at least 30 hours every two years in the areas of mental health recovery, mental health rehabilitative services, and peer support. CPSs in a crisis stabilization team must have completed at least 30 hours of crisis intervention and stabilization training during their first two years on a crisis stabilization team.

Eligible Members

Eligible PrimeWest Health members must:
1. Be age 18 or over
2. Receive ACT, ARMHS, IRTS, or crisis stabilization services

Covered Services

Education
About the recovery journey from pre-recovery engagement, recovery initiation, recovery stabilization, and sustained recovery maintenance.

Assessing Unique Strengths and Abilities
1. As a team member, help peers to identify abilities, strengths, and assets.
2. Assist peers to recognize these strengths and use them to achieve their goals.

Identify, Encourage, and Connect
1. Identify community resources that support the peer’s goals and interests.
2. Identify barriers to participation in community resources.
3. Provide encouragement for involvement in community-based activities such as: work, relationships, physical activity, self-directed hobbies, etc.
4. Connect peers to Wellness Recovery Action Planning (WRAP) or other wellness-oriented groups to develop their own plans for advancing their recovery as appropriate.
5. Develop relationships with community groups/agencies in partnership with others in the agency.
6. Visit community resources to assist them in becoming familiar with potential opportunities.
7. Teach and model the skills needed to successfully utilize community resources.

Self-Advocacy
1. Support peers to identify their need for professional supports and services.
2. Connect peers to appropriate professional resources when needed.

Engagement, Support, and Encouragement
Work as a team member to develop a self-directed recovery plan.

Non-Covered Services

The following services are not covered as CPSS:
1. Transportation
2. Services that are performed by volunteers
3. Household tasks, chores, or related activities such as laundering clothes, moving, housekeeping, and grocery shopping
4. Time spent “on call” and not delivering services to members
5. Job-specific skills services such as on-the-job training
6. Case management
7. Outreach to potential recipients
8. Room and board
9. Service providers that are not approved to provide CPSSs as part of their ARMHS, ACT, IRTS, or crisis stabilization services

Authorization Requirements

No authorization is required.

Billing

Entities eligible to bill for CPSS:
1. ARMHS providers
2. Adult crisis response service providers

CPSSs provided within an ACT team or IRTS facilities are included in the daily rate and may not be billed separately.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Units</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td></td>
<td>Self-help/peer services by Level I CPS</td>
<td>15 minutes</td>
<td>None</td>
</tr>
<tr>
<td>U5</td>
<td></td>
<td>Self-help/peer services by Level II CPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HQ</td>
<td></td>
<td>Self-help/peer services in a group setting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Adult Day Treatment

Adult Day Treatment is a structured program of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team to stabilize a member’s mental health status while developing and improving his/her independent living and socialization skills. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the member to live in the community.

Eligible Adult Day Treatment Providers

Adult and Children’s Day Treatment services have different certifications, standards, and limitations. The following agencies may apply to become day treatment providers:
1. Licensed outpatient hospitals with JCAHO accreditation
2. PrimeWest Health-enrolled CMHCs
3. Entities under contract with a county to operate a day treatment program

Individual members of the Adult Day Treatment multidisciplinary team must meet, at a minimum, the standards for a mental health practitioner. Psychotherapy components of day treatment must be provided by a mental health professional unless a mental health practitioner qualifies under the provisions in the mental health professional service billing section of this chapter.

Day treatment programs follow the staffing requirements for group size as established for group psychotherapy.
If providing Children’s Day Treatment to members ages 18, 19, or 20, providers must also be CTSS-certified.

**Clinical Supervision**

Adult day treatment providers are required to follow [Clinical Supervision of Outpatient Mental Health Services](#) (Rule 47) guidelines

**Eligible Members**

To be eligible for Adult Day Treatment, a member must meet all of the following criteria:

1. Be a PrimeWest Health member
2. Be age 18 or older (members ages 18, 19, or 20 may receive Adult Day Treatment, CTSS, or both, depending on medical necessity)
3. Not be residing in an institution (nursing facility, hospital, IMD, RTC), unless the member has an active discharge plan that indicates a move to an independent living arrangement within 180 days (refer to [Members in Institutions or Residential Facilities](#) section)
4. Have a diagnosis of mental illness (primary diagnoses may not be alcohol or other drug abuse)

Members admitted to Adult Day Treatment programs must be in need of and have the capacity to benefit from the rehabilitative nature, the structured setting, and therapeutic components of psychotherapy and skills activities that are integral to a day treatment program. A group is defined as more than three individuals.

Members with mental illness and a DD or cognitively degenerative disease, such as Alzheimer’s, must have the ability to understand and benefit from day treatment. When a member does not have or ceases to have the cognitive capacity to benefit from day treatment services, day habilitation programs or adult day care, services under a waiver program may be more appropriate. Refer member in need of these or other services to the county human service agencies or private agencies. Day treatment is distinguished from day care by the structured therapeutic program of psychotherapy and other therapeutic components.

**Members in Institutions or Residential Facilities**

Day treatment services are not part of inpatient or residential treatment services. Day treatment programs are rarely appropriate for members residing in institutions (nursing facilities, IMDS); however, members residing in institutions who have an active discharge plan that indicates a move to an independent living arrangement within 180 days may be considered for participation in a day treatment program. A mental health professional must deem the day treatment services medically necessary and the member’s facility plan of care must include day treatment.

Develop a treatment plan for each member with attainable, measurable goals. The primary goal for each member is independence to the degree possible. Develop the treatment plan at the time of admission, review and update until discharge with the member’s progress, and include a sound discharge plan.

Apply the following criteria to identify the appropriate situation or status for members recommended or referred for day treatment services. Members not meeting these criteria should be referred to other services appropriate to their needs.

**Admission Criteria**

For admission, a member must meet the following criteria:

1. Have a primary diagnosis of mental illness as determined by a diagnostic assessment (DA), excluding dementia and other organic conditions
a. The DA must be completed following a face-to-face evaluation of an individual’s nature, severity, and effect of behavioral difficulties, functional impairment, subjective distress, strengths, and resources

2. Have three or more areas of significant impairment in functioning as determined by a functional assessment (FA)
   a. An FA must also be completed prior to receiving services and no sooner than 30 days prior
   b. An FA is valid for 180 days
   c. Update the FA when the person undergoes any significant changes in functioning, life situation, or status in any domain or life area
   d. A significant change in functioning calls for a reassessment of the functional domains, regardless of the due date for updating the functional assessment

3. Have a completed LOCUS assessment with a Level 3 indication
   a. A LOCUS must also be completed prior to receiving services and no sooner than 30 days prior
   b. A LOCUS is valid for 180 days
   c. Update a LOCUS when a person undergoes any significant change in functioning, a significant life event has occurred, or within ten days prior to discharge. These changes call for a new LOCUS assessment

4. Be experiencing symptoms impairing thought, mood, behavior, or perception that interfere with the ability to function with a lesser level of service

5. Have the cognitive capacity to engage in and benefit from this level of treatment

6. Reasonably be expected to benefit in improved functioning at work, school, or social relationships

7. Need a highly structured, focused treatment approach to accomplish improvement and to avoid relapse requiring higher level of treatment.

Day treatment may also be appropriate for the following:
1. Members with a brain injury (BI) diagnosis that coexists with the primary mental illness diagnosis
2. Court ordered treatment or for a member who is a potential danger to self, if the program provides adequate structure and sufficient support systems exist in the community
3. Members residing in inpatient or residential facilities (nursing facilities, IMDs, hospitals, RTC) when an active discharge plan indicates a move to an independent living arrangement within 180 days. A mental health professional must deem the day treatment services medically necessary and the facility plan of care must include day treatment

Continuing Stay Criteria
Consider a member for continuing stay if the following criteria are met:
1. Member’s condition continues to meet admission criteria as evidenced by active psychiatric symptoms and continued functional impairment
2. The treatment plan contains specific goals and documented measurable progress toward goals
3. Member continues to make progress toward goals but they have not yet been fully achieved
4. There is documentation that an active discharge plan is in place
5. There is documentation of active attempts at coordination of care and attempts to transition to other services as clinically indicated

Discharge Criteria
Consider a member for discharge if any one of the following criteria is met:
1. Treatment plan goals and objectives have been met or individual no longer meets continuing stay criteria
2. Mental health disorder(s) impairing thought, mood, behavior, or perception decreased to level that lesser level of service is indicated
3. Member is voluntarily involved in treatment and no longer agrees to attend day treatment
4. Member exhibits severe exacerbation of symptoms and/or disruptive or dangerous behaviors requiring more intensive level of service. Do not close chart if individual is expected to return to day treatment.
5. Member does not participate despite multiple attempts to engage the person and address nonparticipation issues
6. Member does not make progress toward treatment goals and there is no reasonable expectation that progress will be made

**Covered Day Treatment Services**

Adult day treatment consists of the following:

1. At least one hour of group psychotherapy (maximum of two hours)
2. Group time focused on rehabilitative interventions, or other intensive therapeutic services, provided by a multidisciplinary staff
3. A group of at least three, but not more than 12. For a group of three to eight people, one mental health professional or practitioner is required to conduct the group. For a group of nine to 12 people, a team of at least two mental health professionals or two mental health practitioners or one mental health professional and one mental health practitioner is required to co-conduct the group.

The services must:

1. Stabilize the member's mental health status
2. Develop and improve the member’s independent living and socialization skills
3. Be included in the member's individual treatment plan (ITP). The ITP must meet the following criteria:
   a. Be completed before the completion of five working days in which service is provided or within 30 days after the diagnostic assessment is completed or obtained, whichever occurs first
   b. Include attainable, measurable goals as they relate to day treatment services
   c. Be reviewed by the provider and updated with member progress at least every 90 days until discharge, and include an available discharge plan
   d. Document the interventions provided and the member's response on a daily basis
   e. Include an attainable discharge plan for the member
   f. Must be a collaborative and person-centered process involving the member, and with the permission of the member, the member's family, and others in the member's support system

The ITP and subsequent revisions of the ITP must be signed by the member before treatment begins. The mental health professional or practitioner will request the member, or other person authorized by Statute to consent to mental health services for the member, to sign the member's ITP or revision of the ITP.

If the member or authorized person refuses to sign the plan or a revision of the plan, the mental health professional or mental health practitioner will note on the plan the refusal to sign and the reason(s) for the refusal.

**Non-Covered Services**

The following services or activities may not be billed as day treatment:

1. Primarily recreation-oriented, non-medically supervised services or activities, including, but not limited to, the following:
   a. Sports activities
   b. Exercise groups
   c. Craft hours
   d. Leisure time
   e. Social hours
   f. Meal or snack time or preparation
   g. Trips to community activities
   h. Tours
2. Social or educational services that do not have therapeutic outcomes related to the member’s mental health condition
3. Consultations
4. Prevention or education programs provided to the community
5. Services not included in the member’s treatment plan as medically necessary and appropriate
6. Less intensive services, such as a “clubhouse” or social program not covered by PrimeWest Health

**Billing**

1. Use the appropriate claim format.
2. Do not use a modifier.
3. Do not provide or bill for Adult Day Treatment for children under age 18.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2012</td>
<td></td>
<td>Adult Behavioral Day Treatment</td>
<td>1 hour</td>
<td>None</td>
</tr>
</tbody>
</table>

**Adult Rehabilitative Mental Health Services (ARMHS)**

ARMHS do the following:
1. Enable a member to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness
2. Enable a member to retain stability and functioning if the member is at risk of losing significant functionality or being admitted to a more restrictive service setting without these services
3. Instruct, assist, and support a member in areas such as medication education and monitoring, and basic social and living skills in mental illness symptom management, household management, employment-related, or transitioning to community living

**Eligible Adult Rehabilitative Mental Health Services (ARMHS) Providers**

Each ARMHS provider entity must be certified to provide ARMHS. Certification ensures that the provider is capable of providing directly, or contracting for, the full array of ARMHS.

Non-county entities must receive additional certification from each county in which they provide services. The additional certification must be based on the entity’s knowledge of the county’s local health and human services system and the ability of the entity to coordinate its services with other services available in that county.

County-operated entities must receive additional certification from any other counties in which they will provide services.

ARMHS entities must be recertified every three years.

The following individual providers are eligible to provide ARMHS:

1. CNS-MH
2. CPS
3. LMFT
4. LICSW
5. LP
6. LPCC
7. Mental health practitioner: mental health practitioners must receive continuing education as required by their professional license or, if not licensed, at least 30 hours every two years in the areas of mental illness and mental health services.
8. Mental health professional
9. Mental health rehabilitation professional
10. Mental health rehabilitation worker
11. Psychiatric NP
12. Psychiatrist

**Eligible Adult Rehabilitative Mental Health Services (ARMHS) Members**

Members eligible for ARMHS must meet all of the following criteria:
1. Be age 18 or over
2. Have a designation of a serious mental illness as determined by a DA
3. Have a completed *LOCUS Recording Form (DHS-6249)* that indicates a Level 3 or Level 2
4. Have a significant impairment in functioning in three or more areas of the FA domains specified in MN Stat. sec. 245.462, subd. 26 and MN Rules part 9520.0914, subp. 2
5. Be a PrimeWest Health member

**Adult Rehabilitative Mental Health Services (ARMHS) Covered Services**

The following four services are billable as ARMHS:
1. Basic living and social skills
2. Community intervention
3. Medication education
4. Transitioning to community living services
5. CPSS

All covered services are provided face-to-face except Community Intervention. Documentation of activities is included in the covered service and must not be billed separately.

ARMHS can be provided in the following locations:
1. A member’s home
2. The home of a relative or significant other
3. A member’s job site
4. The community, such as the following:
   a. Psychosocial clubhouse
   b. Drop-in center
   c. Social setting
   d. Classroom
   e. Other place in the community

Unless a member is in the process of transitioning to independent living within 180 days and ARMHS offers the services necessary for the member to succeed, do not provide ARMHS to a member residing in any of the following:
1. Regional Treatment Centers (RTCs)
2. Nursing facilities
3. Acute care settings (inpatient hospital)
4. Sub-acute settings (IRTS program)
Basic Living and Social Skills

Basic living and social skills are activities that instruct, assist, and support a member in skill areas essential for every day, independent living. Examples of skill areas include the following:

1. Interpersonal communications
2. Community resource utilization and integration
3. Crisis assistance
4. Relapse prevention
5. Budgeting, shopping, and healthy lifestyle skills and practices
6. Cooking and nutrition
7. Transportation
8. Medication monitoring
9. Mental illness symptom management
10. Household management
11. Employment-related skills
12. Transitioning to community living

Each member’s treatment plan should identify specific skills needed, how each is being addressed, the modality (individually, group), and the medical necessity for each goal.

Provide basic living and social skills individually or in a group setting, when appropriate, to each participating member’s needs and treatment plan. A basic living and social skills group is 2 – 10 individuals, at least one of whom is a PrimeWest Health member. Up to two staff may bill PrimeWest Health for services provided to a group. Each staff person must bill for different members.

Provide basic living and social skills directly (face-to-face) to the member. Do not bill if the contact is conducted by telephone.

Community Intervention

Community intervention is a service of strategies provided on behalf of a member to do the following:

1. Alleviate or reduce a member’s barriers to community integration or independent living; or
2. Minimize the risk of hospitalization or placement in a more restrictive living arrangement.

Community intervention may be conducted with an agency, institution, employer, landlord, or member’s family and may require the involvement of the member’s relatives, guardians, friends, employer, landlord, treatment providers, or other significant people to change situations and allow the member to function more independently.

Community intervention:

1. Must be directed exclusively to the treatment of the member;
2. Must be provided on an individual basis only (cannot be provided in a group);
3. May be conducted in person or by telephone, if the intervention strategy warrants it (document accordingly); and
4. Can be conducted without the member present when the intervention strategy warrants it (document why the strategy is more effective without the member present).

Community intervention may not be billed for any of the following:

1. Routine communication between members of a treatment team, a routine staffing, or a care conference
2. Telephone contacts that do not conform to the definition of this service or that are not properly documented
3. Clinical supervision or consultation with other professionals
4. Treatment plan development
Medication Education
The medication education service educates a member about the following:
1. Mental illness and symptoms
2. The role and effects of medications in treating symptoms of mental illness
3. The side effects of medications

Medical education is coordinated with, but not duplicative of, medication management services. The member must be present to bill for the service.

Medication education:
1. Can include activities that instruct members, families, and/or significant others in the correct procedures for maintaining a member’s prescription medication regimen
2. May be provided individually or in a group setting
3. Can be provided only by a physician, pharmacist, RN, or physician assistant (PA) employed by or subcontracted with a certified ARMHS provider. The ARMHS provider bills for medication education.

If medication education is provided in a pharmacy, ensure that the service is provided apart from the dispensing area. Medication education is not intended to replace any aspect of dispensing medications. Information provided to a member as part of a prescription is an aspect of dispensing medications, is reimbursed separately in the dispensing fee, and is not billable as medical education.

Transitioning to Community Living (TCL) Services
TCL services are services designed to do the following:
1. Establish or re-establish contact between an ARMHS provider and the member prior to the member’s discharge from a higher level of care mental health service, including the following:
   a. RTC
   b. Community hospital
   c. IMD
   d. Intensive Residential Treatment program
   e. Board and care facility
   f. Skilled nursing home
   g. ACT
2. Implement the discharge plan developed by the higher level of care mental health service
3. Coordinate with, but do not duplicate, the discharge planning responsibilities of the higher level of care service
4. Be provided within 180 days, maximum, of discharge from the higher level of care service

TCL services cannot be provided concurrently with other ARMHS services. TCL services are available only when the member is receiving a higher level of care service.

TCL services do not count toward the 300 hours/72-session limit for Basic Living and Social Skills or Community Intervention service categories.

Transitioning services are integrally coordinated with, but not duplicative of, discharge planning.

Do not provide transitioning services concurrently or in conjunction with other ARMHS. Bill transitioning services only when the facility does not have the responsibility to or cannot provide these services.

Transitioning services are claimed through basic living and social skills or community intervention procedure codes with a modifier (UD) indicating that the services are essential for successful entry or re-entry to independent living and provided to a member who is leaving or will be leaving a residential living arrangement.
such as a nursing facility or regional treatment center, an acute care (inpatient) setting, or sub-acute setting such as an IRTS program within 180 days.

**Adult Rehabilitative Mental Health Services (ARMHS) Non-Covered Services**

The following services are not covered ARMHS:
1. Member transporting services
2. Services provided and billed by providers not enrolled to provide ARMHS
3. ARMHS performed by volunteers
4. Provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the member’s household, housekeeping, and grocery shopping for the member
5. Time spent “on call” and not delivering services to members
6. Activities primarily social or recreational in nature, rather than rehabilitative
7. Job-specific skills services such as on-the-job training
8. Time included in case management services
9. Outreach services to potential members
10. Room and board services

**Billing Adult Rehabilitative Mental Health Services (ARMHS)**

1. Use the 837P claim format to bill for all ARMHS.
2. Enter the treating provider NPI on each claim line.
3. ARMHS services must be prior authorized in order to be concurrently provided with ACT or IRTS.

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Units</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2017</td>
<td></td>
<td>Basic living and social skills – individual; mental health professional or practitioner</td>
<td>15 minutes</td>
<td>Authorization is required for more than 3 hours per day/25 hours per month; combined total of H2017, H2017 HM, and H2017 HQ Any units billed over the daily or monthly limit will be denied if authorization is not in place.</td>
</tr>
<tr>
<td>HM</td>
<td></td>
<td>Basic living and social skills – individual; mental health rehabilitation worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HQ</td>
<td></td>
<td>Basic living and social skills – group; mental health professional, practitioner, or rehabilitation worker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| U3    |          | Basic living and social skills, transitioning to community living(TCL), mental health professional or practitioner | 15 minutes | • Authorization required  
• Cannot be done concurrently with other ARMHS services |
| U3 HM |          | Basic skills; TCL by a mental health rehabilitation worker; less than a bachelor’s degree level | 15 minutes | • Authorization Required  
• Cannot be done concurrently with other ARMHS services |
| 90882 |          | Environmental or community intervention; mental health professional or practitioner | 1 session | Authorization is required for more than 10 sessions |
# Adult Rehabilitation Mental Health Services (ARMHS) Benefits

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Units</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HM</td>
<td></td>
<td>Environmental or community intervention; mental health rehabilitation worker</td>
<td></td>
<td>per month or 72 sessions per calendar year</td>
</tr>
<tr>
<td>U3</td>
<td></td>
<td>Environmental or community intervention; TCL intervention</td>
<td>1 session</td>
<td>• Authorization required&lt;br&gt;• Cannot be done concurrently with other ARMHS services&lt;br&gt;• No threshold</td>
</tr>
<tr>
<td>U3 HM</td>
<td></td>
<td>Environmental or community intervention; TCL intervention; less than a bachelor’s degree level; mental health rehabilitation level</td>
<td>1 session</td>
<td>• Authorization required&lt;br&gt;• Cannot be done concurrently with other ARMHS services&lt;br&gt;• No threshold</td>
</tr>
<tr>
<td>H0031</td>
<td>UD</td>
<td>Mental health assessment; by non-physician</td>
<td>Per 15 minutes</td>
<td>• Authorization required for more than 24 units per calendar year</td>
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<tr>
<td>H0031</td>
<td>UD TS</td>
<td>Mental health assessment; by non-physician; follow-up service (review or update)</td>
<td>Per 15 minutes</td>
<td></td>
</tr>
<tr>
<td>H0032</td>
<td>UD</td>
<td>Mental health service plan development by non-physician</td>
<td>Per 15 minutes</td>
<td>• Authorization required for more than 14 units per calendar year</td>
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<tr>
<td>H0032</td>
<td>UD TS</td>
<td>Mental health service plan development by non-physician; follow-up services (review or update)</td>
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<tr>
<td>H0034</td>
<td>HQ</td>
<td>Medication education – individual; physician, RN, PA, or a pharmacist</td>
<td>Per 15 minutes</td>
<td>Authorization is required for more than 26 hours per calendar year of H0034</td>
</tr>
<tr>
<td>H0034</td>
<td>HQ</td>
<td>Medication education – group setting</td>
<td>Per 15 minutes</td>
<td>Authorization is required for more than 26 hours per calendar year of H0034</td>
</tr>
</tbody>
</table>

## Certified Community Behavioral Health Clinic (CCBHC) Federal Demonstration Project

### Background
CCBHCs are authorized under Section 223 of the Protecting Access to Medicare Act (PAMA) (PL 113-93). The goals of CCBHCs are to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care for individuals covered by Medicaid.

Minnesota is one of eight states selected to operate the two-year CCBHC demonstration project. As a condition of participation in the demonstration project, Minnesota certified six participating clinics as meeting the Federal certification criteria for the demonstration program effective July 1, 2017, through June 30, 2019. For more information, refer to the [CCBHC web page](#).

### Overview
CCBHCs provide a community clinic model of care aimed at improving access to and quality of mental health and substance use disorder services by ensuring the CCBHC providers have the capacity to deliver and
coordinate all services under the CCBHC model. CCBHCs must have established collaborative relationships with other providers and health care systems to coordinate care for their recipients. All treatment delivered within the CCBHC is person- and family-centered, recovery-oriented, evidence-based, and trauma-informed. The individual treatment needs of Minnesota Health Care Programs (MCHP) recipients are documented in an integrated treatment plan across all services.

CCBHC providers are required to provide or have access to the full array of CCBHC services and need to be enrolled as an eligible PrimeWest Health provider for each service. Required CCBHC services include existing PrimeWest Health services and an expanded set of billable services unique to CCBHC providers that must be provided in accordance with standards outlined in this section.

In addition to billing for the usual coverage that applies to currently covered CCBHC services, CCBHCs can receive two types of additional payment:
1. Payment for new and expanded services (described in the following)
2. A monthly supplemental wrap payment based on the difference between all other reimbursements and a daily cost-based rate determined individually for each CCBHC (see billing section for more details)

The above additional payments are limited to the six CCBHCs participating in this demonstration program and are only available for services provided to recipients of Medical Assistance, which is Federally funded Medicaid. These additional CCBHC payments are not available to recipients of MinnesotaCare or other types of health care coverage that do not include Federal Title XIX funding. These payment limitations do not absolve the CCBHC from serving people regardless of ability to pay under CCBHC criteria.

For more information on all CCBHC requirements, including those not directly related to PrimeWest Health billing policy, please see the CCBHC Variance and the Federal certification criteria.

Eligible Providers
Eligible CCBHC providers must have the capacity to deliver and coordinate services required under the CCBHC model and be selected as a CCBHC provider by the Minnesota Department of Human Services (DHS) to participate in the Federal CCBHC demonstration program.

CCBHC providers selected to participate in this demonstration include the following:
1. Northwestern Mental Health Center
2. Northern Pines Mental Health Center
3. People Incorporated
4. Ramsey County Mental Health Center
5. Wilder Children and Family Services
6. Zumbro Valley Health Center

Eligible Members
PrimeWest Health eligible members must meet the following criteria to be considered a CCBHC recipient:
1. For new recipients (those not served by the clinic in the six months prior to the current service):
   a. Receive a preliminary screening and risk assessment and one CCBHC service, or
   b. Receive a crisis assessment
2. Existing recipients (those served in any CCBHC in the six months prior to service) are eligible upon receipt of a CCBHC service after July 1, 2017

Preliminary Screening and Risk Assessment
Although not a billable service, providers must complete the preliminary screening and risk assessment with all new recipients of a CCBHC. A new recipient is defined as a person who has not received a service at a CCBHC within the last six months.
Assessment Components
The purpose of the preliminary screening and risk assessment is to determine acuity of need. When determined to be an emergency or crisis need, appropriate action is taken immediately. When determined to be an urgent need, schedule the person to receive an initial evaluation within one business day. If determined to be a routine need, schedule the person to receive an initial evaluation within 10 days.

CCBHC Covered Services
CCBHC providers are required to provide or have access to the full array of CCBHC services and need to be enrolled as an eligible PrimeWest Health provider for each service. Required CCBHC services include existing PrimeWest Health services in addition to an expanded set of billable services unique to CCBHC providers.

Existing PrimeWest Health services required to be provided by CCBHC are to be billed in accordance with the current corresponding PrimeWest Health Provider Manual section.

PrimeWest Health Services for CCBHC
Existing PrimeWest Health services for CCBHC include the following:
1. Adult crisis response services
2. Adult day treatment
3. Adult rehabilitative mental health services (ARMHS)
4. Alcohol and drug abuse services
5. Certified peer specialist services
6. Children’s mental health crisis response services
7. Children’s therapeutic services and supports (CTSS)
8. Diagnostic assessment
9. Dialectical behavior therapy (DBT)
10. Functional assessment for adults (can be billed outside of an ARMHS service)
11. Functional assessment for children or administering and reporting standardized measures (can be billed outside of a CTSS service)
12. Mental health family peer specialist
13. Mental health provider travel time
14. Mental health targeted case management for adults (AMH-TCM)
15. Mental health targeted case management for children (MH-TCM)
16. Neuropsychological services
17. Psychiatric consultation to primary care providers
18. Psychological testing
19. Psychotherapy
20. Psychotherapy for crisis

Expanded CCBHC Services
Expanded CCBHC services include the following:
1. Preliminary screening and risk assessment
2. Initial evaluation
3. Comprehensive evaluation
4. Integrated treatment plan
5. Clinical care consultation
6. Family psychoeducation
7. Certified peer recovery specialist
8. Comprehensive substance use disorder assessment
9. Care coordination
Initial Evaluation
The initial evaluation is required for any new recipient age five and over.

CCBHC recipients receive an initial evaluation that identifies their preliminary diagnosis or diagnoses, determines eligibility for services within the CCBHC (specifically, outpatient SUD services, ARMHS, TCM, CTSS, peer services, and psychotherapy), and establishes medical necessity for those services. The existing Rule 25 assessment and county Service Authorization process may still be used; however, for services provided on or after July 1, 2017, CCBHC recipients who are on Medicaid can have direct access to outpatient substance use disorder services provided within the CCBHC without county approval or authorization.

Required Assessment Components
Providers may gather the required elements of the initial evaluation by reviewing previous diagnostic assessments or documents from other providers that are less than one year old or elements acquired by other internal staff and include the following:
1. Date of birth
2. Gender
3. Ethnicity
4. Race
5. Insurance status and type
6. Primary language
7. Current living situation
8. A determination of whether the person presently is or ever has been a member of the United States Armed Services
9. Referral source
10. Reason for seeking care, as stated by the recipient or other individuals who are significantly involved
11. A drug profile including the person’s prescriptions, over-the-counter medications, herbal remedies, and other treatments or substances that could affect drug therapy, as well as information on drug allergies
12. Assessment of recipient risk to self or to others, including suicide risk factors and other recipient safety concerns
13. Assessment of need for medical care with referral and follow-up as required
14. Screening for co-occurring mental health and substance use disorders
15. Brief narrative within each of the six dimensions of the ASAM criteria addressing the following:
   a. All reasons for seeking care
   b. Strengths, cultural influences, life situations, learning differences, and legal issues
   c. The narrative for dimension 3 must include a brief diagnostic discussion including symptoms, duration, preliminary diagnoses, and how symptoms affect the person’s functioning
   d. Identification of the person’s immediate clinical care needs for mental and substance use disorders related to the diagnoses and effect on functioning including the following:
      i. Recommendations for identified mental health and substance use disorder services (specifically: SUD services, ARMHS, TCM, CTSS, peer services and psychotherapy)
      ii. Determination of medical necessity for those services. For substance use disorder services, utilization of the Minnesota Matrix (DHS-5204B) to provide scores on the six dimensions and the diagnosis of a substance use disorder is required only for those for whom substance use is identified
      iii. Documentation of next steps for service initiation that may include recipient-defined initial goals, short-term objectives, and suggested interventions, including need for further assessment

Although some of the elements of the initial evaluation may be gathered by other clinic staff, a mental health professional or practitioner working under a licensed professional as a clinical trainee must complete a face-to-face interview with the recipient and a review and synthesis of gathered data.
The initial evaluation establishes clinical eligibility for outpatient SUD services for CCBHC recipients. For CCBHC recipients of outpatient SUD services, a comprehensive SUD assessment (according to MN Rule 9530.6422) is still required within three sessions. The results of the comprehensive SUD assessment are then incorporated into the required comprehensive evaluation for each CCBHC recipient that is completed within 60 days of first contact. The comprehensive evaluation includes a psychosocial assessment, including an assessment of level of care needs (CASII, ECSII for children and adolescents, and/or LOCUS for adults) and synthesizes data gathered by the CCBHC between the first contact and up to completion of the comprehensive evaluation. The comprehensive evaluation must be completed on an annual basis for individuals receiving services from a CCBHC.

**ASAM 6 Dimensions**

The initial evaluation, comprehensive evaluation and the integrated treatment plan must be written in the format of the [ASAM 6 Dimensions](#), outlined as follows:

1. Dimension 1: Acute intoxication or withdrawal potential
2. Dimension 2: Biomedical conditions and complications
3. Dimension 3: Emotional, behavioral and cognitive
4. Dimension 4: Readiness for change
5. Dimension 5: Relapse, continued use and continued problem potential
6. Dimension 6: Recovery environment

**Comprehensive Evaluation**

The comprehensive evaluation is a review and synthesis of all information previously gathered from external sources or in the preliminary screening and risk assessment, crisis assessment, initial evaluation, and any other service received at the CCBHC.

**Assessment Components**

The comprehensive evaluation must include the following components:

1. Updates to all required components of the initial evaluation
2. A psychosocial evaluation including housing, vocational and educational status, family or caregiver and social support, pregnancy and parenting status, legal issues, and insurance status
3. For an adult, the [functional assessment](#) (FA) completed within the previous 60 days satisfies this requirement
4. It is allowable, but not required, to complete the WHODAS
5. For children age 5 – 18 years, complete the Strengths and Difficulties Questionnaire (SDQ)
6. Behavioral health (including mental health, chemical health, and physical health) history (including trauma history and previous therapeutic interventions and hospitalizations)
7. Assessment of imminent risk (including suicide risk, danger to self or others, substance withdrawal, urgent or critical medical conditions, and other immediate risks, including threats from another person)
8. Depression screening tool
9. Basic competency or cognitive impairment screening (including the person’s ability to understand and participate in his/her own care)
10. Developmental incidents and history
11. A description of attitudes and behaviors, including cultural and environmental factors, that may affect the person’s treatment plan
12. The recipient’s strengths, goals, and other factors to be considered in recovery planning
13. Depending on whether the CCBHC directly provides primary care screening and monitoring of key health indicators and health risk, either: (a) an assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the person’s primary care provider (with appropriate referral and follow-up), or (b) a basic physical assessment
14. Brief narrative within each of the six dimensions of the [ASAM criteria](#) addressing the following:
   a. All reasons for seeking care
b. Progress in the last 60 days

c. Remaining barriers that will lead to formation of the treatment plan

d. Strengths, cultural influences, life situations, learning differences, and legal issues

e. The narrative for ASAM dimension 3 must include a mental status exam and a brief diagnostic discussion including symptoms, duration, preliminary diagnoses and how symptoms affect the person’s functioning

f. The narrative for ASAM dimension 4 must identify the stage of change for all reasons the recipient sought care

15. Establish medical necessity for services and level of care (LOC) needs for recommended services
   (Approved LOC tools: LOCUS for adults, CASII for children and adolescents, and ECSII for children up to age 5)

16. Assessment of need and medical necessity for behavioral health services beyond what is already provided including:

17. For substance use disorder services, utilization of the **Minnesota Matrix** to provide scores on the six dimensions and the diagnosis of a substance use disorder

18. Assessment of the social service needs of the consumer with necessary referrals made to social services and, for pediatric consumers, to child welfare agencies as appropriate

19. For children under age 5, the DC:0-3R diagnostic system for young children must be utilized for assessment. For CCBHC providers, the comprehensive evaluation for this age group must include the elements listed previously and be completed in a minimum of three sessions and billed under the extended comprehensive evaluation code.

**Integrated Treatment Plan**
The integrated treatment plan is the culmination of a person- and family-centered planning process in which the recipient, any family or recipient-defined natural supports, CCBHC service providers, external service providers as appropriate, and care coordination staff are engaged in creation of the integrated treatment plan. The development of the integrated treatment plan must be completed in a face-to-face interaction with the recipient and, at minimum, a mental health professional, as well as all the interested parties listed previously.

The CCBHC must collaboratively complete a person-centered or family-centered integrated treatment plan within 60 days of the recipient’s first point of contact for new recipients or within 90 days of first CCBHC service for existing recipients.

**Integrated Treatment Plan Components**
The components must be in the format of the six dimensions of the **ASAM Criteria** and must contain the following core elements:

1. Recipient-defined vision
2. Identified problems or functional barriers
3. Measurable goals toward obtaining the recipient-defined vision
4. Measurable objectives toward reaching the goals
5. Interventions
6. Strengths and resources that inform the objectives
7. Cultural considerations
8. Timeline (frequency and duration)
9. Signatures of the mental health professional and the person with dates
10. For a child, the signature of a parent or guardian or other adult authorized by law to provide consent for treatment
11. A client’s parent or guardian may approve the integrated treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature
12. In instances where oral approval is verified by a later written signature, the effective date is the date of oral approval, which is documented in the integrated treatment plan
The integrated treatment plan incorporates all information gathered about and by the recipient including the initial evaluation, comprehensive evaluation and any progress made in all utilized services and the following:
1. Documentation of recipient involvement in plan development
2. Documentation of parental or guardian consent for those under age 18 or under legal guardianship

**Integrated Treatment Plan Update**
Providers must update the person-centered or family-centered integrated treatment plan at least every 90 days, or more often when there is significant change in the recipients’ situation or functions. Also, in services or service methods to be used, or at the request of the recipient or the recipient’s legal guardian. It must be completed with the recipient present, and any recipient-defined support people, CCBHC service providers, and any external service providers of the recipient’s choosing must be engaged in the process. It must incorporate the following components:
1. A review of the previous comprehensive evaluation, progress notes, and information gathered since the last comprehensive evaluation
2. A review of the previous integrated treatment plan, progress notes, and information gathered since the last integrated treatment plan
3. A brief summary of progress made and barriers that remain
4. Diagnostic updates based on any changes, as needed
5. Assessment of need for behavioral health services beyond what is already provided
6. Treatment plan updates, including goal achievement and identification of new goals and objectives
7. Status updates:
   a. Whether recipient received some peer service as of date of update
   b. Whether recipient received some telemedicine service as of date of update
8. Type of health insurance
9. Housing or residential status

**Clinical Care Consultation**
The CCBHC demonstration program expands clinical care consultation services to adult PrimeWest Health members (age 21 and over). CCBHC providers should refer to the PrimeWest Health *Provider Manual* for Children’s Mental Health Clinical Care Consultation for a definition of the covered service.

**Family Psychoeducation**
The CCBHC demonstration program expands family psychoeducation services to adult PrimeWest Health members (age 21 and over). CCBHC providers should refer to the PrimeWest Health *Provider Manual* for Family Psychoeducation for a definition of the covered service.

**Certified Peer Services**
Mental health certified peer specialist services can be provided along the entire continuum of mental health services as long as they are determined to be medically necessary by a mental health professional or practitioner working as a clinical trainee. CCBHC certified peer specialist services are subject to the same standards outlined in the Certified Peer Specialist Services section of the PrimeWest Health *Provider Manual*.

Mental health certified family peer specialist services can be provided along the entire continuum of mental health services as long as they are determined to be medically necessary by a mental health professional or practitioner working as a clinical trainee. CCBHC mental health certified family peer specialist services are subject to the same standards outlined in the Mental Health Certified Family Peer Specialist section of the PrimeWest Health Provider Manual.

Certified peer recovery specialist services can be provided throughout SUD services as long as they are determined to be medically necessary by a mental health professional, a mental health practitioner working as a
clinical trainee, or a licensed alcohol and drug counselor. Providers must provide certified peer recovery specialist services according to the following guidelines:
1. Certified peer recovery specialist qualifications:
2. Have a minimum of one year in recovery from substance use disorder
3. Hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support
4. Receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor or an individual with a certification approved by the commissioner

Certified peer recovery specialist services include the following:
1. Education
2. Advocacy
3. Mentoring through self-disclosure of personal recovery experiences
4. Attending recovery and other support groups with a client
5. Accompanying the client to appointments that support recovery
6. Assistance accessing resources to obtain housing, employment, education, and advocacy services
7. Non-clinical recovery support to assist the transition from treatment into the recovery community

Comprehensive Substance Use Disorder Assessment
An alcohol and drug counselor must coordinate a comprehensive assessment of the client's substance use disorder. The counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. The assessment must include sufficient information to complete the assessment summary. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including the following:
1. Age, sex, cultural background, sexual orientation, living situation, economic status, and level of education
2. Circumstances of service initiation
3. Previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness
4. Chemical use history, including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal
5. Specific problem behaviors exhibited by the client when under the influence of chemicals
6. Current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others
7. Physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional
8. Mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability
9. Arrests and legal interventions related to chemical use
10. Ability to function appropriately in work and educational settings
11. Ability to understand written treatment materials, including rules and client rights
12. Risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases
13. Social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use
14. Whether the client is pregnant and, if so, the health of the unborn child and current involvement in prenatal care
15. Whether the client recognizes problems related to substance use and is willing to follow treatment recommendations
An alcohol and drug counselor must prepare an assessment summary. The narrative summary of the comprehensive assessment results must meet the following requirements:
1. An assessment summary must be prepared by an alcohol and drug counselor and include the following:
   a. A risk description according to Minnesota Rule, part 9530.6622, for the ASAM 6 dimensions
   b. Narrative supporting the risk descriptions
   c. A determination of whether the client meets the DSM criteria for a person with a substance use disorder
   d. Contain information relevant to treatment planning and recorded in the ASAM 6 dimensions

Noncovered Services
Preliminary risk assessments are not billable but are required for CCBHC providers to deliver prior to recipient participation in the CCBHC.

Care coordination is a required service of CCBHC even though it is not considered a billable encounter. Required care coordination tasks include the following:
1. Development of a person- or family-centered plan of care
2. Assistance with obtaining appointments and confirming the appointments were kept
3. Creation of a crisis plan
4. Tracking recipient’s medications
5. Establishing a health IT system that contains the required elements in the CCBHC criteria
6. Implement care coordination agreements according to required standards in the CCBHC criteria

Billing Expanded CCBHC Services
Follow the billing guidelines in the following tables.

### General Billing Guidelines

1. CCBHC billing is subject to the same standards outlined in the PrimeWest Health Billing Policy Provider Manual page.
2. All mental health CCBHC services are billed as a professional claim in the 837P electronic claim format.
3. Outpatient chemical dependency service claims may be billed as an institutional (837I electronic format) or a professional claim (837P electronic claim format.
4. Any non-CCBHC services delivered by CCBHC providers must be submitted separately from CCBHC service claims.

### Initial Evaluation

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Q2 52</td>
<td>Initial evaluation</td>
<td>1 session</td>
</tr>
<tr>
<td>90791</td>
<td>Q2 52 HN</td>
<td>Initial evaluation completed by a clinical trainee</td>
<td>1 session</td>
</tr>
<tr>
<td>90792</td>
<td>Q2 52</td>
<td>Initial evaluation with medical services</td>
<td>1 session</td>
</tr>
</tbody>
</table>

Although some of the elements of the initial evaluation may be gathered by other clinic staff, a mental health professional or practitioner working under a licensed professional as a clinical trainee must complete a face-to-face interview with the recipient and a review and synthesis of gathered data.

### Comprehensive Evaluation

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90791</td>
<td>Q2</td>
<td>Comprehensive evaluation</td>
<td>1 session</td>
</tr>
<tr>
<td>90791</td>
<td>Q2 HN</td>
<td>Comprehensive evaluation completed by a clinical trainee</td>
<td>1 session</td>
</tr>
</tbody>
</table>
1. The DC: 0-3R diagnostic system for young children must be utilized for assessment of children up to 5 years and is to be billed as an extended comprehensive evaluation.
2. When billing an extended comprehensive evaluation, follow current guidance for extended diagnostic assessment.
3. Although some of the elements of the comprehensive evaluation may be gathered by other clinic staff, a mental health professional or practitioner working under a licensed professional as a clinical trainee must complete a face-to-face interview with the recipient and a review and synthesis of gathered data.
4. See PrimeWest Health Mental Health Service Provider Manual section for definition of mental health professional.

### Integrated Treatment Plan

<table>
<thead>
<tr>
<th>Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0032</td>
<td>Q2 UD</td>
<td>Service plan development by non-physician</td>
<td>Per 15 mins</td>
</tr>
<tr>
<td>H0032</td>
<td>Q2 UD TS</td>
<td>Service plan development by non-physician update</td>
<td>Per 15 mins</td>
</tr>
</tbody>
</table>

Although the integrated treatment plan and update must be developed with all service providers, a mental health professional must complete, date, and sign it, along with the signature of the recipient or, for a child, the child’s parent or guardian.

### Clinical Care Consultation for Recipients Age 21 Years or Over

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90899</td>
<td>Q2 U8</td>
<td>Clinical care consultation, face-to-face</td>
<td>5 to 10 minutes</td>
</tr>
<tr>
<td>90899</td>
<td>Q2 U9</td>
<td>Clinical care consultation, face-to-face</td>
<td>11 to 20 minutes</td>
</tr>
<tr>
<td>90899</td>
<td>Q2 UB</td>
<td>Clinical care consultation, face-to-face</td>
<td>21 to 30 minutes</td>
</tr>
<tr>
<td>90899</td>
<td>Q2 UC</td>
<td>Clinical care consultation, face-to-face</td>
<td>31 minutes and above</td>
</tr>
</tbody>
</table>

1. Submit one claim line per day for each service. (Add up all the minutes of service provided for face-to-face or non-face-to-face services for each client for that day and submit a single claim regardless of the number of consultations.)
2. Use modifier U4 for non-face-to-face service
3. For recipients under age 21, use the billing codes outlined in the PrimeWest Health Provider Manual section on Children’s MH Clinical Care Consultation.

### Family Psychoeducation Benefits for Adults Age 21 or Over

<table>
<thead>
<tr>
<th>Proc Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2027</td>
<td>Q2</td>
<td>Family psychoeducation individual (with a single recipient)</td>
<td>15 min</td>
</tr>
<tr>
<td></td>
<td>Q2 HQ</td>
<td>Family psychoeducation recipient group (with multiple recipients)</td>
<td>15 min</td>
</tr>
</tbody>
</table>
Q2 HR | Family psychoeducation recipient and family (with a single recipient and their family)
Q2 HS | Family psychoeducation family (with a single family individual not present)
Q2 HQ HR | Family psychoeducation family group (with multiple families with individuals present)
Q2 HQ HS | Family psychoeducation family group (with multiple families individuals not present)

1. Submit claims only for the recipient who is the primary subject of the family psychoeducation sessions, regardless of the number of other family or group members in the session.
2. When more than one family member is a recipient (such as two or three siblings, each receiving treatment within a specific timeframe), bill only for the time spent conducting family psychoeducation with each recipient.
3. When two professionals render group family psychoeducation, submit only one claim for each recipient. Professionals must determine which recipient will bill for or one professional may claim for all recipients and reimburse the other professional.
4. Enter the treating provider NPI number on each claim line.
5. Use HN modifier for services performed by a clinical trainee.
6. For recipients under age 21, use the billing codes outlined in the Family Psychoeducation for Children and Youth section of the PrimeWest Health Provider Manual.

**CCBHC Peer Specialist Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td></td>
<td>MH peer services by level I certified peer specialist</td>
<td>15 min</td>
</tr>
<tr>
<td></td>
<td>U5</td>
<td>MH peer services by level II certified peer specialist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HQ</td>
<td>MH peer services in a group setting</td>
<td></td>
</tr>
<tr>
<td>H0038</td>
<td>Q2</td>
<td>Certified peer recovery specialist</td>
<td>15 min</td>
</tr>
<tr>
<td>H0038</td>
<td>HA</td>
<td>Certified family peer specialist services</td>
<td>15 min</td>
</tr>
<tr>
<td></td>
<td>HA HQ</td>
<td>Certified family peer specialist services in a group setting</td>
<td></td>
</tr>
</tbody>
</table>

**Comprehensive Substance Use Disorder Assessment**

<table>
<thead>
<tr>
<th>Code</th>
<th>Mod</th>
<th>Brief Description</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0001</td>
<td></td>
<td>Comprehensive substance use disorder assessment</td>
<td>Per session</td>
</tr>
</tbody>
</table>

If billing as an institutional claim, use revenue codes: 0944 (Drug), 0945 (Alcohol), or 0953 (Drug and Alcohol).

**Additional CCBHC Billing and Payment Provisions**

CCBHCs are eligible to receive up to four kinds of MA payment for the following CCBHC services:
1. As enrolled providers of statewide covered services such as outpatient MH and SUD services, MH-TCM, ARMHS, CTSS and other services, CCBHCs receive payment at the same rates and within the same claims processing methodology and restrictions as other similarly enrolled providers. If the recipient is in managed care, the managed care organization (MCO) continues to pay these claims.
2. CCBHCs can receive payment for new and expanded services which are only available as part of the CCBHC demonstration (see notes on Scope of Services table and PrimeWest Health Provider Manual sections pertaining to each of these services). If the recipient is in managed care, these claims are paid by the MCO, with the exception of H0014 Withdrawal Management Level 2, which is paid through fee-for-service (FFS) for all MA recipients.

3. Based on the claims paid in the two methods above, including managed care, DHS (not the MCOs) makes a monthly supplemental wrap payment (see below for details).

4. CCBHCs are eligible to receive quality bonus payments averaging up to five percent of the other payments above. DHS makes these payments, not the MCOs. DHS will make quality bonus payments after the end of each demonstration year, based on each CCBHC’s performance on outcome measures.

Supplemental Wrap Payments
The CCBHC demonstration project provides for a cost-based prospective payment system (PPS) rate for each clinic. The rate is based on a cost report from each clinic, using Federal cost reporting rules. The cost report includes anticipated changes in costs which are necessary to comply with CCBHC criteria. The report also includes historical and projected numbers of qualifying encounters or visits. DHS and a contracted accounting firm have reviewed all cost reports and determined rates for each CCBHC. Total approved costs for demonstration year one are divided by total anticipated encounters to arrive at a rate per encounter. The rate represents an average cost per encounter for all clients receiving CCBHC services from a particular CCBHC. The rate includes the cost of all procedure codes which are listed in the Scope of Services table.

A qualifying encounter is the first billable unit for a CCBHC service on a given service date, for dates of service between July 1, 2017, and June 30, 2019. Billable unit is defined by billing policies that apply to each procedure code. Since MH-TCM is currently paid in monthly units, only one service date per month counts as a qualifying CCBHC encounter. Likewise, other services (such as extended diagnostic assessments) that may involve more than one day of actual service, but only one billing unit, are counted as one encounter for purposes of the wrap payment. Staff travel (H0046) is included only if it is required to provide a CCBHC service.

CCBHCs do not submit a separate claim for the wrap payment. DHS and a contractor calculate the monthly wrap payment by analyzing all claims processed for a CCBHC during the preceding month for CCBHC procedure codes. The payment is determined by the following formula:

1. The full PPS rate is assigned to each qualifying encounter (i.e., one service date per client)
2. The PPS rate is offset by all payments for all CCBHC services on that date of service for that client, including MMIS-FFS, MCO payments, Medicare, spenddown, family deductibles, third party liability, etc.
3. The difference between the PPS rate and the payments is the wrap payment per person per date of service
4. The amounts in the third bullet may be positive or negative. All of these amounts are added up for each CCBHC for a given month. Since the PPS rates are, on average, about double the current payment levels, we expect the total wrap payment per CCBHC will always be positive
5. Wrap payment amounts will be continually adjusted back to the start of the demo (July 1, 2017) if previously processed claims are replaced or changed in any way that affects the wrap calculation

Children’s Day Treatment
Day treatment is a structured mental health treatment program consisting of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team under the clinical supervision of a mental health professional and available 12 months of the year.

Day treatment services stabilize the child’s mental health status while developing and improving the child’s independent living and socialization skills. The goal is to reduce or relieve the effects of mental illness and provide training to enable the child to live in the community. Day treatment services are not part of inpatient or
residential treatment services. The treatment must be provided to a group of children by a multidisciplinary team under the clinical supervision of a mental health professional.

**Eligible CTSS Children’s Day Treatment Providers**

Children and adult’s day treatment services have different certifications, standards, and limitations.

**Agencies**

The day treatment program must be provided in and by:

1. Licensed outpatient hospitals with JCAHO accreditation
2. CMHCs
3. County agencies
4. IHS/638 facilities
5. Entities under contract with a county, tribe, or PrimeWest Health to operate a program meeting requirements under Minnesota law. Children’s Day Treatment providers, including school districts (certified under option 2 or 3). Entities must submit an application, receive certification under CTSS, and contract with each county in which they provide services.

Site-based programs must provide staffing and facilities to ensure the member’s health, safety, and protection of rights, and ensure that the programs are able to implement each member’s ITP.

**Clinical Supervision**

For Children’s Day Treatment programs, the following criteria must be met:

1. The supervisor (a licensed and MHCP-enrolled mental health professional) must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the mental health practitioner is providing a mental health service
2. The diagnosis and the member’s ITP or a change in the diagnosis or ITP must be made by or reviewed, approved, and signed by the supervisor
3. Every 30 days, the supervisor must review and sign the record indicating the supervisor has reviewed the member’s care for all activities in the preceding 30-day period and determined that services remain appropriate for the member’s condition
4. The clinical supervisor must be available for urgent consultation as required by the member’s needs or situation

Clinical supervision may occur individually or in group to discuss treatment and review progress toward goals.

**Note:** A clinical trainee must receive clinical supervision in accordance with clinical supervision requirements specified in MN Rules parts 9505.0370 – 9505.0372.

**Eligible Members**

Eligible members for CTSS Children’s Day Treatment are those who need the intensity level of day treatment as identified in the DA and are:

1. Members under age 18 who meet one of the following requirements:
   a. Diagnosed with an ED
   b. Meet SED criteria
2. Members ages 18 – 21 who meet one of the following requirements:
   a. Diagnosed with a mental illness
   b. Meet SPMI criteria
Members admitted to Children’s Day Treatment must be in need of and have the capacity to benefit from the rehabilitative nature, the structured setting, and therapeutic components of psychotherapy and skills activities that are integral to a day treatment program.

Members with mental illness and a DD must have the ability to understand and benefit from day treatment. When a member does not have or ceases to have the cognitive capacity to benefit from day treatment services, day habilitation programs, or other services under a waiver program may be more appropriate. Refer members in need of these or other services to the county human service agencies, school, or private agencies. Day treatment is distinguished from day care by the structured therapeutic program of psychotherapy and other therapeutic components.

**Covered Services**

Children’s Day Treatment is a program that uses CTSS service components.

1. Psychotherapy – individual or group, provided by a mental health professional or a mental health practitioner working as a clinical trainee under supervision of a qualified clinical supervisor.
2. Skills training – individual or group, provided by a mental health professional or mental health practitioner.

The program must be available at least one day a week for a two-hour time block. The two-hour time block must include at least one hour, and not more than two hours, of individual or group psychotherapy. The remainder of the structured treatment program may include individual or group skills training, if included in the member’s ITP.

Provide Children’s Day Treatment services as described in the member’s ITP.

Interactive Children’s Day Treatment may use physical aids and nonverbal communication to overcome communication barriers because the recipient demonstrates one of the following:

1. Has lost or has not yet developed either the expressive language communication skills to explain his/her symptoms and response to treatment
2. Does not possess the receptive communication skills needed to understand the mental health professional if he/she were to use adult language for communication
3. Needs an interpreter, whether due to hearing impairment or because the recipient’s language is not the same as the provider’s

**Documentation Requirements**

Document the provision of each of the service components. You may use a daily checklist with the services summarized weekly. A checklist must show all of the following:

1. DOS
2. Actual clock time with member
3. Service provided
4. Who provided the service
5. ITP goal worked on
6. Weekly summary of progress toward ITP goals (if part of Children’s Day Treatment)

**Non-Covered Services**

CTSS Day Treatment does not cover MHBA services. MHBAs are not an eligible provider of CTSS Day Treatment services.
CTSS does not cover services that are:
1. The responsibility of a residential or program license holder, including foster care
2. In violation of Medical Assistance (Medicaid) policy
3. Treatment by multiple providers within the same agency at the same clock time
4. MHBA services provided by a personal care assistant who is not qualified as an MHBA and employed by a certified CTSS provider entity
5. Primarily recreation-oriented or provided in a setting that is not medically supervised (such as sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours)
6. A social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child’s ED
7. Consultation with other providers or service agency staff about the care or progress of a child
8. Prevention or education programs provided to the community
9. Treatment for members with primary diagnoses of alcohol or other drug abuse or BI

Authorization

No authorization is required.

Billing

1. Bill Children’s Day Treatment services online using the appropriate claim format.
2. Use the individual treating provider NPI number.
4. Use modifier HK to indicate Children’s Day Treatment.
5. Use modifier UA to indicate CTSS.

<table>
<thead>
<tr>
<th>CTSS Children’s Day Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>H2012</td>
</tr>
<tr>
<td>H2012</td>
</tr>
</tbody>
</table>

CTSS providers can claim separate payment for the following:
1. The development, review, and revision of a child's Individual Treatment Plan (ITP)
2. Administering standardized mental health functional assessments and outcome measures through HCPCS codes H0031 and H0032.

HCPCS codes H0031 and H0032 do not count toward the current counter limits if the service has the UA modifier indicating CTSS.

Children’s Mental Health Clinical Care Consultation

Overview

Mental health clinical care consultation is communication between a treating mental health professional and other providers or educators who are working with the same member. These professionals use the consultation to discuss the following:
1. Issues about the member’s symptoms
2. Strategies for effective engagement, care, and intervention needs
3. Treatment expectations across service settings
4. Clinical service components provided to the member and family

**Eligible Providers**

Any of the following may provide mental health clinical care consultation:
1. Clinical nurse specialist (CNS) in mental health
2. Licensed independent clinical social worker (LICSW)
3. Licensed marriage and family therapist (LMFT)
4. Licensed professional clinical counselor (LPCC)
5. Licensed psychologist (LP)
6. Psychiatric nurse practitioner (NP)
7. Psychiatrist or osteopathic physician
8. Tribal mental health professional
9. Mental health practitioners working as clinical trainees

**Eligible Members**

To be eligible for mental health clinical care consultation, PrimeWest Health members must meet the following requirements:
1. Be age 0 – 21
2. Have a diagnosis of mental illness determined by a diagnostic assessment that includes both of the following:
   a. Meets the definition of complex, as defined in the Minnesota Rules 9505.0372, subp. 1(C), or co-occurs with other complex and chronic health conditions
   b. Requires consultation with other providers working with the child to effectively treat the condition

**Covered Services**

PrimeWest Health covers mental health clinical care consultation between the treating mental health professional and another provider or educator. Examples of appropriate providers and educators who may receive a consultation include the following:
1. Home health care agencies
2. Child care providers
3. Children’s mental health case managers
4. Educators
5. Probation agents
6. Adoption or guardianship workers
7. Guardians ad litem
8. Child protection workers
9. Pediatricians
10. Nurses
11. After-school program staff
12. Mentors

Two mental health professionals treating the same member may consult; however, they need to split the time into two billable amounts that compose the total amount of time.

Mental health clinical care consultation may be done by telephone or face-to-face.
Documentation of Covered Services

Medical Necessity

Document the medical necessity for mental health clinical care consultation in the diagnostic assessment. The diagnostic assessment must describe how the child meets criteria for a complex mental health condition or which complex or chronic health conditions co-occur with the child’s mental health condition. This description may be included in the initial assessment, in an addendum to the diagnostic assessment, or within the narrative portion of the individualized treatment plan (ITP) review process. Submit this information with any request for authorization.

Individualized Treatment Plan

Document specific interventions in the ITP, describing how the mental health professionals will use mental health clinical care consultation to treat the child’s mental illness.

Progress Notes

Document all mental health clinical care consultation in progress notes, including the following information:
1. Mode of performance (phone or face-to-face)
2. Date of service
3. Start and stop time of service
4. Intervention
5. Person consulted (name, position, relationship to member)
6. Reason for consultation
7. Plan and action for next steps
8. Date documented in the client’s record

For consultations performed by clinical trainees, the clinical supervisor must review and approve the member’s progress notes according to the clinical trainee’s supervision plan.

Non-Covered Services

Mental health clinical care consultation does not include the following:
- Communication between the treating mental health professional and a person under the clinical supervision of the treating mental health professional
- Written communication between providers
- Reporting, charting, and record keeping (these activities are the responsibility of the provider)
- Mental health services not related to the member’s diagnosis or treatment for mental illness
- Communication provided during the performance of any of the following mental health services:
  a. Mental health case management
  b. In-reach services
  c. Youth ACT
  d. Intensive treatment services in foster care.

Authorization Requirements

PrimeWest Health will cover 15 hours of consultation time per member per year without an authorization.

Refer to Chapter 5, Service Authorization, of the PrimeWest Health Provider Manual for general authorization policy and procedures.
The following information must be part of the documentation process for services:

1. Copy of the most current diagnostic assessment
2. Individual treatment plan that includes the following:
   a. Measurable and observable goals
   b. Start and end dates
3. Progress notes that include the following:
   a. Mode of performance (i.e., by phone or in person)
   b. Date of service
   c. Start and stop time of service
   d. Intervention
   e. Name and position of person consulted and relationship to member
   f. Reason for consultation with the individual
   g. Plan and action for next steps
   h. Date documentation was made in the member’s record
4. Other elements that may apply, including the following:
   a. Current risk factors the member may be experiencing
   b. Emergency interventions
   c. Consultations with or referrals to other professionals
   d. Summary of effectiveness of treatment, prognosis, discharge planning, etc.
   e. Test results and medications
   f. Symptoms

Billing

1. Enter the treating provider NPI number on each claim line.
2. Submit one claim line per day for each service. (Add up all the minutes of service provided for face-to-face or non–face-to-face services for each member for that day and submit a single claim, regardless of the number of consultations.)
3. Use modifier U4 for non–face-to-face service.

Use the following table for billing services with a date of service on or after January 1, 2015:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>90899</td>
<td>U8</td>
<td>Clinical care consultation, face-to-face</td>
<td>5 – 10 mins.</td>
<td>Calendar year threshold, 15 hours.</td>
</tr>
<tr>
<td>90899</td>
<td>U9</td>
<td>Clinical care consultation, face-to-face</td>
<td>11 – 20 mins.</td>
<td>Upper limit of timed unit to be counted to the threshold.</td>
</tr>
<tr>
<td>90899</td>
<td>UB</td>
<td>Clinical care consultation, face-to-face</td>
<td>21 – 30 mins.</td>
<td></td>
</tr>
<tr>
<td>90899</td>
<td>UC</td>
<td>Clinical care consultation, face-to-face</td>
<td>31 min. and over</td>
<td></td>
</tr>
</tbody>
</table>

Children’s Mental Health Crisis Response Services

Overview

Children’s Mental Health Crisis Response Services are intensive face-to-face, short-term mental health services initiated during a crisis to help the child/youth return to his/her baseline level of functioning. Children’s Mental Health Crisis Response Services must be provided on-site by a mobile crisis response team outside of urgent care, inpatient, or outpatient hospital settings.
Crisis response providers must be experienced in mental health assessment and crisis intervention techniques and have emergency clinical decision-making abilities and knowledge of local services and resources.

Eligible Providers

A provider agency must be approved for primary certification.

Initial Application/Provider Certification

The crisis response services provider certification process includes primary certification. Primary certification involves approval and acceptance of the provider agency’s application based on whether the agency meets the standards in accordance with MN Stat. sec. 256B.0944.

1. Review the Children’s Mental Health Crisis Response Services – Primary Certification Instructions (DHS-4985A)
2. Submit the Children’s Mental Health Crisis Response Services – Primary Certification Application – Part I (DHS-4985)
3. Wait to hear from the Children’s Mental Health Division to ensure that you have been certified to provide crisis response services prior to billing.

The crisis response services provider is responsible for providing and ensuring that all of the crisis response service components are available when the member needs them. If the provider cannot ensure that all of the service components would be available, the application will not be approved.

Recertification

Crisis response service providers must complete recertification four months prior to the end of their certification. Two documents were developed for the primary recertification process.

1. Children’s Mental Health Crisis Response Services – Re-certification Application Instructions (DHS-4990A)
2. Children’s Mental Health Crisis Response Services – Re-certification Application (DHS-4990)

Decertification

The commissioner may intervene at any time and decertify provider with cause.

Enrollable Mental Health Agencies

The following agencies may request DHS primary certification as a crisis response services provider:

1. County-operated agency
2. CMHC
3. IHS/638 facility
4. Provider under contract with a county to provide crisis response services

A mobile crisis intervention team must consist of either of the following:

1. Two or more mental health professionals
2. At least one mental health professional and one mental health practitioner

Enrollable Mental Health Professionals

1. CNS
2. LICSW
3. LMFT
4. LP
5. LPCC
6. Psychiatric NP
7. Psychiatrist

**Mental Health Practitioners**

Mental health practitioners must:
1. Have completed at least 30 hours of crisis intervention and stabilization training during the past two years
2. Be consulted by the clinical supervisor, in person or by phone, during the first three hours the practitioner provides on-site services
3. Be under clinical supervision by a PrimeWest Health-enrolled mental health professional who:
   a. Is employed by or under contract with the crisis response provider; and
   b. Accepts full responsibility for the services provided.

The clinical supervisor must:
1. Be immediately available to staff by phone or in person;
2. Document consultations;
3. Review, approve, and sign the crisis assessment and treatment plan performed by mental health practitioners within one day; and
4. Document on-site observations in the member’s record.

Mental health and chemical dependency services also have contact charts.
1. *Medical Assistance PMAP and MinnesotaCare Contact Grid for Mental Health and Chemical Dependency Services for Metro Area Residents* (DHS-4485)
2. *Greater Minnesota PMAP and MinnesotaCare Contact Grid for Mental Health and Chemical Health Services* (DHS-4484)

**Eligible Members**

To be eligible for Children’s Mental Health Crisis Response Services, a member must:
1. Be eligible for Medical Assistance (Medicaid);
2. Be under age 21;
3. Be experiencing a mental health crisis or emergency; and
4. Meet the criteria for ED (ages 0 – 18) or mental illness (ages 18 – 21).

**Covered Services**

Crisis response services include the following:
1. Crisis assessment
2. Crisis intervention
3. Crisis stabilization
4. Community intervention

**Crisis Screening**

Prior to doing crisis assessment, conduct a screening of the potential crisis situation. The screening must do the following:
1. Gather information
2. Determine whether a crisis situation exists
3. Identify the parties involved
4. Determine an appropriate response

Crisis screening is not a PrimeWest Health-covered service.

**Crisis Assessment**

A crisis assessment is an immediate, face-to-face evaluation by a physician, mental health professional, or practitioner to determine the member’s presenting situation and identify any immediate need for emergency services. A crisis assessment does the following:
1. Provide immediate intervention to provide relief of distress based on a determination that the child’s behavior is a serious deviation from his/her baseline level of functioning;
2. Evaluate in a culturally appropriate way and as time permits the child’s current:
   a. Life situation and sources of stress;
   b. Symptoms, risk behaviors, and mental health problems;
   c. Strengths and vulnerabilities;
   d. Cultural considerations;
   e. Support network; and
   f. Functioning.

Conduct the crisis assessment in the member’s home, the home of a family member, or another community location. Determine the need for crisis intervention services or referrals to other resources based on the assessment.

**Crisis Intervention**

Crisis interventions are face-to-face, short-term intensive mental health services started during a mental health crisis or emergency to help the member do the following:
1. Cope with immediate stressors and lessen his/her suffering;
2. Identify and use member’s available resources and strengths;
3. Avoid unnecessary hospitalization and loss of independent living;
4. Develop action plans; and
5. Begin to return to his/her baseline level of functioning.

Crisis intervention services must be all of the following:
1. Available 24 hours per day, 7 days per week, 365 days per year
2. Provided on-site by a mobile team in a community setting
3. Provided promptly

**Crisis Intervention Treatment Plan**

With the child and the child’s family, develop, document, and implement an initial crisis plan within 24 hours of the initial intervention to reduce or eliminate the crisis. The crisis intervention treatment plan must do the following:
1. List the child’s needs and problems identified in the crisis assessment
2. Identify:
3. Frequency and type of services to be provided
4. Measurable short-term goals
5. Specify objectives directed toward the achievement of each goal
6. Note cultural considerations
7. Recommend needed services, including crisis stabilization
8. Refer to appropriate local resources, such as the county social services agency, mental health services, local law enforcement
9. Write clear progress notes of the outcome of goals
10. If the member has a case manager, coordinate the planning of other services with the case manager

Update the crisis plan as needed to reflect current goals and services.

If the child shows positive change in a baseline level of functioning or a decrease in personal distress do either of the following:
1. Make (and document) a referral to less intensive mental health services, such as CTSS
2. Document that short-term goals have been met and that no further crisis intervention services are needed

The child and/or parent or guardian must sign the crisis plan. If the child and family refuse to approve and sign the plan, the team must note the refusal and the reason(s) for the refusal in the treatment plan. A mental health professional must approve and sign the treatment plan. Give a copy of the treatment plan to the member.

Note: If the services continue into a second calendar day, a mental health professional must contact the member face-to-face on the second day to provide services and update the crisis plan.

For this service, “second calendar day” means 24 hours from the beginning of the face-to-face intervention. The mental health professional is not restricted to only the professional who was supervising the service when the face-to-face intervention began.

Crisis Stabilization

Crisis stabilization services are mental health services provided to a member after crisis intervention to help the member obtain his/her functional level as it was before the crisis. Provide stabilization services in the community, based on the crisis assessment and crisis plan.

Consider the need for further assessment and referrals. Update the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

Crisis Stabilization Plan

Develop a crisis stabilization plan in partnership with the child and family within 24 hours of beginning services with the participation of the member. The crisis stabilization treatment plan, at a minimum, must include the following:
1. Problems identified in the assessment
2. Concrete, measurable short-term goals and tasks to be achieved including time frames for achievement
3. Specific objectives directed toward achieving each goal
4. Clear progress notes about outcomes of goals
5. List of member’s strengths and resources
6. Documentation of participants involved and a crisis response action plan, if another crisis should occur
7. Frequency and type of services initiated, including a list of providers, as applicable

The child and/or family must sign the crisis plan. If the child and family refuse to approve and sign the plan, the team must note the refusal and the reason(s) for the refusal. A member of the crisis team must approve and sign the crisis stabilization plan. Give a copy of the plan to the member.
Non-Covered Services

The following services are not covered as crisis response services:
1. Member transporting services
2. Crisis response services performed by volunteers
3. Provider performance of household tasks, chores, or related activities, such as laundering clothes, moving the member’s household, housekeeping, and grocery shopping for the member
4. Time spent “on call” and not delivering services to members
5. Activities primarily social or recreational in nature, rather than rehabilitative
6. Job-specific skills services such as on-the-job training
7. Case management
8. Outreach services to potential members
9. Crisis response services provided by a hospital, board and lodging, or residential facility to a member of that facility
10. Room and board

Billing for Children’s Mental Health Crisis Response Services

1. Use MN–ITS 837P.
2. Bill for direct, face-to-face service(s) provided to an eligible child by a qualified staff person.
3. Enter the actual POS code; POS may not be 23 (emergency department) for mobile team billing.
4. Enter the individual treating provider NPI.

Each team member providing on-site, face-to-face services may bill.
1. When an off-site team member (professional) works with an on-site team member, the professional may bill for time spent working directly with the on-site member.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Service Name</th>
<th>Eligible Providers</th>
<th>Unit Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9484</td>
<td>UA</td>
<td>Crisis intervention</td>
<td>CNS-MH, LICSW, LLP, LMFT, LP, LPCC, psychiatrist</td>
<td>60 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>mental health service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HN</td>
<td>Health service</td>
<td>Mental health practitioners</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

Children’s Mental Health Residential Treatment Services

Children’s mental health residential treatment services are a 24-hour-a-day program under the clinical supervision of a mental health professional. Services are provided in a community setting other than an acute care hospital or regional treatment center.

Children’s residential treatment must be designed to do the following:
1. Prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child’s needs
2. Help the child improve family living and social interaction skills
3. Help the child gain the necessary skills to return to the community
4. Stabilize crisis admissions
5. Work with families throughout the placement to improve the ability of the families to care for children with SED in the home
Eligible Providers

Providers must be facilities that are licensed by the State of Minnesota to provide children’s mental health residential treatment services and under clinical supervision of a mental health professional.

Eligible Members

To be eligible for this service, a member must meet all of the following criteria:
1. Be under age 18
2. Be eligible for Medical Assistance (Medicaid) or MinnesotaCare
3. Meet the criteria for SED
4. Have been screened by the county before placement in the facility as needing residential treatment services

Notify PrimeWest Health of admissions by calling or faxing the Children’s Residential Mental Health Treatment Facility Notification form to the UM department. Clinical updates must be provided to PrimeWest Health monthly.

Billing

1. Use the 837P claim format.
2. Enter a span of dates within a month; for example, if billing for services during May and June, bill May dates on one claim and bill June dates on another claim.
3. Enter the POS code 99.
4. Enter the number of units (1 unit = 1 day) based on the DOS.
5. Enter the facility’s NPI as the rendering/treating provider.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0019</td>
<td></td>
<td>Children’s Residential Treatment (county only)</td>
<td>Per diem</td>
<td>None</td>
</tr>
</tbody>
</table>

Children’s Therapeutic Services and Supports (CTSS)

Overview

CTSS is a flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. CTSS addresses the conditions of emotional disturbance that impair and interfere with an individual’s ability to function independently. For children with emotional disturbances, rehabilitation means a series or multidisciplinary combination of psychiatric and psychosocial interventions to do the following:
1. Restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or
2. Enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills, deficits, or maladaptive skills acquired over the course of a psychiatric illness.

Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional, and intellectual processing deficits with skills training to restore personal and social functioning to the proper developmental level. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement. Continuing progress toward goals is expected, and rehabilitative potential ceases when successive improvement is not observable over a period of time. CTSS are delivered using various treatment modalities and combinations of services designed to reach measurable treatment outcomes identified in an individual treatment plan (ITP).
Eligible Providers

CTSS providers include CTSS-certified agencies and their qualified employees eligible to enroll as MHCP providers.

The following entities may request MHCP certification as CTSS providers:
1. County-operated entities
2. CMHCs
3. Hospital-based providers
4. IHS/638 facilities
5. Non-county mental health rehabilitative providers

School-based providers
Schools choose from one of the following CTSS options:
1. Contract CTSS – the school chooses to contract mental health services from a CTSS-certified community provider
2. School CTSS – the school employs mental health staff

Provider Responsibilities

Mental health professionals/practitioners providing CTSS must do the following:
1. Develop an ITP for necessary and appropriate care based on information in the child’s comprehensive DA and the documented input of the family and other authorized caregivers
2. Sign the ITP (the child/legal guardian must sign the ITP before implementing service)
3. Review the ITP at least every 90 days
4. Assist the child or the child’s family in arranging crisis services
5. Ensure that the services provided are designed to meet the specific mental health needs of the child and the child’s family according to the child’s ITP
6. Coordinate CTSS services
7. Work with other health care providers (including multiple agencies if, for example, the child has an additional diagnosis of DD, substance abuse, or physical condition requiring regular medical care)

The CTSS provider’s caseload must be of a reasonable size to enable the individual provider to meet the needs of the children and their families.

Mental Health Professionals

1. CNS-MH
2. LICSW
3. LP
4. LPCC
5. LMFT
6. Psychiatric NP
7. Psychiatrist
8. Osteopathic Physician
9. Tribal-approved mental health care professional who meets the standards in Minnesota Statutes, section 256B.02, subd. 7, paragraphs (b) and (c), and who is serving a Federally recognized Indian tribe.
Mental Health Practitioners

Mental health practitioners provide skills training, crisis assistance, and direction of MHBAs under CTSS. Select mental health practitioners who meet limited circumstances listed in the MHCP Professional Certification & Enrollment Requirements are eligible to provide psychotherapy.

Requirements

See the requirements at the beginning of the chapter.

CTSS Certification

Providers must be certified prior to delivering CTSS services. Certification involves approval and acceptance of the provider agency’s application based on whether the agency meets the statutory standards. Initial certification may be for one to three years. Prior to applying for certification, potential CTSS agency providers must attend the following trainings:

1. CTSS Administrative
2. CTS CTSS Clinical

Registration information, training dates, and materials can be found under CTSS Applicant Provider Information Session on the Children’s Mental Health-Training Information page.

The following three documents were developed for the CTSS application and certification process:

1. Children’s Therapeutic Services and Supports Provider Certification Process (DHS-3622)
2. Children’s Therapeutic Services and Supports Provider Entity Application Guideline (DHS-3623)
3. Children’s Therapeutic Services and Supports Provider Entity Primary Certification Application (DHS-3610)

To be certified, providers must be able and certified to deliver the core services of the following:

1. Psychotherapy
2. Skills training
3. Crisis assistance
4. Treatment plan development and review
5. Administering and reporting standardized measures

In addition, providers may be certified to provide the following:

1. CTSS day treatment
2. Mental health behavioral aide service

Initial certification may be limited to certification for core services. Day treatment or mental health behavioral aide services may be added later by submitting the CTSS addendum (DHS-4988) application.

Decertification

Upon the commissioner’s determination that a provider no longer meets the requirements in law or fails to meet the clinical quality standards or administrative standards provided in the application and certification process, the commissioner must require corrective action, Medical Assistance repayment, or decertification of the provider.
Right to Appeal Denial of County Contract
When a county refuses to grant the necessary contract for CTSS Day Treatment services under PrimeWest Health, the provider may Appeal the county decision to PrimeWest Health.

Eligible Members

To be eligible for CTSS, Medical Assistance (Medicaid), or MinnesotaCare members must have an ITP that clearly documents the necessity for the type of mental health service requested, including intensity of treatment and medical necessity. Members must also be:
1. Children under age 18 diagnosed with an ED or SED
2. Young adults ages 18 – 20 diagnosed with mental illness or SPMI

The DA used to establish eligibility for CTSS must be done by a mental health professional or qualified mental health practitioner within 180 days before CTSS services begin.
In addition to the general MHCP requirements for a DA, CTSS requires that the DA do the following:
1. Include current diagnoses, including any differential diagnosis, in accordance with all criteria for a complete diagnosis and diagnostic profile as specified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, or, for children under age 5, as specified in the current edition of the Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood
2. Document CTSS as medically necessary rehabilitation to address an identified disability or functional impairment, and the recipient’s needs and goals
3. Be used in the development of the recipient’s ITP goals and objectives
4. Be completed annually until child is age 18 or updated annually for recipients ages 18 – 20, unless a recipient’s mental health condition has changed markedly since the most recent diagnostic assessment

Use the appropriate codes from the following tables when billing for a condition for a child or adult with an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior. The following codes are effective October 1, 2015:

<table>
<thead>
<tr>
<th>Mental disorders due to known physiological conditions (F01 – F09)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F01 – F09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental and behavioral disorders due to psychoactive substance use (F10 – F19)</th>
</tr>
</thead>
</table>
• Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20 – F29)
• Mood (affective) disorders (F30 – F39)
• Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40 – F48)
• Behavioral syndromes associated with physiological disturbances and physical factors (F50 – F59)
• Disorder of adult personality and behavior (F60 – F68.89)

<table>
<thead>
<tr>
<th>F20.0 – F44.81</th>
<th>F44.9 – F48.2</th>
<th>F48.9 – F51.03</th>
<th>F51.09 – F51.12</th>
<th>F51.3 – F53</th>
<th>F59 – F63.81</th>
<th>F63.9 – F68.8</th>
</tr>
</thead>
</table>

• Pervasive and specific developmental disorders (F80.81 – F89)
• Behavioral and emotional disorders with onset usually occurring in early childhood and adolescence (F90 – F98.9)

<table>
<thead>
<tr>
<th>F80.81 – F80.89</th>
<th>F84.0</th>
<th>F84.3 – F94.8</th>
<th>F95 – F98.9</th>
</tr>
</thead>
</table>

Covered Services

CTSS providers must provide or ensure the following services, as described in the child’s ITP:
1. **Psychotherapy** – individual, family, and group
2. **Skills training** – individual, family, or group
3. **Crisis assistance**
4. **MHBA services**, including direction of a mental health behavioral aide

Psychotherapy and skills training service components may be combined to constitute therapeutic programs, including day treatment programs and therapeutic preschool programs. Day treatment and therapeutic preschool programs have specific member and provider eligibility requirements.

**Psychotherapy**

Mental health professionals must provide the psychotherapy components of rehabilitative mental health services. Refer to the [MHCP Professional Certification & Enrollment Requirements](#).

Psychotherapy to address a child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child under CTSS deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

Individual, family, and group psychotherapy is a planned and structured face-to-face treatment of a member’s mental illness through the psychological, psychiatric, or interpersonal method most appropriate to the member’s needs as identified by the current DA. Psychotherapy is:
1. Directed toward change in an underlying mental health condition or disorder
2. Designed to reduce the symptoms of a disorder/ameliorate the effect of symptoms on the person’s functioning
Provide psychotherapy to members with diagnosable mental health problems and according to current community mental health practice.

**Skills Training**
Unlike a thought, feeling, or perception, a skill is observable by others. It is an activity that must be practiced in order to be mastered and maintained. There are right ways and wrong ways to perform the skill. Typically, a skill is performed for a reason, and a skill can be generalized and adapted to many different situations. Skills training is designed to help the member develop psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory that has been disrupted by a psychiatric illness. Skills training may also be delivered to help the youth to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired during the course of a psychiatric illness.

Skills training is subject to the following requirements:
1. A mental health professional clinical trainee or a mental health practitioner must provide skills training
2. Skills training delivered to children or their families must be targeted to the specific deficits or maladaptations of the child’s mental health disorder and must be prescribed in the child’s ITP
3. Skills training delivered to the child’s family must teach skills needed by parents to enhance the child’s skill development and to help the child use the skills and develop or maintain a home environment that supports the child’s ongoing use of the skills
4. Group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:
   a. One professional or one clinical trainee or one practitioner under clinical supervision of a licensed mental health professional must work with a group of 3 – 8 clients; or
   b. Two professionals or two clinical trainees or two practitioners under clinical supervision of a licensed mental health professional, or one professional or one clinical trainee plus one practitioner must work with a group of 9 – 12 clients
5. The mental health professional delivering or supervising the delivery of skills training must document any underlying psychiatric condition and must document how skills training is being used in conjunction with psychotherapy to address the underlying condition
6. A mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client

**Crisis Assistance**
Crisis assistance is for the child, the child’s family, and all providers of services to the child to:
1. Recognize factors precipitating a mental health crisis
2. Identify behaviors related to the crisis
3. Be informed of available resources to resolve the crisis

Crisis assistance requires the development of a plan that addresses prevention and intervention strategies in a potential crisis, including plans for the following:
1. Actions the family should be prepared to take to resolve or stabilize a crisis
2. Arranging admission to acute care hospital inpatient treatment
3. Crisis placement
4. Community resources for follow-up
5. Emotional support to the family during crisis

**Mental Health Behavioral Aide (MHBA) Services**
An MHBA is a paraprofessional working under the clinical supervision of mental health professionals (employed by the same CTSS provider or another CTSS agency). An MHBA implements the 1:1 MHBA
services identified in a child’s ITP and individual behavior plan (IBP). An MHBA provides either MHBA services or is part of the multidisciplinary staff for therapeutic preschool programs.

Requirements

MHBA requirements are in the Clinical Supervision Requirements section at the beginning of the chapter.

MHBA Clinical Supervision
Clinical supervision of a mental health behavioral aide is guided by the same standards as those established for a mental health practitioner providing outpatient mental health services. A clinical supervision plan must be in place. In addition to clinical supervision requirements, CTSS entities that elect to provide MHBA services also must provide direction for MHBAs.

Services

MHBA services are designed to provide medically necessary services to improve the functioning of the child in the progressive use of developmentally appropriate psychosocial skills. Activities involve working directly with the child, child-peer groupings, or child-family groupings to practice, repeat, reintroduce, and master the skills taught by a professional, or clinical trainee or mental health practitioner including the following:
1. Providing cues or prompts in skill-building peer-to-peer or parent-child interactions so that the child progressively recognizes and responds to the cues independently
2. Performing as a practice partner or role-play partner
3. Reinforcing the child's accomplishments
4. Generalizing skill-building activities in the child's multiple natural settings
5. Assigning further practice activities
6. Intervening as necessary to redirect the child's target behavior and to de-escalate behavior that puts the child or other person at risk of injury

All services provided by an MHBA must be identified in an IBP. The IBP must be developed by the supervising mental health professional or clinical trainee or by a mental health practitioner under the supervision of the mental health professional.

The child’s ITP must do the following:
1. Identify the need for MHBA services
2. Determine the scope, duration, and frequency of services required for the child and child’s family

Before an MHBA provides services, the mental health professionals must approve the IBP that details the following:
1. Instructions of the services the MHBA is expected to provide
2. Time allocated to each service
3. Methods of documenting the child’s behavior
4. Methods of monitoring the progress of the child in reaching objectives
5. Goals to increase or decrease targeted behavior as identified in the ITP

In accordance with the IBP, the MHBA must do the following:
1. Implement activities in the child’s IBP
2. Document the delivery of services and progress on objectives in progress notes
Direction of the MHBA

Direction refers to the activities of mental health professionals or mental health practitioners under the supervision of a mental health professional to guide the work of the MHBA. Direction of the MHBA is a covered service.

The mental health professional or mental health practitioner giving direction must begin with the goals on the ITP and instruct the MHBA on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the MHBA about the member’s diagnosis, functional status, and other characteristics that are likely to affect service delivery. Direction must also include determining that the MHBA has the skills to interact with the member and the member’s family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the member and the activities’ relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the MHBA’s ability to carry out the activities of the ITP and the IBP. When providing direction, the professional or practitioner must do the following:

1. Review progress notes prepared by the MHBA for accuracy and consistency with the DA, treatment plan, and behavior goals, and the professional or practitioner must approve and sign the progress notes
2. Identify changes in treatment strategies, revise the IBP, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly
3. Demonstrate family-friendly behaviors that support healthy collaboration among the child, the child’s family, and providers as treatment is planned and implemented
4. Ensure that the MHBA is able to effectively communicate with the child, the child's family, and the provider; record the results of any evaluation and corrective actions taken to modify the work of the MHBA

Professional/Practitioner Responsibilities

Direction of MHBAs includes all the following:

1. A clinical supervision plan approved by the responsible mental health professional
2. Ongoing on-site observation by a mental health professional or practitioner for at least one total hour every 40 hours of service provided to each child
3. Immediate accessibility of the professional or practitioner to the MHBA during service provision
4. An approved plan for clinical supervision of the MHBA
5. Reviewing progress notes prepared by MHBA for accuracy and consistency with the DA, treatment plan, and behavior goals. Progress notes must be approved and signed by mental health professionals or mental health practitioners.
6. Identifying changes in treatment strategies, revising the IBP, and communicating treatment instructions and methodologies, as appropriate, to ensure that treatment is implemented correctly
7. Demonstrating family-friendly behaviors that support healthy collaboration among the child, child’s family, and providers as treatment is planned and implemented
8. Ensuring that MHBAs are able to effectively communicate with the child, child’s family, and the provider
9. Recording the results of any evaluation and corrective actions taken to modify the work of MHBAs

Additional direction may be provided if an MHBA requires more frequent instruction to carry out the therapeutic activities identified in the ITP and IBP.

Direction of the MHBA is not counted toward the CTSS threshold.
Service Plan Development

Service plan development covers two separately billable activities: (a) individual treatment plan (ITP) development or treatment plan review and (b) functional assessment administration and outcomes reporting.

Time and activities that may be billed under this benefit include the following:
1. Formulating the individual treatment plan or treatment plan review
2. Contacting and arranging with parents or guardians to develop, review, and sign the ITP or ITP review if they are unable to participate at the same time as the treatment team
3. Meeting with family or member and caregivers to review and address what is to be accomplished through CTSS services
4. Making arrangements with external entities to make necessary resources available for implementing the ITP
5. Administering and reporting required standardized measures to Children’s Mental Health Outcome Measures Reporting System

Therapeutic Preschool Program

The intent of a therapeutic preschool program is to provide early intervention in a licensed, structured day program that provides mental health services by a multidisciplinary staff under the clinical supervision of a mental health professional.

Early intervention allows the provider to do the following:
1. Identify the needs and strengths of the child and family
2. Assist in focusing on education and training goals of family/caregivers to help them to develop skills and strategies in reducing and resolving the symptomology of the child’s ED

The therapeutic preschool program is for children who meet the following criteria:
1. Are eligible for Medical Assistance (Medicaid)
2. Are at least age 33 months
3. Have not yet attended the first day of kindergarten
4. Have a diagnosis of ED

The program structure for the therapeutic preschool program requires that the entity makes the therapeutic preschool program available two hours per day, five days per week, and 12 months of each calendar year. (PrimeWest Health payment is limited to two hours per day per member.)

The two hours may be divided into flexible time segments according to the member’s needs, as defined in the ITP.

Non-Covered Services

CTSS does not cover services that are any of the following:
1. Service components of CTSS simultaneously provided by more than one provider entity unless prior authorization is obtained
2. The responsibility of a residential or program license holder, including foster care
3. In violation of Medical Assistance (Medicaid) policy
4. Treatment by multiple providers within the same agency at the same clock time
5. MHBA services provided by a personal care assistant who is not qualified as an MHBA and employed by a certified CTSS provider entity
6. Primarily recreation-oriented or provided in a setting that is not medically supervised (such as sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours)

7. A social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child’s ED

8. Consultations with other providers or service agency staff about the care or progress of a child

9. Prevention or education programs provided to the community

10. Treatment for members with primary diagnoses of alcohol or other drug abuse

Limitations

CTSS are provided primarily in the child’s residence, but may also be provided in the child’s school, the home of a relative or natural parent, a recreational setting, or the child’s day care.

CTSS may also be provided when the service components of CTSS are identified in the discharge plan and are provided within a six-month time period if the child participates in a partial hospitalization program or resides in one of the following:
1. Hospital
2. Group home
3. Residential treatment facility or center
4. Other institutional group setting

Authorization Requirements

Refer to the Authorization section for general authorization policies and procedures.

Family psychoeducation units or sessions are subject to the same calendar year and cumulative limits as psychotherapy. These limits are as follows and are effective January 1, 2019:
1. 26 hours of individual psychoeducation per calendar year, cumulative
2. 26 sessions of family psychoeducation per calendar year, cumulative
3. 52 sessions of peer group psychoeducation per calendar year, cumulative
4. 10 sessions of family group psychoeducation per calendar year, cumulative
5. A maximum of 4 units of family psychoeducation, per individual in one day
6. A maximum of 1 session (or 4 units) of family psychoeducation, per family in one day
7. A maximum of 1 session (or 4 units) of family psychoeducation, per family in a multifamily group in one day
8. A maximum of 1 session (or 4 units) of family psychoeducation, per individual in a group setting in one day

Effective January 1, 2019, follow the authorization process for continuation of psychotherapy services once the limit has been reached. Include a diagnostic assessment, treatment plan goals, and any progress toward those treatment plan goals with the documentation submitted.

Billing

1. There are no spacing requirements between sessions.
2. Do not provide individual, family, and group skills concurrently.
3. Do not provide individual psychotherapy and interactive individual psychotherapy concurrently.
4. Use the appropriate claim format to bill for all CTSS.
5. Enter the treating provider NPI on each claim line.
6. Always add modifier UA to procedure codes to indicate CTSS.
7. Provider Type 47 is not allowed to bill for DAs and other outpatient services outside the CTSS benefit package. These providers must enroll as billing entities (provider type 34).

### Children’s Therapeutic Services and Supports (CTSS) for Children under Age 21

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit (*Per CPT Time Rule)</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>UA</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>30 (16 – 37”) minutes</td>
<td>Interactive complexity add-on code (90785) may be used with:</td>
</tr>
<tr>
<td>90834</td>
<td>UA</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>45 (38 – 52”) minutes</td>
<td>• Psychotherapy (90832, 90834 or 90837)</td>
</tr>
<tr>
<td>90837</td>
<td>UA</td>
<td>Psychotherapy (with patient and/or family member)</td>
<td>60 (53+) minutes</td>
<td>• E/M with psychotherapy add-on codes (90833, 90836, 90838)</td>
</tr>
<tr>
<td>99354</td>
<td>UA</td>
<td>Prolonged service code for psychotherapy services (add on to 90837)</td>
<td>60 (30 – 60) minutes</td>
<td>Use the UA modifier on Interactive Complexity add-on codes when reporting with CTSS services.</td>
</tr>
<tr>
<td>Appropriate E/M and 90833</td>
<td>UA</td>
<td>E/M with psychotherapy add-on (with patient and/or family member)</td>
<td>30 (16 – 37”) minutes</td>
<td>E/M with psychotherapy add-on limited to:</td>
</tr>
<tr>
<td>Appropriate E/M and 90836</td>
<td>UA</td>
<td>E/M with psychotherapy add-on (with patient and/or family member)</td>
<td>45 (38 – 52”) minutes</td>
<td>• CNS-MH</td>
</tr>
<tr>
<td>Appropriate E/M and 90838</td>
<td>UA</td>
<td>E/M with psychotherapy add-on (with patient and/or family member)</td>
<td>60 (53+) minutes</td>
<td>• Psychiatric NP</td>
</tr>
<tr>
<td>90875</td>
<td>UA</td>
<td>Individual psychophysiological therapy incorporating biofeedback, with psychotherapy</td>
<td>30 (16 – 37) minutes</td>
<td></td>
</tr>
<tr>
<td>90876</td>
<td>UA</td>
<td>Individual psychophysiological therapy incorporating biofeedback, with psychotherapy</td>
<td>45 (38 – 52) minutes</td>
<td>Interactive complexity add-on code (90785) may be used with 90853.</td>
</tr>
<tr>
<td>90846</td>
<td>UA</td>
<td>Family psychotherapy without patient present</td>
<td>1 session</td>
<td>None</td>
</tr>
<tr>
<td>90847</td>
<td>UA</td>
<td>Family psychotherapy with patient present</td>
<td>1 session</td>
<td>None</td>
</tr>
<tr>
<td>90849</td>
<td>UA</td>
<td>Multiple family group psychotherapy</td>
<td>1 session</td>
<td></td>
</tr>
<tr>
<td>90853</td>
<td>UA</td>
<td>Group psychotherapy</td>
<td>1 session</td>
<td>Interactive complexity add-on code (90785) may be used with 90853.</td>
</tr>
<tr>
<td>90839</td>
<td>UA</td>
<td>Psychotherapy for crisis</td>
<td>60 minutes</td>
<td>None</td>
</tr>
<tr>
<td>90840</td>
<td>UA</td>
<td>Psychotherapy for crisis (add on to 90839)</td>
<td>30 minutes</td>
<td>None</td>
</tr>
</tbody>
</table>
## Children’s Therapeutic Services and Supports (CTSS) for Children under Age 21

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit (*Per CPT Time Rule)</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0031</td>
<td>UA UD</td>
<td>Administering and reporting standardized measures</td>
<td>15 minutes</td>
<td>Calendar year threshold, see Authorization – Administering and Reporting Standardized Measures. Services count toward the 200 hour CTSS authorization threshold.</td>
</tr>
<tr>
<td>H0032</td>
<td>UA UD</td>
<td>Treatment plan development and review</td>
<td>15 minutes</td>
<td>Calendar year threshold, see Authorization – Treatment Plan Development and Review. Services count toward the 200 hour CTSS authorization threshold.</td>
</tr>
<tr>
<td>H2014</td>
<td>UA</td>
<td>Skills training and development – individual</td>
<td>15 minutes</td>
<td>Only one type of skills training delivered to a recipient during the same clock time will be reimbursed.</td>
</tr>
<tr>
<td></td>
<td>UA HQ</td>
<td>Skills training and development – group</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UA HR</td>
<td>Skills training and development – family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2015</td>
<td>UA</td>
<td>Comp community support services – crisis assistance</td>
<td>15 minutes</td>
<td>Calendar year threshold, see Authorization – Crisis Assistance. Counts toward the 200 hour CTSS authorization threshold.</td>
</tr>
<tr>
<td>H2012</td>
<td>UA</td>
<td>Behavioral health day treatment – therapeutic components of preschool program</td>
<td>60 minutes</td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>UA</td>
<td>Therapeutic behavioral services – Level I MHBA</td>
<td>15 minutes</td>
<td>Level I and Level II MHBA services cannot be delivered at same clock time.</td>
</tr>
<tr>
<td></td>
<td>UA HM</td>
<td>Therapeutic behavioral services – Level II MHBA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>UA HE</td>
<td>Therapeutic behavioral services – direction of MHBA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Eligible Providers

#### Agencies
The day treatment program must be provided in and by one of the following:
1. Licensed outpatient hospital
2. CMHC
3. Entity under contract with a county to operate a program meeting requirements under Minnesota law

Children’s Day Treatment providers, including school districts, must submit an application, receive certification under CTSS, and contract with each county in which they provide services.
Covered Services

Children’s Day Treatment is a program that uses CTSS service components:
1. Psychotherapy – individual or group, provided by a mental health professional or a mental health practitioner working as a clinical trainee under supervision of a qualified clinical supervisor.
2. Skills training – individual or group, provided by a mental health professional or mental health practitioner.

Provide Children’s Day Treatment services as described in the member’s ITP.

Documentation Requirements

Document the provision of each of the service components. You may use a daily checklist with the services summarized weekly. A checklist must show all of the following:
1. DOS
2. Actual clock time with member
3. Service provided
4. Who provided the service
5. ITP goal worked on

Early Intensive Developmental and Behavioral Intervention (EIDBI)

Overview
Early Intensive Developmental and Behavioral Intervention (EIDBI) services offer medically necessary treatment to PrimeWest Health members under age 21 with autism spectrum disorder (ASD) or related conditions. EIDBI provides a range of individualized, intensive developmental and behavioral interventions that target the functional skills and core deficits of ASD and related conditions. EIDBI promotes optimal child independence and participation in family, school, and community life. EIDBI services educate and support families, reduce stress, and improve long-term outcomes and quality of life for children and their families.

Eligible Providers
You must do the following to provide, bill, and receive payment for EIDBI services:
1. Be an enrolled PrimeWest Health provider
2. Meet all provider qualifications on the EIDBI assurance statement for your provider type
3. Have a PrimeWest Health-approved Service Authorization (SA) to provide services for the member

Provider Enrollment
To enroll as an EIDBI provider, follow the instructions on the Early Intensive Developmental Behavioral Intervention (EIDBI) Provider Enrollment page. All PrimeWest Health providers must register a MN–ITS account.

Eligible Recipients
A child must meet all of the following criteria before being considered for EIDBI services:
1. Be a PrimeWest Health member
2. Be under age 21
3. Be medically stable and not need 24-hour medical monitoring or procedures
4. Have a diagnosis of ASD or a related condition

If all of the above are true, the child must then receive a Comprehensive Multi-Disciplinary Evaluation (CMDE) by a licensed mental health professional to determine if EIDBI services are medically necessary. Only children who meet the above criteria and receive a CMDE stating a medical necessity for EIDBI services may become eligible recipients.
Covered Services

PrimeWest Health covers the EIDBI services listed below. Only eligible provider types for each service may perform the service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Eligible Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive multi-disciplinary evaluation (CMDE)</td>
<td>CMDE provider</td>
</tr>
<tr>
<td>Coordinated care conference</td>
<td>CMDE provider; QSP, Level I or II</td>
</tr>
<tr>
<td>EIDBI intervention – individual</td>
<td>QSP, Level I, II, or III</td>
</tr>
<tr>
<td>EIDBI intervention – group</td>
<td>QSP, Level I, II, or III</td>
</tr>
<tr>
<td>Intervention observation and direction</td>
<td>QSP, Level I or II</td>
</tr>
<tr>
<td>Family and caregiver training and counseling – individual</td>
<td>QSP, Level I or II</td>
</tr>
<tr>
<td>Family and caregiver training and counseling – group</td>
<td>QSP, Level I or II</td>
</tr>
<tr>
<td>Individual treatment plan (ITP) development and monitoring</td>
<td>QSP, Level I or II</td>
</tr>
<tr>
<td>Travel Time</td>
<td>CMDE, QSP, Level I, Level II, or Level III</td>
</tr>
</tbody>
</table>

Non-covered Services

PrimeWest Health does not reimburse EIDBI providers for the following:

1. Services that have not been approved by the state’s medical review agent, except for services that do not require authorization
2. Services provided in the absence of required supervision
3. Services that have not been documented in the member’s health service record or in the manner required by this manual or by Minnesota Rules, part 9505.2175
4. Services provided by an unqualified person or a person for whom the provider does not have documentation showing that the person meets the required qualifications
5. Two or more services provided by the same person at the same time
6. Simultaneous services by multiple providers at the same time
7. Services provided in violation of Minnesota Rules, part 9505.0220 (the general MA excluded services provision)
8. Services that are the responsibility of a residential or program license holder, including foster care providers under the terms of an SA or administrative rules governing licensure
9. Services that include or replace academic goals and objectives that otherwise are provided through the child’s individual education plan or individual family service plan as required under the Individual with Disabilities Education Improvement Act of 2004
10. Services that are not provided in a medically supervised setting or are recreational, unless the services are primarily treatment-oriented and provided under the recipient’s ITP
11. Prevention or education programs provided to the community
12. Services that are primarily respite, custodial, or daycare
13. Services you do not provide directly to a recipient who is present, either physically or via interactive video, except for the following:
   a. Coordinated care conference
   b. Family and caregiver training and counseling
   c. ITP development
   d. Telephone calls, postal mail, or emails
   e. Observation and direction that does not include a lower-level provider
   f. Training activities that do not meet the criteria for observation and direction
   g. Activities that do not directly benefit specific EIDBI recipients
h. Reporting, charting, and record keeping, except where this is an integral part of a CMDE or ITP development
i. Family and caregiver training and counseling that is not provided directly to eligible recipients’ family members or significant others who are present either physically or via interactive video
j. Observation and direction of two or more staff members at the same time
k. Services provided by a parent, legal guardian, or legally responsible person
l. Recipient transportation
m. Services that are not provided (no shows)

Access Services
EIDBI does not cover transportation and language interpreter services. As a PrimeWest Health provider, it may be covered through Access Services.

Service Authorization

Overview
Some EIDBI services require Service Authorization. The authorization requirement safeguards against inappropriate and unnecessary use of health care services under State and Federal law. The maximum time span for a Service Authorization is six months.

Having an approved Service Authorization does not guarantee that PrimeWest Health will pay you. You must meet all other PrimeWest Health requirements to receive payment.

Authorized Services
The following services require authorization prior to delivery of service:
1. EIDBI intervention
2. Family and caregiver training and counseling
3. ITP development and monitoring (ongoing)
4. Intervention observation and direction
5. 60-day temporary increase of EIDBI intervention services (DHS-7109D-ENG)

Services that Do Not Require Authorization
The following services do not require authorization prior to service delivery:
1. The initial ITP (one initial ITP per recipient every three years without authorization)
2. The annual CMDE (one per year per recipient without authorization)
3. One coordinated care conference (one per year per recipient without authorization)

Request Additional Authorization of Services

Authorization Request
To request authorization for EIDBI services that exceed the service limit threshold outlined on the EIDBI billing grid (e.g., additional CMDE in a calendar year, additional coordinated care conference in a calendar year, etc.), complete and submit EIDBI DHS-3806. For instructions on how to complete and submit the form, see DHS-3806A. A prior authorization request for these additional services is recommended; however, the medical review agent will accept retro authorization requests for the following EIDBI services only:
1. Additional CMDE within the calendar year
2. Additional coordinated care conferences beyond the one allotted per year

Process
Providers must submit a completed CMDE and ITP for an EIDBI Service Authorization and fax it to PrimeWest Health at 1-866-431-0804. The CMDE and ITP must include the following recommendations:
1. EIDBI treatment, intensity, frequency, intensity, duration, and modality
2. Level of parental involvement
3. Frequency of progress monitoring

PrimeWest Health Utilization Management reviews the CMDE and ITP to ensure and approve medical necessity for EIDBI services. Utilization Management generates a notice of authorization or denial of EIDBI services. This notice is sent to the provider and recipient.

A Service Authorization allows qualified providers to bill and receive payment from PrimeWest Health after providing EIDBI services. You are responsible for ensuring that the information in the Service Authorization is accurate when you receive the authorization notice.

**Required Documentation**
Submit the following information to PrimeWest Health or to the member’s managed care organization:
1. CMDE summary
2. CMDE signature page
3. ITP summary
4. ITP signature page
5. The “week in the life of the child” page

**Provider Responsibilities**
CMDE providers must enter the CMDE summary information, CMDE signature page, and the “week in the life of the child.”

**Responsibilities**
PrimeWest Health will do the following within five business days of receiving the CMDE:
1. Verify that all the required components of the CMDE are present
2. Contact the CMDE provider and family if any documentation is missing

PrimeWest Health will do the following within ten business days of receiving the ITP:
1. Verify all required components of the ITP are present
2. Contact the provider if any documentation is missing
3. Complete an integrated review process of the CMDE, ITP, and other PrimeWest Health-covered services the child receives
4. Determine the medical necessity of EIDBI
5. Enter information into MMIS to create a Service Authorization request
6. Generate a notice to the provider and member

**Additional Resources**
PrimeWest Health Provider Manual – Authorization section

For instructions on how to complete the ITP and CMDE forms, see the DHS EIDBI Policy Manual-CMDE page and ITP page. A MN-ITS log in username and password is required to access the forms. If a provider requires a username and password, see the MHCP Provider Manual MN-ITS User Manual and then select Create/Modify MN-ITS User Access from the table of contents.

**Billing**

**Submitting Claims**
Refer to the EIDBI Billing Grid for service names, procedure codes, modifiers, units, and service limits. Refer to the MHCP Fee Schedule for the most current rate information.
Note: Effective January 1, 2018, all claims submitted for any services delivered by a Level III provider are required to have the UMPI number of the rendering provider.

The following instructions must be followed when submitting claims for EIDBI services:
1. Use MN–ITS Direct Data Entry (DDE) or your own X12 compliance software (batch billing system).
2. Use the Professional (837P) claim.
3. Follow the instructions in the MN–ITS User Guide for EIDBI.
4. Bill only for services already provided.
5. CMDE services must be provided within 30 business days, and up to 5 units. If services are provided in two different months, separate claims should be submitted for each month.
6. A claim submission must include the following:
   a. The pay-to provider
   b. The procedure code for the service provided
   c. The appropriate modifier(s)
   d. The UMPI or NPI of the rendering provider who delivered the service (except for any services delivered by a Level III provider before January 1, 2018)
   e. The supervising provider for any services that require the supervision of a QSP
7. Bill only for services approved on the Service Authorization.
8. Do not bill services that require a Service Authorization on the same claim as services that do not require a Service Authorization.
9. Do not exceed 9 hours a day for any individual or group intervention units.
10. Submit your usual and customary charges for the service.
11. Enter diagnosis codes when submitting claims for all EIDBI services.
12. Use the most current, most specific diagnosis code.
13. PrimeWest Health will display the recipient’s diagnosis code on the Service Authorization letter.
14. Use information from your Service Authorization, such as the following:
   a. The MHCP-enrolled provider who is authorized to provide EIDBI services
   b. The rate of payment for the service
   c. The number of units approved
   d. The date span of authorization
   e. The approved procedure code(s)
   f. Use date spans only when you have provided services for all dates in the span
   g. Tribal providers should refer to the Tribal and Federal Indian Health Services manual page

Note: PrimeWest Health does not accept claims for CMDE services rendered by a CMDE clinical trainee at this time. PrimeWest Health accepts application forms for enrollment as the CMDE supervisor. Refer to the EIDBI Provider Enrollment page for more information. PrimeWest Health will update providers after systems have been programmed and claims are being accepted.

**Telemedicine via Interactive Video**
You may provide certain EIDBI services through interactive video. Use telemedicine billing for these services.

Services provided using telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face. PrimeWest Health does not provide additional reimbursement for services delivered via telemedicine. PrimeWest Health does not reimburse for connection charges or origination, set-up, or site fees.

**Special Needs BasicCare**
If an EIDBI recipient is enrolled in the Special Needs BasicCare program, follow fee-for-service guidelines to obtain authorizations.
Intensive Treatment in Foster Care

Overview
Intensive treatment in foster care (ITFC) is a bundled service for children who are in a family foster care setting with a mental illness diagnosis and require intensive intervention without 24-hour medically monitoring (a CASII score of 4 or higher). The bundled service includes psychotherapy, psycho-education, clinical consultation and crisis assistance performed in addition to prescribed service requirements which are described below.

Eligible Providers
ITFC providers include ITFC certified agencies and their qualified employees enrolled as MHCP providers. The following entities may request MHCP certification as an ITFC provider and obtain a service contract with a county board or tribe:
1. An Indian Health Service facility or Rule 638 tribal organization under Title 25, or Title 3 of the Indian Self-Determination Act, Public Law 93-638
2. A non-county entity

All ITFC services provided to MHCP enrollees must be by a qualified mental health professional or a clinical trainee working under the supervision of a licensed mental health professional.

Provider Responsibilities
A certified ITFC provider must provide services to the child at least three days per week, for a total of six hours of in-person treatment. Services may be provided to the child, parents, siblings, foster parent, and members of the child’s permanency plan and rendered in the child’s home, daycare, school, or other community-based setting that is specified on the child’s individualized treatment plan (ITP). Providers must provide ITFC services in a developmentally and culturally appropriate manner and comply with the following requirements:
1. Each member receiving treatment services must have an extended diagnostic assessment within 30 days of enrollment unless the member has a previous extended diagnostic assessment that the member, parent, and mental health professional agree still accurately describes the member’s current mental health functioning.
2. Request documentation of treatment and assessments the member has received from previous and current mental health, school, and physical health providers. Review and incorporate this information into the diagnostic assessment, team consultation, and treatment planning process.
3. Each member must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, 7 days per week, during the course of treatment. The crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.
4. Assess each member for a trauma history and the member’s treatment plan must document how the results of the assessment will be incorporated into treatment.
5. Each member must have an individualized treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and team treatment planning process.
6. Deliver services in continual collaboration and consultation with the member’s medical providers and, in particular, with the prescribers of psychotropic medications. Members of the service team must be aware of the medication regimen and potential side effects.
7. Conduct transition planning for the child starting with the first treatment plan and address throughout treatment to support the child’s permanency plan and post-discharge mental health service needs.

Eligible Providers
Treating Providers:
1. Clinical nurse specialist (CNS)
2. Licensed independent clinical social worker (LICSW)
3. Licensed marriage and family therapist (LMFT)
4. Licensed professional clinical counselor (LPCC)
5. Licensed psychologist (LP)
6. Psychiatric nurse practitioner (NP)
7. Psychiatry or an osteopathic physician
8. Tribal certified professionals

Mental health practitioners who are qualified as clinical trainees may also provide ITFC services under the supervision of an eligible treating provider.

Requirements
Refer to General MHCP non-enrollable mental health provider requirements for additional practitioner requirements.

ITFC Certification
Providers must be certified prior to delivering ITFC services. Certification involves approval and acceptance of the provider agency’s application based on whether the agency meets the statutory standards. ITFCs may be certified for up to three years by the commissioner or designated certification body. Prior to applying for certification, potential ITFC agencies must attend the ITFC applicant training. Registration information can be found under the ITFC Applicant Provider Information Session on the Children’s Mental Health-Training Information page.

Complete the following three documents for the ITSFC application and certification process:
1. Intensive Treatment in Foster Care Provider Certification Process (DHS-5360A-ENG)
2. Intensive Treatment in Foster Care Provider Application Guideline (DHS-5360B-ENG)
3. Intensive Treatment in Foster Care Provider Entity Primary Certification Application (DHS-5360-ENG)

To be certified, providers must be able to deliver the following core services:
1. Psychotherapy
2. Psychoeducation
3. Crisis assistance
4. Clinical care consultation
5. Team treatment planning

Recertification
Recertification requires reviewing Recertification Review Process and submitting a recertification application. Recertification will include a site review to examine policies and procedures and clinical documentation of ITFC services.

Decertification
The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the State.

Eligible Members
To be eligible for ITFC, members must have an individual treatment plan (ITP) that clearly documents the necessity for the type of mental health service requested, including intensity of treatment and medical necessity. Members must also meet the following requirements:
1. Have a documented diagnosis of mental illness
2. Be living in a family foster care setting
3. Be between ages 0 – 21
4. Have a level of care evaluation indicating that intensive intervention without 24-hour medically monitoring is required to treat the mental illness
A mental health professional or clinical trainee must do the diagnostic assessment establishing eligibility for ITFC within the 180 days prior to the ITFC services beginning.

**Covered Services**
ITFC providers must provide or ensure the following services, as prescribed in the child’s ITP:
1. Psychotherapy (individual, family, and group)
2. Psychoeducation (individual, family, and group)
3. Crisis assistance
4. Clinical care consultation

**Noncovered Services**
Services that are not covered in ITFC but may be billed separately include the following:
1. Inpatient psychiatric hospital treatment
2. Mental health targeted case management
3. Partial hospitalization
4. Medication management
5. Children’s mental health day treatment services
6. Crisis response services
7. Transportation

Services that are not covered under ITFC and are not billable while a child is receiving ITFC services include the following:
1. CTSS
2. Mental health behavioral aide services
3. Home and community-based waiver services
4. Mental health residential treatment
5. Room and board costs

**Authorization**
Refer to the Authorization section of the DHS Provider Manual for general authorization policy and procedures. ITFC services authorization is required after 78 units of service.

**Billing**
1. Bill ITFC services using HCPC code S5145
2. Bill using 837P
3. There are no spacing requirements between sessions
4. Enter the treating provider NPI number on each claim line

Use the following table for billing services with dates of service on or after July 1, 2017.

**Intensive Treatment in Foster Care and Other Concurrent Service**

Note the following:
- The ITFC-certified agency must provide all the covered services.
- When requesting authorization, clearly document medical necessity for the additional service(s), including reasons the ITFC does not or cannot meet recipient’s needs (e.g., specialty service, transitional service, etc.)
<table>
<thead>
<tr>
<th>Other Service</th>
<th>Is service included in ITFC?</th>
<th>Can service be provided in addition to ITFC?</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH-TCM</td>
<td>No</td>
<td>Yes</td>
<td>Day treatment program must request authorization.</td>
</tr>
<tr>
<td>Children’s Mental Health Day Treatment</td>
<td>No</td>
<td>Yes</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Children’s Residential Treatment Services</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>No</td>
<td>Yes</td>
<td>Partial hospitalization thresholds and limitations apply.</td>
</tr>
<tr>
<td>IRTS</td>
<td>No</td>
<td>Yes</td>
<td>ITFC and IRTS may be provided concurrently without authorization.</td>
</tr>
<tr>
<td>CTSS and ARMHS</td>
<td>No</td>
<td>No</td>
<td>Rehabilitative skills training is a not a component of ITFC services and cannot be billed separately.</td>
</tr>
<tr>
<td>Mental Health Behavioral Aide Services</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Crisis Assessment and Intervention (mobile)</td>
<td>No</td>
<td>No</td>
<td>Can be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Crisis Stabilization – Non-residential</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Crisis Stabilization – Residential</td>
<td>No</td>
<td>Yes</td>
<td>Service limits apply. Services must be provided with ITFC and residential provider.</td>
</tr>
<tr>
<td>Medication Management</td>
<td>No</td>
<td>Yes</td>
<td>May be provided by physician or advance practice registered nurse with mental health certification.</td>
</tr>
<tr>
<td>Outpatient Psychotherapy</td>
<td>Yes</td>
<td>No</td>
<td>A component of ITFC. Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>No</td>
<td>Yes</td>
<td>Inpatient hospitalization services are reimbursed separately from ITFC. ITFC claims: enter POS code 21.</td>
</tr>
<tr>
<td>Waivered Services</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Other medical services (e.g., PCA)</td>
<td>No</td>
<td>Yes</td>
<td>Service limits apply to each service.</td>
</tr>
</tbody>
</table>

### Intensive Treatment in Foster Care

<table>
<thead>
<tr>
<th>Proc. Code</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5145 HE</td>
<td>Intensive treatment in foster care (performed by mental health professional)</td>
<td>Per diem</td>
<td>78 Units before Authorization is required.</td>
</tr>
<tr>
<td>S5145 HE HN</td>
<td>Intensive treatment in foster care (performed by clinical trainee)</td>
<td>Per diem</td>
<td></td>
</tr>
</tbody>
</table>
Intensive Residential Treatment Services (IRTS)

IRTS are time-limited mental health services provided in a residential setting to members in need of more restrictive settings (versus community settings) and at risk of significant functional deterioration if they do not receive these services. IRTS are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting.

IRTS must be directed to a targeted discharge date with specified member outcomes and consistent with evidence-based practices.

Eligible IRTS Providers

To be eligible, an IRTS facility must meet the following criteria:
1. Have a contract with a county agency to provide IRTS
2. Be licensed with a variance effective July 1, 2010, to Rule 36 for IRTS
3. Not exceed 16 beds
4. Have a host county recommended and DHS-approved rate

Members of the IRTS interdisciplinary team must be ARMHS-qualified:
1. Mental health professionals;
2. Mental health practitioners;
3. CPSs;
4. Mental health rehabilitation workers; and
5. Include a licensed RN who is also qualified as a mental health practitioner.

IRTS providers must have all of the following:
1. Sufficient staff for 24-hour coverage in the delivery of rehabilitative services described in the ITP
2. Staff available to safely supervise and direct activities of member given his/her level of behavioral and psychiatric stability, cultural needs, and vulnerability
3. The capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to ensure the health and safety of members, including providing medical services directly (through its own medical staff) or indirectly (through referral to medical professionals)

Treatment staff must have prompt access in person or by telephone to a mental health professional or a qualified mental health practitioner. An IRTS provider must ensure, at minimum, the following:
1. Staff are available to provide direction and supervision whenever members are present in the facility
2. Staff remain awake during all work hours
3. There is a staffing ratio of at least one staff to nine recipients each day and evening shift. If more than nine recipients are present, there must be a minimum of two staff members during day and evening shifts, one of whom is a mental health professional or practitioner.

Eligible Members

An eligible IRTS member must meet the following criteria:
1. Be age 18 or over
2. Be eligible for Medical Assistance (Medicaid)
3. Meet IRTS admission criteria

Individuals who are age 17 and transitioning to adult mental health services may be considered for IRTS if the service is determined to best meet their needs. IRTS providers must secure a licensing variance in this situation.
Members may receive IRTS instead of hospitalization, if appropriate.

**IRTS Admission Criteria**

A mental health professional must determine that a member needs mental health services that cannot be met with other available community-based services, is likely to experience a mental health crisis, or requires a more restrictive setting if IRTS are not provided. The professional may consult with a mental health case manager or other county advocate, and/or, with the member’s consent, a spouse, family member, or significant other. Admit a member to IRTS when the member:

1. Has a mental illness (based on a DA)
2. Has a completed FA using the domains specified in statute and have three or more areas of significant impairment in functioning
3. Has a completed LOCUS assessment where a Level 5 is indicated
4. Is reasonably expected to commence or resume illness management and recovery skills/strategies at least at a minimal stage at this level of service and needs a 24-hour supervised, monitored, and focused treatment approach to improve functioning and avoid relapse that would require a higher level of treatment
5. Is not responsive to an adequate trial of active treatment at a less intensive level of care
6. Needs a restrictive setting and is at risk of significant functional deterioration if IRTS are not received
7. Has one or more of the following:
   a. History of two or more inpatient hospitalizations in the past year
   b. Significant independent living instability
   c. Homelessness
   d. Frequent use of mental health and related services yielding poor outcomes in outpatient/community support treatment.

**IRTS Continuing Stay Criteria**

Continue the member’s stay in IRTS when a mental health professional determines that a member’s mental health needs cannot be met by other, less intensive community-based services and:

1. The member continues to meet admission criteria as evidenced by active psychiatric symptoms and continued functional impairment
2. Documentation indicates that symptoms are reduced, but goals to accomplish before leaving have not been met
3. The essential goals are expected to be accomplished within the requested time frame
4. Documentation exists that attempts have been made unsuccessfully to coordinate care and transition the member to other services
5. Clinical updates must be provided to PrimeWest Health monthly

**IRTS Discharge Criteria**

Discharge a member from IRTS when the member meets at least one of the following:

1. No longer meets continuing stay criteria
2. Has met ITP goals and objectives
3. Shows evidence of decreased impairment of thought, mood, behavior, or perception and less restrictive community-based alternatives exist and are appropriate
4. Has symptoms and needs that permit lesser level of service and adequate supports and services are in place
5. Is voluntarily involved in his/her ITP and no longer agrees to participate in IRTS
6. Exhibits severe exacerbation of symptoms, decreased functioning, or disruptive or dangerous behaviors and requires a more intensive level of service
7. Has medical or physical health needs that exceed what can be brought into the residential treatment setting
8. Does not participate in the program despite multiple attempts to engage him/her and to address nonparticipation issues
9. Does not make progress toward treatment goals and there is no reasonable expectation that progress will be made
10. Leaves against medical advice (AMA) for an extended period (determined by written procedures of provider agency)

Covered Services

Plan and coordinate IRTS with the local mental health service delivery system. Members may access and receive IRTS outside of the facility when it would benefit the continuity of treatment and transition to the community. The following services must be provided within the IRTS program:

1. Supervision and direction
2. Individualized assessment and treatment planning
3. Crisis assistance, development of health care directives and crisis prevention plans
4. Nursing services
5. Interagency case coordination
6. Transition and discharge planning
7. Living skills development, including the following:
   a. Medication self-administration
   b. Healthy living
   c. Household management
   d. Cooking and nutrition
   e. Budgeting and shopping
   f. Using transportation
   g. Employment-related skills
8. Integrated dual diagnosis treatment (mental health and substance abuse treatment in a single treatment setting and single treatment regimen with an interdisciplinary approach; able to assess treatment readiness, use motivational interviewing, employ harm reduction strategies and a non-confrontational approach, as appropriate to the member’s needs)
9. Illness management and recovery (educating about mental illness and treatment including characteristic symptoms and early warning signs of relapse, managing stress and developing relapse prevention plans, developing coping skills and strategies for coping with symptoms, developing social skills to improve effectiveness in interactions across a range of settings and situations, and identifying therapeutic and rehabilitative approaches available to members, such as DBT or treatment for Obsessive Compulsive Disorder [OCD])
10. Family education (services to educate, inform, assist, and support family members in mental health illness and treatment, coping mechanisms, medication, community resources)

Notification is required: Notify PrimeWest Health of admissions by calling or faxing the UM department:
   Fax: 1-866-431-0804 (toll free)
   Phone: 1-866-431-0803 (toll free)

Inpatient Admission Authorization Request form

Language Interpreter Services

All providers must provide language interpreter services to comply with MHCP Access Services. Providers may either include the cost of interpreter services in the cost-based per diem rate or bill for the service separately. Please review Chapter 1, Requirements for Providers, of the PrimeWest Health Provider Manual for information on billing for language interpreter services.
Billing

1. PrimeWest Health will reimburse IRTS based on a daily rate per provider. The daily rate includes the following:
   a. Most mental health rehabilitative services
   b. All crisis stabilization services
   c. Other services provided by the IRTS treatment team
2. Bill only direct mental health service days; do not bill for days when direct services were not provided.
3. Bill for date of admission; do not bill for date of discharge
4. Use the 837P claim format to bill for IRTS.
5. Use procedure code H0019.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0019</td>
<td></td>
<td>Intensive Residential Treatment Services</td>
<td>Per diem</td>
<td>None</td>
</tr>
</tbody>
</table>

**IRTS and Other Concurrent Services and Limitations**

When requesting authorization, clearly document medical necessity for the additional service(s), including reasons IRTS does not/cannot meet member’s needs (e.g., specialty service, transitional service). All services provided concurrently with IRTS must be coordinated with IRTS.

<table>
<thead>
<tr>
<th>Other Service</th>
<th>Is Service Included in IRTS?</th>
<th>Can Service Be Provided in Addition to IRTS?</th>
<th>Service Limitations</th>
</tr>
</thead>
</table>
| MH-TCM                                  | No                           | Yes                                         | • Rule 79 applies  
• IRTS must coordinate with member’s case manager |
| Day treatment                           | No                           | Only with authorization                      | • Day treatment provider must coordinate the plan of care with the IRTS provider |
| Partial hospitalization                 | No                           | Only with authorization                      | IRTS provider must coordinate the plan of care with the partial hospitalization provider and seek authorization for any IRTS provided on the same day |
| ACT                                     | No                           | Yes                                         | • ACT rate may be adjusted  
• ACT and IRTS may be provided concurrently without authorization |
| ARMHS                                   | Yes                          |                                              |                                                         |
| Crisis assessment or intervention (mobile) | No                           | Yes                                         | • May be billed separately  
• No authorization required |
| Crisis stabilization – non-residential  | Yes                          | No                                          | • A component of IRTS  
• Cannot be billed separately |
## IRTS and Other Concurrent Services and Limitations

When requesting authorization, clearly document medical necessity for the additional service(s), including reasons IRTS does not/cannot meet member’s needs (e.g., specialty service, transitional service). All services provided concurrently with IRTS must be coordinated with IRTS.

<table>
<thead>
<tr>
<th>Other Service</th>
<th>Is Service Included in IRTS?</th>
<th>Can Service Be Provided in Addition to IRTS?</th>
<th>Service Limitations</th>
</tr>
</thead>
</table>
| Crisis stabilization – residential    | Yes                          | No                                          | • A component of IRTS  
  • Be aware of member transfers  
  • If member is approved for IRTS and residential crisis stabilization, bill only one approved daily rate. Only one of these two services can be billed for a member per day. |
| Psychiatric physician services        | Sometimes                    | Yes                                         | • May be provided by physician, psychiatric NP, CNS-MH, or physician extender if a member of the treatment staff  
  • Bill separately only if not included in IRTS rate  
  • This service component is not excluded from telemedicine delivery |
| Outpatient psychotherapy               | No                           | Yes                                         | • No service authorization needed if a participating provider |
| Inpatient hospitalization              | No                           | No                                          | • Inpatient hospitalization services are reimbursed separately from IRTS  
  • IRTS may not be reimbursed for members admitted to an inpatient hospital |
| Waivered services                     | No                           | Yes                                         | • County must approve concurrent care. Bill to DHS FFS for waivered services. |
| Personal Care Assistant (PCA) or other | No                           | Yes                                         | • Service limits apply to each service |
| medical services                      |                              |                                             |                                                                                                                                                                                                                  |

## Youth Assertive Community Treatment (Youth ACT)

Youth Assertive Community Treatment (Youth ACT) is an intensive, comprehensive, non-residential rehabilitative mental health service team model. Services are consistent with CTSS, except for the following:

1. Youth ACT is provided by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the member’s needs, using a total team approach
2. Youth ACT is directed to eligible members who require intensive services
3. Youth ACT is available 24 hours per day, 7 days per week, for as long as the member requires this level of service

The team promptly and appropriately responds to emergent needs and makes necessary staffing adjustments to ensure the health and safety of members.
Eligible Youth ACT Providers
An eligible Youth ACT program must do the following:
1. Have a contract with DHS
2. Be certified by DHS to provide Adult Mental Health Rehabilitative Services (ARMHS) or CTSS
3. Follow all Minnesota Youth ACT Standards

A Youth ACT team must include the following staff:
1. Mental health professional
2. Licensed alcohol and drug counselor trained in mental health interventions
3. CPS, Level I or II
4. One of the following, credentialed to prescribe medications:
   i. Advanced practice registered nurse (APRN) certified in psychiatric or mental health care
   ii. Board-certified child and adolescent psychiatrist

Based on a member’s needs, the team may also include the following:
1. Additional mental health professionals
2. A vocational specialist
3. An educational specialist
4. A child and adolescent psychiatrist retained on a consultant basis
5. Mental health practitioners
6. Mental health case manager
7. A housing access specialist

Additional Team Members

Other individuals may be included as members of the treatment team for specific members. These individuals must contract with the Youth ACT program. Member-specific team members may include the following:
1. The mental health professional treating the member prior to entering the Youth ACT team (includes therapist and/or psychiatrist)
2. The current substance abuse counselor
3. A representative from the member’s tribe
4. The member’s probation agent or other juvenile justice representative
5. The member’s current vocational or employment counselor

Eligible Members
To be eligible for Youth ACT, PrimeWest Health members must be ages 16 – 20 and have:
1. A diagnosis of serious mental illness or co-occurring mental illness and substance abuse addiction
2. CASII level of care determination of level 4 or above
3. Functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job
4. Probable need for services from the adult mental health system within the next two years
5. A current DA indicating the need for intensive nonresidential rehabilitative mental health services

Covered Youth ACT Services
The Youth ACT team provides the following services:
1. Individual, family, and group psychotherapy
2. Individual, family, and group skills training
3. Crisis assistance
4. Medication management
5. Mental health case management
6. Medication education
7. Care coordination with other care providers
8. Psycho-education to, and consultation and coordination with, the member’s support network (with or without member present)
9. Clinical consultation with the member’s employer or school
10. Coordination with, or performance of, crisis intervention and stabilization services
11. Assessment of recipient’s treatment progress and effectiveness of services using outcome measurements
12. Transition services
13. Integrated dual disorders treatment
14. Housing access support

Members and/or family members must receive at least three face-to-face contacts per week, totaling a minimum of 85 minutes of service.

Authorization
No authorization is needed for this service.

Billing
PrimeWest Health reimburses Youth ACT services based on one, all-inclusive daily rate to one provider per day.

Each claim must be for a face-to-face contact. Count the following services as face-to-face when the need for the member’s absence is documented:
1. Family psycho-education
2. Family psychotherapy
3. Clinical consultation with school or employer

Only one agency may bill when team members are from more than one agency. The billing provider reimburses the other contributing agencies. Mental health professionals acting as team members may not bill their services separately from the Youth ACT team.

Bill Youth ACT program services to PrimeWest Health using the 837P claim format.

1. Use procedure code H0040 and modifier HA
2. Enter one DOS per line, one unit per day
3. Do not enter a rendering provider

Call the PrimeWest Health Provider Contact Center when Youth ACT claims are denied due to claims for concurrent ARMHS, CTSS, day treatment, outpatient psychotherapy, or crisis response services. Resubmit the Youth ACT claims once the concurrent claims have been reversed.

<table>
<thead>
<tr>
<th>Assertive Community Treatment (ACT)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>H0040</td>
</tr>
</tbody>
</table>
**Youth ACT and Other Concurrent Services**

The Youth ACT team must coordinate all concurrent services. When requesting authorization, clearly document medical necessity for the additional service(s). Include the reasons Youth ACT does not/cannot meet the member’s needs (e.g., specialty service, transitional service, etc.).

<table>
<thead>
<tr>
<th>Other service</th>
<th>Is service included in Youth ACT?</th>
<th>Can service be provided in addition to Youth ACT?</th>
<th>Service limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH-TCM</td>
<td>Yes</td>
<td>No</td>
<td>Case management functions are bundled in the Youth ACT rate. CMH-TCM is covered only in the month of admission or discharge from Youth ACT. CMH-TCM must request authorization for coverage other than month of admission/discharge.</td>
</tr>
<tr>
<td>Children’s Mental Health Day Treatment</td>
<td>No</td>
<td>When clinically indicated (documentation of clinical necessity on file with ACT and day treatment)</td>
<td>Day treatment providers may not be additional Youth ACT team members. Day treatment providers must accept clinical direction from the Youth ACT team. No authorization is needed.</td>
</tr>
<tr>
<td>Children’s Residential Treatment Services</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>IRTS</td>
<td>No</td>
<td>Yes</td>
<td>Youth ACT and IRTS may be provided concurrently without authorization.</td>
</tr>
<tr>
<td>CTSS and ARMHS</td>
<td>Yes</td>
<td>No</td>
<td>Rehabilitative skills training is a component of Youth ACT services. Cannot be billed separately.</td>
</tr>
<tr>
<td>Mental health behavioral aide services</td>
<td>No</td>
<td>No</td>
<td>Cannot be billed separately.</td>
</tr>
<tr>
<td>Crisis assessment and intervention (mobile)</td>
<td>Yes</td>
<td>No</td>
<td>A component of Youth ACT. Team must provide or contract with a crisis provider for this service. Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Crisis stabilization – non-residential</td>
<td>Yes</td>
<td>No</td>
<td>A component of Youth ACT. Cannot be billed separately. No authorization required.</td>
</tr>
<tr>
<td>Crisis stabilization – residential</td>
<td>No</td>
<td>Yes</td>
<td>Services must be coordinated between the Youth ACT and residential crisis providers.</td>
</tr>
</tbody>
</table>


Youth ACT and Other Concurrent Services
The Youth ACT team must coordinate all concurrent services.
When requesting authorization, clearly document medical necessity for the additional service(s). Include the reasons Youth ACT does not/cannot meet the member’s needs (e.g., specialty service, transitional service, etc.).

<table>
<thead>
<tr>
<th>Other service</th>
<th>Is service included in Youth ACT?</th>
<th>Can service be provided in addition to Youth ACT?</th>
<th>Service limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication management</td>
<td>Yes</td>
<td>No</td>
<td>Provided by physician or APRN team members.</td>
</tr>
<tr>
<td>Outpatient psychotherapy</td>
<td>Yes</td>
<td>No</td>
<td>A component of Youth ACT. Cannot be billed separately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No authorization required.</td>
</tr>
<tr>
<td>Inpatient hospitalization</td>
<td>No</td>
<td>Yes</td>
<td>Inpatient hospitalization services are reimbursed separately from Youth ACT.</td>
</tr>
<tr>
<td>Waivered services</td>
<td>No</td>
<td>Yes</td>
<td>County must approve concurrent care.</td>
</tr>
<tr>
<td>Other medical services (e.g., PCA)</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Partial Hospitalization Program
Partial hospitalization is a time-limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team, as defined by Medicare, and provided in an outpatient hospital facility or CMHC that meets Medicare requirements to provide partial hospitalization programs services. The goal of the partial hospitalization program is to resolve or stabilize an acute episode of mental illness.

Eligible Partial Hospitalization Providers
To be a partial hospitalization provider, an outpatient hospital or a CMHC must be certified by Medicare to provide partial hospitalization and receive approval from DHS.

Providers must follow Medicare guidelines for partial hospitalization program content, physician certification requirements, and documentation.

Eligible Members
To receive partial hospitalization program services, a member must meet all of the following criteria:
1. Be a PrimeWest Health member
2. Be experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission
3. Have appropriate family or community resources needed to support and enable the member to benefit from less than 24-hour care
4. Be referred for partial hospitalization by a physician

Partial hospitalization may be beneficial to members transitioning out of inpatient mental health stays or in lieu of inpatient psychiatric.
Notify PrimeWest Health of admissions by calling or faxing the UM department:
Fax: 1-866-431-0804 (toll free)
Phone: 1-866-431-0803 (toll free)

**Inpatient Admission Authorization Request form**

**Partial Hospitalization Covered Services**

Partial hospitalization includes, at minimum, one session of individual, group, or family psychotherapy and two or more other services (such as activity therapy or training and education).

To be consistent with Medicare-recommended standards, providers must do the following:
1. Provide at least four days, but not more than five out of seven calendar days of partial hospitalization program services;
2. Ensure a minimum of 20 service components and a minimum of 20 hours in a seven-calendar-day period; and
3. Provide a minimum of five to six hours of services per day for an adult age 18 or over; or
4. Provide a minimum of four to five hours of services per day for a child under age 18.

**Billing**

1. Use the 837I format to bill for partial hospitalization program services.
2. Indicate the patient status information as continuing service; indicating discharge instead of continuing service may deny the claim.
3. Enter the type of bill (TOB) 13X Outpatient or enter the TOB 76X CMHC. Use revenue code 0912 or use revenue code 0913, accordingly.
4. Use procedure code H0035 or H0035 HA for children/adolescent services.
5. Therapy outside the partial hospitalization program is covered only for physician services and medication management:
   a. Bill using the 837P format
   b. Bill visits using the appropriate E/M code
   c. Enter POS code 22 (outpatient hospital) or 53 (CMHC)
6. If the purpose of the visit is to provide psychotherapy only or hybrid psychotherapy/E/M services, the appropriate psychotherapy codes require compliance with the authorization requirements.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0035</td>
<td></td>
<td>Partial hospitalization – age 18 and over</td>
<td>1 hour</td>
<td>None</td>
</tr>
<tr>
<td>H0035 HA</td>
<td>HA</td>
<td>Partial hospitalization – under age 18</td>
<td>1 hour</td>
<td>none</td>
</tr>
</tbody>
</table>

**Inpatient Visits**

PrimeWest Health covers inpatient visits.

**Eligible Providers**

1. CNS-MH
2. LP (with a physician’s order)
3. Physician
4. Psychiatric NP
5. Psychiatrist

PAs are eligible to provide E/M services, consistent with their authorized scope of practice, in an inpatient hospital setting when supervised by a PrimeWest Health-enrolled physician or psychiatrist. A PA may not provide psychotherapy, DA, or clinical supervision.

**Eligible Members**

Hospitalized PrimeWest Health-enrolled members are eligible.

**Covered Services**

PrimeWest Health covers only one inpatient visit by the same physician per day, either one E/M service or one psychiatric service (for example, 99221 or 90819).

A medical physician may provide medical care during the same day that a psychiatrist, CNS-MH, or psychiatric NP provides mental health services.

**Non-Covered Services**

PrimeWest Health does not cover two E/M or two psychotherapy visits per day by the same physician.

**Billing**

1. Use inpatient individual psychotherapy visits (90816 – 90829) when a member is admitted for medical reasons and a psychiatrist, CNS-MH, or psychiatric NP provides psychotherapy.
2. Select the appropriate level of service codes for the care provided for each visit.
3. Use the 837P claim format to bill for physician and non-physician services.
4. Enter the treating provider ID number for each provider rendering services on each claim line item.
5. Enter POS code 21 for all visits in an inpatient setting.
6. Use the appropriate level procedure codes for all mental health services.
7. Use modifier GC when billing for residents.
8. Use modifier HN when billing for interns.

Physician consultation in accordance with E/M services as defined by CPT are covered via telemedicine.

When a member is admitted to an inpatient hospital, only a psychiatrist, CNS-MH, or psychiatric NP may bill for inpatient visits and receive the professional fees (not included in the facility payment).

In the inpatient setting, PrimeWest Health will reimburse the NP or CNS services if the individual is not employed by the hospital or included in the hospital cost report that is currently used for hospital rate setting. The cost report used for the current rates is always from a few years prior to the current year.

When a member is admitted to an inpatient hospital for medical reasons and receives psychological care, PrimeWest Health covers psychiatric care only when ordered by a physician or psychiatrist.

See *Physician Consultation, Evaluation, and Management* for covered service policy when a psychiatrist requests a medical physician to assume responsibility for managing a member’s non-psychiatric medical care.

PrimeWest Health must receive notification of hospitalization within one business day of admission (*Inpatient Admission Authorization Request*).
Use the following chart for physician services provided in inpatient settings:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Brief Description</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221 – 99223</td>
<td>Inpatient hospital care</td>
<td>• Psychiatrist is admitting physician for initial hospital visit; or • Medical physician performs a physical exam as part of admission process. • Only admitting physician uses initial hospital care code • Preliminary diagnosis and plan of care are part of initial visit</td>
</tr>
<tr>
<td>99231 – 99233</td>
<td>Subsequent hospital care</td>
<td>Medical physician manages member’s non-psychiatric medical care after initial inpatient hospital consultation</td>
</tr>
<tr>
<td>99251 – 99255</td>
<td>Initial inpatient consultation</td>
<td>• A physician requests a consultation • <strong>Must see the patient face-to-face</strong></td>
</tr>
<tr>
<td>90816 – 90829</td>
<td>Individual psychotherapy, with or without E/M</td>
<td>By a psychiatrist, NP, or CNS-MH when member is in a medical bed</td>
</tr>
<tr>
<td>90816 90818 90821 90826</td>
<td>Individual psychotherapy, without E/M</td>
<td>By a LP under physician order when member is in a medical bed</td>
</tr>
</tbody>
</table>

**Psychiatric Consultations to Primary Care Providers**

**Eligible Providers**

The following providers can provider psychiatric consultations to primary care providers:

1. Psychiatrists
2. Licensed psychologists (LPs) (working within the scope of practice)
3. Psychiatric nurse practitioners (NPs)
4. Clinical nurse specialists (CNSs)
5. Licensed independent clinical social workers
6. Licensed marriage and family therapists

The following primary care providers are eligible to request a psychiatric consultation:

1. CNMs
2. CNSs
3. NPs
4. PAs
5. Primary care physicians, including pediatricians
6. RNs in a physician-directed clinic as defined in physician extender policy
7. Pediatricians
8. Family practice physicians
9. Psychiatrists
10. Any other prescriber

Services may be provided on the basis of a verbal agreement. The consulting professional and primary care provider must maintain documentation of the consultation in the patient record.
PrimeWest strongly encourages primary care clinics and the consulting psychiatrists to have a written agreement that defines the strategy for payment to the consulting psychiatrist and describes how provider requirements and responsibilities are met.

Providers are responsible for being in compliance with all HIPAA privacy and security protections for the member and ensuring all technology meets HIPAA requirements.

Providers are responsible for the following:
1. Applying HIPAA-compliant privacy and security protections for the member
2. Obtaining and maintaining HIPAA-compliant technology
3. Ensuring procedures are in place to prevent a breach in privacy or cause exposure of member mental health records to unauthorized persons
4. Recording the psychiatric consultation in the member’s medical record (primary care provider)

Eligible Members

All PrimeWest Health members are eligible. Refer to Benefits section for coverage determination.

Covered Services

Communication between a psychiatrist and a primary care provider, for consultation or medical management of a member, is a covered service.

With the member’s consent, psychiatric consultation may be without the member present.

Non-Covered Services

Complex or lengthy consultation by a physician extender (code 99373) is not a covered service.

Authorization Requirements

No authorization required.

Billing

1. Use the 837P claim format to bill for physician and non-physician services.
2. Use the CPT codes below to bill the appropriate level of service.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Provider</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99499</td>
<td>HE AG</td>
<td>Primary care providers</td>
<td>Communication between a consulting psychiatrist and a primary care provider, for consultation or medical management of a member.</td>
<td>I</td>
<td>Add the U4 modifier if not face-to-face Add the U7 modifier if provided by a physician extender</td>
</tr>
</tbody>
</table>
## Psychiatrist Consultation to Primary Care Providers

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Provider</th>
<th>Brief Description</th>
<th>Unit</th>
<th>Service Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>99499</td>
<td>HE AM</td>
<td>Consulting psychiatrist</td>
<td>Communication between a consulting psychiatrist and a primary care provider, for consultation or medical management of a member</td>
<td>I</td>
<td>Add the U4 modifier if not face-to-face</td>
</tr>
</tbody>
</table>

### Physician Consultation, Evaluation, and Management

#### Eligible Providers

Physicians are the only eligible providers to provide physician consultation, evaluation, and management.

#### Eligible Members

All PrimeWest Health members are eligible. Refer to Benefits section for coverage determination.

#### Covered Services

When a medical physician requests an opinion from a psychiatrist about the member’s psychiatric condition, the psychiatrist may bill for a consultation. The consultation must be conducted face-to-face with the member.

When a psychiatrist requests a medical physician to assume responsibility for managing the member’s non-psychiatric medical care after an initial consultation, the medical physician may bill subsequent hospital care for the medical management of the member during the course of a member’s psychiatric hospitalization.

#### Billing

1. Use the 837P claim format to bill for physician and non-physician services.
2. Enter the treating provider ID number for each provider rendering services on each claim line item.
3. Enter POS code 21 for all visits in an inpatient setting.
4. Use the appropriate level procedure codes for all mental health services.
5. Use modifier U7 when billing for residents only.
6. Use modifier HL when billing for interns only.
7. Physician consultation in accordance with E/M services as defined by CPT are covered via telemedicine. See Chapter 6, Physician and Professional Services, for details and billing information. Add GT modifier to indicate the service was provided via telemedicine.
8. Use codes 99241 – 99245 for office or other outpatient consultation, new or established patient.
9. Use codes 99251 – 99255 for initial inpatient consultations, new or established patient.

### Dialectical Behavior Therapy (DBT)

DBT is a treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A DBT program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.
Eligible Providers

Certified DBT teams and their affiliated individual DBT providers are eligible. To become certified, complete the Application for Certification of Dialectical Behavior Therapy Outpatient Providers.

Eligible Teams

To be eligible to bill for DBT, each DBT team must be certified through an application process conducted by DHS. Each team is comprised of, at a minimum, a team leader who is an enrolled mental health professional with a specialty in DBT and other individual treating providers who are trained in DBT.

Individual Provider Qualifications

Team Leader Qualifications
Team leaders must:
1. Be an enrolled mental health professional;
2. Be employed by, affiliated with, or contracted by, a DHS-certified DBT program;
3. Have competencies and working knowledge of DBT principles and practices; and
4. Have knowledge and ability to apply the principles and DBT practices consistent with evidence-based practices.

Team Members
The following individuals are eligible to be team members:
1. Enrolled mental health professionals
2. Mental health practitioner clinical trainees
3. Mental health practitioners

Team members must meet the following criteria:
1. Be employed by, affiliated with, or contracted by a DHS-certified DBT program
2. Have or obtain appropriate competencies and knowledge of DBT principles and practices within the first six months of becoming part of a DBT program
3. Have or obtain knowledge of and ability to apply the principles and practices of DBT consistent with evidence-based practices within the first six months of becoming part of a DBT program
4. Participate in DBT consultation team meetings for the recommended duration of 90 minutes per week
5. Mental health practitioners and mental health practitioner clinical trainees must receive ongoing clinical supervision from a mental health professional who has appropriate competencies and working knowledge of DBT principles and practices

A certificated DBT IOP provider must complete the Program Staff and Qualifications Update (DHS-6442) when the status of any team member changes. To fill out the Program Staff and Qualifications Update, you must use your unique MN–ITS login and password, which are used to access the online certification and recertification application for DBT IOPs.

Eligible Members
Members receiving DBT must meet the following admission criteria:
1. Be age 18 or within three months of becoming 18
2. Have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community-based services
3. Meet criteria as follows:
   a. Have a diagnosis of borderline personality disorder; or
   b. Have multiple mental health diagnoses; and
c. Exhibit behaviors characterized by impulsivity and/or exhibit intentional self-harm behavior or both; and
d. Be at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas.

4. Understand and be cognitively capable of participating in DBT as an intensive therapy program and be able
   and willing to follow program policies and rules assuring safety of self and others
5. Be at significant risk of one or more of the following if DBT is not provided:
   a. Mental health crisis
   b. Requiring a more restrictive setting such as hospitalization
   c. Decompensation of mental health symptoms; a change in recipient’s composite LOCUS score, though
      not required, demonstrates risk of decompensation
   d. Intentional self-harm (suicidal or non-suicidal) or risky impulsive behavior or be currently having
      chronic self-harm thoughts and urges are at a greater risk of decompensation

To remain in DBT, members must meet the following continued stay criteria:
1. The member is actively participating and engaged in the DBT program and its treatment components and
   guidelines in accordance with the treatment team expectations
2. There is demonstrable progress as measured against member’s baseline level of functioning prior to the
   DBT intervention. Examples of demonstrable progress may include the following:
   a. Decreased self-destructive behaviors
   b. Decrease in acute psychiatric symptoms with increased functioning in ADLs
   c. Showing objective signs of increased engagement
   d. Reduction in the number of acute care services (e.g., emergency department visits, crisis services,
      hospital admissions)
   e. Applying skills learned in DBT to life situations
   f. The member continues to make progress toward goals but has not fully demonstrated an internalized
      ability to self-manage and use learned skills effectively
   g. The member is actively working towards discharge including concrete planning for transition and
      discharge
   h. There is ongoing documented evidence of the continued need for treatment as indicated in the above
      criterion in the member record

To be discharged from DBT, members must meet one of the following discharge criteria:
1. The member’s ITP goals and objectives have been met or the individual no longer meets continuing stay
   criteria
2. The member’s thought, mood, behavior, or perception have improved to a level such that a lesser level of
   service is indicated
3. The member chooses to discontinue the treatment contract
4. The ongoing clinical assessment leads to the conclusion that the member no longer meets admission criteria
   or another treatment modality would be more efficacious
5. The provider will complete paperwork and refer the member to needed services

Covered Services

Individual DBT Therapy
DBT programs must provide individual DBT therapy by a qualified member of the certified team for the
recommended duration of one hour per week. Individual DBT is provided by one of the following qualified
team members:
1. Mental health professional
2. Mental health practitioner clinical trainee
Individual DBT is a combination of individualized rehabilitative and psychotherapeutic interventions to treat suicidal and other dysfunctional coping behaviors and reinforce the use of adaptive skillful behaviors by doing the following:
1. Identifying, prioritizing, and sequencing behavioral targets
2. Treating behavioral targets
3. Generalizing DBT skills to members’ natural environments
4. Providing DBT telephone coaching outside of scheduled office hours, 24 hours a day, 7 days per week while observing therapist’s limits*
5. Measuring progress toward DBT targets
6. Managing crisis and life-threatening behaviors
7. Helping members learn and apply effective behaviors in working with other treatment providers

*If phone coaching is provided by someone other than the individual therapist, that person must be another member of the DBT team trained in phone coaching protocol.

**DBT Group Skills Training**
DBT group skills training is a combination of individualized psychotherapeutic and psychiatric rehabilitative interventions conducted in a group format to reduce suicidal and other dysfunctional coping behaviors and restore function through teaching the following adaptive skills modules:
1. Mindfulness
2. Personal effectiveness
3. Emotion regulation
4. Distress tolerance

DBT programs must provide group skills training* by qualified members of the certified team for a minimum of two hours per week with the option to last up to two and a half hours. Group skills training is provided by a combination of the following qualified team members:
1. Two mental health professionals; or
2. One mental health professional co-facilitating with one mental health practitioner; or
3. One mental health professional with one mental health practitioner clinical trainee.

**Billing**

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Brief Description</th>
<th>Units</th>
<th>Service Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2019</td>
<td>U1</td>
<td>Individual DBT therapy</td>
<td>15 minutes</td>
<td>None</td>
</tr>
<tr>
<td>H2019</td>
<td>U1 HN</td>
<td>Individual DBT therapy by clinical trainee</td>
<td>15 minutes</td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>U1 HQ</td>
<td>Group DBT skills training</td>
<td>15 minutes</td>
<td>None</td>
</tr>
<tr>
<td>H2019</td>
<td>U1 HQ HN</td>
<td>Group DBT skills training by clinical trainee</td>
<td>15 minutes</td>
<td></td>
</tr>
</tbody>
</table>

**Exclusionary Services:** Additional justification is needed if the DBT services are provided concurrently with any of the following exclusionary services:
1. Partial hospitalization
2. Outpatient individual or group psychotherapy
3. Day treatment
When provided concurrently with DBT, the above services require prior authorization. If exclusionary services are provided on the same day as DBT without authorization, PrimeWest Health will make an adjustment to pay the DBT provider first and recoup payment from the exclusionary service.

**Behavioral Health Home Services**

**Overview**
The term “behavioral health home” services refers to a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness or children diagnosed with emotional disturbance. The behavioral health home (BHH) services model of care utilizes a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

**Goals of Behavioral Health Home Services**
The goals of behavioral health home services are that an individual:
1. Has access to and utilizes routine and preventative health care services
2. Has consistent treatment of mental health and other co-occurring health conditions
3. Gains knowledge of health conditions, effective treatments and practices of self-management of health conditions
4. Learns and considers healthy lifestyle routines
5. Has access to and uses social and community supports to assist the individual meet his/her health wellness goals

**Eligible Providers**
To provide behavioral health home services, a clinic or agency must be enrolled as a PrimeWest Health provider and must successfully complete the PrimeWest Health certification process.

**Certification Process**
To be certified to deliver behavioral health home services, an agency must demonstrate that all locations from which behavioral health home services will be provided are PrimeWest Health enrolled, and that all behavioral health home service teams operated by the agency or entity meet the behavioral health home services certification standards outlined in DHS-6766-ENG. The behavioral health home certification process consists of an online application and a site visit. Detailed information about certification requirements and standards are available on the DHS provider certification web page.

**Eligible Members**
To be eligible for behavioral health home services, a person must be eligible for PrimeWest Health coverage and have a condition that meets the definition of serious mental illness as defined in MN Stat. sec. 245.462, subd. 20, paragraph (a), or emotional disturbance as defined in MN Stat. sec. 245.4871, subdivision 15, clause (2), and has a current diagnostic assessment (DA) as defined in Minnesota Rules, part 9505.0372, subp. 1, item B or C. The diagnostic codes list can be found in the DHS Provider Manual.

Certified BHH services providers must ensure that the following elements are complete prior to determining eligibility for BHH services:
1. The BHH services provider confirms that the member has current PrimeWest Health coverage.
2. The BHH services provider reviews and explains the Behavioral Health Home (BHH) Services Rights, Responsibilities and Consent form (DHS-4797B-ENG) to the member. If the member is receiving a duplicative service, the member must decide which service he/she wants to receive. If the member chooses to receive BHH services, the member must sign the DHS-4797B form. The BHH services provider should give the member a copy of the form for his/her records.
3. A mental health professional (MHP) employed by or under contract with the BHH services provider must perform or review a diagnostic assessment appropriate to the member’s age and symptoms to determine if
the member meets the eligibility criteria for BHH services. See the MHCP Provider Manual Diagnostic Assessment section for more information. If the member does not have a current diagnostic assessment, the BHH provider is responsible for supporting the member in obtaining a diagnostic assessment.

4. Intake for BHH services is considered complete as of the date that all of the above elements have been completed.

Diagnostic Assessments
MN Stat. sec. 256B.0757, subd. 4, specifies that eligibility for BHH services must be determined based on a diagnostic assessment (DA) as defined in Minnesota Rules, part 9505.0372, subp. 1, item B or C. The diagnostic assessment must be performed or reviewed by a mental health professional employed by or under contract with the behavioral health home provider.

For purposes of eligibility for BHH services, one of the following types of diagnostic assessment is allowable:
1. Standard diagnostic assessment
2. Extended diagnostic assessment
3. Adult diagnostic assessment update

Assessments must be performed in accordance with requirements outlined in the DHS Provider Manual’s Diagnostic Assessment section.

Covered Services
BHH services providers must have the capacity to deliver the following six core services based on the individual’s needs and in accordance with the BHH Certification Standards (DHS-6766-ENG):

1. Care Management
   Comprehensive care management is a collaborative process designed to manage medical, social and behavioral health conditions more effectively based on population health data and tailored to the member.

2. Care Coordination
   Care coordination occurs when the BHH services team acts as the central point of contact in the compilation, implementation, and monitoring of the individualized health action plan through appropriate linkages, referrals, coordination, and follow-up to needed services and supports. Specific care coordination activities are conducted with members and their identified supports; medical, behavioral health, and community providers; and across and between care settings.

3. Health and Wellness
   Health and wellness promotion services encourage and support healthy living and motivate members and their identified supports to adopt healthy behaviors and promote better management of their health and wellness. The providers place a strong emphasis on skills development so members and their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

4. Comprehensive Transitional Care
   Comprehensive transitional care activities are specialized care coordination services that focus on the movement of members between different levels of care or settings. Transition services are designed to streamline plans of care and crisis management plans; reduce barriers to timely access; reduce inappropriate hospital, residential treatment, and nursing home admissions; interrupt patterns of frequent emergency department use; and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

5. Individual and Family Supports
   Individual and family support services are activities, materials, or services aimed to help members reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

6. Referral to Community Supports
   Referral to community and social support services are activities that ensure members have access to resources to address their identified goals and needs. Resources should address social, environmental, and community factors. These factors affect holistic health, including but not limited to, medical and behavioral
health care; entitlements and benefits; and respite, housing, transportation, legal, educational, employment, and financial services. The BHH services team will close the loop on all referrals to ensure members are supported in achieving their goals.

**Service Delivery Requirements**
Service delivery requirements are listed in section six of the [BHH certification standards (DHS-6766-ENG)](https://example.com). Adherence to the service delivery requirements will be monitored as part of the recertification process.

**Initial Engagement and Assessment**
BHH services providers must meet and deliver initial engagement and assessment services that meet the requirements of [BHH certification standard 6E (DHS-6766)](https://example.com). During the initial 90-day engagement period, a member of the BHH team must meet with the member face-to-face to do the following:
1. Complete the intake process and the brief needs assessment and develop a plan to address immediate needs as appropriate
2. Complete the initial health wellness assessment within 60 days after intake
3. Develop the health action plan within 90 days after intake
4. BHH services providers must update a member’s health action plan at least every six months

**Noncovered Services**
Members eligible for behavioral health home services are eligible for all MA-covered services. However, payment for duplicative services in the same calendar month is prohibited. The member must choose which available MA-covered service best meets his/her needs.

The following services are considered duplicative of behavioral health home services:
1. Adult mental health targeted case management (AMH-TCM)
2. Children’s mental health targeted case management (CMH-TCM)
3. Assertive community treatment (ACT)
4. Vulnerable adult/developmental disability targeted case management (VA/DD-TCM)
5. Relocation services coordination targeted case management (RSC-TCM)
6. Health care home (HCH) care coordination services

For members who have fee-for-service MA coverage, MHCP pays on the first claim submitted in a calendar month for any one of the duplicative services. Subsequent claims in the same calendar month for one of the identified duplicate services will not be paid. Medical Assistance (Medicaid) managed care organizations (MCOs) are also prohibited from payment of duplicative services in the same calendar month. However, MCOs may develop different mechanisms to avoid duplicate payments, such as a take-back of payment following a reconciliation of monthly claims, or denial of a subsequent duplicate claim in the same calendar month. Providers should contact the MCO directly to learn what procedures the MCO will use to ensure no duplicate payment. [BHH MCO Contact Information](https://example.com)

**Integration of BHH Services and Other MA Covered Services**
Behavioral health home services are designed to help connect members to medically appropriate services, and to help members remove barriers that keep them from effectively engaging with medically necessary services. Unless a service has been specifically identified as a duplicative service (see Noncovered Services section), it is permissible for a BHH provider to bill for other MA-covered services delivered to a member who is also receiving BHH services. The BHH services rate was developed as a per member, per month payment to allow the provider flexibility to provide the right service, at the right time, based on the member’s needs and circumstances.
Examples
Behavioral health home provider “A” is also certified to provide ARMHS. A member receiving BHH services has been determined to be eligible for ARMHS. The BHH services provider organization is permitted to bill for both services as long as the provider organization has met the billing requirements for each service.

Behavioral health home provider “B” is also a primary care services provider. A member receiving BHH services has been determined to be in need of asthma education. The BHH provider organization is permitted to bill for both services as long as the provider organization has met the billing requirements for each service.

Billing
The rate for behavioral health home services is a per member, per month payment. Certified behavioral health home services providers are required to carry out a service eligibility determination prior to billing for behavioral health home services.

To receive payment for delivery of behavioral health home services, certified providers must meet the following requirements:
1. Have personal contact with the member or the identified support at least once per month
2. The contact must be connected to at least one of the six required services linked to the member’s goals in the health action plan
3. Personal contact may include face-to-face, telephone contact, or interactive video. A letter, voicemail, or text alone does not meet the requirement for monthly personal contact

Billing information for procedure codes S0280 and S0281:

<table>
<thead>
<tr>
<th>Proc</th>
<th>Mod</th>
<th>Service</th>
<th>Unit</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0280</td>
<td>U5</td>
<td>BHH services care engagement, initial plan</td>
<td>Per member per month (pmpm)</td>
<td>Lifetime limit of six payments in enrollee’s lifetime. No payment if prior payment for duplicative service was made in same calendar month.</td>
</tr>
<tr>
<td>S0281</td>
<td>U5</td>
<td>BHH services ongoing standard care maintenance of plan</td>
<td>pmpm</td>
<td>No payment if prior payment for duplicative service was made in the same calendar month.</td>
</tr>
</tbody>
</table>

An individual may receive no more than six payments at the enhanced rate per member in the member’s lifetime. Providers should track the number of times S0280 U5 has been claimed. If a member is covered on a fee-for-service basis, any claim for the enhanced payment beyond the allowed six will automatically be denied and converted to the base rate. For members enrolled in PrimeWest Health, the process for tracking the enhanced payment requires PrimeWest Health to review a monthly report produced by DHS to see how many times a provider has billed at the enhanced rate (including payments made by PrimeWest Health, another MCO, or fee-for-service). PrimeWest Health is responsible for taking back any enhanced payment that exceeds the lifetime six month payment limit.

Additional billing information
1. The initial plan code (S0280 U5) can be billed at any time and no break is required to bill for the six maximum lifetime services (i.e., code S0280 U5 can be billed for the months of January – June or January, February, and November)
2. Code S0281 U5 (maintenance plan) does require that code S0280 U5 (initial plan) be submitted prior to the S0281 U5 submission
3. Code S0280 U5 cannot be submitted in the same month as S0281 U5
4. To receive payment, the claim for BHH services must use the NPI and address listed on the organization’s BHH services certification approval letter

**Treating Provider**

For individuals who have fee-for-service MA coverage, most BHH services providers are not required to identify a treating provider. BHH services providers that bill using a billing entity must identify a treating provider. The treating provider must be affiliated with the billing entity and is required to be the integration specialist.

For individuals who are enrolled in an MCO, BHH services providers will need to contact the individual’s MCO to determine what the MCO requires on the claim for BHH services. See the [BHH MCO Contact Information](#) for further information.

BHH services providers submitting electronic claims should use the 837P.

BHH services providers should use the diagnostic code(s) that corresponds with the person’s mental health diagnosis that established the person’s eligibility for BHH services.

**Managed Care Recipients**

**Notification**

If a person who has been determined eligible for BHH services is enrolled in managed care, the BHH provider must send a copy of the Determination of Eligibility for Behavioral Health Home (BHH) services (DHS-4797-ENG) form to the MCO’s designated contact. BHH providers should consult the [BHH MCO Contact Information](#) to obtain the appropriate contact information for the MCO.

**Communication and Coordination**

BHH services providers are required to communicate and coordinate with MCOs to ensure that services and activities are coordinated to most effectively meet the goals of the person and to ensure that duplication between the MCO and the BHH services provider is avoided. BHH providers and MCOs must adhere to the communication and coordination protocols established in [BHH MCO Roles and Responsibilities worksheet](#). An MCO and a BHH services provider can choose to add requirements for communication or coordination to the BHH Services MCO Roles and Responsibilities worksheet by mutual agreement. If the MCO and the BHH services provider agree to make additions to the worksheet, the MCO and the BHH provider must provide a copy of the updated worksheet and signatures from responsible staff at the MCO and the BHH provider to demonstrate that both entities have agreed to the additional terms specified in the updated worksheet.

**Legal References**

- MN Stat. Chap. 147 – Board of Medical Practice
- MN Stat. secs. 148.88 – 148.98 – Psychologists
- MN Stat. sec. 148.907 – Licensed Psychologist
- MN Stat. sec. 148.908 – Licensed Psychological Practitioner
- MN Stat. sec. 148.925, subd. 7 – Supervision: Variance from supervision requirements
- MN Stat. secs. 148B.29 – 148B.39 – Board of Marriage and Family Therapy
- MN Stat. secs. 245.461 – 245.468 – Adult Mental Health Act
- MN Stat. secs. 245.461 – 245.486 – Adult Mental Health Act; Community Support and Day Treatment Services
- MN Stat. sec. 245.462 – Adult Mental Health Act: Definitions
- MN Stat. secs. 245.487 – 245.4887 – Children’s Mental Health Act
- MN Stat. sec. 245.4882 – Residential Treatment Services
MN Stat. sec. 245.4885 – Screening for Inpatient and Residential Treatment
MN Stat. secs. 245.50 – 245.52 – Interstate Contracts, Mental Health, Chemical Health, Detoxification Services; Interstate Compact on Mental Health; Commissioner of Human Services as Compact Administrator
MN Stat. secs. 245.61 – 245.66 – County Boards: Grants for Local Mental Health Programs; Community Mental Health Center; Assistance or Grant for a Mental Health Services Program; Regional Treatment Centers: Services for Chemical Use; Community Mental Health Center Boards

MN Stat. sec. 245.62 – Community Mental Health Center
MN Stat. sec. 245.697 – State Advisory Council on Mental Health
MN Stat. sec. 245.70 – Mental Health: Federal Aid
MN Stat. sec. 245.71 – Conditions to Federal Aid for Mentally Ill
MN Stat. sec. 245.715 – Qualifications as a Community Mental Health Center Board

MN Stat. sec. 256B.04 – Duties of State Agency
MN Stat. sec. 256B.0615 – Mental Health Certified Peer Specialist
MN Stat. sec. 256B.0622 – Intensive Rehabilitative Mental Health Services

MN Stat. sec. 256B.0623 – Adult Rehabilitative Mental Health Services Covered

MN Stat. sec. 256B.0623, subd. 7 – Adult Rehabilitative Mental Health Services Covered: Personnel file
MN Stat. sec. 256B.0623, subd. 10 (2) – Adult Rehabilitative Mental Health Services Covered: Individual treatment plan

MN Stat. sec. 256B.0624 – Adult Crisis Response Services Covered
MN Stat. sec. 256B.0625 – Covered Services
MN Stat. sec. 256B.0625, subd. 3 – Covered Services: Physicians’ services

MN Stat. sec. 256B.0625, subd. 3b – Covered Services: Telemedicine consultations
MN Stat. sec. 256B.0625, subd. 4 – Covered Services: Outpatient and physician-directed clinic services

MN Stat. sec. 256B.0625, subd. 5 – Covered Services: Community mental health center services
MN Stat. sec. 256B.0625, subd. 51 – Covered Services: Intensive mental health outpatient treatment
MN Stat. sec. 256B.0625, subd. 20 – Covered Services: Mental health case management

MN Stat. sec. 256B.0625, subd. 46 – Covered Services: Mental health telemedicine
MN Stat. sec. 256B.0625, subd. 48 – Covered Services: Psychiatric consultation to primary care practitioners

MN Stat. sec. 256B.0625, subd. 61 – Covered Services: Family psychoeducation services
MN Stat. sec. 256B.0625, subd. 62 – Covered Services: Mental health clinic care consultation

MN Stat. sec. 256B.0943 – Children’s Therapeutic Services and Supports
MN Stat. sec. 256B.0945 – Services for Children with Severe Emotional Disturbance

MN Stat. sec. 256B.761 – Reimbursement for Mental Health Services
MN Stat. sec. 256B.81 – Mental Health Provider Appeal Process

MN Stat. sec. 256B.82 – Prepaid Plans and Mental Health Rehabilitative Services

MN Stat. sec. 256D.03 – Responsibility to Provider General Assistance

MN Stat. sec. 256L.03 – Covered Health Services

MN Stat. secs. 260 – 260.191 – General Provisions; Organization of the Court; Salaries

MN Rules part 9503.0015, subp. A – Options for Child Care Programs
MN Rules part 9505.2175 – Case Documentation

MN Rules part 9505.0322 – Mental Health Case Management Services
MN Rules parts 9505.0322 – 9505.0475 – Medical Assistance Payments

MN Rules part 9505.0325 – Nutritional Products
MN Rules parts 9505.0370 – 9505.0372 – Medical Assistance Payments

MN Rules part 9505.0370, subp. 6 – Definitions: Clinical supervision

MN Rules part 9505.0370, subp. 7 – Definitions: Clinical supervisor

MN Rules part 9505.0370, subp. 12 – Definitions: Dialectical behavior therapy

MN Rules part 9505.0370, subp. 13 – Definitions: Explanation of findings

MN Rules part 9505.0370, subp. 16 – Definitions: Medication management

MN Rules part 9505.0370, subp. 17 – Definitions: Mental health practitioner
MN Rules part 9505.0370, subp. 19 – Definitions: Mental health telemedicine
MN Rules part 9505.0370, subp. 28 – Definitions: Supervisee
MN Rules part 9505.0371 – definitions of clinical supervision, mental health professionals, diagnostic assessment
MN Rules part 9505.0371 – Medical Assistance Coverage Requirements for Outpatient Mental Health Services
MN Rules part 9505.0371, subp. 4 – Medical Assistance Coverage Requirements for Outpatient Mental Health Services: Clinical supervision
MN Rules part 9505.0371, subp. 5, item C – Medical Assistance Coverage Requirements for Outpatient Mental Health Services: Qualified providers
MN Rules part 9505.0371, subp. 5, item D – Medical Assistance Coverage Requirements for Outpatient Mental Health Services: Qualified providers
MN Rules part 9505.0372 – definitions of clinical supervision, mental health professionals, diagnostic assessment
MN Rules part 9505.0372, subp. 5 – Covered Services: Explanations of findings
MN Rules part 9505.0372, subp. 7 – Covered Services: Medication management
MN Rules part 9505.0372, subp. 10 – Covered Services: Dialectical behavior therapy (DBT)
MN Rules part 9505.0540 – Criteria for Readmissions
MN Rules part 9505.2175 – Health Service Records
MN Rules part 9505.2180 – Financial Records
MN Rules parts 9505.5000 – 9505.5105 – Conditions for Medical Assistance and General Assistance Medical Care Payment
MN Rules parts 9520.0500 – 9520.0670 – Licensing Residential Programs for Adults Who Are Mentally Ill
MN Rules parts 9520.0750 – 9520.0870 – Mental Health Center and Mental Health Clinic Standards
MN Rules part 9520.0800 – Minimum Quality Assurance Standards
MN Rules parts 9520.0900 – 9520.0926 – Case Management for Children with Severe Emotional Disturbance
MN Rules part 9520.0914, subp. 2 – Case Manager’s Responsibilities
MN Rules part 9535.4068 – Orientation and Training
Title 42 Code of Federal Regulations (CFR) Part 435.1008 – FFP in expenditures for Medical Assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity
42 CFR 435.1009 – Institutionalized individuals
42 CFR 440.60(a) – Medical or other remedial care provided by licensed practitioners
42 CFR 440.160 – Inpatient psychiatric services for individuals under age 21
42 CFR 440.170(e) – Any other medical care or remedial care recognized under State law and specified by the Secretary: Emergency hospital services
42 CFR 440.230 – Sufficiency of amount, duration, and scope
Title XIX, section 1915(g) of the Social Security Act
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