ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers –Rehabilitative Services for Persons with Mental Illness (RSPMI)**

DATE: **October 4, 2009**

SUBJECT: **Provider Manual Update Transmittal #110**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	10-4-09
202.000	11-1-08	202.000	10-4-09
211.000	10-13-03	211.000	10-4-09
218.000	5-1-08	218.000	10-4-09
219.100	10-13-03	219.100	10-4-09
219.110	10-13-03	219.110	10-4-09
219.120	6-1-05	—	—
219.121	6-1-05	—	—
219.122	6-1-05	—	—
219.123	6-1-05	—	—
223.000	6-1-05	223.000	10-4-09
226.200	11-1-08	226.200	10-4-09
227.000	10-1-04	227.000	10-4-09
—	—	227.001	10-4-09
227.100	10-13-03	227.100	10-4-09
230.000	Blank	230.000	Blank
231.000	7-1-07	231.000	10-4-09
231.100	7-1-07	231.100	10-4-09
231.200	7-1-07	—	—
240.000	5-1-08	240.000	10-4-09
252.100	7-1-07	252.100	10-4-09
252.110	11-1-08	252.110	10-4-09
252.120	5-1-08	—	—
252.200	11-1-08	252.200	10-4-09
—	—	252.430	10-4-09

Explanation of Updates

Section 201.000 is revised to clarify general information regarding where RSPMI services will be provided.

Section 202.000 is included to clarify billing for multiple service sites. Minor text changes have been made that do not affect policy.

Section 211.000 is included to inform RSPMI providers that they must maintain a written policy for 24 hours emergency response capability.

Section 218.000 is revised to change the title of the section and change the name of treatment plan to master treatment plan.

Section 219.100 is revised to change the definition of outpatient services.

Section 219.110 is revised to change the name of the subtitle and to clarify the daily maximum amount of services per beneficiary.

Sections 219.120, 219.121, 219.122, 219.123 are deleted.

Section 223.000 is revised to add ICF/MR to the exclusions list. Minor text changes have been made that do not affect policy.

Section 226.200 is revised to include appropriate release information under documentation requirements.

Section 227.00 is a new statement regarding medical necessity.

Section 227.001 is added to describe prescription services under RSPMI

Section 227.100 is revised to change verbiage in the subtitle. Minor text changes have been made that do not affect policy.

Sections 230.000 and 231.000 are revised to add extension of benefits information.

Section 231.100 is included to revise the section heading and to add extension of benefits information and to update instructions for prior authorization protocol. Procedure codes requiring prior authorization or extension of benefits are updated.

Section 240.00 is revised to clarify that no more than four units are billable for a single hour. Minor text changes have been made that do not affect policy.

Section 252.100 is revised to remove reference to the verbiage regarding restrictions and to add IFC/MR residents. Language is also added to state that staffing requirements must be met as stated in the scope of service.

Section 252.110 is revised to remove reference to the words “non-restricted”. The service definitions are updated for the covered procedure codes.

Section 252.120 is deleted.

Section 252.200 is revised to clarify the definition of an RSPMI Facility Service Site.

Section 252.430 is added to define daily service billing exclusions.

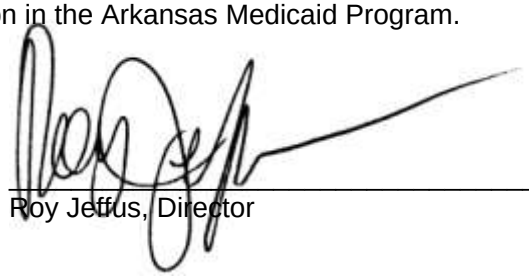
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

SECTION II - REHABILITATIVE SERVICES FOR PERSONS WITH MENTAL ILLNESS (RSPMI)

CONTENTS

201.000 Introduction 10-4-09

Medicaid (Medical Assistance) is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Rehabilitative Services for Persons with Mental Illness (RSPMI) are covered by Medicaid when provided to eligible Medicaid beneficiaries by enrolled providers.

RSPMI may be provided to eligible Medicaid beneficiaries at all provider facility certified sites. Certain RSPMI services may be provided off site from the provider facility.

202.000 Arkansas Medicaid Participation Requirements for RSPMI 10-4-09

In order to ensure quality and continuity of care, all mental health providers approved to receive Medicaid reimbursement for services to Medicaid beneficiaries must meet specific qualifications for their services and staff. Providers with multiple service sites must enroll each site separately and reflect the actual service site on billing claims.

To enroll as an RSPMI Medicaid provider, the following must occur:

A. Providers must be located within the State of Arkansas.

B. A provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. **View or print a provider application (form DMS-652), Medicaid contract (form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

C. A provider must be certified by the Division of Behavioral Health Services (DBHS). (See section 202.100 for certification requirements.)

D. A copy of the current DBHS certification as an RSPMI provider must accompany the provider application and Medicaid contract. Subsequent certifications must be provided when issued.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Contract.

DMS shall exclude providers for the reasons stated in 42 U.S.C. §1320a-7(a) and implementing regulations and may exclude providers for the reasons stated in 42 U.S.C. §1320a-7(b) and implementing regulations. The following factors shall be considered by DHS in determining whether sanction(s) should be imposed:

A. Seriousness of the offense(s)

B. Extent of violation(s)

C. History of prior violation(s)

D. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

211.000 Coverage of Services 10-4-09

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. The provider must be certified as an RSPMI provider by the Division of Behavioral Health Services.

An RSPMI provider must have 24-hour emergency response capability to meet the emergency treatment needs of the RSPMI clients they are serving. The provider must implement and maintain a written policy reflecting the specific coverage plan to meet this requirement. An answering machine message to call 911 or report to the nearest emergency room in and of itself is not sufficient to meet the requirement.

218.000 Master Treatment Plan 10-4-09

For each beneficiary entering the RSPMI Program, the treatment team must develop an individualized master treatment plan. This consists of a written, individualized plan to treat, ameliorate, diminish or stabilize or maintain remission of symptoms of mental illness that threaten life, or cause pain or suffering, resulting in diminished or impaired functional capacity. The master treatment plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessments during the treatment process. The master treatment plan must be included in the beneficiary records and contain a written description of the treatment objectives for that beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to meet the treatment objectives;

B. A projected schedule for service delivery—this includes the expected frequency and duration of each type of planned therapeutic session or encounter;

C. The type of personnel that will be furnishing the services and

D. A projected schedule for completing reevaluations of the patient's condition and updating the master treatment plan.

The RSPMI master treatment plan must be completed by a mental health professional and approved by a psychiatrist or physician, within 14 calendar days of the individual's entering care (first billable service). Subsequent revisions in the master treatment plan will be approved in writing (signed and dated) by the psychiatrist or physician verifying continued medical necessity.

219.100 Outpatient Services 10-4-09

RSPMI outpatient services, based on a plan of care, include a broad range of services to Medicaid-eligible beneficiaries. Beneficiaries shall be served with an array of treatment services outlined on their individualized master treatment plan in an amount and duration designed to meet their medical needs.

219.110 Daily Limit of Beneficiary Services 10-4-09

Medicaid Beneficiaries will be limited to a maximum of eight hours per 24 hour day of outpatient services with the exception of Crisis Intervention, Crisis Stabilization Intervention by Mental Health Professional and Crisis Stabilization Intervention by Mental Health Paraprofessional. Beneficiaries will be eligible for an extension of the daily maximum amount of services based on

a medical necessity review by the contracted utilization management entity (See Section 231.100 for details regarding extension of benefits).

223.000 Exclusions 10-4-09

Services not covered under the RSPMI Program include, but are not limited to:

A. Room and board residential costs;

B. Educational services;

C. Telephone contacts with patient or collateral;

D. Transportation services, including time spent transporting a beneficiary for services **(reimbursement for other RSPMI services is not allowed for the period of time the Medicaid beneficiary is in transport)**;

E. Services to individuals with developmental disabilities that are non-psychiatric in nature, except for testing purposes;

F. RSPMI services which are found not to be medically necessary and

G. RSPMI services provided to nursing home and ICF/MR residents other than those specified in section 252.150.

226.200 Documentation 10-4-09

The RSPMI provider must develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity or session for which Medicaid reimbursement is sought. This documentation, at a minimum, must consist of:

A. Must be individualized to the beneficiary and specific to the services provided, duplicated notes are not allowed.

B. The date and actual time the services were provided (Time frames may not overlap between services. All services must be outside the time frame of other services.),

C. Name and credentials of the person, who provided the services,

D. The setting in which the services were provided. For all settings other than the provider's enrolled sites, the name and physical address of the place of service must be included,

E. The relationship of the services to the treatment regimen described in the plan of care and

F. Updates describing the patient's progress and

G. For services that require contact with anyone other than the beneficiary, evidence of conformance with HIPAA regulations, including presence in documentation of Specific Authorizations, is required.

Documentation must be legible and concise. The name and title of the person providing the service must reflect the appropriate professional level in accordance with the staffing requirements found in section 213.000.

For Therapeutic Day/Acute Day and Rehabilitative Day Services, progress notes must be entered daily. Daily notes may be brief; however, they must meet requirement of item F above.

Providers may enter weekly progress notes that summarize the beneficiary's progress in relationship to the plan of care.

All documentation must be available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Program Integrity Unit. All documentation must be available at the provider's place of business. No more than thirty (30) days will be allowed after the date on the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30-day period.

227.000 Medical Necessity 10-4-09

All RSPMI services must be medically necessary.

227.001 Prescription for RSPMI Services 10-4-09

Medicaid will not cover any RSPMI service without a current prescription signed by a psychiatrist or physician. Prescriptions shall be based on consideration of the RSPMI Assessment and proposed master treatment plan and an evaluation of the enrolled beneficiary (directly or through review of the medical records and consultation with the treatment staff). The prescription of the services will be documented by the psychiatrist's or physician's written approval of the RSPMI master treatment plan. Subsequent revisions of the patient's RSPMI master treatment plan will also be documented by the psychiatrist's or physician's written approval in the enrolled beneficiary's medical record. Approval of all updates or revisions to the Master treatment plan must be documented within 14 calendar days by the physician's dated signature on the revised document.

227.100 Prescription for Speech Therapy 10-4-09

Speech therapy services are available to Medicaid-eligible beneficiaries. Providers of speech therapy services are required to have a physician prescription for services in each patient's record.

A written prescription is required for speech therapy services, signed and dated by the PCP or the attending physician. Form DMS-640 is required for the prescription. The form must be in the patient's record. **View or print form DMS-640.**

A. The beneficiary's PCP or attending physician must sign the prescription.

B. A prescription for speech therapy services is valid for 1 year unless the prescribing physician specifies a shorter period of time.

230.000 PRIOR AUTHORIZATION (PA) AND EXTENSION OF BENEFITS

231.000 Introduction to Prior Authorization and Extension of Benefits 10-4-09

The Division of Medical Services contracts with First Health Services and APS Healthcare to complete the prior authorization and extension of benefit processes.

When a provider requests PA for services to be provided via telemedicine, the procedure codes and modifiers (if any) listed below must be shown on the claim form, "telemedicine" must be specified on the request.

A request for prior authorization for services to be provided to a foster child must specify that the request is for a foster child. A request for services to be provided to a child in the custody of the Division of Youth Services (DYS) must specify DYS custody.

231.100 Prior Authorization and Extension of Benefits 10-4-09

Prior Authorization is required for certain services provided to Medicaid-eligible individuals. Extension of benefits is required for all other services when the maximum benefit for the service is exhausted. Yearly service benefits are based on the state fiscal year running from July 1 to June 30. Extension of Benefits is also required whenever a beneficiary exceeds eight hours of outpatient services in one 24-hour day, with the exception of crisis intervention, crisis stabilization intervention by a mental health professional, and crisis stabilization intervention by paraprofessional.

Prior authorization and extension requests must be sent to APS Healthcare for beneficiaries under the age of 21. **View or print APS Healthcare contact information.** Information related to clinical management guidelines and authorization request processes is available at **www.apshealthcare.com**.

Prior authorization and extension requests must be sent to First Health for beneficiaries age 21 and over. **View or print First Health contact information.** Information related to clinical management guidelines and authorization request processes is available at **https://arkansas.fhsc.com/**

Procedure codes requiring prior authorization:

National Codes	Required Modifier	Service Title
90846 90846 90846	HA, U3, -- U5 (telemedicine)	Marital/Family Therapy without patient present
90853 90853	HA, U1 --	Group Outpatient – Group Psychotherapy
90862	HA, HQ	Group Outpatient – Pharmacologic Management by Physician
H2012 H2012	HA UA	Therapeutic Day/Acute Day Treatment
90887 90887	HA, U1 --	Collateral Intervention, MHP
90887	HA, UB	Collateral Intervention, MHPP
H2015 H2015 H2015	HA, U5 U6 U7 (telemedicine)	Intervention, MHP
H2015 H2015	HA, U1 U2	Intervention, MHPP
H2017 H2017	HA, U1 --	Rehabilitative Day Service

Procedure codes requiring Extension of Benefits:

National Codes	Required Modifier	Service Title	Yearly Maximum
90801 90801	-- HA, UI	Mental Health Evaluation/Diagnosis	16
96101	HA, UA	Psychological Evaluation	32
90885	HA, U2	Master Treatment Plan	8
90887 90887	HA, U2 U3	Interpretation of Diagnosis	16
H0004 H0004	 HA	Individual Psychotherapy	48
90847 90847 90847	HA, U3 -- U5 (telemedicine)	Marital/Family Therapy with patient present	48
H2011 H2011	HA, U7 U4 (telemedicine)	Crisis Intervention	72
T1023 T1023	 HA, U1	Diagnostic Assessment by Physician (Formerly Assessment and Treatment Plan/Plan of Care)	1
99201 99202 99203 99204 99205 99212 99213 99214 99215 AND 99201 99202 99203 99204 99205 99212 99213 99214 99215	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA	Physical Examination	12
90862 90862 90862	HA — HA, UB	Pharmacologic Management	24

National Codes	Required Modifier	Service Title	Yearly Maximum
90885 90885	HA HA, U1	Periodic Review of Master treatment plan	10
36415	HA	Routine Venipuncture for Collection of Specimen	12
H2011 H2011	HA, U6 U2	Crisis Stabilization, MHP	72
H2011 H2011	HA, U5 U1	Crisis Stabilization, MHPP	72

240.000 REIMBURSEMENT 10-4-09

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the beneficiary is eligible for Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units

RSPMI services are billed on a per unit basis. A unit of service for an outpatient service is fifteen (15) minutes unless otherwise stated. Any unit less than five (5) minutes in duration is not considered a valid length of service and should not be submitted to Medicaid for payment. To determine how many units should be submitted on the claim, follow these steps. Begin by totaling the number of minutes of service rendered and divide by fifteen (15). If the remainder is five (5) or greater, round up to the next highest unit, but if the remainder is less than five (5), the quotient will be the valid units of service.

Providers may collectively bill for a single date of service but may not collectively bill for spanning dates of service. For example, an RSPMI service may occur on behalf of a beneficiary on Monday and then again on Tuesday. The RSPMI provider may bill for the total amount of time spent on Monday and the total amount of time spent on Tuesday but may not bill for the total amount of time spent both days as a single date of service. The maximum allowable for a procedure is the same for all RSPMI providers.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

B. Inpatient Services

The length of time and number of units that may be billed for inpatient hospital visits are determined by the description of the service in *Current Procedural Terminology (CPT).*

252.100 Procedure Codes for Types of Covered Services 10-4-09

Covered RSPMI services are outpatient services. Specific RSPMI services are available to inpatient hospital patients (as outlined in Section 240.000 and 220.100), through telemedicine, and to nursing home and ICF/MR residents. RSPMI services are billed on a per unit basis. Unless otherwise specified in this manual or the appropriate CPT or HCPCS book, one unit equals 15 minutes. All services must be provided by at least the minimum staff within the licensed or certified scope of practice to provide the service.

NOTE: RSPMI providers will continue to use modifiers 22 and 52. Effective for claims received on or after December 5, 2005, modifier 22 will be replaced with UA and modifier 52 will be replaced with UB.

252.110 Outpatient Procedure Codes 10-4-09

National Code	Required Modifier	Definition
92506	HA	***Diagnosis: Speech Evaluation*** 1 unit = 30 minutes Maximum units per day: 4 Maximum units per state fiscal year (SFY) = 4 units
90801	HA, UI	**SERVICE*:* Mental Health Evaluation/Diagnosis (Formerly known only as Diagnosis*)*** **DEFINITION:** The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8, **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of the face to face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem (s) • Culturally- and age-appropriate psychosocial history and assessment

National Code	Required Modifier	Definition
		• Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • Five axis DSM diagnostic impressions • Treatment recommendations • Staff signature/credentials/date of signature **NOTES and COMMENTS:** This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. Prior Authorization requests, master treatment plans, etc.).
90801	—	**Mental Health Evaluation/Diagnosis***:* Use the above description Additional requirement: 90801 with no modifier is for service provided via telemedicine only. Note: Telemedicine POS 99
96101	HA, UA	**SERVICE: Psychological Evaluation (Formerly Diagnosis – Psychological Test/Evaluation and Diagnosis – Psychological Testing Battery)** **DEFINITION:** A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 16 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension**: 32 **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • Axis Five DSM diagnostic impressions • Treatment recommendations and findings related to rationale for service and guided by the master treatment plan and test results • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Medical necessity for this service is met

National Code	Required Modifier	Definition
		when the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions, when the history and symptomatology are not readily attributable to a particular psychiatric diagnosis and the questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview, observation in therapy, or an assessment for level of care at a mental health facility, *Or* Medical necessity is met when the beneficiary has demonstrated a complexity of issues related to cognitive functioning or the impact of a disability on a condition or behavior and the service is necessary to develop treatment recommendations after the beneficiary has received various treatment services and modalities, has not progressed in treatment, and continues to be symptomatic. Medicaid WILL NOT reimburse evaluations or testing that is considered primarily educational. Such services are those used to identify specific learning disabilities and developmental disabilities in beneficiaries who have no presenting behavioral or psychiatric symptoms which meet the need for mental health treatment evaluation. This type of evaluation and testing is provided by local school systems under applicable state and federal laws and rules. Psychological Evaluation services that are ordered strictly as a result of court-ordered services are not covered unless medical necessity criteria are met. Psychological Evaluation services for employment, disability qualification, or legal/court related purposes are not reimbursable by Medicaid as they are not considered treatment of illness. A Psychological Evaluation report must be completed within fourteen (14) calendar days of the examination; documented; clearly identified as such; and signed/dated by the staff completing the evaluation. This service constitutes both face to face time administering tests to the beneficiary and time interpreting these test results and preparing the report.
T1023	HA, U1	**SERVICE: Diagnostic Assessment by Physician (Formerly Assessment and Treatment Plan/Plan of Care)** **DEFINITION:** A direct face-to-face service contact occurring between the physician and the beneficiary for the process of certifying the beneficiary as SED or SMI and determining the need for RSPMI services for a specified time period. Eligibility for these services must be based on diagnosis, past psychiatric history, level of functioning and current support needs. The plan must provide for the least restrictive medically necessary treatment that may reasonably be expected to benefit the beneficiary. (See Section 224.000 for additional requirements.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** This service must be billed as 1 per episode. **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED** May be billed one (1) time upon initial admission to RSPMI services and once yearly thereafter. **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); and for ages 21 and over, RSPMI Clinic (Telemedicine) (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS:**

National Code	Required Modifier	Definition
		Date of Service Start and stop times Place of service Diagnosis Diagnostic Impression Psychiatric (re)assessment Functional (re)assessment Discharge criteria Physician's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** The beneficiary must be reassessed, reviewed, and recertified at least every year or in accordance with Division of Behavior Health Services certification requirements. The DBHS Physician Certification form must be completed and filed in the beneficiary's record, or all of the equivalent information covered and documented in the record.
T1023	-	**SERVICE: Diagnostic Assessment by Physician (Formerly Assessment and Treatment Plan/Plan of Care):** Use the above description. T1023 with no modifier is for services provided via telemedicine only.
90885	HA, U2	**SERVICE: Master Treatment Plan** **DEFINITION:** A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 8** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's

National Code	Required Modifier	Definition
		strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity /date of signature **NOTES and COMMENTS:** This service may be billed one (1) time upon entering care and once yearly thereafter. The master treatment plan must be reviewed every ninety (90) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to insure that all paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA	**SERVICE: Periodic Review of Master Treatment Plan** **DEFINITION:** The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 10** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** **Completed by the primary MHP (If not, then must have a rationale for another MHP completing the documentation and only with input**

National Code	Required Modifier	Definition
		from the primary MHP) • Date of service • Start and stop times for review and revision of plan • Place of service • Diagnosis and pertinent interval history • Beneficiary's updated strengths and needs • Progress/Regression with regard to treatment goal(s) as documented in the master. • Progress/Regression of the measurable objectives as documented in the master treatment plan • Individualized rationale to support the medical necessity of continued services • Updated schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Modifications to discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/date of signature(s) • Physician's signature indicating continued medical necessity/date of signature **NOTES and COMMENTS:** This service must be provided every ninety (90) days or more frequently if there is documentation of significant change in acuity or change in clinical status requiring an update/change in the beneficiary's master treatment plan. If progress is not documented, then modifications should be made in the master treatment plan or rationale why continuing to provide the same type and amount of services is expected to achieve progress/outcome. It is the responsibility of the primary mental health professional to insure that all paraprofessionals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.
90885	HA, U1	**Periodic Review of Master Treatment Plan** Apply the above description. Additional information: 90885 plus modifier “U1” is for this service when provided by a non-physician.
90887	HA, U2	**SERVICE: Interpretation of Diagnosis** **DEFINITION:** A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 16 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home

National Code	Required Modifier	Definition
		(12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); if above the age of 21 RSPMI Clinic (Telemedicine)(99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and intervention used that must coincide with the master treatment plan or proposed master treatment plan or recommendations. • Participant response and feedback • Any changes or revision to the master treatment plan, diagnosis, or medication(s) • Staff signature/credentials/date of signature(s) **NOTES AND COMMENTS:** For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.
90887	U3	**Interpretation of Diagnosis** Use above description Additional information: 90887 plus modifier "U3" is for service provided via telemedicine only. Note: Telemedicine POS 99
H0004	HA	**SERVICE: Individual Psychotherapy** **DEFINITION** Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** **48** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31) School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); and for ages 21 and over, RSPMI Clinic (Telemedicine) (99). **AGE GROUP(S):** Ages 21 and over; U21, but not for beneficiaries under the age of 3 except in documented exceptional cases

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		REQUIRED DOCUMENTATION (See Section 226.200 for additional requirements): • Date of Service • Start and stop times of face to face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the intervention used that must coincide with the master • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature **NOTES and COMMENTS:** Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.
H0004	—	**Individual Psychotherapy** Use above description. Additional information: H0004 with no modifier is for ages 21 and over.
H0004	—	**Individual Psychotherapy** Use above description. Additional information: H0004 with no modifier is for services provided via telemedicine only.
90846	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is not present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **REQUIRES PRIOR AUTHORIZATION** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); and for ages 21 and over, RSPMI Clinic

National Code	Required Modifier	Definition
		(Telemedicine) (99), **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of actual encounter with spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and intervention used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPPA compliant Release of information forms, completed, signed and dated • Staff signature/credentials/date of signature **NOTES and COMMENTS:** Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.
90846	—	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above description. Additional information: 90846 with no modifier is for ages 21 and over.
90846	U5	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above description. Additional information: 90846 with the modifier "U5" is for a service provided via telemedicine only.
90847	HA, U3	**SERVICE: Marital/Family Psychotherapy – Beneficiary is present** **DEFINITION:** Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen

National Code	Required Modifier	Definition
		marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** **48** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); and for ages 21 and over, RSPMI Clinic (Telemedicine) (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of intervention used that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated **NOTES and COMMENTS:** Natural supports may be included in these sessions if justified in service documentation and if supported in the master treatment plan. Only one beneficiary per family per therapy session may be billed. Additional information: 90847 plus modifiers “HA U3” is for under age 21.
90847	—	**Marital/Family Psychotherapy – Beneficiary is present** Use the above description. Additional information: 90847 with no modifier is for ages 21 and over.
90847	U5	**Marital/Family Psychotherapy – Beneficiary is present** Use the above description.

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		Additional information: 90847 with the modifier "U5" is for a service provided via telemedicine only.
92507	HA	**Individual Outpatient – Speech Therapy, Speech Language Pathologist** Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92507	HA, UB	**Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.
92508	HA	**Group Outpatient – Speech Therapy, Speech Language Pathologist** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
92508	HA, UB	**Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant** Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
90853	HA, U1	**SERVICE: Group Outpatient – Group Psychotherapy** **DEFINITION:** Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness. The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); **AGE GROUP(S):** Ages 21 and over; Ages 4 – 20; Under age 4 by prior authorized medically needy exception **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):**

National Code	Required Modifier	Definition
		• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group intervention and intervention used that must coincide with master treatment plan • Beneficiary's response to the group intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature **NOTES and COMMENTS:** This does NOT include *psychosocial groups*. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 21 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 21 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e.: 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities,
90853	—	**Group Outpatient – Group Psychotherapy** Apply the above description. Additional information: 90853 with no modifier is for ages 21 and over.
H2012	HA	**SERVICE: Therapeutic Day/Acute Day Treatment** **DEFINITION:** Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and

National Code	Required Modifier	Definition
		availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provides services and oversight. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services must include constant staff supervision of beneficiaries and physician oversight. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 32 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11) **STAFF to CLIENT RATIO:** 1:5 for ages 21 and over; 1:4 for U21 **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and interventions used that must coincide with the master treatment plan • Beneficiary's response to the intervention must include current progress or lack of progress toward symptom reduction and attainment of goals • Rationale for continued acute day service, including necessary changes to diagnosis, master treatment plan or medication(s) • Staff signature/credentials **NOTES and COMMENTS:** Providers may bill for services only at times during which beneficiaries participate in program activities. Providers are expected to sign patients in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting. See Section 219.110 for additional information.
H2012	UA	**Therapeutic Day/Acute Day Treatment** – 8 units minimum See Section 219.110 for additional information.
H2011	HA, U7	**SERVICE: Crisis Intervention** **DEFINITION:** Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.) **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12

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		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 72 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); Nursing Facility (32); Skilled Nursing Facility (31); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); ICF/MR (54); RSPMI Clinic (For ages 21 and over) (Telemedicine) (99) ; Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service (If 99 is used, specific location and rationale for location must be included) • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U4	**Crisis Intervention** Apply the above description. Additional information: H2011 plus modifier "U4" is for service provided via telemedicine only.
Physician: 99201 99202 99203 99204 99211 99212 99213	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB	**SERVICE: Physical Examination – Psychiatrist or Physician Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 1 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 12** **ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for**

National Code	Required Modifier	Definition
99214 PCNS & PANP: 99201 99202 99203 99204 99211 99212 99213 99214	 HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA	**additional requirements):** • Start and stop times of actual encounter with beneficiary • Date of service • Place of service • Identifying information • Referral reason and rationale for examination • Presenting problem(s) • Health history • Physical examination • Laboratory and diagnostic procedures ordered • Health education/counseling • Identification of risk factors • Mental status/clinical observations and impressions • ICD-9 diagnoses • Five axis DSM diagnostic impressions • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Treatment recommendations for findings, medications prescribed, and indicated informed consents • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be billed only by the RSPMI provider. The physician, Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner may not bill for an office visit, nursing home visit, or any other outpatient medical services procedure for the beneficiary for the same date of service. Pharmacologic Management may not be billed on the same date of service as Physical Examination, as pharmacologic management would be considered one component of the full physical examination (office visit).
90862	HA	**SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)** **Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** **DEFINITION:** Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 2 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 24** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); and if age 21 and over, RSPMI Clinic (Telemedicine) (99)

National Code	Required Modifier	Definition
		AGE GROUP(S): Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS(See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (If 99 is used for telemedicine, specific locations and rationale for using telemedicine must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and intervention used that must coincide with the master treatment plan • Beneficiary's response to intervention that includes current progress or regression and prognosis • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist • Staff signature/credentials/date of signature **NOTES and COMMENTS:** Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan.
90862	—	**Pharmacologic Management by Physician** Apply description above. Additional information: 90862 with no modifier is for ages 21 and over.
90862	—	**Pharmacologic Management by Physician** Apply description above. Additional information: 90862 with no modifier is for services provided via telemedicine only.
90862	HA, UB	**Pharmacologic Management by Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** Apply description above.
T1502	_	**SERVICE: Medication Administration by a Licensed Nurse** **DEFINITION:** Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for**

National Code	Required Modifier	Definition
		additional requirements): • Date of Service • Start and stop times of the specific procedure • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for dosing schedule and intervention used must coincide with the master treatment plan • Beneficiary's response to intervention that includes current progress or regression, prognosis, and reaction to medication • Revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • Staff signature/credentials/date of signature **NOTES and COMMENTS: Applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan.** Drugs and biologicals that can be self-administered shall not be in this group unless there is a documented reason the patient cannot self administer. Non-prescriptions and biologicals purchased by or dispensed to a patient are not covered.
90862	HA, HQ	**SERVICE: Group Outpatient – Pharmacologic Management by a Physician** **DEFINITION:** Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 6 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 18 and over **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis and pertinent interval history • Focus of group • Brief mental status and observations • Rationale for group intervention and intervention used that must coincide with master treatment plan • Beneficiary's response to the group intervention that includes current progress or regression and prognosis

National Code	Required Modifier	Definition
		• Any changes indicated for the master treatment plan, diagnosis, or medication(s) • If provided by physician that is not a psychiatrist, then any off label uses of medications must include documented consultation with the overseeing psychiatrist • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service applies only to medications prescribed to address targeted symptoms as identified in the master treatment plan. This does NOT include *psychosocial groups* in rehabilitative day programs or educational groups. The maximum that may be served in a specified group is ten (10). Providers may bill for services only at times during which beneficiaries participate in this program activity.
36415	HA	**SERVICE: Routine Venipuncture for Collection of Specimen** **DEFINITION:** The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1,** Per routine **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 12** **ALLOWABLE PLACES OF SERVICE:** Office (11); Assisted Living Facility (13); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Start and stop times of the specific procedure • Place of service (If 99 is used, specific location and rationale for location must be included) • Diagnosis • Brief mental status and observations • Rationale for and procedure used that must coincide with master treatment plan and physician or psychiatrist orders • Description of procedure • Beneficiary's response to procedure, if any • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for follow-up services • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** This service may be provided only to beneficiaries taking prescribed psychotropic medication or who have a substance abuse diagnosis.
90887	HA	**SERVICE: Collateral Intervention, Mental Health Professional** **DEFINITION:** A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share

National Code	Required Modifier	Definition
		relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99); and for ages 21 and over, RSPMI Clinic (Telemedicine) (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Rationale for and intervention used that must coincide with the master treatment plan • Collateral contact's response to intervention • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next contact, if any • Staff signature/credentials/Date of signature **NOTES and COMMENTS:** The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Billing for interventions performed by a mental health professional must warrant the need for the higher level of staff licensure. Professional interventions of a type which could be provided by a paraprofessional will require documentation of the reason it was needed. Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.
90887	U1	**Collateral Intervention, Mental Health Professional** Apply the above description. Additional information: 90887 plus modifier "U1" is for service provided via telemedicine only.
90887	HA, UB	**SERVICE: Collateral Intervention, Mental Health Paraprofessional** **DEFINITION:** A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-

National Code	Required Modifier	Definition
		based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 4 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Patient's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements:** • Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with collateral contact • Place of Service (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Rationale for and intervention used that must coincide with the master treatment plan • Collateral contact's response to intervention • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP • Plan for next contact, if any • Staff signature/credentials/Date of signature **NOTES and COMMENTS** Supervision by a Mental Health Professional must be documented in personnel files and addressed in accordance of agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision. The collateral intervention must be identified on the master treatment plan as a medically necessary service. Medicaid WILL NOT pay for incidental or happenstance meetings with individuals. For example, a chance meeting with a beneficiary's adult daughter at the corner store which results in a conversation regarding the well-being of the beneficiary may not be billed as a collateral contact. Contacts between individuals in the employment of RSPMI agencies or facilities are not a billable collateral intervention.
H2011	HA, U6	**SERVICE: Crisis Stabilization Intervention, Mental Health Professional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

National Code	Required Modifier	Definition
		DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 72** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); RSPMI Clinic (for ages 21 and over) (Telemedicine) (99); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of service • Start and stop time of actual encounter with beneficiary • Place of service, (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation, OR rationale for crisis intervention activities utilized • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning.
H2011	U2	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above description. Additional information: H2011 plus modifier "U2" is for ages 21 and over.
H2011	HA, U5	**SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional** **DEFINITION:** Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 12 **YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 72** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for**

National Code	Required Modifier	Definition
		additional requirements): • Date of service • Start and stop time of actual encounter with beneficiary • Place of service If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Behavioral observations • Consult with MHP or physician regarding events that necessitated this service and the review of the outcome of the intervention • Intervention used must coincide with the master treatment plan, psychiatric advance directive or crisis plan which must be documented and communicated to the supervising MHP • Beneficiary's response to intervention that includes current progress or regression and prognosis • Plan for next session, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2011	U1	**Crisis Stabilization Intervention, Mental Health Paraprofessional** Apply the description above. Additional information: H2011 plus modifier "U1" is for ages 21 and over
H2015	HA, U5	**SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)** **DEFINITION:** Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); RSPMI Clinic for Ages 21 and over (Telemedicine) (99); Other Locations (99) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for**

National Code	Required Modifier	Definition
		additional requirements): • Start and stop times of actual encounter with beneficiary • Date of service • Place of service, (If 99 is used, specific location and rationale for location must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and intervention used that must be medically necessary • Beneficiary's response to intervention that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Interventions of a type that could be performed by a paraprofessional may not be billed at a mental health professional rate unless the medical necessity for higher level staff is clearly documented.
H2015	U6	**Intervention, Mental Health Professional** Apply the above description. Additional information: H2015 plus modifier "U6" is for ages 21 and over.
H2015	U7	**Intervention, Mental Health Professional** Apply the above description. Additional information: H2015 plus modifier "U7" is for services provided via telemedicine only.
H2015	HA, U1	**SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)** **DEFINITION:** Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family. **DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:** 8 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14); Other Locations (99 **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of service • Start and stop times of actual encounter with beneficiary • Place of service (If 99 is used, specific location and rationale for

National Code	Required Modifier	Definition
		location must be included) • Diagnosis and pertinent interval history • Rationale for and intervention used that must coincide with the master treatment plan • Beneficiary's response to intervention that includes current progress or regression and prognosis • Plan for next intervention, including any homework assignments • Staff signature/credentials/date of signature(s) **NOTES and COMMENTS:** Billing for this service does not include time spent transporting the beneficiary to a required service, nor does it include time spent waiting while a beneficiary attends a scheduled or unscheduled appointment. Supervision by a Mental Health Professional must be documented and addressed in personnel files in accordance with the agency's policies, quality assurance procedures, personnel performance evaluations, reports of supervisors, or other equivalent documented method of supervision.
H2015	U2	**Intervention, Mental Health Paraprofessional** Apply the above description. Additional information: H2015 plus modifier "U2" is for ages 21 and over
H2017	HA, U1	**SERVICE: U21 Rehabilitative Day Service** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** No more than 16 units may be billed per day. **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 80 for ages up to 18; 120 for ages 18-20. **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Assisted Living Facility (13); Group Home (14)

National Code	Required Modifier	Definition
		MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS: 1:10 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. **AGE GROUP(S):** U21 **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Start and stop times of actual program participation by beneficiary • Date of service • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and interventions used that must coincide with the master treatment plan • Beneficiary's response to the intervention that includes current progress or lack of progress toward functional improvement and attainment of goals • Rationale for continued rehabilitative day service • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • a weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished **NOTES and COMMENTS:** Providers may bill for services only at times during which beneficiaries participate in program activities, Providers are expected to sign patients in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.
H2017	—	**SERVICE: Adult Rehabilitative Day Service** **DEFINITION:** An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness

National Code	Required Modifier	Definition
		and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan . **DAILY MAXIMUM UNITS THAT MAY BE BILLED:** 24 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 120 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); Assisted Living Facility (13); Group Home (14) **MAXIMUM PARAPROFESSIONAL STAFF to CLIENT RATIOS:** 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs. **AGE GROUP(S):** Ages 21 and over **DOCUMENTATION REQUIREMENTS (See Section 226.200 for additional requirements):** • Date of service • Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and interventions used that must coincide with the master treatment plan • Beneficiary's response to the intervention that includes current progress or lack of progress toward functional improvement and attainment of goals • Rationale for continued rehabilitative day service • Staff signature/credentials • Supervising staff signature/credentials/date of signature(s) • a weekly summary describing therapeutic activities provided and the beneficiary's progress or lack of progress in achieving the treatment goal(s) and established outcomes to be accomplished through participation in rehabilitative day service. **NOTES and COMMENTS:** Rehabilitative Day services do NOT include vocational services and training, academic education, personal care or home health services, purely recreational activities and may NOT be used to supplant services which may be obtained or are required to be provided by other means. Providers may bill for services only at times during which beneficiaries participate in program activities, Providers are expected to sign patients in and out of the program to provide medically necessary treatment therapies. However, in order to be claimed separately, these therapies must be identified on the Master Treatment Plan and serve a treatment purpose which cannot be accomplished within the day treatment setting.

252.200 Place of Service Codes 10-4-09

Electronic and paper claims now require the same national place of service codes.

Place of Service	POS Codes
Outpatient Hospital	22
Office (RSPMI Facility Service Site)	11
Patient's Home	12
Nursing Facility	32
Skilled Nursing Facility	31
School (Including Licensed Child Care Facility)	03
Homeless Shelter	04
Assisted Living Facility (Including Residential Care Facility)	13
Group Home	14
ICF/MR	54
Other Locations	99
RSPMI Clinic (Telemedicine)	99
Emergency Services in ER	23

252.430 Daily Service Billing Exclusions 10-4-09

RSPMI providers may not bill for the following services together on the same date of service:

National Codes and Modifiers	Service Titles
90885 -HA, U2 AND 90885 – HA or 90885 – HA, U1	Master treatment plan and Periodic Review of Master treatment plan
H2017-HA, U1 AND H2017	Adult Rehabilitative Day Service AND U21 Rehabilitative Day Service
90801 or 90801-HA, U1 AND 90885-HA, or 90885 HA, U1	Mental Health Evaluation/Diagnosis AND Periodic Review of Master treatment plan

National Codes and Modifiers	Service Titles
90862 or 90862-HA or 90862-HA,UB	Pharmacologic Management
AND	AND
90862-HA, HQ	Group Outpatient – Pharmacologic Management by a Physician
H2012 – HA or H2012 – UA	*Therapeutic Day/Acute Day
AND	AND
H2017	Adult Rehabilitative Day Service
H2012 – HA or H2012 – UA	*Therapeutic Day/Acute Day
AND	AND
H2017 – HA, U1	U21 Rehabilitative Day Service
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA;	Physical Examination
AND	AND
90862 or 90862-HA or 90862-HA,UB	Pharmacologic Management
99201-HA,UB; 99202-HA, UB; 99203-HA, UB; 99204-HA, UB; 99211-HA, UB; 99212 – HA, UB; 99213 – HA, UB; 99214–HA,UB; 99201-HA,SA; 99202-HA, SA; 99203-HA, SA; 99204-HA, SA; 99211-HA, SA; 99212 – HA, SA; 99213 – HA, SA; 99214 – HA, SA;	Physical Examination
AND	AND
90862-HA, HQ	Group Outpatient – Pharmacologic Management by a Physician

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Not Provided.
d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual. Revised methods did not affect rates. No services were added therefore there is not a fiscal impact.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- **SERVICE: Speech Evaluation**
  DEFINITION: Evaluation for Speech Therapy defined by applicable state and federal rules and regulations.

  This service must be performed by a professional as described in the Physical, Occupational, and Speech Therapy Program provider manual.

- **SERVICE: Mental Health Evaluation/Diagnosis**
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family.
Setting information could be summarized in the description if the State would like to include this information.

This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Psychological Evaluation**
  DEFINITION: A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional.

  This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Psychiatric Diagnostic Assessment**
  DEFINITION: A direct face-to-face service contact occurring between the physician and the beneficiary for the purpose of evaluation. Psychiatric Diagnostic Assessment includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for additional requirements.)

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a physician and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Master Treatment Plan**
  DEFINITION: A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician.

  This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary and is necessary for developing an array of rehabilitative treatment services according to goals and objectives for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Periodic Review of Master Treatment Plan**
  DEFINITION: The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary to ensure that the array of rehabilitative treatment services is producing the desired outcome according to goals and objectives and to determine if the maximum reduction of a mental disability restoration of the beneficiary to his or her best possible functional level is progressing.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Interpretation of Diagnosis**
  DEFINITION: A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician or licensed mental health professional to assist the beneficiary and his or her primary support persons in understanding what is necessary for developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Individual Psychotherapy**
  DEFINITION: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is not present**
  DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

  When all three conditions are taken together, it would be necessary to address marital/family dynamics and improve/strengthen the marital/family interactions and functioning in order o focus on the Medicaid eligible beneficiary's condition and how it can be improved.

  The reason for providing this service is to improve the integrity of the patient's support system and documentation must reflect how the therapy accomplishes that rather than becoming therapy for the caregiver in and of itself.

  The service may only be provided by a mental health professional practicing within the scope of their licensure.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is present DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.**

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.**

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant**
  Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist assistant and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **Group Outpatient – Speech Therapy, Speech Language Pathologist**
  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
  Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant

  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Group Outpatient – Group Psychotherapy**
  DEFINITION: Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Therapeutic Day/Acute Day Treatment**
  DEFINITION: This service includes the administration of individual, family/marital and group therapies, face to face interventions and supportive services and is designed to be more intensive in nature than rehabilitative day services.

  The providers are a combination of licensed professionals (psychologist, LCSW, LPC, LPE, RN, and paraprofessionals. Licensed professionals must supervise the milieu and a physician must provide oversight. Paraprofessionals must be supervised by a licensed professional.

  Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age,

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

These services must include constant staff supervision of beneficiaries and physician oversight.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Intervention**
  DEFINITION: Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Physical Examination – Psychiatrist or Physician**
  Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

DEFINITION: A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary.

This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)**
  Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner
  DEFINITION: Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Medication Administration by a Licensed Nurse**
  DEFINITION: Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Group Outpatient – Pharmacologic Management by a Physician**
  DEFINITION: Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Routine Venipuncture for Collection of Specimen**
  DEFINITION: The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Collateral Intervention, Mental Health Professional**
  DEFINITION: A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Collateral Intervention, Mental Health Paraprofessional**
  DEFINITION: A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Professional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)**
  DEFINITION: Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)**
  DEFINITION: Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Rehabilitative Day Service for Persons under Age 18**
  DEFINITION: An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **Rehabilitative Day Service for Persons Ages 18-20**
  Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
  Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- **SERVICE: Adult Rehabilitative Day Service**
  DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals who are mentally ill and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

  E. Pharmaceutical supervision and/or

  G. Health monitoring.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan .

This service also includes the administration of individual intervention services, individual therapy, group therapy and supportive services, but are designed to assist with beneficiary functioning on a day to day basis within the community.

The providers are licensed mental health professionals and paraprofessionals under their supervision.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

B. Provider Qualifications

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. The provider must be certified as an RSPMI provider by the Division of Behavioral Health Services. Providers not certified by the Division of Behavioral Health Services may not provide these services.

Providers for each specific RSPMI service, as detailed in the scope of the program section, must practice within the scope of their Arkansas licensure. Individuals providing RSPMI services must be:

1. Licensed in the State of Arkansas as a mental health professional as defined in the RSPMI provider manual;

2. Medical records librarian as defined in the RSPMI provider manual;

3. Licensed in the State of Arkansas as a Psychiatrist - The psychiatrist may provide oversight, medical care, or both. If the psychiatrist does not provide all medically necessary RSPMI medical care, then a medical doctor may provide medical care in addition to a psychiatrist;

4. Licensed Psychologist or Licensed Psychological Examiner

5. Licensed Physician or

6. Certified Mental Health Paraprofessional, under the direct supervision of a Licensed Mental Health Professional

See Section 213.000 of the RSPMI provider manual for additional provider qualifications.

Qualified professionals must be present to furnish all medically necessary RSPMI services, including all services in each patient's care plan.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Not Provided.
d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual. Revised methods did not affect rates. No services were added therefore there is not a fiscal impact.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- **SERVICE: Speech Evaluation**
  DEFINITION: Evaluation for Speech Therapy defined by applicable state and federal rules and regulations.

  This service must be performed by a professional as described in the Physical, Occupational, and Speech Therapy Program provider manual.

  SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family.

Setting information could be summarized in the description if the State would like to include this information.

This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

page 5d18. Please refer to Provider Qualifications on page 5d19.

- **SERVICE: Psychological Evaluation**
  DEFINITION: A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional.

  This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  page 5d18. Please refer to Provider Qualifications on page 5d19.

- **SERVICE: Psychiatric Diagnostic Assessment**
  DEFINITION: A direct face-to-face service contact occurring between the physician and the beneficiary for the purpose of evaluation. Psychiatric Diagnostic Assessment includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for additional requirements.)

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a physician and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Master Treatment Plan**
  DEFINITION: A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician.

  This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary and is necessary for developing an array of rehabilitative treatment services according to goals and objectives for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Periodic Review of Master Treatment Plan**
  DEFINITION: The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary to ensure that the array of rehabilitative treatment services is producing the desired outcome according to goals and objectives and to determine if the maximum reduction of a mental disability restoration of the beneficiary to his or her best possible functional level is progressing.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Interpretation of Diagnosis**
  DEFINITION: A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician or licensed mental health professional to assist the beneficiary and his or her primary support persons in understanding what is necessary for developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Individual Psychotherapy**
  DEFINITION: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is not present**
DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

When all three conditions are taken together, it would be necessary to address marital/family dynamics and improve/strengthen the marital/family interactions and functioning in order o focus on the Medicaid eligible beneficiary's condition and how it can be improved.

The reason for providing this service is to improve the integrity of the patient's support system and documentation must reflect how the therapy accomplishes that rather than becoming therapy for the caregiver in and of itself.

The service may only be provided by a mental health professional practicing within the scope of their licensure.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is present**
DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist**
Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant**
  Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist assistant and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **Group Outpatient – Speech Therapy, Speech Language Pathologist**
  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
  Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant

  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Group Outpatient – Group Psychotherapy**
  DEFINITION: Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Therapeutic Day/Acute Day Treatment**
  DEFINITION: This service includes the administration of individual, family/marital and group therapies, face to face interventions and supportive services and is designed to be more intensive in nature than rehabilitative day services.

  The providers are a combination of licensed professionals (psychologist, LCSW, LPC, LPE, RN, and paraprofessionals. Licensed professionals must supervise the milieu and a physician must provide oversight. Paraprofessionals must be supervised by a licensed professional.

  Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age,

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

These services must include constant staff supervision of beneficiaries and physician oversight.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Intervention**
  DEFINITION: Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Physical Examination – Psychiatrist or Physician**
  Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

DEFINITION: A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary.

This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)**
  Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner
  DEFINITION: Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Medication Administration by a Licensed Nurse**
  DEFINITION: Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Group Outpatient – Pharmacologic Management by a Physician**
  DEFINITION: Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Routine Venipuncture for Collection of Specimen**
  DEFINITION: The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Collateral Intervention, Mental Health Professional**
  DEFINITION: A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Collateral Intervention, Mental Health Paraprofessional**
  DEFINITION: A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Professional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. ***This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.***

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)**
  DEFINITION: Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)**
  DEFINITION: Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Rehabilitative Day Service for Persons under Age 18**
  DEFINITION: An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **Rehabilitative Day Service for Persons Ages 18-20**
  Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
  Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- **SERVICE: Adult Rehabilitative Day Service**
  DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals who are mentally ill and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

  E. Pharmaceutical supervision and/or

  G. Health monitoring.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan .

This service also includes the administration of individual intervention services, individual therapy, group therapy and supportive services, but are designed to assist with beneficiary functioning on a day to day basis within the community.

The providers are licensed mental health professionals and paraprofessionals under their supervision.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

B. Provider Qualifications

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. **The provider must be certified as an RSPMI provider by the Division of Behavioral Health Services. Providers not certified by the Division of Behavioral Health Services may not provide these services.**

Providers for each specific RSPMI service are licensed by the State and must practice within the scope of Arkansas licensure. Individuals providing RSPMI services must be:

1. Licensed in the State of Arkansas as a mental health professional.;

2. Medical records librarian;

3. Licensed in the State of Arkansas as a Psychiatrist - The psychiatrist may provide oversight, medical care, or both. If the psychiatrist does not provide all medically necessary RSPMI medical care, then a medical doctor may provide medical care in addition to a psychiatrist;

4. Licensed Psychologist or Licensed Psychological Examiner

5. Licensed Physician or

6. Certified Mental Health Paraprofessional, under the direct supervision of a Licensed Mental Health Professional

Qualified professionals must be present to furnish all medically necessary RSPMI services, including all services in each patient's care plan

Coverage authority for these mental health rehabilitative services expires on September 1, 2010.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Negotiated statewide contract bid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Not provided.
e. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness **(RSPMI)**

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. **Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, 1988 and are effective for services provided on or after that date. All rates are published on the agency's website at www.medicaid.state.ar.us.**

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments **at the RSPMI fee schedule rates** and a year-end cost settlement. **The provider will be paid the** lesser of **actual** costs **identified using a CMS approved cost report** or customary charges. **Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, may result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.**

Medical professionals affiliated with **Arkansas State Operated Teaching Hospitals** are not eligible for additional reimbursement for services provided in these clinics.

Reimbursement authority for these mental health services expires on September 1, 2010.