ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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

DATE: **April 1, 2012**

SUBJECT: **Provider Manual Update Transmittal RSPMI-2-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
224.201	3-10-12	224.201	4-1-12
224.202	3-10-12	224.202	4-1-12
252.110	3-10-12	252.110	4-1-12

Explanation of Updates

Section 224.201 is updated to include Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner as a provider option for an Initial Psychiatric Diagnostic Assessment.

Section 224.202 is updated to include Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner as a provider option for a Continuing Care Psychiatric Diagnostic Assessment.

Section 252.110 is updated to include Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner as a provider option for Outpatient Procedure Code T1023 (HA, U1) for Psychiatric Diagnostic Assessment – Initial and Outpatient Procedure Code T1023 (HA, U2) for Psychiatric Diagnostic Assessment – Continuing Care.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

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Andrew Allison, PhD
Director

TOC not required

224.201 Psychiatric Diagnostic Assessment – Initial 4-1-12

The purpose of this service is to determine the existence, type, nature and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9. This face-to-face psychodiagnostic assessment must be conducted by one of the following:

- an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18)
- an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)

The PMHNP-BC must meet all of the following requirements:

- Licensed by the Arkansas State Board of Nursing
- Practicing with licensure through the American Nurses Credentialing Center
- Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the PMHNP-BC has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment – Initial conducted by the PMHNP-BC must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat.
- Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act
- Practicing within a PMHNP-BC's experience and competency level

The initial Psychiatric Diagnostic Assessment must include:

A. An interview with the beneficiary, which covers the areas outlined below. The initial Psychiatric Diagnostic Assessment may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

1. The beneficiary's understanding of the factors leading to the referral
2. The presenting problem (including symptoms and functional impairments)
3. Relevant life circumstances and psychological factors
4. History of problems
5. Treatment history
6. Response to prior treatment interventions
7. Medical history (and examination as indicated)

B. The initial Psychiatric Diagnostic Assessment must include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete multi-axial (5) diagnosis

C. For beneficiaries under the age of 18, the initial Psychiatric Diagnostic Assessment must also include an interview of a parent (preferably both), the guardian (including the

responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the reason for referral
2. Clarify the nature of the current symptoms and functional impairments
3. To obtain a detailed medical, family and developmental history

The initial Psychiatric Diagnostic Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the assessment and treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The initial Psychiatric Diagnostic Assessment can only be provided at the start of an episode of care.

224.202 Psychiatric Diagnostic Assessment – Continuing Care 4-1-12

The purpose of this service is to determine the continuing existence, type, nature and most appropriate treatment of a mental illness or emotional disorder as defined by DSM-IV or ICD-9CM. This face-to-face psychodiagnostic reassessment must be conducted by one of the following:

- an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18)
- an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)

The PMHNP-BC must meet all of the following requirements:

- Licensed by the Arkansas State Board of Nursing
- Practicing with licensure through the American Nurses Credentialing Center
- Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the PMHNP-BC has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment – Continuing Care conducted by the PMHNP-BC must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat.
- Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act
- Practicing within a PMHNP-BC's experience and competency level

The continuing care Psychiatric Diagnostic Assessment must include:

A. An interview with the beneficiary, which covers the areas outlined below. The continuing care Psychiatric Diagnostic Assessment may build on information obtained through other assessments reviewed by the physician or the PMHNP-BC and verified through the physician's or the PMHNP-BC's interview. The interview should obtain or verify all of the following:

   1. Psychiatric assessment (including current symptoms and functional impairments)
   2. Medications and responses
   3. Response to current treatment interventions
   4. Medical history (and examination, as indicated)

B. The continuing care Psychiatric Diagnostic Assessment must also include:

1. A mental status evaluation (a developmental mental status evaluation for beneficiaries under age 18)
2. A complete multi-axial (5) diagnosis

C. For beneficiaries under the age of 18, the continuing care Psychiatric Diagnostic Assessment must include an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:

1. Clarify the reason for referral
2. Clarify the nature of the current symptoms and functional impairments
3. Obtain a detailed, updated medical, family and developmental history

The continuing care Psychiatric Diagnostic Assessment must contain sufficient detailed information to substantiate all diagnoses specified in the continuing care assessment and updated treatment plan, all functional impairments listed on SED or SMI certifications and all problems or needs to be addressed on the treatment plan. The continuing care Psychiatric Diagnostic Assessment must be performed every 12 months during an episode of care.

252.110 Outpatient Procedure Codes 4-1-12

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, U1	**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

National Code	Required Modifier	Definition
		• 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), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions to include all five axes • 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	U7	**Mental Health Evaluation/Diagnosis***:* Use the above definition and requirements. Additional information: Use code 90801 with modifier "U7" to claim for services 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

National Code	Required Modifier	Definition
		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 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

National Code	Required Modifier	Definition
		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: Psychiatric Diagnostic Assessment – Initial (Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care)** **DEFINITION:** A direct face-to-face service contact occurring between the physician or the Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC) and the beneficiary for the purpose of evaluation. The initial 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 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:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS:** • Date of Service • Start and stop times • Place of service • Diagnosis (all 5 Axes) • Diagnostic Impression • Psychiatric (re)assessment • Functional (re)assessment • Discharge criteria • Physician's or Adult Psychiatric Mental Health Advanced Nurse Practitioner's/Family Psychiatric Mental Health Advanced Nurse Practitioner's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** The initial Psychiatric Diagnostic Assessment can only be provided to a beneficiary at the start of an episode of care.

National Code	Required Modifier	Definition
T1023	U7	**SERVICE: Psychiatric Diagnostic Assessment** – Initial **(Note that code T1023-HA,U1 was formerly applied to Assessment and Treatment Plan/Plan of Care):** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
T1023	HA, U2	**SERVICE: Psychiatric Diagnostic Assessment - Continuing Care** **DEFINITION:** A direct face-to-face service contact occurring between the physician or the Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC) and the beneficiary during an episode of care for the purpose of evaluation. The continuing care Psychiatric Diagnostic Assessment includes a Psychiatric assessment, mental status examination, functional assessment, medications, 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 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:** 1 **ALLOWABLE PLACES OF SERVICE:** Office (11); Beneficiary's Home (12); School (03); Homeless Shelter (04); Assisted Living Facility (13); Group Home (14) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS:** • Date of Service • Start and stop times • Place of service • Diagnosis (all 5 Axes) • Psychiatric assessment • Functional assessment • Mental Status Examination • Medications • Discharge criteria • Physician's or Adult Psychiatric Mental Health Advanced Nurse Practitioner's/Family Psychiatric Mental Health Advanced Nurse Practitioner's signature indicating medical necessity/credentials/date of signature **NOTES and COMMENTS:** The continuing care Psychiatric Diagnostic Assessment must be performed, at a minimum, at

National Code	Required Modifier	Definition
		least every 12 months during an episode of care.
T1023	U7, U1	**SERVICE: Psychiatric Diagnostic Assessment – Continuing Care:** Use the above definition and requirements. Additional Information: Use code T1023 with modifier "U7, U1" to claim for services provided via telemedicine only. **NOTE:** Telemedicine POS 99
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 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

National Code	Required Modifier	Definition
		• 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:** The service formerly coded as T1023 and titled "Assessment and Treatment Plan/Plan of Care" is now incorporated into this service. 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

National Code	Required Modifier	Definition
		additional requirements): Completed by the primary MHP (If not, then must have a rationale for another MHP completing the documentation and only with input 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: Use code 90885 with modifier “U1” to claim for this service when provided by a non-physician.
90887	HA, U2	**SERVICE: Interpretation of Diagnosis**

National Code	Required Modifier	Definition
		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 (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): • 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, U7	**Interpretation of Diagnosis** Use above definition and requirements Additional information: Use code 90887 with modifier “U3, U7” to claim for services provided via telemedicine only. Note: Telemedicine POS 99
H0004	HA	**SERVICE: Individual Psychotherapy** **DEFINITION**: Face-to-face treatment provided by a licensed

National Code	Required Modifier	Definition
		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. **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) **AGE GROUP(S):** U21, but not for beneficiaries under the age of 3 except in documented exceptional cases **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 definition and requirements. Additional information: Use code H0004 with no modifier to claim

National Code	Required Modifier	Definition
		for services provided to beneficiaries ages 21 and over.
H0004	U7	**Individual Psychotherapy** Use above definition and requirements. Additional information: Use code H0004 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
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) **AGE GROUP(S):** 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

National Code	Required Modifier	Definition
		• 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 definition and requirements. Additional information: Use code 90846 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90846	U7	**Marital/Family Psychotherapy – Beneficiary is not present** Use the above definition and requirements. Additional information: Use code 90846 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
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 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) **AGE GROUP(S):** U21

National Code	Required Modifier	Definition
		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: Use code 90847 with modifiers “HA, U3” to claim for services provided to beneficiaries under age 21.
90847	—	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90847	U7	**Marital/Family Psychotherapy – Beneficiary is present** Use the above definition and requirements. Additional information: Use code 90847 with modifier “U7” to claim for services provided via telemedicine only. Telemedicine POS 99
92507	HA	**Individual Outpatient – Speech Therapy, Speech Language Pathologist** Scheduled individual outpatient care provided by a licensed

National Code	Required Modifier	Definition
		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 4 – 20; Under age 4 by prior authorized medically needy exception **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements): • Date of Service

National Code	Required Modifier	Definition
		• 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 18 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 18 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 definition and requirements. Additional information: Use code 90853 with no modifier to claim for services provided to beneficiaries 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

National Code	Required Modifier	Definition
		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, 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 18 and over; 1:4 for U18 **AGE GROUP(S):** 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) and plans to transition to less restrictive services • 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 beneficiaries 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.

National Code	Required Modifier	Definition
H2012	UA	**Therapeutic Day/Acute Day Treatment** Apply the above definition and requirements. Additional Information: Use code H2012 with modifier "UA" to claim for services provided to beneficiaries ages 21 and over. See Section 219.110 for additional information.
H2011	HA	**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 **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); 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

National Code	Required Modifier	Definition
		• 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	U7	**Crisis Intervention** Apply the above definition and requirements. Additional information: Use code H2011 plus modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
Physician:		**SERVICE: Physical Examination – Psychiatrist or Physician**
99201 99202 99203 99204 99212 99213 99214	HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB HA, UB	**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
PCNS & PANP:		**YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:** 12
99201 99202 99203 99204 99212 99213 99214	HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA HA, SA	**ALLOWABLE PLACES OF SERVICE:** Office (11) **AGE GROUP(S):** Ages 21 and over; U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for 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

National Code	Required Modifier	Definition
		• ICD-9 diagnoses • DSM diagnostic impressions to include all five axes • 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); Nursing Facility (32); Skilled Nursing Facility (31); ICF/MR (54) **AGE GROUP(S):** 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

National Code	Required Modifier	Definition
		locations of the beneficiary and the physician 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 within 24 hours of the prescription being written • 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 the above definition and requirements. Additional information: Use code 90862 with no modifier to claim for services provided to beneficiaries ages 21 and over.
90862	U7	**Pharmacologic Management by Physician** Apply the above definition and requirements. Additional information: Use code 90862 with modifier “U7” to claim for services provided via telemedicine only. Note: Telemedicine POS 99
90862	HA, UB	**Pharmacologic Management by Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner** Apply the above definition and requirements.
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)

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 • Time of the specific procedure • Place of service • Physician's order must be included in medication log • 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

National Code	Required Modifier	Definition
		• 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) • 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 • Time of the specific procedure • Place of service (If 99 is used, specific location and rationale for location must be included) • 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**

National Code	Required Modifier	Definition
		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. **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) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives • 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.

National Code	Required Modifier	Definition
		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	U7	**Collateral Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code 90887 with modifier "U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
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-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) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Information gained from collateral contact and how it relates to master treatment plan objectives

National Code	Required Modifier	Definition
		• 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 for consideration • 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. **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):** 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

National Code	Required Modifier	Definition
		• 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 definition and requirements. Additional information: Use code H2011 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over.
H2011	U2, U7	**Crisis Stabilization Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2011 with modifier "U2, U7" to claim for services provided via telemedicine only. Note: Telemedicine POS 99
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):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for additional requirements):

National Code	Required Modifier	Definition
		• 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 • 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 above definition and requirements. Additional information: Use code H2011 with modifier "U1" to claim for services provided to beneficiaries 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

National Code	Required Modifier	Definition
		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):** U21 **DOCUMENTATION REQUIREMENTS** (See Section 226.200 for 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) • Client diagnosis necessitating intervention • Brief mental status and observations • Document how interventions used address goals and objectives from the master treatment plan • 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 definition and requirements. Additional information: Use code H2015 with modifier “U6” to claim for services provided to beneficiaries ages 21 and over.
H2015	U7	**Intervention, Mental Health Professional** Apply the above definition and requirements. Additional information: Use code H2015 with modifier “U7” to claim for services provided via telemedicine only. Note: Telemedicine POS 99
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

National Code	Required Modifier	Definition
		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):** 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 location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from 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 definition and requirements. Additional information: Use code H2015 with modifier "U2" to claim for services provided to beneficiaries ages 21 and over
H2017	HA, U1	**SERVICE: Rehabilitative Day Service for Persons under Age 18** **DEFINITION:** An array of face-to-face interventions providing a

National Code	Required Modifier	Definition
		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:** 16 for ages 0-17 **WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED:** 80 for ages 0-17 **PRIOR AUTHORIZATION REQUIRED** **ALLOWABLE PLACES OF SERVICE:** Office (11); School (03); Assisted Living Facility (13); Group Home (14); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the beneficiary's treatment plan). **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):** U18 **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 • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and

National Code	Required Modifier	Definition
		objectives from the master treatment plan • Beneficiary's participation and response to the intervention • 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 beneficiaries 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	—	**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. DAILY MAXIMUM UNITS THAT MAY BE BILLED: 24 WEEKLY MAXIMUM OF UNITS THAT MAY BE BILLED: 120 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.
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

National Code	Required Modifier	Definition
		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 . **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); Other Locations (99) (churches, community centers, space donated solely for clinical services, and appropriate community locations tied to the beneficiary's treatment plan). **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 • Client diagnosis necessitating intervention • Behavioral observations • Document how interventions used address goals and objectives from the master treatment plan • Beneficiary's participation and response to the intervention • 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 beneficiaries in and out of the program to provide medically necessary treatment therapies. However, in order to be

National Code	Required Modifier	Definition
		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.

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 **or Advanced Practice Nurse** 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.)

*This service must be performed by a physician **or Advanced Practice Nurse** 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.

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

d. Rehabilitative Services (continued)

An APN performing the Psychiatric Diagnostic Assessment MUST meet the following:

1. ***Licensed by the Arkansas State Board of Nursing***
2. ***Practicing with licensure through the American Nurses Credentialing Center***
3. ***Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the Advanced Practice Nurse has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment conducted by the Advanced Practice Nurse must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may do it to.***
4. ***Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act***
5. ***Practicing within an Advanced Practice Nurse's experience and competency level***

- 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

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 5d18.

- 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 5d18.

- SERVICE: Psychiatric Diagnostic Assessment
DEFINITION: A direct face-to-face service contact occurring between the physician **or Advanced Practice Nurse** 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.)

  *This service must be performed by a physician **or Advanced Practice Nurse** 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.

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

d. Rehabilitative Services (continued)

An APN performing the Psychiatric Diagnostic Assessment MUST meet the following:

4. ***Licensed by the Arkansas State Board of Nursing***
5. ***Practicing with licensure through the American Nurses Credentialing Center***
6. ***Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the Advanced Practice Nurse has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment conducted by the Advanced Practice Nurse must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may do it to.***
6. ***Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act***
7. ***Practicing within an Advanced Practice Nurse's experience and competency level***

- 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