

Medicaid Community Behavioral Health Services

For

Substance Abuse and Co-occurring Disorders

April 2009

Overview

- Purpose of the Program and Definitions
- Provider Enrollment and Staff Qualifications
- Program Billing Requirements
- Service Exclusions and Limitations
- Reimbursement, Procedure Codes and Fees
- Medical Record and Documentation Requirements
- Service Categories and Services
- Questions and Answers

Community Behavioral Health Services Purpose and Definitions

What are CBH Services?

- Outpatient mental health and substance abuse services provided to individuals with mental health, substance abuse and co-occurring disorders.
- Services designed to achieve maximum reduction of a disability and restoration of best possible functional level.
- Services which are medically necessary, recommended by a licensed practitioner and prescribed in an individualized treatment plan.

What is Medically Necessity?

Medically necessary services are:

- Necessary to protect life, prevent significant illness or disability, or alleviate pain;
- Individualized and specific to symptoms or diagnosis under treatment, not provided in excess of need;
- Consistent with accepted medical practice, safely furnished, not investigational or experimental;
- Most conservative and cost effective; and,
- Not primarily for the convenience of the provider.

Additional Definitions

- Other responsible persons – relative, guardian or caretaker, or for services provided in schools, teacher or guidance counselor.
- Institutions for Mental Disease (IMD) are hospitals or other institutions of more than 16 beds primarily engaged in treatment or care to persons with behavioral diseases.
- Licensed Practitioner of the Healing Arts - Florida licensed psychiatrist, physician, ARNP, PA, psychiatric nurse, RN, clinical social worker, mental health counselor, marriage and family therapist or psychologist.

Definitions - continued

- Treating Practitioner – a licensed practitioner of the healing arts that authorizes Medicaid services.
- Treatment Team – all staff involved in planning and providing services to the recipient.
- Interventions – strategies or approaches used by the provider to prevent undesirable outcomes, promote desirable outcomes, or alter existing undesirable conditions. Documentation should include a brief description of the strategy or approach and the recipient's response.

Provider Requirements and Staff Qualifications

How to Become a Provider

Enroll with Electronic Data Systems, the current Medicaid fiscal agent. A provider must:

- Have a regular license as defined by Chapter 397, Florida Statutes.
- Employ or contract with a Medicaid enrolled psychiatrist or physician.
- Complete a Medicaid Provider Enrollment Application; and
- Achieve compliance with the Pre-Enrollment Certification Review.

Provider Requirements

Enrolled providers must agree to:

- Comply with the Florida Medicaid Provider General and Reimbursement Handbooks, the Health Insurance Portability and Accountability Act (HIPAA), and the Medicaid Provider Enrollment Application.
- Submit a Medicaid enrollment application and under-go a pre-enrollment review for each Medicaid area in which programs are operated.
- Obtain a site locator code for distinct service sites within each Medicaid area.
- Make records available for compliance and quality of care reviews by AHCA or its agent.

Staff Qualifications

Service providers may include Substance Abuse and Behavioral Health Technician, Substance Abuse Counselor, Bachelor's and Master's level Practitioner, Certified Addictions Professional, Bachelor's and Master's level CAP, Certified Behavior Analyst, and medical professionals with education or experience in human services.

- Services must be provided within the scope of the provider's professional licensure, protocols, training, competence and applicable statutes.
- Staff must at least meet minimum education and training standards as outlined, by service, in the policy handbook.

Program Billing Requirements

Billing Requirements

Prior to rendering service, the recipient must be informed of the responsibility for payment. The agreement should be clearly documented in the medical record.

A provider who agrees to bill Medicaid:

- must bill correctly and in a timely manner;
- except for co-pays, must consider the Medicaid reimbursement as payment in full;
- may not bill the recipient, relatives or any designee; and
- may not apply money from any state source to a claim paid by Medicaid;

Billing Requirements - continued

Providers may not bill for services:

- provided by unpaid interns or volunteers;
- free of charge to non-Medicaid recipients;
- when an appointment is missed; or,
- other than those noted in the services section, which are not provided face-to-face.

Billing - continued

If a recipient has insurance coverage, the provider must bill and exhaust the third party (TPL) before billing Medicaid.

- To bill Medicare crossover and TPL claims, an agency must have two Medicaid “provider type” group numbers, a Medicaid agency number to bill CBH codes and a physician group number to bill TPL and Medicare CPT codes.
- Since Medicare and most TPL carriers do not have CBH programs, billing must be made under the type of the practitioner’s group provider number and the claim will crossover to the applicable Medicaid CPT code to pay the difference.

Billing - continued

The recipient can be billed for services if:

- the service is not covered by Medicaid;
- the recipient has been advised in advance that the provider does not accept Medicaid for a specific service and the recipient has agreed to pay;
- the recipient is not Medicaid eligible on the date of service;
or,
- the recipient has exceeded the coverage limit and has agreed in advance to pay.

Billing - continued

Co-pays for Community Behavioral Health services are a \$2.00 fee per service established by Medicaid that the recipient owes to a provider for all non-emergency services.

- Co-pays are not required for children under 21 years of age.
- Service cannot be denied due solely to the inability of the recipient to pay the co-pay amount.
- The recipient may be billed for an unpaid co-pay.

Billing - continued

Certain exceptions to Medicaid as payer of last resort* include:

- Federal funds from IDEA, Part B or C;
- Victim's compensation;
- Some programs funded through state and county funds, such as indigent drug programs via DOH, vocational rehabilitation programs, etc.

Reimbursement, Codes and Fees

- Reimbursement is available for services provided by individuals employed, under contract, or compensated monetarily by the agency.
- Services are billed under the authorization of the agency's (group's) and the treating practitioner's Medicaid numbers regardless of who actually renders the service.
- Services are authorized for a range of diagnoses, 290 through 315.9, as included in the International Classification of Diseases-9th Revision-Clinical Modification (ICD-9-CM). Consult the handbook (p. 2-1-1) for specific exceptions.

Reimbursement, Procedure Codes and Fees

Each service has a unique alpha numeric procedure code. Bill each service using the appropriate code and modifier.

- Services with the same title may have separate codes depending on the problem and diagnosis for which the service is provided.
- Certain services may be provided by different levels of practitioner.
- Services/procedures may only be reimbursed once a day.

Reimbursement – cont.

Reimbursement is by unit of service or for a distinct service event.

- A unit is 15 minutes. For services billed in units, units are totaled by day by service. One entry is made per service per day on the claim form. For multiple units of the same service on the same day, total the actual minutes and round up to the nearest 15 minute increment.
- “If the minutes total end in a seven or less, round down to the nearest 15 minute increment. If the minutes total ends in 8 or more, round up to the nearest 15 minute increment. For example, 37 minutes is billed as two units; 38 minutes is billed as three units.”

Reimbursement - continued

- Do not round up each service episode to the nearest 15 minute increment before totaling the units per day per service.
- An event is a distinct service paid at an established fee. These include medication management, behavioral health services – verbal and specimen, limited functional assessment, treatment plan, psychiatric evaluation, review of records, etc.

Service Exclusions and Limitations

Service Exclusions

Payment is not available for:

- Services not specified in the handbook, such as case management or partial hospitalization;
- Services to recipients in institutions;
- Administrative functions such as determining eligibility, staff training, record keeping, etc;
- Services paid by another funding source;
- Travel time or simply escorting a recipient to a service; and
- Unless otherwise specified, services not provided face to face.

Exclusions - continued

- Services to persons in nursing homes unless pursuant to a referral from the facility. Methadone, psychosocial rehab, behavioral health screening, and behavioral health services day services, and clubhouse are not covered in NFs.
- Services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation are not covered.
- Services for persons with OBS, dementia, delirium, or other neurological conditions are not covered if the deficit is severe enough to prevent benefit.

Service Limitations

Service limitations are defined as an established number of units or events, and are tabulated per recipient per state fiscal year.

Limitations in quantity of service are unique by service.

The only exception to the per recipient per state fiscal year rule is the Treatment Plan Development service. This service is reimbursable once per provider per state fiscal year, not to exceed a total of two per state fiscal year.

Medical Record and Documentation Requirements

Medical Record Requirements

The recipient medical record must contain:

- An evaluation or assessment of the recipient, conducted by a licensed practitioner, to be used for diagnostic and treatment planning purposes;
- Relevant assessments, reports and tests;
- Documentation of specific service eligibility, as applicable;

Record Requirements - continued

- Current treatment plan, reviews, and addenda;
- Copies of all certification forms, as appropriate;
- Physician's orders and results of diagnostic and laboratory tests, and medication assessment, prescription and management; and,
- Clear documentation (service notes) to identify and support each service billed.

General Documentation Requirements

Written documentation must be maintained to support each service for which payment is made. Each service note must include:

- Recipient's name;
- Date the service was provided;
- Setting for the service;
- Identification of the specific Medicaid service provided, including the intervention;

Documentation Requirements

-continued-

- Actual start and end time of the service, unless the service is billed as an event.
- Identification of the problem, behavior or skill deficit for which the service is provided;
- Updates on the progress, or lack of progress, toward meeting the goals and objectives on the treatment plan; and,
- The original, legible signature and credential or functional title of the person delivering the service.

Documentation - continued

- Avoid the sole use of checklists – any checklist should be accompanied by some narrative note.
- Follow policy as it is written in the handbook or written policy updates. Be wary of verbal interpretations.

Medicaid
Community Behavioral Health
Service Categories

Service Requirements

Prior to the authorization of services, an assessment must be performed (mental status, functional capacity, recipient strengths and service needs) by a licensed practitioner to gather data to formulate a diagnosis and develop an individualized treatment plan.

A Medicaid enrolled treating licensed practitioner must authorize services by reviewing, agreeing to or modifying, and signing an individualized treatment plan.

CBH Service Categories

Major categories of service include:

- Assessment
- Treatment Plan Development and Modification
- Medical and Psychiatric
- Behavioral Health Therapy
- Community Support and Rehabilitation
- Therapeutic Behavioral On-Site for Children and Adolescents

Assessment Services

Medicaid will pay for the following services:

- Psychiatric Evaluation
- Brief Behavioral Health Status Exam
- Psychiatric Review of Records
- In-Depth Assessment
- Bio-psychosocial Evaluation
- Psychological Testing
- Limited Functional Assessment

Psychiatric Evaluation

A comprehensive clinical status and history concluding with finding, diagnostic formulation, and recommendations for treatment.

- Should be conducted at the onset of illness or when the recipient first presents for treatment.
- May be used again if an extended hiatus occurs, a marked change in mental status or admission or readmission to inpatient setting is considered or occurs.
- Not considered necessary when recipient has established diagnosis of organic brain disorder unless a change in mental status has occurred requiring evaluation to rule out treatable psychiatric or neurological conditions.

Brief Behavioral Health Status Exam

A brief clinical psychiatric diagnostic or evaluative interview to assess behavioral stability or treatment status.

- Must be provided by a licensed practitioner or master's level certified addictions professional.
- Documentation may be a report or progress note, and must include the purpose of the exam, setting, mental status of the recipient, findings, and plan.

Psychiatric Review of Records

The review of recipient records, psychiatric reports, psychometric or projective tests, clinical and psychological evaluation data for use in evaluating and planning for care.

- May be documented by report or progress note* by the individual performing the service and it must be included in the recipient record.
- Does not include review of the agency's own records except for psychological testing and other evaluative data used explicitly to address documented diagnostic questions.
- Must be performed by a psychiatrist, physician, or psychiatric ARNP.

In-Depth Assessment

A diagnostic tool to gather information to establish or support a diagnosis, provide the basis for treatment planning or modification, and development of discharge criteria.

- Criteria for recipient eligibility include:
 - proven need for services more intensive than outpatient;
 - high risk (step down from or denied admission to inpatient);
 - failed to progress after 6 months of treatment;
 - identified by Medicaid as high use or high users; and,
 - infants <6 exhibiting symptoms and development atypical for the age.

In-depth Assessment - continued

- Mandatory assessment components, as applicable, include:
 - complaint, desired services and goals from recipient's perspective;
 - personal, legal, educational history, resources and strengths;
 - prior and present psychiatric treatment and psychotropic medications;
 - inpatient, substance use, medical, counseling and therapy; and,
 - current behavioral and mental status.

In-depth Assessment – cont.

- Must include an integrative summary to evaluate, integrate and interpret the history and assessment information; identify and prioritize the recipient's service needs; establish a diagnosis; evaluate effectiveness of past interventions; and, help establish discharge criteria.
- Assessment and summary must be provided by a master's level practitioner.

Bio-Psychosocial Evaluation

An evaluation describing the biological, psychological and social factors which may have led to the recipient's need for service.

- Must include a brief mental status exam and preliminary service recommendations.
- Must be provided at a minimum by a bachelor's level practitioner or certified addictions professional.
- Must be reviewed by a master's level practitioner or bachelor's level CAP prior to completion of the treatment planning process, and include clinical impressions, a provisional diagnosis, and a statement of concurrence with or alternative recommendations for treatment.

Psychological Testing

The assessment evaluation and diagnosis of mental status or psychological conditions by standardized testing methods.

- Testing is available at onset of illness or when the recipient first presents for treatment; if an extended hiatus, marked change in status, or consideration of inpatient occurs; to clarify a diagnosis; or to gather data to evaluate or redirect treatment.
- Provider must be operating within the scope of licensure, competence, training and applicable statutes.
- A written report by the provider of the evaluation and results must be in the record.

Limited Functional Assessment

Administration of the Multnomah Community Ability Scale (MCAS), Functional Assessment Rating Scale (FARS), or the Children's Functional Assessment Rating Scale (CRARS) or any other functional assessment required by DCF*.

- Assessment must be provided by an individual authorized by DCFC to administer the assessment.
- A copy of the assessment must be placed in the medical record.
- Does not require authorization by the treatment plan.
- Limited to three per year.

Treatment Plan Development and Modification Services

Treatment Plan Development – An individualized, goal driven schedule of services designed by the recipient and treatment team and based on an assessment by a licensed practitioner completed within the past six months.

Treatment Plan Review – A process in which the treatment team and recipient assess the recipients need to continue service and, if so, whether the goals, objectives and services remain appropriate.

Treatment Plan Components

Mandatory components include:

- An ICD-9 diagnosis consistent with the assessment(s);
- Goals appropriate to the recipient;
- Measurable objectives and target dates;
- A list of services to be provided;
- The amount, frequency and duration of each service;
- Signature of the recipient, parent, custodian or legal guardian;
- A signed and dated statement by the treating practitioner of medical necessity and service appropriateness; and,
- Transition or discontinuation of services.

Treatment Planning – cont.

- Medicaid will pay for services provided 45 days prior to the date the plan is signed and dated by the treating practitioner.
- An addendum may be used to make changes to the plan. It becomes part of the plan and must be signed and dated by the recipient and treating practitioner.
- Limited Service Authorization Form - Used to report any temporary increase in service must be reported and may also be used to document services provided to a recipient who leaves treatment before completion of the treatment plan. Depending on use, it must be completed within 14 days of the service increase or 45 days of intake (first service), and retained in the recipient's record.

Treatment Plan Review

Changes to the treatment plan, or lack of, must be based upon a treatment plan review and documented in the record.

- The review process, discussions, findings, conclusions, and recommendations must be documented in the record.
- The plan must be reviewed at least every six months and may be reviewed more often if significant changes occur.
- The review must be signed, dated and credentialed by the treating practitioner and the recipient. If the recipient is unable (age or condition) to participate in the review, document the reason for lack of participation.

Medical and Psychiatric Services

- Medication Management
- Brief Individual Medical Psychotherapy
- Group Medical Therapy
- Behavioral Health Screening Services
- Behavioral Health Services
- Methadone/Buprenorphine Administration

Medication Management

The review of relevant laboratory tests, prior pharmacy interventions (dosages, blood levels, course of treatment), current use, and the discussion of indications and contraindications, risks and management strategies with the recipient or significant others.

- Record documentation must include the results of the assessment, findings and plan.
- Must be provided by a psychiatrist, physician, physician assistant (PA) or psychiatric advanced registered nurse practitioner (ARNP).

Brief Individual Medical Psychotherapy

Insight oriented, cognitive behavioral or supportive therapy designed to reduce maladaptive behaviors, maximize self control, or restore normalized functioning, more appropriate interpersonal skills and social relationships.

- “Results of the assessment, findings, and plan” must be included in the recipient record.
- Must be provided by a psychiatrist, physician, physician assistant or psychiatric ARNP.

Group Medical Therapy

A treatment activity designed to reduce maladaptive behaviors; maximize self control; or restore normalized functioning, reality orientation and emotional adjustment thus enabling improved functioning and interpersonal and social skills. Also includes continuing medical diagnostic evaluation and drug management, as indicated, and may include insight oriented, cognitive behavioral or supportive therapy.

- Must be provided by a psychiatrist or psychiatric ARNP.
- To be paid, group size must not exceed ten participants.
- Documentation must include the topic, assessment of the group, level of participation, findings, and plan.

Behavioral Health Screening Service

A face to face assessment of physical status, a brief history, and decision making of low complexity.

- Must include, at a minimum:
 - Vital signs;
 - Medication concerns and side effects;
 - Brief mental status assessment; and
 - Plan for follow-up, if needed.
- Must be provided by a psychiatrist, physician, physician's assistant, ARNP, or RN.
- Results must be included in the clinical record.

Behavioral Health Services

Specimen collection, taking vital signs, administration of injections; or, a verbal interaction of at least 15 minutes duration between the practitioner and the recipient.

- Must be directly related to the recipients disorder or to monitoring side effects of medication.
- Provided by, respectively, a person qualified by licensure, training, protocol and competence, and within applicable professional statutes, or a PA, ARNP, or RN.
- Documentation must describe the need and the recipient's interaction.

Methadone or Buprenorphine Administration

The administration of Meth or Buprenorphine for opioid addiction by a state and federal licensed/certified program.

- Must be provided by a person qualified by licensure, training, protocols and competency and within applicable professional statutes.
- Must be documented according to state and federal regulations.
- No other Medicaid code can be used to bill this service.

Behavioral Health Therapy Services

- Individual and Family Therapy
- Group Therapy
- Behavioral Health Day Services

Individual and Family Therapy

The provision of insight oriented, cognitive behavioral, or supportive therapy to an individual or family.

- May include the recipient, the recipient's family without the recipient, or a combination of therapy with the recipient and family.
- Must be provided by a master's level practitioner.
- Documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Group Therapy

Cognitive behavioral, supportive therapy or counseling to individuals or families and consultation with family or other responsible persons for sharing of clinical information.

- May also include education, counseling or advising family or other responsible persons on how to assist the client.
- Group size is limited by diagnosis: 10 if mental health; 15 if substance abuse.
- Must be provided by a bachelor's level practitioner or CAP.
- Documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Behavioral Health Day Services

Individual, group and family therapy, and therapeutic care services to stabilize symptoms in order to reduce the need for a more intensive level of care; to transition from an acute episode; or provided intensity not possible in outpatient.

- Staff and supervisory qualifications vary by type of service provided - care service, group, or individual or family.
- A licensed practitioner must be available during all hours of operation.
- Group size limited to 10 for MH and 15 for SA disorder.

Behavioral Health Day Services – cont.

- Additional documentation requirements include a weekly summary with exact dates and times, a description of the service(s) and the response in relation to objectives and goals. Clinical services must identify the name and credentials of the service practitioner.
- Service is billable by the hour, however recipient must attend a minimum of two hours daily in order to bill. At least one hour must be therapy services.
- Will not pay on same day as psychosocial rehabilitation.

Community Support and Rehabilitation

Psychosocial Rehabilitation Services are:

- Services to assist the recipient in strengthening or regaining interpersonal skills; psycho-social therapy targeted toward rehabilitation; and, development or environmental supports necessary to thrive in the community.
- Designed for recipients exhibiting psychiatric, behavioral or cognitive symptoms, addictive behavior, or clinical conditions of sufficient severity to cause significant impairment in daily personal, social, pre-vocational and educational functioning.

Psychosocial Rehabilitation - cont.

- Include independent living skills restoration, training and support provided in a facility, home or the community.
- Unlike counseling or therapy, concentrates less on amelioration of symptoms and more on restoring functional capabilities.
- May be used to facilitate cognitive and socialization skills for functioning in a work environment; work readiness assessment; job development on behalf of the recipient; job matching, and job support.

Psychosocial Rehabilitation – cont.

- Must be provided by a behavioral health technician under supervision of a master's level practitioner; a certified behavioral health technician under supervision of a bachelor's level practitioner; a substance abuse technician, or CAP.
- Special documentation requirements include:
 - a daily note describing activities to enhance or support the recipient's skill deficits; and,
 - a monthly note relating the service(s) to goals and objectives and describes the recipient's progress .
- Group size maximum is 12 for mental health and 15 for substance abuse diagnoses.

Therapeutic Behavioral On-Site for Children and Adolescents

Therapy, behavior management and therapeutic behavioral support services directed toward meeting the needs of recipients (under 21) with involvement from their biological or foster families.

- Special eligibility criteria apply.
- Additional planning requirements apply.
- Additional service documentation requirements apply.
- Increased staff qualifications apply.
- Not reimbursed on the same day as therapy, group, or day services, PSR, therapeutic group or foster care, or BHOS-JJ.

Questions and Answers

What's next in CHB Services?

Where to get help?

PMC, LLC

Resources

- Medicaid General Handbook - www.mymedicaid-florida.com, then click Public Information for Providers, Provider Support, and Provider Handbook
- FADAA – www.fadaa.org
- Medicaid Area and Central Offices
- DCF SAMH Program and local offices

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