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SECTION 13—BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

The Psychology/Counseling Manual contains policy and procedures for providing mental health services to children and adults.

Medically necessary mental health services are available to Medicaid eligible children under the age of 21 (0-20). All State only funded categories of assistance are covered, including: ME codes 07, 08, 29, 30, 36, 37, 50, 52, 56, 57, 63, 64, 66, 68, 69, and 70 (children in state custody). Refer to Section 9 for complete information concerning the HCY Program.

Medically necessary mental health services are available to Medicaid eligible adults age 21 and over through the adult Psychology Program. Medicaid eligible adults, 21 years and older, may receive mental health services when provided by a licensed psychiatrist, licensed psychiatric clinical nurse specialist (PCNS) and licensed psychologist. An adult, 21 years and older, may receive mental health services through a Federally Qualified Health Care center (FQHC) and a Rural Health Clinic (RHC). Licensed psychiatrists, psychiatric clinical nurse specialists, licensed or provisionally licensed psychologists, as well as licensed or provisionally licensed clinical social workers who are members of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) may provide adult services as part of the clinic as their license permits. Individually Medicaid enrolled licensed or provisionally licensed social workers who are not part of a FQHC or RHC may not provide services to adults, 21 years and older.

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid coverable services be provided when medically necessary when identified as a result of an HCY screening. These services include psychology and counseling services. Senate Bill 765 of the 85th General Assembly provided state legislation for program implementation.

13.2 DEFINITIONS

The following definitions are applicable for the Missouri Medicaid Psychology Program.

**Licensed or Provisionally Licensed Psychologist Services: Assessment:** The testing, evaluation, development of a Treatment Plan and treatment of mental disorders.

**Licensed or Provisionally Licensed Professional Counseling Services: Assessment:** The development of a Treatment Plan and counseling for mental disorders.
Licensed or Provisionally Licensed Clinical Social Work Services: The application of methods, principles, of group work, planning, psychotherapy and counseling methods and techniques to persons, families and groups in assessment, diagnosis, and treatment of mental conditions.

Treatment Plan: A plan of action developed by the provider based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the patient’s situation and reflects the need for psychology/counseling services.

Crisis Intervention: A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient’s well being or is a danger to himself/herself or others. Crisis Intervention services cannot be scheduled.

Appointments: Services for which the CPT does not indicate a time frame have been defined by DMS as being a 30 minute unit.

Services defined by DMS as 30 minutes must be delivered in full 30 minute face-to-face sessions (e.g., group or family therapy).

Services defined by the CPT as 60 minutes must be delivered in full 60 minute sessions (e.g., testing or crisis intervention).

Travel time is not reimbursed and must not be included as part of the scheduled appointment time.

Diagnostic Assessment: A diagnostic assessment from a Medicaid enrolled provider shall be documented in the patient’s case record, which shall assist in ensuring an appropriate level of care, identifying necessary services, developing an Individualized Treatment Plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;
- Presenting situations/problem and referral source;
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions; documentation of prior counseling received by previous and current provider including date range, purpose, duration, and provider;
- Current medications and identifications of any medication allergies and adverse reactions;
- Recent alcohol and drug use for at least the past 30 days and, when indicated, a substance abuse history that includes duration, patterns, and consequences of use;
- Current psychiatric symptoms;
• Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required unless short-term crisis intervention or detoxification is the only services being provided;

• Current use of resources and services from other community agencies;

• Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and

• Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD9-CM). The ICD9-CM is required on the Treatment Plan for billing purposes.

An assessment service is for the purpose of identifying the treatment needs of the individual or family. Described below are the two types of assessment.

**Psychiatric diagnostic interview examination (90801)** *must* include direct patient contact and may include the following types of activities with patient present at least 75% of time billed:

• Interview with child (includes topics of family, peers, school relationships, behavior, emotions, observation of social skills, developmental level of planning skills and informal assessment of overall development)

• Parent report:
  a. Complete child behavior checklist
  b. Interview to complete Vineland Adaptive Behavior Scale or similar rating tool.

• Teacher report:
  a. Complete form regarding child’s development, academic progress, and social adaptive behavior
  b. Complete Conner’s Teacher Rating Form
  c. Child Behavior checklist—Teacher’s report form

This procedure is limited to six half-hour units per provider per rolling year.

**Interactive psychiatric diagnostic interview (90802)** which may be used to overcome barriers of communication for those children who have *not* yet developed or have lost expressive language skills.
• This procedure consists of interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter or other mechanisms of communication.

• This procedure has been placed on prepayment review and must be submitted on a paper claim form with progress notes attached adequately documenting the medical need for this service and type of equipment, device or other mechanisms of communication used.

This procedure is limited to two units per patient per rolling year.

Psychological Testing: Psychological testing services may be provided in addition to assessment when warranted for proper evaluation. This procedure is limited to a maximum of four hours per patient per provider per rolling year. Testing services are only reimbursed when provided by a licensed psychologist.

Missouri Medicaid reimburses for two types of psychological testing:

• **Procedure code 96101** - psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report. The report must include the clinical justification for conducting the test as well as the intended purpose of the results.

• **Procedure code 96103** - psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with interpretation and reporting by a psychologist. This procedure is limited to a maximum of four hours per patient per provider per rolling year.

• **Procedure code 96105 assessment of aphasia** (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g. by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour.

• **Procedure code 96116 neurobehavioral status exam** (clinical assessment of thinking, reasoning and judgment, e.g. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report.

Family therapy: Family therapy is defined as the treatment of the members of a family together, rather than an individual “patient”. The family unit is viewed as a social system that affects all its members. A “family” may be defined as biological, foster, adoptive or other family unit. Family therapy focuses on helping the family function in more positive and constructive ways by exploring patterns of
communication and providing support and education. Only one family therapy session may be billed per family per day and each child may not be seen separately with parents and billed as family therapy. Family therapy is provided within a time-limited, goal-specific, face-to-face interaction based upon planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment.

Psychology/counseling services must be directed exclusively to the effective treatment of the patient. When submitting a psychology/counseling claim for family therapy services rendered to benefit a specific child, that child’s DCN must be used on the claim for reimbursement.

- **Family therapy without patient present (90846)** requires prior authorization regardless of the age and is not allowed under the four hours of non-prior authorized services. Services are provided to a family, and the session is billed as one service. Family therapy focuses on helping the family function in more positive and constructive ways by exploring patterns of communication and providing support and education. Family therapy without the Patient Present is provided within a time-limited, goal-specific, face-to-face interaction based upon planned intervention documented in the Treatment Plan developed in response to the issues identified in the Diagnostic Assessment.

Two or more children may not be seen together and billed as family therapy except under extreme circumstances.

All requests for family therapy without the parent(s) or entire family present must be prior authorized.

- **Family therapy with patient present (90847)** services is provided to a family and the session is billed as one service. Only one family therapy session may be billed per family per day and each child may not be seen separately with parents and billed as family therapy. At least 75% of the session must have both child/children and parent(s) present.

If there is more than one eligible child (of a biological, foster, adoptive or any other family unit) and no child is exclusively identified in the session as the primary recipient of treatment, then the oldest child’s DCN must be used for billing purposes. A family unit is not a group and providers may not submit a claim for each eligible child attending the same session. Submitting claims for family therapy with parent(s) and individual children versus the family unit is a violation of DMS policy.

**Individual Therapy:** Individual therapy must consist of a medically necessary, time-limited, specific process in which the child interacts on a face-to-face basis with the licensed Medicaid provider, in accordance with the written Treatment Plan, to treat a mental disorder, resolve problematic behaviors, and reduce barriers to effective functioning. Individual therapy may be billed by a licensed psychologist, licensed or provisionally licensed professional counselor (LPC, PLPC.), or licensed or provisionally licensed clinical social worker (LCSW, PLCSW) who is enrolled as a Missouri Medicaid provider.
Individual therapy procedure codes are divided into two categories, Interactive Psychotherapy (90810, 90812, 90823, 90826) and Insight Oriented Behavior Modifying Therapy (90804, 90806, 90816, 90818). Providers may bill an insight oriented and interactive procedure code for the child, on the same date of service, when warranted or medically necessary. The provider must document, in the record, the necessity of furnishing both procedure code 90804 and 90810 on the same date of service. The provider cannot bill both codes for the same or overlapping time frames.

- **Procedure code 90804 individual psychotherapy**, is insight oriented behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient.

- **Procedure code 90806 individual psychotherapy**, is insight oriented behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.

This procedure is limited to 1 unit per day/ 5 units per month.

- **Procedure code 90810 individual psychotherapy, interactive**, is for children who have not developed or have lost expressive language skills. The record must document the need for interactive therapy and the type of equipment, device or other mechanism of communication. This procedure can include services such as play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication. This procedure is used to bill services performed in an office, home, school or other place of service, approximately 20 to 30 minutes face-to-face with the patient.

Evaluating children playing on playground equipment, playing at daycare, and children playing at home in their normal routine or taking them to a playroom in a public place is not included in this procedure and must not be billed. Individual interactive therapy is NOT play therapy.

**Procedure code 90812 individual psychotherapy, interactive**, is for children who have not developed or have lost expressive language skills. The record must document the need for interactive therapy and the type of equipment, device or other mechanism of communication. This procedure can include services such as play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication. This procedure is used to bill services performed in an office, home, school or other place of service, approximately 45 to 50 minutes face-to-face with the patient.

Evaluating children playing on playground equipment and children playing at home in their normal routine or taking them to a playroom in a public place is not included in this procedure and must not be billed.

This procedure is limited to 1 unit per day/ 5 units per month.

Services Delivered in an Inpatient Hospital Setting:
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- **Procedure code 90816** is for individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient setting only, approximately 20 to 30 minutes face-to-face with the patient.

- **Procedure code 90818** is for individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient setting only, approximately 45 to 50 minutes face-to-face with the patient.

This procedure is limited to one unit per day; monthly limits do *not* apply when in an Inpatient Hospital setting.

- **Procedure code 90823** is for individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient setting only, approximately 20 to 30 minutes face-to-face with the patient.

- **Procedure code 90826** is for individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient setting only, approximately 45 to 50 minutes face-to-face with the patient.

This procedure is limited to one unit per day; monthly limits do *not* apply when in an Inpatient Hospital setting.

- **Group Therapy: Procedure code 90853** uses the power of group dynamics and peer interactions to increase understanding and improve social skills. Groups are medically necessary, time-limited, goal-specific, face-to-face interactions based upon planned intervention documented in the Treatment Plan developed in response to issues identified in the Diagnostic Assessment. Group therapy *must* consist of a group oriented process delivered to groups of 3 but no more than 10 children (other than of a multiple-family group).

This procedure is limited to three 30 minute units per day; monthly limits do *not* apply when in an inpatient hospital setting.

### 13.3 PATIENT ELIGIBILITY

The Missouri Medicaid Program pays for approved Medicaid services for psychology/counseling services when furnished within the provider’s scope of practice. The patient *must* be eligible on the date the service is furnished. Patients may have specific limitations for psychology/counseling services according to the type of assistance for which they have been determined eligible. It is the provider’s responsibility to determine the coverage benefits for a patient based on their type of assistance. The provider shall ascertain the patient’s Medicaid/MC+ and managed care or other lock-in status before any service is performed. The patient’s eligibility shall be verified in accordance with methodology outlined in Section 1 and Section 3.
13.4 PROVIDER PARTICIPATION REQUIREMENTS

To be eligible to participate in the Missouri Medicaid Psychology/Counseling Program, the mental health provider must satisfy the following requirements:

- Hold a valid current Missouri license if located in Missouri; or
- Hold a corresponding valid current license if located outside the state of Missouri that meets the licensing criteria specified;
- Have a signed and accepted Participation Agreement in effect with the Missouri Department of Social Services, Division of Medical Services. The enrolled Medicaid provider shall agree to:

Keep any records necessary to disclose the extent of services the provider furnishes to patients, and;

On request furnish to the Medicaid agency or State Medicaid Fraud Control Unit any information regarding payments claimed by the provider for furnishing services under the plan.

A monthly maximum of 175 hours per provider is billable.

Additional information on provider conditions of participation can be found Section 2 of this provider manual.

13.4.A PSYCHOLOGISTS

A psychologist or provisionally licensed psychologist may provide psychological services for children and adults.

A psychologist or provisionally licensed psychologist must have and maintain:

- A valid license or provisional license issued by the State Committee of psychologists when practicing in Missouri; or
- A valid license or provisional license issued by the licensing authority of the state in which they practice.
- A separate provider number for each private office where services are provided to Medicaid patients.
- A separate provider number for each different employer, if payment is made to the employer, including local school districts when place of service is “03” for a Public School setting.

NOTE: A provisionally licensed psychologist must only provide services allowed under the provisional licensure. A provisionally licensed psychologist may not operate as an independent practitioner, receive direct payment from the Division of Medical Services or own their own business in the practice as a provisionally licensed psychologist. Provisionally licensed psychologists...
psychologist must submit a copy of their permanent license to the Missouri Medicaid Provider Enrollment Unit upon receipt.

13.4.B PROFESSIONAL COUNSELORS

Licensed or provisionally licensed professional counselors may provide psychology/counseling services for children under 21.

Adults, 21 and older, are not covered for individually licensed or provisionally licensed professional counselors.

Licensed or provisionally licensed professional counselors must have and maintain:

- A valid license or provisional license with the State Committee of Professional Counselors if practicing in Missouri; or
- A valid license or provisional license issued by the licensing authority of the state in which they practice.
- A separate provider number for each private office where services are provided to Medicaid patients.
- A separate provider number for each different employer, if payment is made to the employer.

NOTE: a provisionally licensed professional counselor must only provide services allowed under the provisional licensure. provisionally licensed professional counselors must submit a copy of their permanent license to the Missouri Medicaid Provider Enrollment Unit when their provisional license expires.

13.4.C LICENSED OR PROVISIONALLY LICENSED CLINICAL SOCIAL WORKERS

Licensed or provisionally licensed clinical social workers may provide psychology/counseling services for children under 21.

Adults, 21 and older, are not covered for individually licensed or provisionally licensed clinical social workers. Licensed or provisionally licensed clinical social workers who are members of a Federally Qualified Health Center (FQHC) or licensed clinical social workers who are members of a Rural Health Clinic (RHC) may provide psychological services for adults as part of the clinic.

Licensed or provisionally licensed clinical social workers must have and maintain:
• A valid license or provisional license issued by the State Committee for Social Workers administered by the Division of Professional Registration, Office of Economic Development if practicing in Missouri; or
• A valid license or provisional license issued by the licensing authority of the state in which they practice.
• A separate provider number for each private office where services are provided to Medicaid patients.
• A separate provider number for each different employer, if payment is made to the employer.

NOTE: A provisionally licensed clinical social worker must only provide services allowed under the provisional licensure. Provisionally licensed clinical social workers must submit a copy of their permanent license to the Missouri Medicaid Provider Enrollment Unit when their provisional license expires.

13.4.D LICENSED PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSE SPECIALIST (PCNS)

Licensed psychiatrists and PCNS may treat children and adults.

Licensed psychiatrists and PCNS must have and maintain:
• A valid license issued by the Division of Professional Registration.
• A separate provider number for each private office where services are provided to Medicaid patients.
• A separate provider number for each different employer, if payment is made to the employer.

A psychiatrist must have:
• A valid permanent license issued by the Division of Professional Registration.

A clinical nurse specialist with a specialty in Psychiatry must have:
• A valid RN license AND a valid Document of Recognition with a specialty in Psychiatry through the Missouri State Board of Nursing.
13.4.E  NOTIFICATION OF PROVIDER CHANGES

The Provider Enrollment Unit must be notified in writing of any changes in provider records. The notification must include the provider number and the requested changes. A provider must notify the Provider Enrollment Unit promptly by certified mail of:

- Change of provider address or “pay to” address, if different (necessary to ensure that all checks, correspondence, bulletins and annual updates are received promptly). Indication of change of address on a claim form is not sufficient.

- Change of ownership of business. (new participation agreement is required.)

- Change from Social Security number to a Tax Payer I.D. number.

- Change in licensure or certification including but not limited to status.

Mailing Address:

Provider Enrollment Unit  
Division of Medical Services  
P. O. Box 6500  
Jefferson City, MO 65102

Refer to Section 2 of this manual for additional information.

13.4.F  SCHOOL-BASED SERVICES

Providers who wish to provide services in a public school setting must also enroll with a pay-to of the school district in which the school is located. If the provider furnishes services for children in schools located in more than one school district the provider must enroll with a pay-to for each school district in which services are furnished.

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located.

13.4.F(1)  Enrollment Instructions

The provider must identify the tax ID number, name, address and county/school district code for each public school district in which school-based services are to be provided. This information should be placed on the application form in the pay-to information field. Applications without this information cannot be processed and are returned.
13.5 NONDISCRIMINATION

Providers must comply with the 1964 Civil Rights Act, as amended; Section 504 of the Rehabilitation Act of 1973; the Age Discrimination Act of 1975; the Omnibus Reconciliation Act of 1981 and the Americans with Disabilities Act of 1990 and all other applicable Federal and State Laws that prohibit discrimination in the delivery of services on the basis of race, color, national origin, age, sex, handicap/disability or religious beliefs.

Further, all parties agree to comply with Title VII of the Civil Rights Act of 1964 which prohibits discrimination in employment on the basis of race, color, national origin, age, sex, handicap/disability, and religious beliefs.

13.6 ADEQUATE DOCUMENTATION

All services provided must be adequately documented in the medical record. The requirement to document services and to release records to representatives of the Department of Social Services or the U.S. Department of Health and Human Services is stated in the following documents, Medicaid state regulation (13 CSR 70-3) Conditions of Provider Participation, Reimbursement and Procedure of General Applicability. These requirements are also repeated in the Title XIX Participation Agreement, which is a document signed by all providers upon enrollment as a Medicaid provider.

The Code of State Regulation, 13 CSR 70-3.030, Section (1)(A) defines “adequate documentation” and “adequate medical records” as follows:

- (2)(A) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty.

- Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.

- An adequate and complete patient record is a record which is legible, which is made contemporaneously with the delivery of the service, which addresses the patient specifics, which include, at a minimum, individualized statements that support the assessment or treatment encounter, and shall include documentation of the following information:
  - First name, and last name, and either middle initial or date of birth of the Medicaid recipient
  - An accurate, complete, and legible description of each service(s) provided
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- Name, title, and signature of the Missouri Medicaid enrolled provider delivering the service. Inpatient hospital services must have signed and dated physician or psychologist orders within the patient’s medical record for the admission and for services billed to Missouri Medicaid. For patients registered on hospital records as outpatient, the patient’s medical record must contain signed and dated physician orders for services billed to Missouri Medicaid. Services provided by an individual under the direction or supervision are not reimbursed by Missouri Medicaid. Services provided by a person not enrolled with Missouri Medicaid are not reimbursed by Missouri Medicaid.

- The name of the referring entity, when applicable

- The date of service (month/day/year)

- For those Medicaid programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (except for services as specified under 13 CSR 70-91.010 Personal Care Program (4)(A) the actual begin and end time taken to deliver the service (for example, 4:00-4:30 p.m.) must be documented.

- The setting in which the service was rendered

- The plan of treatment, evaluation(s), test(s), findings, results, and prescription(s) as necessary. Where a hospital acts as an independent laboratory or independent radiology service for persons considered by the hospital as “non-hospital” patients, the hospital must have a written request or requisition slip ordering the tests or procedures.

- The need for the service(s) in relationship to the Medicaid Recipient’s treatment plan

- The Medicaid recipient’s progress toward the goals stated in the treatment plan (progress notes) and

- Long-term care facilities shall be exempt from the seventy-two (72) hour documentation requirements rules applying to paragraphs (2)(A)9 and (2)(A)10. However, applicable documentation should be contained and available in the entirety of the medical report.

- (2)(D) Contemporaneous means at the time the service was performed or within seventy-two (72) hours of the time the service was provided.

Electronic signatures are accepted. Stamped signatures are not acceptable.

All documentation must be legible and written/submitted in English. As referenced above, documentation must be entered in the patient record within 72 hours of the service delivered.

13.6.A DOCUMENTATION REQUIREMENTS

Psychology counseling services under Missouri Medicaid have specific documentation requirements as noted in the Code of State Regulations, 13 CSR 70-98.015.
Reimbursement for each date of service must contain the following documentation in the patient’s medical record.

- This documentation must be in narrative form fully describing each session billed.
- A check-off list or pre-established form is not accepted as sole documentation.

13.6.A(1) Diagnostic Assessment

A Diagnostic Assessment from a Medicaid enrolled provider shall be documented in the patient's medical record. The Diagnostic Assessment shall assist in ensuring an appropriate level of care, identifying necessary services, developing an individualized Treatment Plan, and documenting the following:

A. Statement of needs, goals, and treatment expectations from the individual requesting services. The family's perceptions are also obtained, when appropriate and available;

B. Presenting situations/problem and referral source;

C. History of previous psychiatric and/or substance abuse treatment including number and type of admissions; documentation of prior/current counseling including date range, purpose, duration and provider;

D. Current medications and identifications of any medication allergies and adverse reactions;

E. Recent alcohol and drug use for at least the past 30 days and, when indicated, a substance abuse history that includes duration, patterns, and consequences of use;

F. Current psychiatric symptoms. These current symptoms must address the diagnostic criteria in support of the diagnosis being made.

G. Family, social, legal, and vocational/educational status and functioning. The collection and assessment of historical data is also required unless short-term crisis intervention or detoxification is the only services being provided;

H. Current use of resources and services from other community agencies;

I. Personal and social resources and strengths, including the availability and use of family, social, peer and other natural supports; and

J. Multi-axis diagnosis or diagnostic impression in accordance with the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the International Classification of Diseases, Ninth Revision,
Clinical Modification (ICD9-CM). The ICD9-CM is required on the Treatment Plan for billing purposes.

The Diagnostic Assessment must be signed and dated by the provider delivering the service. The date should reflect the date the service was provided. If the Diagnostic Assessment was completed over a span of days each portion of the Diagnostic Assessment should reflect the date that portion of the service was delivered with the date at the end of the form reflecting the date the entire Diagnostic Assessment was completed. The dates billed should reflect the dates each portion was delivered.

A Diagnostic Assessment should result in a determination that no further services are required or should be used in developing an individualized Treatment Plan. The Diagnostic Assessment must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13.

An update to the Diagnostic Assessment is required in occurrence of a crisis or significant clinical event.

13.6.A(2) Plan Of Treatment Documentation

A plan of treatment is a required document in the overall record of the patient. A Treatment Plan must be developed by the provider based on a Diagnostic Assessment that includes:

- Examination of the medical, psychological, social, behavioral, and developmental aspects of the patient’s situation and reflects the need for psychology/counseling services.

The Treatment Plan shall be individualized to reflect the patient's unique needs and goals. The plan shall include, but is not limited to, the following:

A. Measurable goals and outcomes;

B. Services, support, and actions to accomplish each goal/outcome. This includes services and supports and the staff member responsible, as well as action steps of the patient and other supports (family, social, peer and other natural supports);

C. Involvement of family, when indicated;

D. Identification of other agencies working with the patient, plans for coordinating with other agencies, or identification of medications, which have been prescribed, where applicable;
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E. Services needed beyond the scope of the organization or program that are being addressed by referral or services at another community organization, where applicable;

F. Projected time frame for the completion of each goal/outcome not to exceed 12 months; and

G. Estimated completion/discharge date for the level of care.

Documentation required by Missouri Medicaid does not replace or negate documentation/reports required by the Children's Division for individuals in their care or custody. Providers are expected to comply with policies and procedures established by the Children's Division and DMS.

The Treatment Plan must be signed and dated by the provider delivering the service. The Treatment Plan must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13.

An update to the Treatment Plan is required in the occurrence of a crisis or significant clinical event.

13.6.A(3) Progress Notes

Progress Notes for psychology/counseling services shall be written and maintained in the patient’s medical record for each date of service for which a claim is filed. Progress Notes shall specify:

• First and last name of patient;

When family therapy is furnished:

• Each member of the family included in the session must be identified. (The family unit is viewed as a social system that affects all its members. A parent must be present 75% of the time to be billed as family therapy.

• The description of immediate issue addressed in therapy.

• Identification of underlying roles, conflicts or patterns,

• Description of therapist intervention must also be identified.

When group therapy is furnished:

• Each service shall include the number of group members present. (Minimum of three but no more than 10 patients)
• Description of immediate issue addressed in therapy, identification of underlying roles, conflicts or patterns.
• Description of therapist intervention and progress towards goals.

When interactive therapy is furnished:
• Documentation of the need for service
• Describe the type of equipment, devices or other mechanisms used
• The specific service(s) rendered including the Procedure Code;
• Name of person who provided the service;
• The date (month/date/year) and the actual begin and end time (e.g., 4:00-4:30 p.m. the face-to-face services;
• The setting in which the service was rendered;
• The patient's report of recent symptoms and behaviors related to their diagnosis and Treatment Plan goals;
• The therapist interventions for that visit and patient's response;
• The pertinence of the service to the Treatment Plan; and
• The patient's progress toward one or more goals stated in the Treatment Plan.
• The progress note must be signed and dated by the provider delivering the service.
• The progress note must document the specific service delivered. The service must be a covered service as defined in Section 13.17 to be billed to Missouri Medicaid.

NOTE: The Missouri Medicaid enrolled provider is the only person who can provide psychology/counseling services and be reimbursed for these services. Services provided by someone other than the enrolled provider are not covered by Missouri Medicaid and may not be billed to Missouri Medicaid by or on behalf of another individual. Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

13.6.A(4) Plan Of Treatment Review

The Treatment Plan shall be reviewed on a periodic basis to evaluate progress towards treatment goals and outcomes and to update the plan.
• Each person shall directly participate in the review of his or her individualized Treatment Plan.

• The frequency of Treatment Plan reviews shall be based upon the individual’s level of care or other applicable program rules. The occurrence of a crisis or significant clinical event may require further review and modification of the Treatment Plan.

• The individualized Treatment Plan shall be updated and changed as indicated.

• Each Treatment Plan update shall include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress to treatment goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications.

• The therapist's plan for continuing treatment and/or termination from therapy and aftercare shall be considerations expressed in each Treatment Plan update.

The Treatment Plan update must be signed and dated by the provider delivering the service. The Treatment Plan update must be current – within one year for adults and adolescents (age 13 to 20) or six months for children under 13. An update to the Treatment Plan would be necessary in the occurrence of a crisis or significant clinical event.

13.6.A(5) Aftercare Plan

When care is completed, the Aftercare Plan shall include, but is not limited to, the following:

• Dates begin and end;
• Frequency and duration of visits;
• Target symptoms/behaviors addressed;
• Interventions;
• Progress to goals achieved;
• Final diagnosis; and
• Final recommendations including further services and providers, if needed, and activities to promote further recovery.

For all medically necessary covered services, a writing of all stipulated documentation elements referenced in this section is an essential and integral part of the service itself.
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No service has been performed if documentation requirements are *not* met. No service is reimbursed if documentation requirements are *not* met.

The Aftercare Plan *must* be signed and dated by the provider delivering the service.

### 13.6.B RETENTION OF RECORDS

Medicaid providers *must* retain for six (6) years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the Medicaid Program, and *must* furnish or make the records available for inspection or audit by the Department of Social Services (DSS) or its representative upon request. Failure to furnish, reveal and retain adequate documentation for services billed to the Medicaid Program may result in recovery of the payments for those services *not* adequately documented and may result in sanctions to the provider’s participation in the Medicaid Program. This policy continues to apply in the event of the provider’s discontinuance as an actively participating Medicaid provider through change of ownership or any other circumstance.

### 13.7 PATIENT COST SHARING AND COPAY

Patients eligible to receive certain Missouri Medicaid services are required to pay a small portion of the cost of the services. This amount is referred to as copay. The copay amount is paid by the patient at the time services are rendered. Services of the Psychology/Counseling Program described in this manual are subject to a copay amount. The provider *must* accept in full the amounts paid by the state agency plus any copay amount required of the patient.

#### 13.7.A PROVIDER RESPONSIBILITY TO COLLECT COPAYMENT

Providers of service *must* charge and collect the copay amount. Providers of service may *not* deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the patient's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the patient's statement of inability to pay at the time the charge is imposed.

The provider of service *must* keep a record of copay amounts collected and of the copay amount due but uncollected because the patient did *not* make payment when the service was rendered.
The copay amount is *not* to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the copay amount is deducted from the Medicaid maximum allowable amount, as applicable, before reimbursement is made.

### 13.7.B PATIENT RESPONSIBILITY TO PAY COPAYMENT

It is the responsibility of the patient to pay the required copay amount due. Whether or not the patient has the ability to pay the required copay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. The copay only applies to identified services and patients with certain ME codes.

### 13.7.C PATIENTS WHO ARE REQUIRED TO PAY A COPAY *(text del. 5/07)*

### 13.7.D SERVICES REQUIRING A COPAY

Adults receiving a limited benefit package are required to pay a co-payment for psychotherapy services of $2.00 when provided by a psychologist (49 provider type); and a $1.00 when provided by a psychiatrist (27 provider type).

Copay is applied once regardless of how often the procedure code is billed to get the total allowed units.

The copay amount is deducted from the Medicaid Maximum Allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

### 13.8 PATIENT NONLIABILITY

Medicaid covered services rendered to an eligible patient are *not* billable to the patient if Medicaid would have paid had the provider followed the proper policies and procedures for obtaining payment through the Medicaid Program as set forth in 13 CSR 70-4.030.

### 13.9 CARE MANAGEMENT ORGANIZATION

From March 1, 1999 through March 31, 2006, the Department of Social Services funded a comprehensive, coordinated system of behavioral health care for children through a care management organization (CMO), responsible for organizing and developing a locally organized system of services and supports for children and families.
13.10 TARGET POPULATION

13.10.A LOCK IN IDENTIFICATION OF CMO PATIENTS

From March 1, 1999 through March 31, 2006, Medicaid-eligible children who were enrolled with the CMO and were otherwise eligible for fee-for-service reimbursement for certain behavioral health needs, were “locked-in” to the CMO. The CMO was responsible for all behavioral health care during the lock-in time period, including inpatient psychiatric care as well as outpatient services, but excluding pharmacy benefits. Lock-in information is available to providers through the interactive voice response (IVR) system at (573)635-8908 as well as the point of service (POS) units. Medicaid providers of behavioral health care that provide services to children who were enrolled with the CMO may contact the appropriate CMO as identified in the lock-in information for additional information. A CMO Lock-In Provider is recognized by an 87 provider number. Beginning April 1, 2006, Medicaid no longer locks children into CMO providers for behavioral health services.

13.10.B FEE FOR SERVICE PROVIDERS

For dates of service prior to April 1, 2006, Medicaid reimbursement is not made to any other behavioral health provider during the CMO lock-in period.

13.10.C MANAGED CARE PLAN PROVIDERS

For dates of service prior to April 1, 2006, those children enrolled with the CMO whose behavioral health needs are the obligation of the managed health care plans continue to receive behavioral health care services through their health plans. Services are coordinated by the CMO in cooperation with the health plans. Pharmacy benefits are the responsibility of the health plans.

13.11 EMERGENCY SERVICES

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient’s health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.
13.12 OUT-OF-STATE, NONEMERGENCY SERVICES

All non-emergency, Medicaid covered services that are to be performed or furnished out-of-state for eligible Missouri Medicaid patients and for which Missouri Medicaid is to be billed, must be prior authorized before the services are provided. Services that are not covered by the Missouri Medicaid Program are not approved.

Out-of-state is defined as not within the physical boundaries of the State of Missouri or within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same Medicaid participation basis as providers of services located within the State of Missouri.

A Prior Authorization Request form is not required for out-of-state non-emergency services. To obtain prior authorization for out-of-state, non-emergency services, a written request must be submitted by a physician to:

Division of Medical Services  
Recipient Services Unit  
P.O. Box 6500  
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request must include:

1. A brief past medical history.
2. Services attempted in Missouri.
3. Where the services are being requested and who will provide them.
4. Why services can’t be done in Missouri.

NOTE: The out-of-state medical provider must agree to complete an enrollment application and accept Missouri Medicaid reimbursement. Prior authorization for out-of-state services expires 180 days from the date the specific service was approved by the state.

13.12.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/Medicaid crossover claims.
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2. All Foster Care children living outside the State of Missouri. However, non-emergency services or services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a Foster Care child.

3. Emergency ambulance services.

4. Independent laboratory services.

13.13 PRIOR AUTHORIZATION

Under the Missouri Medicaid Program, certain covered services and equipment require prior approval if the provider is to be reimbursed for them. Prior authorization (PA) is used to promote the most effective and appropriate use of available services and to determine the medical necessity of the service and does not guarantee payment.

Authorizations for services that require PA are established for a period of time not to exceed one year. Mental health providers are required to obtain PA for certain specified services before delivery of that service. Services may not begin until they have been authorized.

ALL family therapy without the patient present requires PA regardless of age and is not allowed under the four hours of non-prior authorized services.

Individual interactive therapy is not allowed under the four hours of non-prior authorized services. All individual interactive therapy must be prior authorized.

All services for children age birth through two must be prior authorized.

13.13.A REQUESTING PRIOR AUTHORIZATION

Providers may deliver four hours of psychological services without prior authorization (PA) to a patient they have not provided treatment to within the last 12 month rolling year. The four hours are intended to assist a provider seeing a patient for the first time in making the transition to PA should more than four hours be required for treatment. Providers who have been paid for services in excess of four hours for a patient in the last year do not receive four non-prior authorized hours for that patient.

Family therapy without the patient present, individual therapy for 3-4 year olds, individual interactive therapy and all psychological services for patients age 0 through 2 years are not included in the four non-prior authorized hours and continue to require PA.

The claims for the four non-Prior Authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.
If services are required beyond the initial four non-prior authorized hours, the provider must request PA. To request an initial PA the provider or a staff member may call (866) 771-3350. Although not mandatory, the provider should complete the Psychological Services Request for Prior Authorization form as the information on this form is required to complete the request for services. Telephoned requests receive an approval or denial at the time of the call. (If additional information is needed, the caller is instructed to fax or mail the Psychological Services Request for Prior Authorization form and required documentation. This PA request is not approved during the phone call.)

To request continuing services beyond the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the current updated Treatment Plan, current Diagnostic Assessment and copies of the last three Progress Notes reflecting the therapy type being requested.

This documentation may be faxed to: (573) 635-6516 or mailed to:

Division of Medical Services  
PO Box 4800  
Jefferson City, MO 65102.

Before requesting additional hours, 75% of the current authorized hours must be used. The PA approves the delivery of the requested services only and does not guarantee payment. The PA must be obtained prior to delivery of services. The patient must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

All family therapy without the patient present and individual interactive therapy requires the Psychological Services Request for Prior Authorization form, current Diagnostic Assessment, current Treatment Plan, and the last three Progress Notes be mailed or faxed. All services for children ages birth through two require written clinical justification sufficient to determine need for services when requesting PA.

Providers do not receive a disposition letter when services are authorized or denied via a phone call. An authorization number is provided. Services that require submission of the Psychological Services Request for Prior Authorization form and attachments receive a disposition letter after review. When PA requests are denied partially or in full, the patient receives a letter outlining the reason for denial and their appeal rights. Do not give patients the provider Prior Authorization Request telephone number or fax number. Their contact information is listed in their denial letter.
If the patient is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the patient, requesting a change in provider, in order to close the current PA. The signed release must include the client DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The patient’s name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

When a patient changes providers any available units are transferred from the closed PA to the new provider’s approved PA if requested. The new provider does not receive an additional 10 or 20 hours for therapy. However, clinical exceptions may be granted based upon documentation of extenuating circumstances. A patient may have an open PA with one provider for individual therapy and/or family therapy and a second PA open with the same or different provider for group therapy.

Most PAs are requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning with 50 must request PA using the individual (49) provider number. However, authorization for services being delivered by a member of an FQHC must be requested by using the FQHC (50) provider number. Services being rendered by a member of an RHC must request PA using the RHC (59) provider number.

Prior authorization is required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior authorization is required for patients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home.

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

13.13.B PRIOR AUTHORIZATION GUIDELINES - ADULTS

All prior authorizations issued for adults during any calendar year have an authorized through date of December 31st of that same year.

Independent LCSWs and LPCs may not see adults and should not request PA for psychological services for clients 21 year of age or older.
LCSWs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services require PA but the request is made using the facility provider number.

The first four hours of psychological services for adults do not require PA. These four hours are intended to allow the provider opportunity to assess the patient’s need for ongoing treatment. The first four hours are per patient, per provider, per rolling year. These four non-prior authorized hours do not include family therapy without the patient present or individual interactive therapy. All hours of these therapies must be Prior Authorized before delivering services.

Providers who have delivered psychological services to a patient within the past 12 months are considered as having used their four non-prior authorized hours.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, PA must be obtained. This PA must be requested before delivering additional services. In order not to interrupt services it is recommended that providers request authorization before all 4 hours are used. The first PA request is the initial PA and any services requested after this is considered continued treatment.

Psychological services are covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. PA approval is based on the DSM IV-TR diagnosis code. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Up to 10 hours of individual or family therapy or a combination of both for adults is authorized initially for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes. The intent is to limit any PA to no more than 10 hours of individual or family therapy or a combination of the two for these diagnosis codes for any patient regardless of the provider.

Up to 20 hours are authorized initially for individual and family therapy or a combination of both for adults, for all other covered diagnosis codes. The intent is to limit the first PA to no more than 20 hours of individual or family therapy in any combination for any patient regardless of provider.

The authorized hours for adults may be divided between individual and family therapy based upon provider request, patient need and documentation in the Treatment Plan.

Based upon provider request up to 10 hours of group therapy are authorized for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes.

Based upon provider request for adults only, up to 20 hours of group therapy are authorized for all other covered diagnosis codes.
Group therapy may be requested for adults in addition to the individual and family request outlined above. The intent is to limit the first PA to no more than 20 hours of group therapy for any patient regardless of provider.

An additional 10 hours of individual, family or group therapy or any combination may be requested based upon documentation of patient need. PAs for continued treatment (authorizations beyond the initial approved hours) are based upon review of clinical documentation to include:

- Psychological Services Request for Prior Authorization form;
- Current Diagnostic Assessment – see Section 13.6.A(1);
- Current/Updated Treatment Plan – see Section 13.6.A(2) and Section 13.6.A(4) and Section 13.6.A(5);
- Three Progress Notes reflective of therapy type requested (i.e. requests for additional family therapy should include Progress Notes from the three most recent family therapy sessions attended by the patient);
- PAs for continued treatment are not issued for diagnosis codes including Adjustment Disorder, V codes, or NOS codes.

All documentation submitted must meet the requirements as stated in 13 CSR 70-98-015. Requests submitted with non-compliant documentation as outlined above result in denial of the request.

Regarding Adults, DMS recognizes there are rare instances where psychological services may be authorized beyond the limits outlined above. For those persons requiring more than the 50 hours of individual, family or group therapy per year, as discussed above, Clinical Exceptions may be granted based upon documentation of extenuating circumstances. Providers requesting clinical exceptions may contact the Psychology Help Desk at (866) 771-3350.

13.14 ADULT SERVICES

PSYCHOLOGIST, PSYCHIATRIST, PCNS, RHC, FQHC

Many psychological services provided to adults (21 years of age or older) must be prior authorized when performed by a psychiatrist, psychologist, psychiatric clinical nurse specialist (PCNS), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC).

Adult services provided by LCSWs are not covered by Missouri Medicaid, except in an RHC or FQHC setting. Adult services provided by LPCs are not covered by Missouri Medicaid in any circumstance.

**PSYCHOLOGIST, PSYCHIATRIST, PCNS, RHC, and FQHC and LCSW**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Units Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>90802</td>
<td>Interactive Psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (30 Minute session)</td>
<td>Maximum of 2 units per rolling year.</td>
</tr>
<tr>
<td>90804</td>
<td>Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility (approx. 20 to 30 minutes face-to-face with the patient)</td>
<td></td>
</tr>
<tr>
<td>90806</td>
<td>Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility (approx. 45 to 50 minutes face-to-face with the patient)</td>
<td></td>
</tr>
<tr>
<td>90810</td>
<td>Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility (approx. 20 to 30 minutes face-to-face with the patient)</td>
<td>Maximum of 1 unit, either 30 minute or 45-50 minute session allowed per day; Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month.</td>
</tr>
<tr>
<td>90812</td>
<td>Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility (approx. 45 to 50 minutes face-to-face with the patient)</td>
<td></td>
</tr>
<tr>
<td>90846</td>
<td>Family Psychotherapy (without patient present) (30 minute sessions)</td>
<td></td>
</tr>
<tr>
<td>90847</td>
<td>Family Psychotherapy (conjoint Psychotherapy with patient present) (30 minute sessions)</td>
<td>Maximum of 2 units allowed per day;</td>
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</tbody>
</table>
Maximum of 10 units allowed per month.

90853  Group Psychotherapy (other than of a multi-family group)
(30 minute sessions)
Maximum of 3 units per day;
Maximum of 15 units per month.

90880  Hypnotherapy
Maximum of 1 Psychotherapy unit allowed per day.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly, yearly limits represent a violation of DMS policy and are not reimbursed.

The AH modifier must be included when billing claims for psychologists or provisionally licensed psychologists.


PSYCHOLOGIST, PSYCHIATRIST, PCNS, RHC and FQHC

90801  Psychiatric diagnostic interview examination
30 minute session)
Maximum of 6 - 30 minute units per patient, per provider, per rolling year. This code is not payable in an Inpatient setting.

96101  Psychological testing (includes Psycho diagnostic assessment of emotionality, intellectual abilities, personality and Psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report
(60 minute session)

96103  Psychological testing (includes Psycho diagnostic assessment of emotionality, intellectual abilities, personality and Psychopathology, e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report
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(60 minute session)

Maximum of 4 units per provider, per rolling year.

90816 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an office outpatient facility with medical evaluation and management services

(60 minute session)

90823 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting

(60 minute session)

90818 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting

(60 minute session)

90826 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting

(60 minute session)

Maximum of one Interactive or Inpatient Psychotherapy session allowed per day.

90885 Psychiatric evaluation of hospital records, other Psychiatric reports, Psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes

(No time frame noted)

Maximum of one Psychotherapy unit allowed per day.

90805 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an office or outpatient facility with medical evaluation and management services

(60 minute session)
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90807 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an office or outpatient facility, with medical evaluation and management services

(approx. 45 to 50 minute face-to-face with the patient)

90811 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communications, in an office or outpatient facility, with medical evaluation and management services

(approx. 20 to 30 minute face-to-face with the patient)

90813 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communications, in an office or outpatient facility, with medical evaluation and management services

(approx. 45 to 50 minute face-to-face with the patient)

Maximum of 1 unit, either 30 minute or 45-50 minute session per day;

Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions, allowed per month.

90817 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services

(approx. 20 to 30 minute session)

90819 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, with medical evaluation and management services

(approx. 45 to 50 minutes face-to-face with the patient)

90824 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services

(approx. 20 to 30 minutes face-to-face with the patient)

90827 Individual Psychotherapy, Interactive, using play equipment, physical devices,
language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services (approx. 45 to 50 minutes face-to-face with the patient)

Maximum of one Interactive or Inpatient Psychotherapy unit allowed per provider, per patient, per day.

S9484 Crisis intervention – A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient’s well-being or is a danger to him/herself or others (60 minute session)

Maximum of 6 units allowed per calendar year. This code is not payable in an inpatient setting.

96105 Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report (60 minute session)

Maximum of one Psychotherapy unit allowed per day.

96111 Developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report (60 minute session)

Maximum of one Psychotherapy unit allowed per day.

90862 Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical Psychotherapy.

90865 Narcosynthesis for Psychiatric diagnostic and therapeutic purposes (e.g. sodium amobarbital (amytal) interview).

Maximum of one Psychotherapy unit allowed per day.

96116 Neurobehavioral status exam (clinical assessment of thinking, reasoning and
judgment, e.g. acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities)

(Per 60 minute session of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report)

Maximum of one Psychotherapy unit allowed per day. This code is not payable in an Inpatient setting.

Electroconvulsive therapy (includes necessary monitoring)

Maximum of 1 Psychotherapy unit allowed per day.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly, and yearly limits represent a violation of DMS policy and are not reimbursed.

13.15 PRIOR AUTHORIZATION GUIDELINES – CHILDREN

Effective for dates of service May 01, 2005 and after, the prior authorization (PA) process was implemented for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

The requirement for prior authorization includes services provided by a psychiatrist, psychologist or provisionally licensed psychologist, PCNS, licensed clinical social worker (LCSW) or provisionally licensed clinical social worker (PLCSW), licensed professional counselor (LPC) or provisionally licensed professional counselor (PLPC), RHC or FQHC.

Please refer to Section 8 for additional information regarding prior authorization.

13.15.A PRIOR AUTHORIZATION GUIDELINES - CHILDREN 0 THROUGH 20

The prior authorization (PA) process includes services provided by a psychiatrist, psychologist, provisionally licensed psychologist, PCNS, PLCSW, LCSW, PLPC, LPC, RHC, and FQHC.

The first four hours of psychological services for most children and services do not require PA. These four hours are intended to assist a provider seeing a patient for the first time make the transition to PA should more than four hours be required for treatment. These four hours may consist of individual therapy, group therapy or family therapy. the first four hours are per patient,
per provider, per rolling year. Providers who have been paid for services in excess of four hours for a patient in the last 12 month rolling year do not receive four non-Prior Authorized hours for that client.

The four non-prior authorized hours does not apply if providing services to children under the age of 3, individual interactive therapy, family therapy without the patient present, and children ages 3 to 4 for individual therapy. All hours for these services must be prior authorized.

The claims for the four non-prior authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, PA must be obtained. This PA must be requested before rendering additional services. In order not to interrupt services it is recommended that providers request authorization before all 4 hours are used. The first PA request is the initial authorization and any services requested after this are considered continued treatment. Except for those situations indicated above, the preferred method of therapy may be requested by calling the Psychological Services Prior Authorization telephone number.

The provider or a staff member may place the call but the Psychological Services Request for Prior Authorization form, although not mandatory, should be completed as the information on this form is required to complete the request for services. Telephoned requests receive an approval or denial at the time of the call. If additional information is needed the caller is instructed to fax or mail the Psychological Services Request for Prior Authorization form and required documentation. This PA request is not approved during the phone call. Prior authorization of psychology/counseling services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include individual, family, and group therapy.

Assessment and Testing for a child under the age of 3 must be prior authorized and providers must submit clinical justification for providing these services. Prior authorization does not allow the provider to exceed the unit limitations for these services.

To request continuing services after the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the current/updated Treatment Plan, current Diagnostic Assessment and copies of the last three Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached. Before requesting additional hours, 75% of the current authorized hours must be used.

Approval is based on the DSM IV-TR diagnosis code. Up to 10 hours of individual therapy is allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to 20 hours is
allowed for all other covered diagnosis codes. The authorized number of hours is based on the primary diagnosis and the provider’s documentation must support the diagnosis code.

Multiple therapies are the treatment of the individual with more than one therapy such as individual and family, simultaneously within the same authorization period. The Treatment Plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

Providers do not receive a disposition letter when services are authorized or denied via a phone call. An authorization number is provided. Services that require submission of the Psychological Services Request for Prior Authorization form and attachments receive a disposition letter after review. When PA requests are denied partially or in full, the patient receives a letter outlining the reason for denial and their appeal rights. Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information is listed in their denial letter.

When requesting PA for multiple therapies the Psychological Services Request for Prior Authorization form must be completed and faxed or mailed, along with the requested documentation, to DMS. The PA request must indicate all types of therapy being requested.

If a child’s age changes during the PA period, the PA continues as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers apply. LPCs and LCSEWs who are restricted to seeing children under the age of 21 are not paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

13.15.B PRIOR AUTHORIZATION OF CHILDREN BY AGE GROUP

Psychology/counseling services for children under the age of 3, family therapy without the patient present, individual interactive therapy and children ages 3 to 4 for individual therapy are not allowed under the 4 hours of non-prior authorized service. The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request prior authorization (PA). Services other than the preferred method and multiple therapies require the Psychological Services Request for Prior Authorization form and documentation be submitted via fax or mail.

13.15.B(1) Children Birth Through 2

Assessment for three hours and/or testing for four hours is authorized with submission of documentation. Assessment and testing for a child under the age of three must be
prior authorized and providers \textit{must} submit clinical justification for providing these services.

- Family therapy is authorized initially up to 20 hours based upon the submission of required clinical documentation
- Individual therapy is \textit{not} authorized
- Group therapy is \textit{not} authorized

13.15.B(2) Children 3 Through 4

- Family therapy is authorized initially up to five hours without submitting documentation
- Family therapy may be reauthorized up to 15 hours based upon the submission of required clinical documentation
- Individual therapy is \textit{not} authorized with the exception of interactive therapy, which may be authorized for up to 10 hours based upon the submission of required clinical documentation. The provider’s documentation \textit{must} support the reason why individual interactive therapy is being provided
- Group therapy is \textit{not} authorized

13.15.B(3) Children 5 Through 12

- Family therapy is authorized initially for up to 20 hours \textbf{without} submitting documentation
- Family therapy may be reauthorized for up to 20 hours based upon the submission of required clinical documentation
- Individual therapy is authorized initially for up to 5 hours \textbf{without} submitting documentation
- Individual therapy may be reauthorized for up to 10 hours based on the submission of required documentation
- Group therapy is authorized initially for up to 5 hours \textbf{without} submitting documentation
- Group therapy may be reauthorized for up to 10 hours based on the submission of required documentation
13.15.B(4) Children 13 Through 17

- Individual or family therapy or a combination of both are authorized initially for up to 25 hours **without** submitting documentation
- Individual or family therapy or a combination of both may be reauthorized for up to 30 hours based on the submission of required documentation
- Group therapy is authorized initially for up to 5 hours **without** submitting documentation
- Group therapy may be reauthorized for up to 10 hours based on the submission of required clinical documentation

13.15.B(5) Children 18 Through 20

- Individual therapy is authorized initially for up to 20 hours **without** submitting documentation
- Individual therapy may be reauthorized for up to 20 hours based on the submission of required clinical documentation
- Family therapy is authorized initially for up to 5 hours **without** submitting documentation
- Family therapy may be reauthorized for up to 10 hours based on the submission of required documentation
- Group therapy is authorized initially or up to 5 hours **without** submitting documentation
- Group therapy may be reauthorized for up to 10 hours based on the submission of required documentation

Prior authorization (PA) requests may be made by calling: (866) 771-3350

OR submitting the Psychological Services Request for Prior Authorization form and required documentation to:

Mail: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102
Fax: (573) 635-6516
13.16 CHILDREN CODES

13.16.A CHILDREN - CODES REQUIRING PA

PSYCHOLOGIST, PSYCHIATRIST, PCNS, PLCSW, LCSW, PLPC, LPC, FQHC & RHC

90802 Interactive Psychiatric Diagnostic Interview Examination using play equipment, physical devices, language interpreter or other mechanisms of communication

(30 Minute session)

Maximum of 2 units per rolling year.

90804 Individual Psychotherapy Insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility

(approx. 20 to 30 minutes face-to-face with the patient)

90806 Individual Psychotherapy, Insight Oriented, behavior modifying and/or supportive, in an office or outpatient facility

(approx. 45 to 50 minutes face-to-face with the patient)

90810 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility

(approx. 20 to 30 minutes face-to-face with the patient)

90812 Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility

(approx. 45 to 50 minutes face-to-face with the patient)

Maximum of 1 unit, either 30 minute or 45-50 minute session allowed per day; Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions allowed per month.

90846 Family Psychotherapy (without the patient present)

(30 minute session)

90847 Family Psychotherapy (conjoint Psychotherapy with patient present)
(30 minute session)

Maximum of 2 units allowed per day,

Maximum of 10 units allowed per month.

90853 Group Psychotherapy (other than of a multi-family group)

(30 minute session)

Maximum of 3 units allowed per day;

Maximum of 15 units allowed per month.

Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units billed over the daily, monthly and yearly limits represent a violation of DMS policy and is not reimbursed.

13.16.B CHILDREN - CODES NOT REQUIRING PRIOR AUTHORIZATION

PSYCHOLOGIST, PSYCHIATRIST, PCNS, PLCSW, LCSW, PLPC, LPC, FQHC & RHC

90801 Psychiatric diagnostic interview examination.

(30 minute session)

Maximum of 6 – 30 minute units per provider, per patient, per rolling year allowed. This code is not payable in an Inpatient setting.

96101 Psychological testing (includes Psycho diagnostic assessment of emotionality, intellectual abilities, personality and Psychopathology, e.g. MMPI, Rorschach, WAIS), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report

(60 minute session)

96103 Psychological testing (includes Psycho diagnostic assessment of emotionality, intellectual abilities, personality and Psychopathology, e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report.

(60 minute session)
Section 13 - Benefits and Limitations

Maximum of 4 units allowed per provider per rolling year

90816 Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting

(approx. 20 to 30 minute session)

90823 Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting

(approx. 20 to 30 minutes face-to-face with the patient)

90818 Individual Psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting

(approx. 45 to 50 minutes face-to-face with the patient)

90826 Individual Psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting

(approx. 45 to 50 minutes face-to-face with the patient)

90827 Individual Psychotherapy, Interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, with medical evaluation and management services

(approx. 45 to 50 minutes face-to-face with the patient)

Maximum of one Interactive or Inpatient Psychotherapy unit allowed per patient, per provider, per day.

S9484 Crisis intervention - A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient’s well-being or is a danger to himself/herself or others

(60 minute session)

Maximum of 6 units per calendar year. This code is not payable in an inpatient setting.
Regardless of prior authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily, monthly, and yearly limits are not reimbursed.

### 13.17 PREPAYMENT REVIEW PROCESS

For services that are on prepayment review, the provider must bill the services on a paper claim form (CMS-1500) and attach Progress Notes adequately documenting that the services were medically necessary. Before the provider’s claim can be processed for payment, the current diagnostic assessment, treatment plan, claim and progress note must be reviewed by a consultant to determine if the services were medically necessary. This process is called “prepayment review.” If at any time during the prepayment review process there is a new diagnostic assessment or updated treatment plan, they must be submitted as well.

It is important to remember that after a prepayment review has been conducted by DMS, recommendations for approval of payment are in no way a guarantee payment is made. The claim must still pass all required Medicaid claim processing edits, such as the provider must be eligible to provide the service, the individual must be eligible for Medicaid at the time the service was provided, etc.

### 13.18 POSTPAYMENT REVIEW

All services reimbursed through the Medicaid Psychology/Counseling Program are subject to postpayment reviews to monitor compliance with established policies and procedures pursuant to Title 42 CFR 456.1 through 456.23. Non-compliance may result in monetary recoupments according to State regulation 13 CSR 70-3.030(5) and the provider may be subjected to prepayment review on all Medicaid claims. Continued non-compliance may result in termination of the provider enrollment agreement.

### 13.19 PROCEDURE CODE LIMITATIONS

Any code listed below that is not assigned a time value in the Current Procedural Technology (CPT) book is considered a 30 minute code.

#### 13.19.A PROCEDURE CODES FOR LCSW, PLCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW, PLCSW or LPC. The appropriate AJ or UD must be used for all codes.

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<th>Maximum Quantity</th>
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Psychology/Counseling Manual

Archived - 09##2012  Last Updated - 06/27/2008
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### Section 13 - Benefits and Limitations

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### 13.19.B PROCEDURE CODES FOR PSYCHOLOGISTS OR PROVISIONALLY LICENSED PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a psychologist or provisionally licensed psychologist. The AH modifier *must* be used on all codes.

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## Section 13 - Benefits and Limitations

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### 13.19.C PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC, AND RHC

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<td>$30.00</td>
<td>6</td>
<td>Psychiatric diagnostic interview examination</td>
</tr>
<tr>
<td>90801 U8</td>
<td></td>
<td>$35.00</td>
<td>6</td>
<td>Psychiatric diagnostic interview examination, home-private school PS</td>
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<tr>
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<td>Interactive psychiatric diagnostic interview examination -home/PS</td>
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### Section 13 - Benefits and Limitations

<table>
<thead>
<tr>
<th>Code</th>
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<td>Individual psychotherapy, insight oriented, inpatient hospital</td>
</tr>
<tr>
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<td>Description</td>
<td>Frequency</td>
<td>Rate</td>
<td></td>
</tr>
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<tr>
<td>90818</td>
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<td>90827</td>
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<td>90846</td>
<td>Family psychotherapy w/o Patient</td>
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</tr>
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<td>90846</td>
<td>Family psychotherapy w/o Patient-home/PS</td>
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<td>$35.00</td>
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</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy w/ Patient</td>
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<td>$30.00</td>
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</tr>
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<td>90847</td>
<td>Family psychotherapy w/ Patient-home/PS</td>
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<td>$35.00</td>
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<td>90853</td>
<td>Group psychotherapy (other than a multiple-family group)</td>
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<td>90862</td>
<td>Pharmacologic management</td>
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<td>$12.50</td>
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<tr>
<td>90865</td>
<td>Narcosynthesis</td>
<td>1</td>
<td>$25.00</td>
<td></td>
</tr>
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<td>90870</td>
<td>Electroconvulsive therapy (includes monitoring)</td>
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<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>90880</td>
<td>Hypnotherapy</td>
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<td>$8.00</td>
<td></td>
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<tr>
<td>90885</td>
<td>Psychiatric evaluation of records</td>
<td>1</td>
<td>$24.00</td>
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</tr>
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### 13.19.D PROCEDURE CODES

Procedure codes 90871, 96100, and 96115 are no longer valid codes for billing.

Providers must use the new, appropriate procedure code when billing for testing, 96101 or 96103.

Psychological testing may NOT be performed by an LCSW or LPC.

Psychological testing administered by a technician (96102) is NOT a covered service.

Neuropsychological testing (96118, 96119, and 96120) are NOT covered services.

### 13.20 TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service, which represents 20-30 minutes, must include at least 20 minutes face-to-face with the client. When less than 30 minutes is spent face-to-face with the client, the remainder of the time must be...

---

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Rate</th>
<th>Units</th>
<th>Notes</th>
</tr>
</thead>
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<td>Psychological Testing – admin by Psychologist</td>
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<td>4</td>
<td></td>
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<td>96101 U8</td>
<td>Psychological Testing – Psychologist - home/PS</td>
<td>$60.00</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>96103</td>
<td>Psychological Testing – admin by computer, Prof interpretation and Report</td>
<td>$20.00</td>
<td>4</td>
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<td>96103 U8</td>
<td>Psychological Testing – admin by computer, Prof interpretation and Report, home/PS</td>
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<td>4</td>
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<tr>
<td>96105</td>
<td>Assessment of aphasia</td>
<td>$35.00</td>
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<td></td>
</tr>
<tr>
<td>96111</td>
<td>Developmental testing, extend</td>
<td>$35.00</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavior status exam</td>
<td>$35.00</td>
<td>1</td>
<td></td>
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<tr>
<td>S9484</td>
<td>Crisis intervention, per hour</td>
<td>$60.00</td>
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<td>Crisis intervention, per hour home/PS</td>
<td>$65.00</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home) or 99 (private school – PS) as indicated.
directed towards the benefit of the client including, but *not* limited to, report writing, note summary, reviewing Treatment Plan, etc.

A unit of service, which represents 45-50 minutes, *must* include at least 45 minutes face-to-face with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time *must* be directed towards the benefit of the client including, but *not* limited to, report writing, note summary, reviewing Treatment Plan, etc.

Currently, the CPT definition for assessment, family therapy with or without the patient present, and group therapy is *not* time limited; and DMS defines a unit of service as a half hour. (These therapies *must* be provided in full 30-minute units.)

Testing and crisis intervention are defined in the CPT as hour services and a full 60 minutes of services *must* be provided or the service is *not* billable.

Travel time is *not* reimbursable and *must not* be included as part of the scheduled appointment time.

The patient’s progress toward the goals stated in the Treatment Plan/Progress Notes and or need for the service in relationship to the patient’s Treatment Plan *must* be documented within seventy-two (72) hours of the service.

### 13.21 COMBINATION BILLING

Providers may *not* bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is *not* covered on the same date of service.

Providers may *not* bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are *not* covered on the same date of service.

Providers may *not* document in the same Progress Note and/or bill a combination of two therapy types for the same time period.

Certain services include a medical component and are *not* billable by a psychologist, LCSW, or LPC. These codes are 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, and 90870.

Certain services are *not* covered when provided by an LCSW or LPC and may *not* be billed for an adult or child in any setting. These codes are 96101, 96103, 96105, 96111, and 96116.

Psychology/counseling services are *not* billable by a psychiatrist, PCNS, psychologist, LCSW or LPC in a nursing home setting. psychiatrists and PCNS may provide pharmacologic management, procedure code 90862 in the nursing home setting.
13.22 FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill for family therapy for each family member. This is monitored by the Program Integrity Unit. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family therapy furnished by an LCSW or LPC must be directed exclusively to the treatment of the child. Parental issues may not be billed and family therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.

A psychiatrist, PCNS, and psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult’s issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child’s DCN.

Only one prior authorization (PA) is approved and open at a time for family therapy. If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child’s DCN must be used for PA and billing purposes. When a specific child is identified as the primary patient of treatment, that child’s DCN must be used for PA and billing purposes. providers should not request more than one family therapy PA per family.

A family may be biological, foster, adoptive or other family unit. A family is not a group and providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.

13.23 GROUP THERAPY

Group therapy must consist of 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient group therapy sessions also.

Group therapy may not be billed on the same date of service as family therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. Services must be provided at the facility location. Group therapy in a group home is billed with POS 14. Group therapy in a residential/custodial facility is billed with POS 33. Group therapy in a shelter type setting is billed with POS 04.
13.24 COVERED SERVICES

Mental health services are covered when the need for treatment is a result of a complete, partial, or interperiodic Healthy Children and Youth (HCY) screening and the service is medically necessary. See Section 9 of this provider manual for additional information on Healthy Children and Youth (HCY) Screening services.

Mental health services may be covered when performed by a licensed psychiatrist, PCNS, licensed psychologist, or provisionally licensed psychologist, or licensed or provisionally licensed clinical social worker and within limits a FQHC and RHC.


Partial EPSDT/HCY screens for Developmental Mental Health Assessment may be performed by a psychiatrist, PCNS, psychologist, professional counselor, or social worker. Other providers who may perform Developmental Mental Health Assessments are listed in Section 9.

A Developmental Mental Health Assessment includes:

- Assessment of personal, social and language development.
- Assessment of fine and gross motor skill development.
- Assessment of emotional and psychological status.

Age appropriate guides can be found on the HCY Screening Guide included in Section 9.

The diagnosis code of “V202” must appear as the primary diagnosis in Field #23A on the CMS-1500 claim form when billing for HCY developmental screening service.

Developmental partial screens (9942959 and 9942959UC) are covered for children under the age of 21 in the HCY psychology/counseling program. It is the provider’s responsibility to encourage the child/youth to have an HCY examination to facilitate total health care that establishes the need for the treatment services.

13.24.B EPSDT/HCY PARTIAL SCREEN FOR DEVELOPMENTAL ASSESSMENT

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>DESCRIPTION</th>
<th>MEDICAID MAXIMUM ALLOWABLE AMOUNT</th>
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<tbody>
<tr>
<td>9942959</td>
<td>Developmental/mental health partial screen</td>
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</tr>
<tr>
<td>9942959UC</td>
<td>Developmental/mental health partial screen with referral</td>
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</tbody>
</table>
13.24.C PARTIAL SCREENERS

The provider of a partial medical screen should have a patient referral source for the remaining required components of the screen. Examples of partial screeners may include but are not limited to:

- Public Health Departments
- Early Childhood Programs
- School Districts

13.24.D INPATIENT MENTAL HEALTH SERVICES

When providing mental health services in an inpatient place of service, the monthly limitation and prior authorization requirements do not apply. In accordance with 19 CSR 30-20.02, a psychologist may admit an individual to the hospital if the admitting privileges to the hospital have been obtained. The hospital is responsible for making sure that Health Care Excel (HCE) is notified and the admission is certified for Missouri Medicaid. The hospital is reimbursed for inpatient services as long as all Medicaid hospital policies are followed.

13.25 NONCOVERED SERVICES

Services that are performed to treat individuals over 21 associated with an EPSDT/HCY child are not covered. If it is determined that the parent/guardian or other individual is in need of service, the appropriate referral should be made to a psychologist, psychiatrist or PCNS.

The following services are not covered under the Psychology/Counseling Program:

- Biofeedback therapy
- Electroshock therapy by a psychologist, licensed or provisionally licensed professional counselor or licensed or provisionally licensed clinical social worker.
- Telephone consultations
- Auditory Therapy
- Court Appearances
- Services that require prior authorization (PA), but were performed without a PA; or
- Testing when performed by a licensed or provisionally licensed professional counselor or licensed or provisionally licensed clinical social worker.
13.25.A NON-ALLOWED SERVICES

The following services are non-allowed under the Psychology/Counseling Program and may not be billed to a Medicaid patient:

- Courtesy calls such as patient drop in visits to give a progress report that was not scheduled, and no therapy services were rendered
- Missed appointments or failure to show
- Additional payment is not made for services that are performed after regularly scheduled office hours, on holidays, or on weekends
- Services performed by non-licensed, non-enrolled personnel; or
- Participation in Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) meeting
- Telephone calls
- Court appearances
- Mental health services that are performed to treat the parent of a Medicaid eligible child who is not in MC+ are not covered on a fee-for-service basis. If it is determined that the parent/guardian is in need of mental health services, the appropriate referral must be made. Non-covered services may be billed to the patient.

13.25.B PSYCHOLOGICAL SERVICES IN A NURSING HOME

Medicaid does not cover psychological services, with the exception of 90862, to nursing facility residents when those services are provided in a nursing home. This is the policy regardless of any arrangement a provider may have with a nursing facility concerning the leasing of office space within the nursing home. If psychotherapy services are provided in the long term facility itself, there is no Medicaid coverage afforded a patient. Any costs incurred by a facility for the provision of these services are not allowable costs on the nursing facility's Medicaid cost report.

13.26 MODIFIERS

Claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

- AH – Psychologist
- AJ – Licensed Clinical Social Worker
- UD – Licensed Professional Counselor
- U8 – in home (12) or private school (99)
(The U8 modifier is *not* appropriate when billing 90853 regardless of POS)

The CR modifier is used to track services provided to patients identified as catastrophe/disaster victims in any part of the country CR – Catastrophe/Disaster Related. This modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

**13.27 FREQUENTLY USED PLACE OF SERVICE CODES**

- 03 – Public School
- 04 – Homeless Shelter
- 11 - Office
- 12 – Home
- 14 – Group Home
- 21 – Inpatient Hospital
- 22 – Outpatient Hospital
- 33 – Custodial Care Facility
- 50 - FQHC
- 51 – Inpatient Psychiatric Facility
- 55 – Psychiatric R
- 56 – Psychiatric Residential Treatment Facility
- 61 – Comprehensive Inpatient Rehabilitation Facility
- 72 – Rural Health Clinic
- 99 – Private School

**13.27.A PLACE OF SERVICE CODE**

The only valid setting for using place of service code 99 is a private/parochial school. (Head Start is *not* considered a private school.)

Services provided in a public school setting should use place of service 03.

Place of service 99 *cannot* be used for therapy provided in a public setting. A public setting includes but is *not* limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers *must* use the appropriate place of service code for the setting in which they provide services.
services are rendered. If there is no place of service code that matches the setting, services may not be billed to Medicaid. Although there is a place of service 15 for mobile unit, Medicaid does not cover services provided in this setting.

Place of service 11 (office) may be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) have defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

Providers who provided care for children who reside in a Residential Treatment Center and who are under the care and custody of the Children’s Division must use place of service code “33.”

Group therapy services are not covered in the home, place of service “12.”

- When providing therapy to a group of children in a group home, group therapy (90853) is billed with a place of service group home (POS 14)(Documentation must show the reason for providing services in the home.).

**13.28 DIAGNOSIS CODES (text del. 5/07)**

**13.29 REFERRAL SERVICES**

Services for parent(s)/guardian(s) and/or the family unit that are medically necessary but beyond the scope of the HCY psychology/counseling Program may be obtained through the adult Psychology Program or by a referral to other programs. Medically necessary psychology services are also available through the Department of Mental Health’s Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program, Community Psychiatric Rehabilitation (CPR) Program, or in an FQHC/RHC setting; however, these services are available under specific guidelines.

Medicaid provides for Psychiatric/psychological services to patients without regard to age when medically necessary. These services are covered only when performed by an enrolled psychiatrist, PCNS or enrolled psychologist. psychiatrists, PCNS and psychologists must bill for covered services including HCY services through the Psychology Program.

**13.30 THIRD PARTY LIABILITY (TPL)**

When a Medicaid patient has a third party resource (TPR) that may be liable for the payment of all or a portion of the service, it must be submitted to the insurance company before Medicaid considers the
claim for payment. See Section 5 of this provider manual for further instructions on how to submit claims affected by a TPR.

Federal regulation 42 CFR 447.20 states the following: “A provider may not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party’s potential liability for the service(s).”

13.30.A TPL BYPASS

Certain services are eligible to bypass Third Party Liability (TPL) editing in the Medicaid payment system. Those claims involve preventative pediatric services (including EPSDT services), prenatal care, and those that the third party resource is derived from a non-custodial parent whose medical support obligation is being enforced by the Family Support Division. Federal regulation, 42 CFR 433.139 (B)(3)(i)(ii) requires the state Medicaid agency to pay and chase these claims when the provider elects not to pursue the third party resource for payment.

If the claim falls into one of the above categories and the provider elects not to bill the third party resource, the Third Party Liability Unit pursues reimbursement of the Medicaid payment for this service directly from the TPR. The provider must indicate on the claim form whether or not the TPR has been billed.

When this option is exercised, the provider’s payment is limited to the Medicaid payment amount. If a TPR payment is received after Medicaid has been billed for the service, the payment must be forwarded to the Medicaid agency to be distributed as specified by federal regulation.

13.30.B TPL LIABILITY INSURANCE REPORTING FORM

Many providers have requested the capability to report changes in insurance coverage directly to the Medicaid agency when they learn of them from the patient or the insurance company. In the past, changes were to be reported to the patient’s caseworker. A form has been developed for the provider to report changes or additions to a patient’s insurance records.

Please refer to Section 5 of this manual for additional information regarding submission of this form.

13.31 MANAGED CARE BEHAVIORAL HEALTH SERVICES

Managed care health plans provide behavioral health services for children except for those children in state care and custody (Group 4). Children in Group 4 receive behavioral health services on a fee-for-service basis outside of the health plan. Refer to Section 1 and Section 11 for further information.
13.32 REPORTING CHILD ABUSE CASES

State Statute at 210.115 RSMo (Cum. Supp. 1992) requires hospitals and other specified personnel to report possible child abuse cases to the Family Support Division Child Abuse Hotline. Children's Division Child Abuse and Neglect Hotline Unit (CA/NHU) accepts confidential reports of suspected child abuse, neglect, or exploitation. Reports are received through a toll-free telephone line which is answered 7 days a week, 24 hours a day. Members of certain occupational groups, such as teachers, social workers, and physicians, are mandated by law to make reports to the hotline. Any person may report, and anonymous reports are accepted from individuals who are not mandated by occupation to report. Effective August 28, 2004, Missouri law requires Mandated Reporters to identify themselves when making a report.

The toll-free number is (800) 392-3738.

Persons calling from outside Missouri should dial (573) 751-3448.

Text telephone number: (800) 669-8689.