SECTION 2

Mental Health Centers

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1. GENERAL POLICY

1 - 1 Authority

Rehabilitative mental health services are provided under the authority of 42 CFR 440.130, Diagnostic, Screening, Preventive, and Rehabilitative Services. Under this authority, services may be provided in settings other than the mental health center, as appropriate, with the exception of an inpatient hospital.

1 - 2 Qualified Mental Health Providers

Rehabilitative mental health services are covered benefits when provided by or through a mental health center under contract with or directly operated by a local county mental health authority.

Children in State Custody

For the provision of outpatient services to children in state custody, mental health centers may follow this provider manual. However, children in state custody must have more frequent reviews of their treatment plans. The review schedule for children in state custody is outlined in Chapter 1 - 8, Periodic Review of the Treatment Plan.

1 - 3 Definitions

Habilitation Services: typically means interventions for the purpose of helping individuals acquire new functional abilities whereas rehabilitative services are for the purpose of restoring functional losses. (See Rehabilitative Services definition below.)

Medically Necessary Services: means any mental health service that is necessary to diagnose, correct or ameliorate a mental illness or condition, or prevent deterioration of that mental illness or condition or development of additional health problems and there is no other equally effective course of treatment available or suitable that is more conservative or substantially less costly.

Non-Traditional Medicaid Plan: means the reduced benefits plan provided to adult Medicaid eligibles age 19 through age 64 who are in TANF, or certain Medically Needy or Transitional Medicaid eligibility categories. Their Medicaid cards say ‘Non-Traditional Medicaid.’

Prepaid Mental Health Plan (PMHP): means the Medicaid managed care plan that is responsible for all needed inpatient and outpatient mental health care for Medicaid clients living in certain geographic areas of the state. Medicaid clients enrolled in the PMHP must receive inpatient and outpatient mental health services through PMHP contractors (mental health centers) paid on a capitation basis. Children in state custody, and children with an adoption subsidy exempted from the PMHP, are **not** enrolled in the PMHP for outpatient mental health services; they are only enrolled in the PMHP for inpatient mental health services.

Rehabilitative Services: means in accordance with 42 CFR 440.130, any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law, for maximum reduction of a physical or mental disability and restoration of a recipient to his best possible functional level.

1 - 4 Scope of Services

The scope of rehabilitative mental health services includes the following:

- Psychiatric Diagnostic Interview Examination
- Mental Health Assessment by a Non-Mental Health Therapist
- Psychological Testing
- Individual Psychotherapy
- Individual Psychotherapy with Medical Evaluation and Management Services
- Family Psychotherapy with patient present
- Family Psychotherapy without patient present
- Group Psychotherapy
- Multiple-Family Group Psychotherapy
- Pharmacologic Management
- Therapeutic Behavioral Services
- Psychosocial Rehabilitative Services

Rehabilitative mental health services are limited to medically necessary services designed to promote the client's mental health, reduce the client's mental disability, restore the client to the highest possible level of functioning, promote the client's self-sufficiency, and systematically reduce the client's reliance on mental health support systems.

Note: Rehabilitative substance abuse services are not included under this provider manual. (See the Medicaid provider manual entitled *Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse* that details the Medicaid fee-for-service substance abuse program.)

See Chapter 2, Scope of Services, for service definitions and limitations.

1 - 5 Provider Qualifications

A. Providers Qualified to Prescribe Services

Rehabilitative services must be prescribed by an individual defined below:

1. licensed mental health therapist practicing within the scope of his or her license in accordance with Title 58, Utah Code Annotated, 1953, as amended:

a. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
b. licensed psychologist qualified to engage in the practice of mental health therapy;
c. licensed clinical social worker;
d. licensed certified social worker under the supervision of a licensed clinical social worker;
e. licensed advanced practice registered nurse (APRN), either as a nurse specialist or a nurse practitioner, with psychiatric mental health nursing specialty certification;
f. licensed marriage and family therapist;
g. licensed professional counselor; or

2. an individual who is working within the scope of his or her certificate or license in accordance with Title 58, Utah Code Annotated, 1953, as amended:

a. certified psychology resident under the supervision of a licensed psychologist qualified to engage in the practice of mental health therapy;
b. licensed APRN without psychiatric mental health nursing specialty certification;
c. licensed APRN intern;
d. associate marriage and family therapist under the supervision of a licensed marriage and family therapist;
e. associate professional counselor under the supervision of a licensed mental health therapist except a certified social worker; or

3. an individual exempted from licensure:

a. a student enrolled in an education/degree program leading to licensure in one of the professions above, not currently licensed but exempted from licensure under Title 58, Utah Code Annotated, 1953, as amended, because of enrollment in qualified courses, internship or practicum, and under the supervision of qualified faculty. [See Title 58-1-307(1)(b).]; or

b. an individual who was employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his official duties for that agency or political subdivision. [See Title 58-61-307(2)(h).]

B. Providers Qualified to Render Services

In accordance with the provider limitations set forth in Chapter 2, Scope of Services, rehabilitative services may be provided by:

1. individuals identified in paragraph A of this chapter;
2. one of the following individuals working within the scope of his or her certificate or license in accordance with Title 58, Utah Code Annotated, 1953, as amended :

a. licensed social service worker; or individual working toward licensure as a social service worker;

b. licensed registered nurse;

c. licensed practical nurse;

d. licensed physician assistant (or other medical practitioner);

3. registered nursing student enrolled in an education/degree program leading to licensure [See Title 58-1-307(1)(b)]; or
4. other trained individual.

.C. Supervision

See Chapter 2, Scope of Services, for service-specific supervision requirements. For certified social workers specified in paragraph A. 1, individuals specified in paragraph A. 2 and 3, and individuals specified in paragraph B. 2 and 3 above, the mental health center must ensure supervision is provided in accordance with requirements set forth in Title 58 of the Utah Code Annotated, 1953, as amended, and the applicable profession's practice act rule as set forth by the Utah Department of Commerce and found at the Department of Administrative Services, Division of Administrative Rules, at: www.rules.utah.gov/publicat/code.htm

1 - 6 Evaluation Procedures

In accordance with state law, individuals identified in paragraph A of Chapter 1-5 are qualified to conduct an evaluation (psychiatric diagnostic interview examination). An evaluation must be conducted to assess the existence, nature, or extent of illness, injury or other health deviation for the purpose of determining the client's need for medically necessary services. (See Chapter 2-2, Psychiatric Diagnostic Interview Examination.)

1 - 7 Treatment Plan

A. If it is determined that services are medically necessary, an individual identified in paragraph A of Chapter 1-5 must develop a treatment plan.

B. The treatment plan is a written, individualized plan which contains measurable treatment goals related to problems identified in the psychiatric diagnostic interview examination. The treatment plan must be designed to improve and/or stabilize the client's condition.

C. The treatment plan must include the following:

1. measurable treatment goals;

   If the treatment plan contains psychosocial rehabilitative services, there must be measurable goals specific to all issues being addressed with this treatment method. Actual treatment goals may be developed by qualified providers identified in the "Who" section in Chapter 2 - 10, Psychosocial Rehabilitative Services, and they may be documented in an addendum to the treatment plan;

2. the treatment regimen–the specific treatment methods that will be used to meet the measurable treatment goals;

3. a projected schedule for service delivery, including the expected frequency and duration of each treatment method;

4. the licensure or credentials of the individuals who will furnish the prescribed services; and

5. the signature and licensure or credentials of the individual who developed the treatment plan.

1 - 8 Periodic Review of the Treatment Plan

A. An individual identified in paragraph A of Chapter 1-5 must periodically review the client's treatment plan (at a minimum, every six months) with completion during the calendar month in which it is due. Reviews may be conducted more frequently if the nature of needed services changes or if there is a change in the client's condition or status as determined by the individual identified in paragraph A of Chapter 1-5 overseeing the treatment plan. B. For children in state custody, periodic reviews of the treatment plan must be conducted in accordance with the Department of Human Services review policy (i.e., at least quarterly), or more often as needed, if there is a change in the client's condition or status as determined by the individual identified in paragraph A of Chapter 1- 5 overseeing the treatment plan.

B. An individual identified in paragraph A of Chapter 1-5 must have sufficient face-to-face contact with the client and input from providers of services delivered during the review period in order to complete the review of progress toward the treatment goals, the appropriateness of the services being prescribed and the medical necessity of continued rehabilitative services.

1. If an individual identified in paragraph A of Chapter 1-5 provides ongoing services to the client, then the treatment plan review conducted by this individual may not require a face-to-face contact. However, if the treatment plan review does not include a face-to-face contact, it cannot be billed.

2. If the individual identified in paragraph A of Chapter 1-5 who will conduct the review has had only limited or no contact with the client during the review period, and therefore, does not have sufficient clinical information to evaluate the treatment prescription and medical necessity of continued rehabilitative services, then the client must be seen face-to-face to conduct the treatment plan review.

C. Treatment plan reviews shall be documented in detail in the client's record and include:

1. the date, actual time and duration of the service;

2. the specific service rendered (i.e., treatment plan review);

3. an update of progress toward established treatment goals, the appropriateness of the services being furnished, and the need for continued rehabilitative services; and4. the signature and licensure or credentials of the individual who conducted the treatment plan review.

D. If the individual identified in paragraph A of Chapter 1-5 determines during a treatment plan review that the treatment plan (e.g., problems, goals, methods, etc.) needs to be modified, then as part of the treatment plan review, an updated treatment plan also must be developed.

E. The treatment plan review may be billed only if the review is conducted during a face-to-face interview with the client.

F. The treatment plan review may be billed as psychiatric diagnostic interview examination as long as the elements of the service are met; as individual psychotherapy or individual psychotherapy with medical evaluation and management services, if it is conducted during an individual psychotherapy session, or an individual psychotherapy with medical evaluation and management services session, as family psychotherapy if it is conducted during a family psychotherapy session; or as pharmacologic management if it is conducted during a pharmacologic management service.. (See Chapters 2-2, 2-5, 2-6 and 2-8.)

1 - 9 Documentation

A. The provider must develop and maintain sufficient written documentation for each service or session for which billing is made.

B. See Chapter 2, Scope of Services, for documentation requirements specific to each service.

As specified in Chapter 2, documentation of actual time of the service is required. However, an acceptable practice is to round to the nearest five minute interval to determine the time and duration of the service.

C. The clinical record must be kept on file, and made available for state or federal review, upon request.

1 - 10 Quality Improvement

PMHPs– PMHPs must implement a quality improvement plan in accordance with the PMHP Contract. (See PMHP Contract, Article VIII, Quality Assessment and Performance Improvement, Section F., Peer Review.)

Fee-For-Service Mental Health Centers– Fee-for-service mental health centers must have a written quality improvement plan. The plan must have the means to evaluate all aspects of the organization as well as the quality and timeliness of services delivered. The plan must include an interdisciplinary quality improvement committee that has the authority to report its findings and recommendations for improvement to the agency's director. The quality improvement committee must meet a least quarterly to conduct or review quality improvement activities and make recommendations for improvement. The quality improvement plan must also include written peer review procedures to assess access and the quality and adequacy of the services being delivered. The quality improvement plans must also include written peer review procedures for determining adherence to Medicaid policy outlined in this manual and in the *Medicaid Provider Manual for Targeted Case Management for the Chronically Mentally Ill*, including a process for determining whether claims for Medicaid payment have been made appropriately. Peer reviews must be conducted no less than two times per year. The quality improvement committee, and any subcommittees, must maintain written documentation of quality improvement meetings and the results of peer reviews subject to review by state and federal officials.

1 - 11 Collateral Services

Services must be provided to or directed exclusively toward the treatment of the Medicaid individual. Collateral services may be billed if the following conditions are met:

1. the service is provided face-to-face to an immediate family member (for example, parent or foster parent) on behalf of the identified client and the client is not present;

2. the identified client is the focus of the session; and

3. the progress note specifies the service was a collateral service and documents how the identified client was the focus of the session. Other documentation requirements under the 'Record' section of the applicable service also apply.

4. If the client is receiving individual psychotherapy or family psychotherapy and the client is not present, procedure code 90846 (family psychotherapy without patient present) must be used. If the collateral service is not individual psychotherapy or family psychotherapy, the applicable service code must be used.

1 - 12 Billing Multiple Same-Service Contracts in a Day

If the same service is provided multiple times in a day, and each service meets the minimum time requirements for billing, then each service may be billed. If a service contact does not meet the minimum time requirement, it may not be billed. Minimum time requirements for services are delineated in Chapter 2, Scope of Services.

When multiple same services are provided in a day and each service independently meets the time specifications, each service may be billed. With the exception of individual psychotherapy, multiple same services provided in a day may be billed on separate lines of a claim, or the units for the separate services may be totaled and billed on one line of the claim. See Chapter 2-5, Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management Services, 'Units,' for instructions on billing multiple individual psychotherapy services in a day.

2. SCOPE OF SERVICES

Rehabilitative mental health services are covered benefits when they are medically necessary services. Medically necessary services may include psychiatric diagnostic interview examination, mental health assessment by a non-mental health therapist, psychological testing, individual psychotherapy, individual psychotherapy with medical evaluation and management services, family psychotherapy, group psychotherapy, pharmacologic management, therapeutic behavioral services, and psychosocial rehabilitative services, as described in Chapters 2 - 2 through 2 - 10.

2 - 1 General Limitations

1. Rehabilitative services do not include:

   a. Services provided to inmates of public institutions or to residents of institutions for mental diseases;

   b. Habilitation services;

c. Educational, vocational and job training services;

d. Recreational and social activities;

e. Room and board;

f. Services where the therapist or others during the session use coercive techniques (e.g., coercive physical restraints, including interference with body functions such as vision, breathing and movement, or noxious stimulation) to evoke an emotional response in the child such as rage or to cause the child to undergo a rebirth experience. Coercive techniques are sometimes also referred to as holding therapy, rage therapy, rage reduction therapy or rebirthing therapy; and.

g. Services wherein the therapist instructs and directs parents or others in the use of coercive techniques that are to be used with the child in the home or other setting outside the therapy session.

2. Medicaid adults in the Non-Traditional Medicaid Plan have the following limitations:

a. Inpatient mental health care– There is a 30-day maximum per calendar year per client for inpatient mental health care.

b. Outpatient mental health services/visits– There is a maximum of 30 outpatient mental health treatment services/visits per client per calendar year for outpatient mental health care. Targeted case management services for the chronically mentally ill also count toward the 30 outpatient mental health services/visits maximum. (See provider manual entitled *Utah Medicaid Provider Manual, Targeted Case Management for the Chronically Mentally Ill*.)

Substitutions– Substitution of outpatient mental health services/visits for inpatient days may be made if the client requires more than 30 outpatient mental health services/visits per year, the client would otherwise be hospitalized for treatment of the mental illness or condition, and in lieu of hospitalization, outpatient mental health services could be used to stabilize the client. If the criteria for substitution are met, all outpatient mental health services, with the exception of psychosocial rehabilitative services, may be substituted at a rate of one outpatient mental health service/visit for one inpatient day. Psychosocial rehabilitative services may be substituted at a rate of two visits for each inpatient mental health day.

Example: A client has utilized the maximum outpatient mental health benefits by using ten outpatient psychosocial rehabilitative services visits and 20 other outpatient mental health services. However, without continued outpatient mental health treatment, the client would require inpatient mental health care. Therefore, the client utilizes another 20 psychosocial rehabilitative services visits and 15 other outpatient mental health services. The 20 outpatient psychosocial rehabilitative services visits are substituted for ten inpatient days and the 15 other outpatient mental health services are substituted for 15 inpatient days. The client now has five inpatient mental health days available for the remainder of the year. The client discontinues outpatient mental health treatment. An additional five outpatient mental health services could be used later in the year only if the client again meets the substitution criteria. Without meeting this criteria, there are no remaining outpatient mental health benefits, only the five inpatient mental health days.

c. The following services are also excluded and may not be billed under any of the services specified in chapters 2 - 2 through 2 - 10;

1) Services for conditions without manifest mental health diagnoses (i.e., conditions that do not warrant a mental health diagnosis);

2) Hypnosis, occupational or recreational therapy;

3) Office calls in conjunction with medication management for repetitive therapeutic injections; and

4) Psychiatric diagnostic interview examination for legal purposes only (e.g., for custodial or visitation rights, etc.).

2 - 2 Psychiatric Diagnostic Interview Examination

Psychiatric diagnostic interview examination means a face-to-face evaluation with the client to determine the existence, nature and extent of a mental illness or disorder for the purpose of identifying the client's need for mental health services, with interpretation and report. The evaluation includes a history, mental status and a disposition. It may also include communication with family or other sources and ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants will be seen in lieu of the client.

Interactive psychiatric diagnostic interview examination- This service is typically furnished to children. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a client who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language and includes physical devices, play equipment, language interpreter, or other mechanisms of non-verbal communication to aid in the examination.

If it is determined services are medically necessary an individual identified in Chapter 1-5, paragraph A, must develop an individualized treatment plan. (See Chapter 1-7, Treatment Plan.)

Psychiatric diagnostic interview examinations may also be provided in a tele-health setting to rural clients where distance and travel time create difficulty with access. See 'Limits' section below.

Who: 1. In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure.

a. licensed physicians and surgeons or osteopathic physicians regardless of specialty may perform this service;

b. licensed APRNs without psychiatric mental health nursing specialty certification may provide this service if;

1) the licensed APRN is formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under

the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;

2) the licensed APRN is not formally working toward the psychiatric mental health nursing specialty but is under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification or other licensed mental health therapist, except licensed certified social workers; or

3) the individual is a licensed APRN intern under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification or other licensed mental health therapist, except licensed certified social workers.

2. When evaluations are conducted for the purpose of determining need for medication prescription, these evaluations may be conducted by licensed physician assistants when practicing within their scope of practice and under the delegation of services agreement required by their practice act.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. report of psychiatric diagnostic interview examination findings that includes:
   a. history and mental status (mental status report may be based on formal assessment or on observations from the evaluation process); and
   b. disposition, including diagnosis(es), recommended mental health services, and other recommended services as appropriate; and
6. signature and licensure or credentials of individual who rendered the service.

Unit: **90801 - Psychiatric Diagnostic Interview Examination - per 15 minutes**

90802 –Interactive Psychiatric Diagnostic Interview Examination - per 15 minutes

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits:

1. The periodic reevaluation of the client's treatment plan by an individual identified in paragraph A of Chapter 1 - 5 may be billed only if the reevaluation conducted includes a face-to-face interview with the client and the elements of this service are met.

2. Psychiatric diagnostic interview examinations provided in a tele-health setting are limited to clients residing in rural areas of Utah and are limited to evaluations conducted to determine need for medication prescription.

3. When a psychiatric diagnostic interview examination is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.

2 - 3 Mental Health Assessment by a Non-Mental Health Therapist

Mental health assessment by a non-mental health therapist means individuals listed below participating as part of a multi-disciplinary team in the psychiatric diagnostic interview examination process and in the periodic reevaluation/review of the treatment plan by gathering psychosocial data, including basic historical, social, functional, psychiatric, developmental, or other information, through face-to-face contacts with the client. Also see #1 in 'Limits' section below.

Who:

1. licensed social service worker or individual working toward licensure as a social service worker;

2. licensed registered nurse; or

3. licensed practical nurse; under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or

4. registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3.

Although one of these individuals may assist in the evaluation or reevaluation process by gathering the psychosocial data as directed by the supervisor, under state law, an individual identified in the 'Who' section of Chapter 2-2 must conduct the psychiatric diagnostic interview examination or the reevaluation /treatment plan review. (See Chapter 1-8, Periodic Review of the Treatment Plan.) These individuals may also participate as part of the multi-disciplinary team in the development of the treatment plan, but they may not independently diagnose or prescribe treatment. Individuals identified in the 'Who' section of Chapter 2-2, based on their evaluation of the client, must diagnose and prescribe treatment.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);

2. duration of the service;

3. setting in which the service was rendered;

4. specific service rendered;

5. summary of psychosocial findings; and

6. signature and licensure or credentials of individual who rendered the service.

Unit: **H0031 - Mental Health Assessment by a Non-Mental Health Therapist – per 15 minutes**

When billing or reporting this procedure code, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits: This service is meant to accompany the psychiatric diagnostic interview examination or the reevaluation/periodic review of the treatment plan. Therefore, it should be billed only if a psychiatric diagnostic interview examination or a reevaluation/treatment plan review is also provided.

However, if the psychiatric diagnostic interview examination or the reevaluation/treatment plan review is not conducted after this assessment is performed, this assessment may be billed if:

(1) all of the documentation requirements in the ‘Record’ section are met; and

(2) the reason for non-completion of the psychiatric diagnostic interview examination or the reevaluation/treatment plan review is documented.

2 - 4 Psychological Testing

Psychological testing means a face-to-face evaluation to determine the existence, nature and extent of a mental illness or disorder using psychological tests appropriate to the client’s needs, including psychometric, diagnostic, projective, or standardized IQ tests, with interpretation and report.

Who: 1. licensed physician and surgeon, or osteopathic physician engaged in the practice of mental health therapy;

2. licensed psychologist qualified to engage in the practice of mental health therapy;

3. certified psychology resident under the supervision of a licensed psychologist qualified to engage in the practice of mental health therapy;

4. psychology student enrolled in a predoctoral education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a; or.

5. an individual exempted from licensure in accordance with Chapter 1-5, paragraph A.3.b, employed as a psychologist by a state, county or municipal agency or other political subdivision of the state prior to July 1, 1981, and who subsequently has maintained employment as a psychologist in the same state, county, or municipal agency or other political subdivision while engaged in the performance of his/her official duties for that agency or political subdivision. [See Title 58-61-307(2)(h).]

Record: Documentation must include:

1. date(s) and actual time(s) of testing (time may be rounded to the nearest five minute interval);
2. duration of the testing;
3. setting in which the testing was rendered;
4. specific service rendered;
5. signature and licensure or credentials of individual who rendered the service; and
6. written test reports which include:

a. brief history
b. tests administered;
c. test scores;
d. evaluation of test results;
e. current functioning of the examinee;
f. diagnoses;
g. prognosis; and
h. specific treatment recommendations for mental health services, and other recommended services as appropriate.

Unit: **96101** - **Psychological Testing** - includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI, with interpretation and report - **per hour**

96105 - Assessment of Aphasia - includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading spelling, writing, e.g., Boston Diagnostic Aphasia Examination, with interpretation and report **- per hour**

96110 -Developmental Testing: limited - e.g., Developmental Screening Test ll, Early Language Milestone Screen, with interpretation and report - **per hour**

96111 - Developmental Testing: extended -includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development, with interpretation and report - **per hour**

96116 - Neurobehavioral Status Exam - Clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning, with interpretation and report - **per hour**

96118 - Neuropsychological Testing Battery - e.g., Halstead-Reitan, Luria, WAIS-R, with interpretation and report - **per hour**

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 30 minutes equals 0 units;

30 minutes through 89 minutes of service equals 1 unit;

90 minutes through 149 minutes of service equals 2 units;

150 minutes through 209 minutes of service equals 3 units; and

210 minutes through 269 minutes of service equals 4 units; etc.

Limits: None.

2 - 5 Individual Psychotherapy and Individual Psychotherapy with Medical Evaluation and Management Services

Individual psychotherapy means face-to-face interventions with an individual client. Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development so that the client may be restored to his/her best possible functional level.

Individual psychotherapy includes insight oriented, behavior modifying and/or supportive psychotherapy, and interactive psychotherapy.

Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of the above to provide therapeutic change.

Interactive psychotherapy is typically furnished to children. It involves the use of physical aids or devices, play equipment, language interpreter, or other mechanisms of non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a client who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the clinician if he/she were to use ordinary adult language for communication.

Individual Psychotherapy with Medical Evaluation and Management Services

Some clients receive psychotherapy only and others receive psychotherapy and medical evaluation and management services from a prescriber identified below. These evaluation and management services

involve a variety of responsibilities unique to the medical management of psychiatric patients, such as medical diagnostic evaluation (e.g., evaluation of comorbid medical conditions, drug interactions, and physical examinations), drug management when indicated, physician orders, interpretation of laboratory or other medical diagnostic studies and observations.

Individual psychotherapy/interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services may also be provided in a tele-health setting to rural clients where distance and travel time create difficulty with access. See 'Limits' section below.

Who: A. **Individual Psychotherapy/Interactive Psychotherapy**

In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or an individual exempted from licensure.

APRNs may perform this service if the individual is:

1. a licensed APRN with psychiatric mental health nursing specialty certification;
2. a licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
3. a licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or
4. an APRN student specializing in psychiatric mental health nursing enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a.

B. **Individual Psychotherapy/Interactive Psychotherapy with Medical Evaluation and Management Services**

1. licensed physician and surgeon or osteopathic physician engaged in the practice of mental health therapy;
2. licensed APRN with psychiatric mental health nursing specialty certification;
3 licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
4. licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

5. APRN student specializing in psychiatric mental health nursing enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);
6. clinical note that documents:
   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);
   b. the focus of the psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);
   c. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers;
7. for individual psychotherapy with medical evaluation and management services, if applicable, a medication order or copy of the prescription signed by the prescribing practitioner; and
8. signature and licensure or credentials of individual who rendered the service.

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

90804 - **approximately 20 to 30 minutes**

90806 - approximately 45 to 50 minutes

90808 - **approximately 75 to 80 minutes**

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

90805 – approximately 20 to 30 minutes

90807 – approximately 45 to 50 minutes

90809 – approximately 75 to 80 minutes

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

90810 - **approximately 20 to 30 minutes**

90812 - **approximately 45 to 50 minutes**

90814 - **approximately 75 to 80 minutes**

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

90811 - **approximately 20 to 30 minutes**

90813 - **approximately 45 to 50 minutes**

90815 - **approximately 75 to 80 minutes**

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified service provided:

Less than 10 minutes, equal 0 units;

10-37 minutes, use the applicable procedure code with a 20-30 minute time frame;

38-62 minutes, use the applicable procedure code with a 45-50 minute time frame; and

63 or more minutes, use the applicable procedure code with a 75-80 minute time frame.

Note: In accordance with Chapter 1-12, if for example, two separate individual psychotherapy sessions are provided in a day and each independently meets the time specifications for billing the services, both services may be billed.

If both services independently meet the time specifications for the *same* CPT code (e.g., two services are provided and each service meets specifications for 90804), the two services may be billed, either on separate lines of the same claim with one unit per line, or on one line of the claim with two units representing the two services.

However, if each service independently meets time specifications for *different* CPT codes (e.g., one service meets the time specifications for 90804 and the other service meets the time specifications for 90806), each service must be billed separately.

Limits:

1. The periodic reevaluation of the client's treatment plan may be billed under individual psychotherapy/interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services only if the reevaluation is conducted during a face-to-face session with the client.

2. Individual psychotherapy, interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services provided in a tele-health setting are limited to clients residing in rural areas of Utah.

3. When individual psychotherapy, interactive psychotherapy or individual psychotherapy/interactive psychotherapy with medical evaluation and management services is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.

2 - 6 Family Psychotherapy

Family psychotherapy with patient present means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with family members and the identified client with the goal of treating the client's condition and improving the interaction between the client and family members so that the client and family may be restored to their best possible functional level.

Family psychotherapy without patient present means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with family member(s) without the identified client present with the goal of treating the client's condition and improving the interaction between the client and family member(s) so that the client and family may be restored to their best possible functional level.

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

Who: In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure.

APRNs may perform this service if the individual is:

1. a licensed APRN with psychiatric mental health nursing specialty certification;

2. a licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;

3. a licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or

4. an APRN student specializing in psychiatric mental health nursing enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);

2. duration of the service;

3. setting in which the service was rendered;

4. specific service rendered;

5. treatment goal(s);

6. clinical note that documents;

   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);

   b. the focus of the family psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);

   c. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

Unit: **90847** - **Family Psychotherapy - with patient present - per 15 minutes**

90846 - **Family Psychotherapy - without patient present - per 15 minutes**

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits: The periodic reevaluation of the client's treatment plan may be billed under family psychotherapy only if the reevaluation is conducted during a face-to-face session.

2 - 7 Group Psychotherapy

Group psychotherapy means, in accordance with the definition of psychotherapy in Chapter 2-5 and as specified below, face-to-face interventions with two or more clients in a group setting so that the clients may be restored to their best possible functional level. Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the client and through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or changes maladaptive patterns of behavior, and encourage personality growth and development.

Like individual psychotherapy, group psychotherapy includes interactive group psychotherapy. It also includes multiple family group psychotherapy.

Services are based on measurable treatment goals identified in each client's individual treatment plan.

Who: In accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or an individual exempted from licensure.

APRNs may perform this service if the individual is:

1. a licensed APRN with psychiatric mental health nursing specialty certification;
2. a licensed APRN formally working toward psychiatric mental health nursing specialty certification through enrollment in a specialized mental health education program or through completion of post-education clinical hours under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification;
3. a licensed APRN intern formally working toward psychiatric mental health nursing specialty certification and accruing the required clinical hours for the specialty certification under the supervision of a licensed APRN with psychiatric mental health nursing specialty certification; or
4. an APRN student specializing in psychiatric mental health nursing enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);

6. per session clinical note that documents:

   a. the psychotherapeutic approach used to produce therapeutic change as described in the service definition above (i.e., insight oriented, behavior modifying and/or supportive psychotherapy for the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination to provide therapeutic change);

   b. the focus of the group psychotherapy session (i.e., alleviation of the emotional disturbances, reversal or change of maladaptive patterns of behavior, and encouragement of personality growth and development);

   c. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

Unit: **90853 - Group Psychotherapy - per 15 minutes per Medicaid client**

90857 – Interactive Group Psychotherapy - per 15 minutes per Medicaid client

90849 - Multiple-Family Group Psychotherapy - per 15 minutes per Medicaid client

When billing or reporting these procedure codes, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits:

1. Psychotherapy groups (90853 and 90857) are limited to twelve clients in attendance.
2. Multiple family psychotherapy groups (90849) are limited to ten families in attendance.
3. Co-leaders must meet the provider qualifications outlined in the 'Who' section above.

2 - 8 Pharmacologic Management

Pharmacologic management means, when provided by a qualified prescriber identified in the 'Who' section below, a face-to-face service that includes prescription, use and review of the client's medication(s) and medication regimen, and providing appropriate information regarding the medication(s) and medication regimen, and administering as appropriate, and with no more than minimal medical psychotherapy. If more than minimal medical psychotherapy is provided, see Chapter 2-5, individual psychotherapy/interactive psychotherapy with medical evaluation and management services. The review of the client's medication(s) and medication regimen includes dosage, effect the medication(s) is having on the client's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage. The service also may include assessing and monitoring the client's other health issues that are either directly related to the behavioral health disorder or to its treatment (e.g., diabetes, cardiac and/or blood pressure issues, weight gain, etc.).

When provided by a qualified nurse identified in the 'Who' section below, pharmacologic management means a face-to-face service that includes review/monitoring of the client's medication(s) and medication regimen, and providing appropriate information regarding the medication(s) and medication regimen, and administering as appropriate. The review of the client's medication(s) and medication regimen includes dosage, effect the medication(s) is having on the client's symptoms, and side effects. The provision of appropriate information should address directions for proper and safe usage. The service also may include assessing and monitoring the client's other health issues that are either directly related to the behavioral health disorder or to its treatment (e.g., diabetes, cardiac and/or blood pressure issues, weight gain, etc.).

Pharmacologic management services may also be provided in a tele-health setting to rural clients where distance and travel time create difficulty with access. See 'Limits' section below.

Who: Qualified Prescribers

1. licensed physician and surgeon or osteopathic physician regardless of specialty;
2. licensed APRN regardless of specialty;
3. licensed APRN intern under the supervision of a licensed APRN or licensed physician and surgeon or osteopathic physician;
4. APRN student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph A.3.a; or
5. other medical practitioner licensed under state law who can perform the activities defined above when acting within the scope of his/her license (e.g., licensed physician assistants when practicing under the delegation of services agreement required by their practice act).

Qualified Nurses

1. licensed registered nurse; or registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3; or

2. licensed practical nurse under the supervision of a licensed physician and surgeon or osteopathic physician, a licensed APRN, a licensed physician assistant or a licensed registered nurse.

Record: Documentation must include

1. as appropriate, medication order or copy of the prescription signed by the prescribing practitioner;
2. date and actual time of service (time may be rounded to the nearest five minute interval);
3. duration of the service;
4. setting in which the service was rendered;
5. specific service rendered;
6. treatment goal(s);
7. note that documents:
   a. the condition for which medication is needed (required for prescribers only);
   b. medication(s) prescribed or used;
   c. dosage;
   d. results of the review;
   e. summary of the information provided;
   f. if medications are administered, documentation of the medication(s) and method of administration;
   g. if applicable, a summary of the assessment and monitoring of other health issues;
   h. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
8. signature and licensure or credentials of individual who rendered the service.

Unit: **90862 - Pharmacologic Management by prescriber - per encounter**

90862 with TD modifier - Pharmacologic Management by nurse - per encounter

When billing or reporting this procedure code/modifier, bill or report 1 unit regardless of the length of the service. Service is based on an encounter.

Note: In accordance with Chapter 1-12, if the same pharmacologic management service is provided more than once in a day, the services may be billed on separate lines of a claim with one unit per line, or on one line of the claim with the total number of units corresponding to the number of services provided (e.g., if two pharmacologic management by prescriber services are provided, each service would be billed on the same claim on separate lines with one unit per line, or on the same line with two units).

Limits:

1. Pharmacologic management services provided in a tele-health setting are limited to clients residing in rural areas of Utah and to services of a qualified prescriber.
2. When pharmacologic management is provided in a tele-health setting, only this subcontracted service may be billed. The time spent by a mental health center case manager or other mental health professional to assist the client during the service provided in the tele-health setting may not also be billed.
3. Distributing medications (i.e., handling, setting out or handing medications to clients) is not a covered service and may not be billed to Medicaid;
4. Solely administering medications (i.e., giving an injection only) is not a covered service and may not be billed to Medicaid.
5. Performance of ordering labs including urine analyses (UAs) in not a covered service and may not be billed to Medicaid.
6. The periodic reevaluation of the client's treatment plan by a prescriber qualified to prescribe a mental health treatment plan (see Chapter 1-5, paragraph A), may be billed under pharmacologic management only if the reevaluation is conducted during a face-to-face service with the client.

2 - 9 Therapeutic Behavioral Services

Therapeutic behavioral services means face-to-face interventions with an individual, family, or group of individuals where the provider solely uses a psychoeducational approach to assist clients to apply techniques related to a behavior problem.

Who:

1. licensed registered nurse; or a registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3.; or
2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure also may perform this service.

Record: Documentation must include:

1. date and actual time of the service(time may be rounded the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);

6. clinical note per session that documents:

    a. the nature of the approach used to produce change as described in the service definition above;

    b. the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

Unit: **H2019 - Individual/Family Therapeutic Behavioral Services - per 15 minutes**

H2019 with HQ modifier - Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client

When billing or reporting this procedure code/modifier, follow these rounding rules for converting actual time to the specified number of units:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits:

1. Groups are limited to twelve clients in attendance unless a co-leader is present; then groups may not exceed 24 clients in attendance.
2. Multiple family therapeutic behavioral services groups are limited to ten families in attendance.
3. Co-leaders must meet the provider qualifications outlined in the 'Who' section above.

2 - 10 Psychosocial Rehabilitative Services

Psychosocial rehabilitative services may be provided to a group of individuals in a day treatment program, residential treatment program or in other settings. It may also be provided to an individual. Psychosocial rehabilitative services are primarily designed to treat adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbance (SED and means face-to-face interventions to: (1) eliminate or reduce symptomatology related to the client's diagnosis, (2) increase compliance with the medication regimen, as applicable, (3) avoid unnecessary psychiatric hospitalization,

(4) eliminate or reduce maladaptive or hazardous behaviors and develop effective behaviors, (5) improve personal motivation and enhance self-esteem, (6) develop appropriate communication, and social and interpersonal interactions, and (7) regain the basic living skills necessary for living in the least restrictive environment possible. Services are provided to individuals who require support and cuing/modeling of appropriate life skills to maximize rehabilitation and prevent need for more restrictive levels of care.

Who:

1. licensed registered nurse; or a registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3;

2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1;

3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or

4. other trained individual (but not including foster parents or other proctor parents), under the supervision of a licensed mental health therapist identified in Chapter 1 - 5, paragraph A.1, a licensed registered nurse or a licensed social service worker.

   The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure also may perform this service.

Record: **Psychosocial Rehabilitative Services Provided in Day Treatment or Residential Treatment Programs**

1. For each date of participation in the program, documentation must include:

   a. the name of each group the client participated in (e.g., anger management, interpersonal relations, cooking group, etc.);

   b. the date, actual time and duration of each group time may be rounded to the nearest five minute interval); and

   c. setting in which the group was rendered (e.g., day treatment program).

2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals/objectives, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

   Therefore, for each unique type of psychosocial rehabilitative group the client participated in during the immediately preceding two-week period, at a minimum one summary note must be prepared.

   The required summary note may be written by:

   (1) an individual who provided the group, or

(2) by one individual who is most familiar with the client's involvement and progress across groups.

The summary note must include:

a. the name of the group;

b. treatment goal(s) related to the group;

c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

d. signature and licensure or credentials of the individual who prepared the documentation.

Psychosocial Rehabilitative Services Provided to a Group of Individuals in Other Settings

When psychosocial rehabilitative services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each unique type of psychosocial rehabilitative group and for each group session, documentation must include:

1. date and actual time of the group (time may be rounded to the nearest five minute interval);

2, duration of the group;

3. setting in which the group was rendered;

4. the specific type of group (e.g., cooking group, etc.);

5. treatment goal(s) related to the group;

6. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of the individual who rendered the service.

Psychosocial Rehabilitative Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);

2. duration of the service;

3. setting in which the service was rendered;

4. specific service rendered;

5. treatment goal(s);

6. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

If psychosocial rehabilitative services goals are met as a result of participation in the service, then new individualized goals must be added to the treatment plan.

Unit: **H2017 Group Psychosocial Rehabilitative Services - per 15 minutes per Medicaid client**

H2017 with U1 modifier Group Psychosocial Rehabilitative Services - Intensive Children's - per 15 minutes per Medicaid client when the ratio is no more than five clients per provider

H2014 – Psychosocial Rehabilitative Services provided to an individual (This is coded as Individual Skills Training and Development) - per 15 minutes

When billing or reporting these procedure codes/modifier, follow these rounding rules for converting actual time to the specified number of units*:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

***Psychosocial rehabilitative services provided in day treatment or residential treatment programs**

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), in accordance with Chapter 1-12, if attendance in each group meets the minimum time requirement for billing (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for billing purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be billed.

Limits: 1. In accordance with 42 CFR 440.130, and the definition of rehabilitative services, the following do not constitute medical or remedial services and may not be billed to Medicaid:

a. activities in which providers are not present and actively involved helping individuals regain functional abilities and skills;
b. routine supervision of clients, including routine 24-hour supervision of clients in residential settings;

c. activities in which providers perform tasks for the client, including activities of daily living and personal care tasks (e.g., grooming and personal hygiene tasks, etc.);
d. time spent by the client in the routine completion of activities of daily living, including chores, in a residential setting; this time is part of the routine 24-hour supervision;

e. habilitation services;
f. job training, job coaching, vocational and educational services;
g. social and recreational activities (although these activities may be therapeutic for the client, and a provider may obtain valuable observations for processing later, they do not constitute billable services. However, time spent before and after the activity addressing the clients' skills and behaviors related to the clients' rehabilitative goals is allowed); and

h. routine transportation of the client or transportation to the site where a psychosocial rehabilitative service will be provided.

2. In group child and adolescent psychosocial rehabilitative services, a ratio of no more than twelve clients per provider must be maintained during the entire service.

3. In intensive group child and adolescent psychosocial rehabilitative services, a ratio of no more than five clients per provider must be maintained during the entire service.

3. 1915(b)(3) SERVICES – FOR PREPAID MENTAL HEALTH PLAN CONTRACTORS ONLY

In accordance with Utah's approved 1915(b) freedom-of-choice waiver, mental health centers that contract with Medicaid to provide services under the PMHP have the authority to provide the 1915(b)(3)

services specified below in addition to the scope of Medicaid State Plan-covered rehabilitative services defined in this manual.

These services are a benefit only for Medicaid clients in the Traditional Medicaid Plan. They are not a benefit for adult Medicaid clients age 19 and older in the Non-Traditional Medicaid Plan. 1915(b)(3) services are not a benefit for individuals enrolled in the PMHP only for inpatient psychiatric care.

In accordance with Chapter 1- 7, Treatment Plan, 1915(b)(3) services must be included on the client's treatment plan and meet requirements of Chapter 1-7. In accordance with Chapter 1-8, Periodic Review of the Treatment Plan, 1915(b)(3) services also must be included in this periodic review.

3 - 1 Personal Services

Personal Services are recommended by a physician or practitioner of the healing arts (see Chapter 1-5, paragraph A) and are furnished for the primary purpose of assisting in the rehabilitation of clients with SPMI or SED. These services include assistance with instrumental activities of daily living (IADLs) that are necessary for individuals to live successfully and independently in the community and avoid hospitalization. Personal services include assisting the client with varied activities based on the client's rehabilitative needs: picking up prescriptions, banking and paying bills, maintaining the living environment including cleaning and shopping, and the transportation related to the performance of these activities, and representative payee activities when the mental health center has been legally designated as the client's representative payee. These services assist clients to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed registered nurse; or a registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3;
2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1;
3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or
4. other trained individual (but not including foster or proctor parents) under the supervision of a licensed mental health therapist identified in Chapter 1 - 5, paragraph A. 1, a licensed registered nurse or a licensed social service worker.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure also may perform this service.

Record: Documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);

2. duration of the service;

3. setting in which the service was rendered;

4. specific service rendered;

5. treatment goal(s);

6. note describing the client's progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

Unit: **H0046 – per 15 minutes**

When reporting this procedure code, follow these rounding rules for converting actual time to the specified number of units;

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits: This service is limited to individuals enrolled in the Traditional Medicaid Plan.

3 - 2 Respite Care

Respite Care is recommended by a physician or practitioner of the healing arts (see Chapter 1-5, paragraph A) and is furnished for the primary purpose of assisting in the rehabilitation of children with serious emotional disorders (SED). This rehabilitative service helps the SED client achieve his/her remedial and/or rehabilitative treatment goals by giving parents respite from the challenges of caring for a mentally ill child. Without respite, parents may be at risk for neglect or abuse of the child, particularly if they suffer from a mental illness themselves. Respite care is provided for the primary purpose of giving parent(s) temporary relief from the stresses of care giving to a mentally ill child so that they are better able to interact in appropriate ways that are not counter-therapeutic to the child's achievement of his/her remedial and/or rehabilitative goals. During the provision of this service staff has a therapeutic focus with the child. Therefore, this service is provided in tandem with the child's other mental health treatment services and also assists the child to achieve his/her rehabilitative goals and to be restored to his/her best possible functioning level.

Who:
1. licensed registered nurse; or registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3;
2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1;
3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or
4. other trained individual (but not including foster or proctor parents) under the supervision of a licensed mental health therapist identified in Chapter 1 - 5, paragraph A. 1, a licensed registered nurse or a licensed social service worker.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure also may perform this service.

Record: Each provider delivering respite care must provide documentation as follows:

1.

1. For each date of respite care:
   a. the name of the service;
   b. the date, actual time and duration of the service (time may be rounded to the nearest five minute interval);
   c. setting in which the service was rendered; and
2. for each preceding two-week period during which the client received respite services, at a minimum, one summary note that includes:
   a. the name of the service;
   b. treatment goal(s);
   c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
   d. signature and licensure or credentials of the individual who rendered the service(s).

Unit: **S5150 – per 15 minutes**

When reporting this procedure code, follow these rounding rules for converting actual time to the specified number of units;

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

Limits: This service is limited to individuals through age 20 enrolled in the Traditional Medicaid Plan.

3 - 3 Psychoeducational Services

Psychoeducational Services are recommended by a physician or practitioner of the healing arts (see Chapter 1-5, paragraph A) and are furnished for the primary purpose of assisting in the rehabilitation of Enrollees with serious and persistent mental illness (SPMI) or serious emotional disorders (SED). This rehabilitative service includes interventions which help clients achieve goals of remedial and/or rehabilitative vocational adequacy necessary to restore them to their best possible functioning level.

Who:

1. licensed registered nurse; or a registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3;

2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1;

3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or

4. other trained individual (but not including foster or proctor parents) under the supervision of a licensed mental health therapist identified in Chapter 1 - 5, paragraph A. 1, a licensed registered nurse or a licensed social service worker.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or license or an individual exempted from licensure also may perform this service.

Record: **Psychoeducational Services Provided in Day Treatment or Residential Treatment Programs**

1. For each date of participation in psychoeducational services, documentation must include:

   a. the name of the service;

   b. the date, actual time and duration of the service (time may be rounded to the nearest five minute interval); and

c. setting in which the group was rendered.

2. Because rehabilitation is a process over time requiring frequent repetition and practice to achieve goals, progress is often slow and intermittent. Consequently, there must be sufficient amounts of time for progress to be demonstrated.

   Therefore, for each preceding two-week period during which the client received psychoeducational services, at a minimum one summary note must be prepared that includes:

   a. the name of the service;

   b. treatment goal(s);

   c. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

   d. signature and licensure or credentials of individual who rendered the service.

Psychoeducational Services Provided to a Group of Individuals in Other Settings

When psychoeducational services are provided to groups of clients outside of an organized day treatment or residential treatment program, for each psychoeducational group session, documentation must include:

1. date and actual time of the psychoeducational group (time may be rounded to the nearest five minute interval);
2. duration of the group;
3. setting in which the group was rendered;
4. the specific service rendered;
5. treatment goal(s);
6. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and
7. signature and licensure or credentials of the individual who rendered the service.

Psychoeducational Services Provided to an Individual

When provided to an individual, for each service documentation must include:

1. date and actual time of the service (time may be rounded to the nearest five minute interval);
2. duration of the service;
3. setting in which the service was rendered;
4. specific service rendered;
5. treatment goal(s);

6. progress toward treatment goal(s) or if there was no reportable progress, documentation of reasons or barriers; and

7. signature and licensure or credentials of individual who rendered the service.

If psychoeducational services goals are met as a result of participation in the service, then new individualized goals must be added to the treatment plan.

Unit: **H2017 – Psychoeducational Services - per 15 minutes per Medicaid client**

When reporting this procedure code, follow these rounding rules for converting actual time to the specified number of units*:

Less than 8 minutes equals 0 units;

8 minutes through 22 minutes of service equals 1 unit;

23 minutes through 37 minutes of service equals 2 units;

38 minutes through 52 minutes of service equals 3 units;

53 minutes through 57 minutes of service equals 4 units;

68 minutes through 82 minutes of service equals 5 units;

83 minutes through 97 minutes of service equals 6 units;

98 minutes through 112 minutes of service equals 7 units; and

113 minutes through 127 minutes of service equals 8 units, etc.

***Psychoeducational services provided in day treatment or residential treatment programs**

Because clients may leave and return later in the day (e.g., to attend other services, for employment, etc.), in accordance with Chapter 1-12, if attendance in each psychoeducational services group meets the minimum time requirement for billing (i.e., at least eight minutes), then time spent throughout the day may be totaled to determine units of service provided for reporting purposes. If attendance in some groups does not meet the eight minute minimum, then those groups may not be included in the daily total for determining the amount of time spent and the number of units to be reported.

Limits: This service is limited to individuals enrolled in the Traditional Medicaid Plan.

3 - 4 Supportive Living

Supportive Living means costs incurred in residential treatment/support programs when Medicaid Enrollees are placed in these programs in lieu of inpatient hospitalization. Costs include those incurred for 24-hour staff, facility costs associated with providing discrete Covered Services (e.g., individual psychotherapy, pharmacologic management, etc.) at the facility site, and apportioned administrative costs.

Costs do not include the Covered Services costs or room/board costs. This level of care is recommended by a physician or other practitioner of the healing arts (see Chapter 1-5, paragraph A), and helps to restore clients with serious and persistent mental illness or serious emotional disorders to their best possible functioning level. Whenever possible, the PMHP will provide this level of care in lieu of inpatient hospitalization so that individuals may remain in a less restrictive community setting.

Who:

1. licensed registered nurse; or registered nursing student enrolled in an education/degree program exempted from licensure and under supervision in accordance with Chapter 1-5, paragraph B.3;
2. licensed social service worker or an individual working toward licensure as a social service worker under the supervision of a licensed mental health therapist identified in Chapter 1-5, paragraph A.1;
3. licensed practical nurse under the supervision of a licensed registered nurse, or a licensed mental health therapist identified in Chapter 1-5, paragraph A.1; or
4. other trained individual (but not including foster or proctor parents) under the supervision of a licensed mental health therapist identified in Chapter 1 - 5, paragraph A. 1, a licensed registered nurse or a licensed social service worker.

The providers identified above are the core providers of this level of service; however, in accordance with Chapter 1-5, paragraph B.1, a licensed mental health therapist, an individual working within the scope of his or her certificate or an individual exempted from licensure also may perform this service.

Record: Documentation must include:

1. Note each month documenting the dates supportive living was provided during the month; and
2. signature and licensure or credentials of the individual who prepared the documentation.

Unit: **H2016 – 1 unit per day**

Limits: This service is limited to individuals enrolled in the Traditional Medicaid Plan.

4. PROCEDURE CODES AND MODIFIERS FOR REHABILITATIVE MENTAL HEALTH SERVICES

For each date of service, enter the appropriate five digit procedure code and modifier as indicated below:

Procedure Codes	Service and Units
90801	Psychiatric Diagnostic Interview Examination -per 15 minutes
90802	Interactive Psychiatric Diagnostic Interview Examination - per 15 minutes
H0031	Mental Health Assessment by a Non-Mental Health Therapist –per 15 minutes
96101	Psychological Testing - per hour
96105	Assessment of Aphasia - per hour
96110	Developmental Testing: limited - per hour
96111	Developmental Testing: extended - per hour
96116	Neurobehavioral Status Exam - per hour
96118	Neuropsychological Testing Battery - per hour
	Individual Psychotherapy
90804	approximately 20 to 30 minutes
90806	approximately 45 to 50 minutes
90808	approximately 75 to 80 minutes
	Individual Psychotherapy - Interactive
90810	approximately 20 to 30 minutes
90812	approximately 45 to 50 minutes
90814	approximately 75 to 80 minutes
	Individual Psychotherapy - with medical evaluation and management services
90805	approximately 20 to 30 minutes
90807	approximately 45 to 50 minutes
90809	approximately 75 to 80 minutes
	Individual Psychotherapy - Interactive with medical evaluation and management services
90811	approximately 20 to 30 minutes
90813	approximately 45 to 50 minutes
90815	approximately 75 to 80 minutes
90847	Family Psychotherapy - with patient present - per 15 minutes
90846	Family Psychotherapy - without patient present - per 15 minutes
90849	Group Psychotherapy - Multiple-family group psychotherapy -per 15 minutes per Medicaid client
90853	Group Psychotherapy - Group psychotherapy (other than of a multiple-family group)- per 15 minutes per Medicaid client
90857	Group Psychotherapy - Interactive - per 15 minutes per Medicaid client
90862	Pharmacologic Management by prescriber - per encounter
90862 with TD modifier	Pharmacologic Management by Nurse - per encounter
H2019	Individual Therapeutic Behavioral Services - per 15 minutes
H2019 with HQ modifier	Group Therapeutic Behavioral Services - per 15 minutes per Medicaid client
H2014	Individual Psychosocial Rehab Services (coded as Individual Skills Training and Development)- per 15 minutes

H2017	Group Psychosocial Rehabilitative Services -per 15 minutes per Medicaid client
H2017 with U1 modifier	Group Psychosocial Rehabilitative Services - Intensive Children's - per 15 minutes per Medicaid client

5. PROCEDURE CODES FOR 1915(b)(3) SERVICES – PREPAID MENTAL HEALTH PLAN CONTRACTORS ONLY

For each date of service, enter the appropriate five digit procedure code and modifier as indicated below:

Procedure Codes	Service and Units
H0046	Personal Services-per 15 minutes
S5150	Respite Care- per 15 minutes
H2017	Psychoeducational Services–per 15 minutes per Medicaid client
H2016	Supportive Living - per day

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