

North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance

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Attention:

**Mental Health Service Providers
Substance Abuse Service Providers
Psychiatric Hospitals
General Hospitals**

**Psychiatric Residential Treatment Facilities
Levels II through IV Residential Treatment Facilities**

**Psychiatrists
Physicians**

Area Mental Health Centers/Public Health Departments

**Mental Health
and
Substance Abuse Services
Guidelines**

TABLE OF CONTENTS

New Contract for Utilization Review	1
Prior Approval for Psychiatric Outpatient Visits.....	2
Recipients Under the Age of 21.....	2
Billing Guidelines.....	2
Prior Approval	2
Recipients Aged 21 and Over	3
Billing Guidelines.....	3
Incident to Service Policy.....	4
Licensed Clinical Social Workers and Advanced Practice Psychiatric Clinical Nurse Specialists.....	4
Billing Guidelines.....	4
Licensed Psychological Associates	4
Outpatient Mental Health Services for Children Birth Through 20 Years of Age	5
Prior Approval Guidelines for Inpatients (Adults and Children) Applying for Medicaid During a Psychiatric Hospital Stay	6
Criteria for Acute Inpatient Hospitalization	
Psychiatric Admission Criteria for Medicaid Beneficiaries Under the Age of 21.....	7
N.C. Administrative Code 10T: 26B.0112	7
Criteria for Continued Stay in an Inpatient Psychiatric Facility.....	9
N.C. Administrative Code 10T: 26B.0113	9
Clarification of Record Submission Guidelines for Inpatients (Adults and Children) Applying for Medicaid During or After a Psychiatric Hospital Stay	11
Certification of Need Process for Acute Inpatient Admissions	12
Preadmission Certification Process for Adults	16
Indications for Hospitalization	16
Level of Care Required.....	16
Residential Services.....	17
Instructions for Completing Application for Residential Services Provider Enrollment	17
Important Points to Remember	18
Application for Residential Services Provider Enrollment.....	19
The Role of Area Programs	21
Clinical Case Manager Responsibilities	21
Prior Approval Process for Psychiatric Residential Treatment Facilities.....	22

Psychiatric Residential Treatment Facilities.....	23
Psychiatric Residential Treatment Facility Services	23
Certification of Need Process	23
Criteria for Admission	24
Continued Stay Criteria	24
Discharge Criteria.....	25
Level II, III, and IV Residential Treatment	26
Prior Approval Process	26
Definitions of Service for Residential Treatment Services.....	27
Definitions of Service – Level IV.....	27
Definitions of Service – Level III.....	31
Definitions of Service – Level II	36
Billing Instructions for Residential Services and Psychiatric Residential Treatment Facility Providers	42
Current Procedural Terminology.....	43
Mental Health Procedure Codes	43
Removal of Limits to CPT Code 90862	44
Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21	45
Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21 – Psychiatric Residential Treatment Facility	46

NEW CONTRACT FOR UTILIZATION REVIEW

The N.C. Medicaid program has awarded a new contract to ValueOptions for utilization review of acute inpatient/substance abuse hospital care for recipients through age 64; Psychiatric Residential Treatment Facilities (PRTF); Levels II through IV Residential Treatment Facilities (four beds or more); and outpatient psychiatric services.

Effective January 1, 2002, this contract will encompass all elective and emergency admission reviews, concurrent continued stay reviews, and post discharge reviews when applicable.

Registration information for seminars and a list of the seminar sites has been mailed to all enrolled providers. These seminars are scheduled for early December 2001.

Copies of ValueOptions' utilization review manual, which provides more detailed information on procedures, will be available at the seminars.

PRIOR APPROVAL FOR PSYCHIATRIC OUTPATIENT VISITS

Recipients Under the Age of 21

This article is reprinted and modified from the June 2000 general Medicaid bulletin where it was titled *A New Health Benefit*.

Effective July 1, 2000, a new preventive/early intervention mental health benefit was made available to approximately 400,000 state employees and teachers and 60,000 children enrolled in Health Choice. Medicaid adopted this policy for recipients under the age of 21, which allows for 26 unmanaged visits in a calendar year.

Billing Guidelines

- Medicaid will pay for six unmanaged visits without a diagnosis of mental illness.
- The first two visits can be coded with ICD-9 CM code 799.9 (a nonspecific code) and the following four visits can be coded with “V” diagnosis codes.

OR

- The first visit can be coded with diagnosis 799.9 and the remaining five can be coded with “V” diagnosis codes.
- A specific diagnosis code should be used as soon as a diagnosis is established.
- This service coverage ends on the last date of the birthday month in which a recipient turns 21 years of age.

Prior Approval

- Prior approval may be requested after the 20th “unmanaged” psychiatric visit.
- The prior approval request form must include dates of service that the provider requesting prior approval has rendered treatment.
- If a recipient received outpatient psychiatric services from another provider, indicate the number of unmanaged visits used by this provider.
- A summary of progress obtained during the “unmanaged” visits must be included on the prior approval outpatient form (372-016) in block #11.
- Prior approval must be obtained prior to the 27th visit.
- Once prior approval has been granted, the recipient is not eligible for any additional “unmanaged” visits, regardless of the number previously reimbursed.

Note: This process replaced the policy of requesting prior approval after the 2nd visit for recipients under the age of 21. These guidelines now apply to area mental health programs as well as other outpatient providers for recipients under the age of 21.

Prior approval forms can be obtained by calling ValueOptions at 1-888-510-1150.

Recipients Aged 21 and Over

Effective January 1, 2002, Medicaid recipients aged 21 and over receiving outpatient mental health services will require prior approval after the 8th visit. This includes area mental health programs and private providers. This process replaces the policy of requesting prior approval after the 2nd visit for non-area mental health programs.

The 24-office visit limitation per year is removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval will be based on medical necessity.

Billing Guidelines

These visits can be counted in a number of ways. Each individual visit is counted as one visit; each group visit is counted as ½ visit. Group codes that will be involved are Y2306, 90846, 90847, 90849, 90853, and 90857.

Individual codes that will be counted as one visit are Y2305, Y2306, 90801 through 90853 and 96100 through 96117.

Prior approval forms can be obtained by calling ValueOptions at 1-888-510-1150.

INCIDENT TO SERVICE POLICY

Licensed Clinical Social Workers and Advanced Practice Psychiatric Clinical Nurse Specialists

This article is reprinted from the August 2000 general Medicaid bulletin. **Note:** The “incident to service” policy applies to recipients of all ages. The prior approval process referenced below is for recipients under the age of 21.

Effective August 1, 2000, the Division of Medical Assistance (DMA) has expanded the “incident to service” policy to include Licensed Clinical Social Workers (LCSW) and Advanced Practice Psychiatric Clinical Nurse Specialists (CNS) who are masters level registered nurses with psychiatric certification in providing mental health/substance abuse services. The LCSWs and CNSs must be employed by the supervising physician, physician group practice or of the legal entity that employs the physician who provides direct personal supervision. (Refer to the article concerning the incident to service policy in the July 1997 general Medicaid bulletin for additional information.)

Billing Guidelines

- LCSWs can bill the following codes: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845, 90846, 90847, 90849, 90853, 90857.
- CNSs can bill the following codes: 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90846, 90849, 90853, 90857.
- The attending physician’s provider number is used when filing claims.
- The prior approval process will follow the new preventive/early intervention mental health guidelines, which allows for 26 unmanaged visits.

Note: This information is not directly related to DMA’s plan to allow the direct enrollment of LCSWs, CNSs, and psychologists.

Licensed Psychological Associates

This article is reprinted and modified from the May 2001 general Medicaid bulletin. **Note:** This “incident to service” extension only applies to services for recipients under 21 years of age by the Licensed Psychological Associate (LPA).

Effective August 1, 2000, DMA has expanded the “incident to service” policy to include LCSWs and CNSs who are masters level registered nurses with psychiatric certification in providing mental health/substance abuse services. The LCSW and CNS must be an employee of the supervising physician, physician group practice or of the legal entity that employs the physician who provides direct personal supervision.

Effective June 1, 2001, this policy is further expanded to allow LPAs to bill for services “incident to” if they are supervised and employed by Ph.D. psychologists or, as is currently the case, physicians.

OUTPATIENT MENTAL HEALTH SERVICES FOR CHILDREN BIRTH THROUGH 20 YEARS OF AGE

Effective February 1, 2001, DMA increased access to mental health/substance abuse services to children birth through 20 years of age by directly enrolling Licensed Psychologists, Licensed Clinical Social Workers, Advanced Practice Psychiatric Nurse Practitioners, and Advanced Practice Psychiatric Clinical Nurse Specialists as Medicaid providers.

The benefit package includes 26 outpatient visits per calendar year when referred by the Carolina ACCESS (CA) primary care physician (PCP) or area mental health programs. Visits beyond the 26-visit limit will require the mental health provider to request prior authorization from Value-Options, the utilization review organization.

As the referring provider, the CA PCP or area mental health program will give the mental health provider a referral number for payment of the claim. The mental health provider cannot be paid unless the referring provider's number appears on the claim. To facilitate the referral process, referrals may be made by telephone, fax, or in writing. Mental health providers are expected to communicate the plan of care and anticipated length of treatment to the referring provider following the guidelines for patient confidentiality as a means to assure continuity of care.

**PRIOR APPROVAL GUIDELINES FOR INPATIENTS
(ADULTS AND CHILDREN)
APPLYING FOR MEDICAID DURING A PSYCHIATRIC
HOSPITAL STAY**

This article is reprinted from the September 2000 general Medicaid bulletin. It is a policy statement to follow up the DMA memorandum dated July 16, 2000 to all hospitals.

Hospitals admitting a patient, who is neither Medicaid eligible on or before admission, nor pending eligibility, but **applies for Medicaid during a psychiatric hospitalization**, must send in the entire medical record to ValueOptions within 30 days of discharge. ValueOptions will perform a post discharge review to determine prior approval for medically necessary days of acute care.

A phone call to ValueOptions will no longer be necessary for patients **who apply for Medicaid during or after the stay**. Hospitals must obtain a Medicaid identification (MID) number for the patient and send it to ValueOptions along with the medical record.

In addition to the MID number, if the patient is a child or adolescent admitted to a psychiatric hospital, a Certification of Need (CON) form must also be sent to ValueOptions. Due to difficulties in being able to meet the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) requirements for performing a CON “on or before the Medicaid application date” and realizing that hospitals may have problems receiving notification of a patient’s application for Medicaid, DMA suggests that a CON be performed and immediately submitted to ValueOptions on **every** child or adolescent admission to a psychiatric hospital, regardless of Medicaid status on admission. ValueOptions will place the CON in a holding file if the form indicates the patient has yet to apply for Medicaid. If a patient applies for Medicaid **on or after the discharge date**, the hospital must still send the entire medical record to ValueOptions for review with the CON (if applicable) and the MID number.

Once eligibility has been verified, it will be determined by ValueOptions whether days were medically necessary. ValueOptions will send a notification letter to the hospital stating approval or denial of acute care days. Any approval will include a prior approval number.

If eligibility verification reflects the Medicaid application occurred **on or before admission** rather than during the stay as reported, the hospital stay will not be reviewed. For any patient already eligible or pending eligibility on admission, the hospital must still request **telephone prior approval** from ValueOptions within 48 working hours of admission and continue with the concurrent review process.

CRITERIA FOR ACUTE INPATIENT HOSPITALIZATION

Psychiatric Admission Criteria for Medicaid Beneficiaries Under the Age of 21

Refer to the following section of the N.C. Administrative code for psychiatric admission criteria for recipients under the age of 21.

N.C. Administrative Code 10T: 26B.0112

.0112 PSYCHIATRIC ADMISSION CRITERIA/MEDICAID BENEFICIARIES UNDER AGE 21

Medicaid criteria for the admission of those persons under age 21 to psychiatric hospitals or psychiatric units of general hospitals is limited herein. To be approved for admission, the patient must meet criteria in Items (1), (2) and (3) of this Rule as follows:

- (1) Client meets criteria for one or more DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, fourth Edition – a manual whose purpose is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders) diagnoses. This manual is hereby incorporated by reference including subsequent amendments and editions. Copies may be obtained from the American Psychiatric Association 1400 K Street, NW Washington, DC 2000 tel: 1-800-368-5777 at a cost of fifty-four dollars and ninety-five cents (\$54.95) (hard cover); forty-two dollars and ninety-five cents (\$42.95) (soft cover); five dollars (\$5.00) s. and h. The manual is available for inspection at the Division of Medical assistance 1985 Umstead Dr., Raleigh, NC; and
- (2) At least one of the following criteria:
 - (a) Client is presently a danger to self (e.g., engages in self-injuries behavior, has a significant suicide potential, or is acutely manic). This usually would be indicated by one of the following:
 - (i) Client has made a suicide attempt or serious gesture (e.g., overdose, hanging, jumping from or placing self in front of moving vehicle, self-inflicted gunshot wound), or is threatening same with likelihood of acting on the threat, and there is an absence of supervision or structure to prevent suicide of the client who has made an attempt, serious gesture or threat.
 - (ii) Client manifests a significant depression, including current contemplation of suicide or suicidal ideation, and there is an absence of supervision or structure to prevent suicide.
 - (iii) Client has a history of affective disorder:
 - (A) with mood which has fluctuated to the manic phase, or
 - (B) has destabilized due to stressors or non-compliance with treatment.
 - (iv) Client is exhibiting self-injurious behavior (cutting on self, burning self) or is threatening same with likelihood of acting on the threat; or
 - (b) Client engages in actively violent, aggressive or disruptive behavior or client exhibits homicidal ideation or other symptoms, which indicate he is a probable danger to others. This usually would be indicated by one of the following:
 - (i) Client whose evaluation and treatment cannot be carried out safely or effectively in other settings due to impulsivity, impaired judgment, severe oppositionalism, running away, severely disruptive behaviors at home or school, self-defeating and self-endangering activities, antisocial activity, and other behaviors which may occur in the context of a dysfunctional family and may also include physical, psychological, or sexual abuse.

- (ii) Client exhibits serious aggressive, assaultive, or sadistic behavior that is harmful to others (e.g., assaults with or without weapons, provocations of fights, gross aggressive over-reactivity to minor irritants, harming animals) or is threatening same with likelihood of acting on the threat. This behavior should be attributable to the client's specific DSM-IV diagnosis and can be treated only in a hospital setting; or
- (c) Acute onset of psychosis or severe thought disorganization or clinical deterioration in condition of chronic psychosis rendering the client unmanageable and unable to cooperate in treatment. This usually would be indicated by the following: Client has recent onset or aggravated psychotic symptoms (e.g., disorganized or illogical thinking, hallucinations, bizarre behavior, paranoia, delusions, incongruous speech, severely impaired judgment) and its resisting treatment or is in need of assessment in a safe and therapeutic setting; or
- (d) Presence of medication needs, or a medical process or condition which is life-threatening (e.g., toxic drug level) or which requires the acute care setting for its treatment. This usually would be indicated by one of the following:
 - (i) Proposed treatments require close medical observation and monitoring to include, but no limited to, close monitoring for adverse medication effects, capacity for rapid response to adverse effects, and use of medications in clients with concomitant serious medical problems.
 - (ii) Client has a severe eating disorder or substance abuse disorder, which requires 24-hour-a-day medical observation, supervision, and intervention.
 - (iii) Client has Axis I or Axis II diagnosis, with a complicating or interacting Axis III diagnosis, the combination of which requires psychiatric hospitalization in keeping with any one of these criteria, and with the Axis III diagnosis treatable in a psychiatric setting (e.g., diabetes, malignancy, cystic fibrosis); or
- (e) Need for medication therapy or complex diagnosis evaluation where the client's level of functioning precludes cooperation with the treatment regimen, including forced administration of medication. This usually would be indicated by one of the following:
 - (i) Client whose diagnosis and clinical picture is unclear and who requires 24 hour clinical observation and assessment by a multi-disciplinary hospital psychiatric team to establish the diagnosis and treatment recommendations.
 - (ii) Client is involved in the legal system (e.g., in a detention or training school facility) and manifests psychiatric symptoms (e.g., psychosis, depression, suicide attempts or gestures) and requires a comprehensive assessment in a hospital setting to clarify the diagnosis and treatment needs; and
- (3) To meet the federal requirement at 42 CFR 441.152, all of the following must apply.
 - (a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
 - (b) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
 - (c) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

History Note: Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 441, subpart D; 42 C.F.R. 441.151; Eff. February 1, 1976; Readopted Eff. October 31, 1977; Amended Eff. November 2, 1992.

Criteria for Continued Stay in an Inpatient Psychiatric Facility

Refer to the following section of the N.C. Administrative code for continued stay criteria for individuals under the age of 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital.

N.C. Administrative Code 10T: 26B.0113

.0113 NC MEDICAID CRITERIA FOR CONTINUED ACUTE STAY IN AN INPATIENT PSYCHIATRIC FACILITY

The following criteria apply to individuals under the age 21 in a psychiatric hospital or in a psychiatric unit of a general hospital, and to individuals aged 21 through 64 receiving treatment in a psychiatric unit of a general hospital. These criteria shall be applied after the initial admission period of up to three days. To qualify for Medicaid coverage for a continuation of an acute stay in an inpatient psychiatric facility a patient must meet each of the conditions specified in Items (1) through (4) of this Rule. To qualify Medicaid coverage for continued post-acute stay in an inpatient psychiatric facility a patient must meet all of the conditions specified in Item (5) of this Rule.

- (1) The patient has one of the following:
 - (a) A current DSM-IV, Axis I diagnosis, or
 - (b) A current DSM-IV, Axis II diagnosis and current symptoms/behaviors which are characterized by all of the following:
 - (i) Symptoms/behaviors are likely to respond positively to acute inpatient treatment; and
 - (ii) Symptoms/behaviors are not characteristic of patient's baseline functioning; and
 - (iii) Presenting problems are an acute exacerbation of dysfunctional behavior patterns, which are recurring and resistive to change.
- (2) Symptoms are not due solely to mental retardation.
- (3) The symptoms of the patient are characterized by:
 - (a) At least one of the following:
 - (i) Endangerment of self or others; or
 - (ii) Behaviors which are grossly bizarre, disruptive, and provocative (e.g., feces smearing, disrobing, pulling out hair); or
 - (iii) Related to repetitive behavior disorders which present at least five times in a 24-hour period; or
 - (iv) Directly result in an inability to maintain age appropriate roles; and
 - (b) The symptoms of the patient are characterized by a degree of intensity sufficient to require continual medical/nursing response, management, and monitoring.
- (4) The services provided in the facility can reasonably be expected to improve the patient's condition or prevent further regression so that treatment can be continued on a less intensive level of care, and proper treatment of the patient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- (5) In the event that not all of the requirements specified in Items (1) through (4) of this Rule are met reimbursement may be provided for patients through the age 17 for continued stay in an inpatient psychiatric facility at a post-acute level of care to be paid at the High Risk Intervention Residential High (HRI-R High) rate if the facility and program services are appropriate for the patient's treatment needs and provided that all of the following conditions are met:
 - (a) The psychiatric facility has made a referral for case management and after care services to the area Mental Health Developmental Disabilities. Substance Abuse (MH/DD/SA) program, which serves the patient's county of eligibility.
 - (b) The area MH/DD/SA program has found that no appropriate services exist or are accessible within a clinically acceptable waiting time to treat the patient in a community setting.

- (c) The area MH/DD/SA program has agreed that the patient has a history of sudden decompensation or significant regression and experiences weakness in his or her environmental support system which are likely to trigger a decompensation or regression. This history must be documented by the patient's attending physician.
- (d) The inpatient facility must have a contract to provide HRI-R High with the area MH/DD/SA program which serves the patient's county of eligibility, or the area program's agent. Psychiatric hospitals or psychiatric units in general hospitals are eligible to establish contract relationships with all non-Carolina Alternatives area MH/DD/SA programs or their agents in accordance with statutory procedures as defined in G.S.-122C-142.
- (e) The Child and Family Services Section of the Division Mental Health Developmental Disabilities. Substance Abuse Services shall approve the use of extended HRI-R High based on criteria in Sub-items (a)-(c) of this Item.
- (f) The area MH/DD/SA program shall approve the psychiatric facility for the provision of extended HRI-R High receive claims from the inpatient facility, and provide reimbursement to the facility in accordance with the terms of its contract.

History Note: Authority G.S. 108A-25(b); 108A-54; 42 C.F.R. 441, Subpart D;
Eff. January 1, 1998;
Temporary Amendment Eff. August 20, 1999.

**CLARIFICATION OF RECORD SUBMISSION GUIDELINES FOR
INPATIENTS (ADULTS AND CHILDREN) APPLYING
FOR MEDICAID DURING OR AFTER A PSYCHIATRIC
HOSPITAL STAY**

This policy statement elaborates on the article appearing in the September 2000 general bulletin. (This information was also printed in the November 2000 Medicaid Special Bulletin II.)

Hospitals admitting a patient who is neither Medicaid-eligible on or before admission, nor pending eligibility, but applies for Medicaid during a psychiatric hospitalization, **must send in the entire medical record to ValueOptions for psychiatric review within 30 days of discharge**. If a patient applies for Medicaid after hospital discharge, the **complete medical record must be sent to ValueOptions within four months of the patient's Medicaid application date**. It is the facility's responsibility to make sure the record is mailed within this time frame. ValueOptions will perform a post discharge review to determine prior approval for medically necessary days of acute care if the record arrives at their place of business on time. A medical record received after the deadline will not be reviewed.

All other aspects of the September 2000 general Medicaid bulletin article and the November 2000 Special Medicaid Bulletin II regarding the prior approval process for acute psychiatric hospital stays remain the same including the certification of need process.

CERTIFICATION OF NEED PROCESS FOR ACUTE INPATIENT ADMISSIONS

Federal regulations require a CON form for admission to a psychiatric hospital for Medicaid recipients under the age of 21. 42 CFR 441.152 and 441.153 give detailed requirements that must be followed. It is vital that this CON meet all the federal requirements and a copy of it be maintained in the patient's medical record for inspection during any federal or state audit that might occur. The state-approved CON form is required only for psychiatric hospitals.

The N.C. Medicaid program is using an independent contractor to assist us in assuring that psychiatric admissions of patients are appropriate. Below is a summary of the policies and procedures in effect that must be followed for admission approval by all psychiatric hospitals and the general hospitals.

Under federal regulations, the procedures to be followed for the CON vary depending on the status of the patient's Medicaid at the time of admission. The hospital is responsible for determining the Medicaid status at the time of admission. If the proper procedures for admission approval are not followed, denial of Medicaid payment will be made as indicated below.

- I. For patients under the age of 21 who are Medicaid recipients at the time of admission to the hospital:
 - A. for elective admissions:
 1. the hospital must:
 - a. contact ValueOptions at 1-888-510-1150 for admission approval on or before the date of admission. For psychiatric hospitals, federal regulations require that the CON form must be completed on or before the date of admission. Medicaid payment for psychiatric hospitals cannot begin prior to the date the CON is completed. Medicaid payment for the psychiatric units of the general hospitals cannot begin prior to the date ValueOptions' preadmission approval is completed.
 - b. Supply ValueOptions with the recipient's MID number. The claims payment system at EDS cannot accept an admission approval until the MID is entered by ValueOptions in the prior approval segment.
 2. If ValueOptions determines that they can approve the admission, ValueOptions will:
 - a. verbally issue the prior approval and follow this with a written notice of the admission approval. The admission approval is valid for 15 days. Failure to admit the patient within this time frame will necessitate a new admission approval to be initiated by the hospital.
 - b. complete the CON if the admission is to a psychiatric hospital and forward a copy of the CON to the hospital to be maintained in the patient's medical record for federal or state audit. Approval for Medicaid payment cannot begin prior to the date the CON is completed.
 - c. send the approval information to EDS.

3. If ValueOptions is unable to approve the admission, they will notify the patient or patient's guardian, the hospital, and the patient's county department of social services (DSS) by certified mail, return receipt requested, with instructions for appeal.
- B. for emergency admissions:
1. the hospital must:
 - a. call ValueOptions at 1-888-510-1150 for admission approval within two working days of the admission. Delay in contacting ValueOptions beyond the two days will result in denial of admission approval from the date of admission to the date the hospital contacts ValueOptions to initiate admission approval.
 - b. supply ValueOptions with the recipient's MID number. The claims payment system at EDS cannot accept an admission approval until the MID is entered by ValueOptions in the prior approval segment.
 - c. if it is a psychiatric hospital, in addition to other general information needed for admission approval, send ValueOptions the completed state-approved CON form signed by appropriate interdisciplinary team members. A faxed copy of the CON is not acceptable. The hospital should maintain a copy of the completed and signed CON in the patient's record for federal or state audit.
 2. ValueOptions will determine if the admission meets the criteria for emergency admission:

“Sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm to another person by the individual.”

- a. If the admission does not meet the criteria for emergency, ValueOptions must treat the admission as an elective admission (and follow the guidelines listed in I.A. above).
 - b. If the admission meets the criteria for emergency, ValueOptions can continue the admission approval process as outlined below.
3. For psychiatric hospitals, ValueOptions will review the state-approved CON form submitted by the hospital to ensure that the signatures of the interdisciplinary team members are individually dated within 14 days of the admission.
- a. If both of the signatures are within 14 days of admission, ValueOptions can enter the “start date” for admission approval as the admission date, if:
 - i) the admission is otherwise approvable, and
 - ii) the hospital contacted within two working days of admission. If the hospital did not contact within the two working days, ValueOptions will enter the “start date” for admission approval no earlier than the date the hospital contacted ValueOptions to initiate the admission review.
 - b. If either of the signatures is beyond the 14 days from admission, the earliest “start date” for admission approval that ValueOptions can enter is the latest date that the CON was signed by either team member, if:
 - i) the hospital contacted ValueOptions within two working days after admission, (see I.B.3.a.ii above for directions), and

- ii) the admission is otherwise approvable.

Example: date of admission: March 3, 2001
 date hospital called XX: March 4, 2001
 first CON signature date: March 13, 2001
 second CON signature date: March 20, 2001
 earliest "start date" for admission approval:
 March 20, 2001, if otherwise approvable

- c. Admission approval can not be given until ValueOptions has received a valid CON.
- 4. If ValueOptions determines that they can approve the admission, ValueOptions will:
 - a. verbally issue approval to the hospital and will follow this with a written notice of the admission approval, and
 - b. submit admission approval information to EDS.
- 5. If ValueOptions is unable to approve the admission, they will notify the patient or patient's guardian, the hospital, and the patient's county DSS by certified mail, return receipt requested, with instructions for appeal.

II. For patients under the age of 21 whose Medicaid was pending at the time of admission:

A. the hospital must:

- 1. contact ValueOptions at 1-888-510-1150 for admission approval as soon as the hospital becomes aware of the Medicaid application. The hospital must supply ValueOptions with the applicant's MID number. (This number is assigned at the time that the application is taken.) ValueOptions cannot complete an admission approval and submit the approval to EDS without the MID.
- 2. if it is a psychiatric hospital, in addition to other required materials for admission approval, send the completed state-approved CON form signed by appropriate interdisciplinary team members. The interdisciplinary team members must certify that the three criteria were met for the date that the hospital is seeking to have Medicaid coverage begin. The hospital should maintain a copy of the completed and signed CON in the patient's record for federal or state audit.

B. ValueOptions will determine whether admission approval can be given.

- 1. ValueOptions will verify the dates of application and approval for Medicaid eligibility through DMA.
 - a. If the patient was a Medicaid recipient at the time of admission, ValueOptions must use the appropriate process for admission approval of recipients listed in I.A. or I.B. above.
 - b. If the patient was not a Medicaid recipient at the time of admission, ValueOptions can enter a "start date" for admission approval as early as the date the hospital is seeking to have Medicaid coverage begin, if otherwise approvable.
- 2. For psychiatric hospital, ValueOptions will review the state-approved CON form submitted by the hospital and will ensure that it is properly completed and signed. The interdisciplinary team members must certify that the three criteria were met for the date that the hospital is seeking to have Medicaid coverage become effective.

3. If ValueOptions determines that they can approve the admission, ValueOptions will verbally issue the approval to the hospital and will follow this with a written notice of the admission approval.
 - a. ValueOptions will send the approval information to EDS.
4. If ValueOptions is unable to approve the admission, they will notify the patient or patient's guardian, the hospital, and the patient's county DSS by certified mail, return receipt requested, with instructions for appeal.

III. General information regarding admission approvals for psychiatric care:

- A. Admission approval by ValueOptions is not a guarantee of Medicaid eligibility. It is a certification of need for admission for inpatient services. The hospital must separately verify the patient's period of eligibility for Medicaid.
- B. When submitting the request for admission approval, the hospital must provide ValueOptions with the following information at a minimum. It is vital that the person contacting ValueOptions has all of this information available at the time of the initial contact.
 1. The recipient's MID number. (These are issued and available even on pending applications.)
 2. The recipient's name, date of birth, county of residence, and sex.
 3. The name of the hospital, the provider number, and (planned) date of admission.
 4. The DSM-III-R diagnosis (diagnoses) applicable for the patient at the time of admission. For requests for retroactive admission approval as allowed above, these must be applicable for the date the hospital is requesting Medicaid payment to begin.
 5. A description of the initial treatment plan relating to the admitting symptoms.
 6. Precipitating event/current symptoms requiring inpatient treatment.
 7. Medication history.
 8. Prior hospitalization.
 9. Prior alternative treatment.
- C. When the initial call to ValueOptions does not result in a decision regarding admission approval, if the hospital or physician becomes aware of new or other non-reported information, the hospital or physician should provide the information to ValueOptions at any time up to the date of denial by ValueOptions. Faxed copies can be used; this may avert the need for a peer to peer review.

- D. Federal regulations do not require that general hospitals have a CON form as defined in 42 CFR 441.152 and 441.153.
Effective September 1, 2001, for acute care hospitals the physician orders for admission and treatment, history and physical, progress notes or discharge summary are considered acceptable certification for Medicaid recipients.
- E. Admission approval must be secured for all admissions. This includes admissions on the same day as a previous discharge at either the same hospital or a different hospital. (This also includes situations where a patient never left the hospital, but the hospital record shows a discharge and readmission.)

Federal regulations require that the team providing the CON must include, at a minimum, a board-eligible or board-certified psychiatrist and one of the following:

- a psychiatric social worker
- a registered nurse with specialized training or one year's experience in treating mentally ill individuals
- an occupational therapist who is licensed and has specialized training or one year of experience in treating mentally ill individuals
- a psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

For further details on the composition of the team, refer to 42 CFR 441.156.

Preadmission Certification Process for Adults

Indications for Hospitalization

The following criteria are to be utilized for preadmission review for psychiatric treatment of adult (ages 21 through 64) with non-substance abuse and all other conditions.

Any DSM-IV Axis I or II diagnosis and **one** of the following:

- Impaired reality testing (e.g., delusions, hallucinations), disordered or other acute disabling symptoms not manageable by alternative treatment.
- Potential danger to self or others not manageable by alternative treatment.
- Concomitant severe medical illness or substance abuse necessitating inpatient treatment.
- Severely impaired social, familial, occupational or developmental functioning, which cannot be effectively evaluated or treated by alternative treatment.
- Failure of or inability to benefit from alternative treatment, in the presence of severe disabling psychiatric illness.
- Need for skilled observation, special diagnostic or therapeutic procedures or therapeutic milieu necessitating inpatient treatment.

Level of Care Required

A treatment plan and expected length of stay is needed for certification of admission.

Note: Concurrent review criteria for adults are listed in NCAC 26I.0113.

RESIDENTIAL SERVICES

Instructions for Completing Application for Residential Services Provider Enrollment

Residential Services providers must file an application for enrollment as a Medicaid provider and sign a provider agreement to qualify for reimbursement for Level II, III, IV HRI-Residential Services, and Psychiatric Residential Treatment Facility services. A separate application and provider agreement must be completed for **each business site**. The enrollment process includes the following steps:

1. Provider requests enrollment with the Division of Medical Assistance (DMA). Provider Services can be reached at 919-857-4017.
2. DMA sends the provider a Residential Services provider application and a provider agreement.
3. Provider completes the application, signs the provider agreement, and forwards both documents, along with the required credentials to:
Provider Services
Division of Medical Assistance
2506 Mail Service Center
Raleigh, NC 27699-2506
4. If the application or agreement are not completed properly, DMA returns the document(s) for correction or for additional information.
5. If the provider meets all qualifications, DMA assigns a provider number, which must be entered on all claims for reimbursement of services rendered.
6. DMA sends the provider a letter with the provider number and a copy of the signed provider agreement.
7. The provider begins billing upon receipt of the provider number and provider agreement.
8. The provider is responsible for applying for re-enrollment before the enrollment end date to ensure continued enrollment. The enrollment end date will be the earlier of 1) the end date of the accreditation credential or 2) the end date of the license.

Important Points to Remember

- **Each** residential service **site** must have a separate application and provider agreement.
- Facilities must have four beds or more.
- All parts of the Residential Services provider application must be completed. Signature must be original.
- All pages of the provider agreement must be returned to DMA. The provider receives a signed copy in the mail.

- Copies of accreditation and licensure must accompany the application. If these documents are missing, the application is returned to the provider. Permissible license types are:
 - Level II, III, and IV Residential: 14V.1300, 14V.1500, 14V.5200, 14V.3400
 - PRTF: Hospital license or 14V.1500
- The accreditation document must have an end date.
- Services cannot be billed until the provider receives notification of the provider number. The notification letter will include the effective date.

**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
APPLICATION FOR PROVIDER ENROLLMENT**

RESIDENTIAL SERVICES

Name of Business/Agency

Site Address (_____) Phone

City State Zip

Mailing Address (if different from above)

- 1) Please check the services for which you are applying to provide. Each **site** must have a separate provider number and provider agreement. More than one type of service may be provided at a site if all service definition requirements are met.

Check Desired Service	Required Accreditation Credential	Required License
<input type="checkbox"/> Level II HRI - Residential <input type="checkbox"/> Level III HRI - Residential <input type="checkbox"/> Level IV HRI - Residential	Copy of JCAHO, COA, CARF*, Area Mental Health Program, N.C. Council of Community Programs or NC Division of MH/DD/SAS accreditation showing end date of accreditation	Copy of license as required by G.S.122C from the N.C. Division of Facility Services (14V.1300, 14V.1500, 14V.3400 or 14V.5200)
<input type="checkbox"/> Psychiatric Residential Treatment Facility	Copy of JCAHO, COA, or CARF accreditation showing end date of accreditation period	Copy of license as required by G.S. 122C or G.S. 131E, Article 5 from the N.C. Division of Facility Services (Hospital license or 14V.1500)

* JCAHO – Joint Commission on the Accreditation of Healthcare Organizations
 COA – Council on Accreditation of Services for Families and Children
 CARF – Rehabilitation Accreditation Commission

Residential Services Provider Application
Page 2

2) Number of beds in the residential placement: _____

3) Is the placement state-owned: () Yes () No

4) Is the residential placement hospital-based? () Yes () No

Name of associated hospital: _____

5) Have individuals or organizations having a direct or indirect ownership or control interest of 5% or more in this business been convicted of a criminal offense related to the involvement of such persons or organizations in the programs of Medicaid (Title XIX), Medicare (Title XVIII or Social Services Block Grant (Title XX)?

____ Yes (Provide names in this space or attach documentation.)

____ No

6) Have any directors, officers, agents, or managing employees of the agency or organization been convicted of a criminal offense related to their involvement in the programs of Medicaid, Medicare, or Social Services Block Grant?

____ Yes (Provide names in this space or attach documentation.)

____ No

SIGNATURE OF PROVIDER:

Printed Name of Owner or Corporate Officer Title

Signature of Owner or Corporate Officer

Please enclose a copy of the applicable accreditation credential and license with a completed provider participation agreement and mail to:

Provider Services
DMA
2506 Mail Service Center
Raleigh, NC 27699-2506

THE ROLE OF AREA PROGRAMS

The area mental health program serves as the established portal of entry, and its role should be consistent across Levels II, III, and IV of residential treatment and the Psychiatric Residential Treatment Facilities (PRTF). The area program is responsible for furnishing a list of providers who are enrolled and accredited/privileged for specific residential treatment services. Providers who foresee Medicaid eligibility for children whom they already have in treatment should inform the area mental health program of these possible recipients. The area mental health program will receive referrals from primary care physicians, health departments, physicians, and other qualified professionals to assess the need for residential treatment. If it is determined that a consumer is appropriate for a residential level of care, the area mental health program will assist the consumer in choosing a provider. Clinical case management is to be done only by the appropriate area program.

Clinical Case Manager Responsibilities

- The area mental health program case manager or area program designee will solicit certification authorization from ValueOptions immediately after completing the CON form for the PRTF level of care.
- The case manager is responsible for assuring that an assessment of the consumer is performed to determine the appropriate treatment services.
- The case manager is responsible for offering the consumer a choice of providers within the appropriate level of care.
- The case manager will work with the consumer's family, local support system, and other involved agencies to develop an appropriate and culturally competent treatment plan that addresses the consumer's needs across all life domains in strength-based fashion.
- The case manager is responsible for ensuring that the child receives treatment in the most appropriate and least restrictive setting possible.
- The case manager is responsible for coordination of indicated treatment services.
- The case manager will assume responsibility as the primary case manager for the first 30 days after the consumer is admitted to the PRTF. After the initial 30 days, the case manager will serve as a member of the treatment team at the residential facility until 30 days before discharge when they will again resume the role as primary case manager.

PRIOR APPROVAL PROCESS FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

The prior approval process for PRTF begins when the area mental health program becomes aware that a recipient is in need of services. An assessment is done to determine medical necessity and the appropriate level of care. Once the level of care is determined, the case manager from the area mental health program will contact the independent utilization review contractor for Medicaid. The case manager will provide pertinent recipient information by telephone to the utilization reviewer.

Federal regulations require a certification of need (CON) form to be completed prior to admission when the recipient is already Medicaid-eligible or Medicaid is pending. The CON must meet all federal requirements and a copy must be maintained in the recipient's medical record. If application for Medicaid is made after admission, a CON must be done at the time the application is made and the independent utilization reviewer contacted immediately so that review can begin. Authorization for payment will be determined by the latest date of a signature on the CON form.

The following is the minimum data required from the facility representative in order to complete a preadmission certification review:

1. a DSM-IV diagnosis on Axis I through V
2. a description of the initial plan of care relating to the admitting symptoms
3. the current symptoms and precipitating factors requiring inpatient treatment
4. medication history
5. prior hospitalization
6. prior alternative treatment
7. appropriate medical, social, and family histories
8. proposed aftercare placement/community-based treatment
9. the recipient's Medicaid identification (MID) number
10. recipient's name, date of birth, county of eligibility, and sex
11. residential facility name, provider number, and planned date of admission

Reviewers will request the transmittal of appropriate medical records or additional written documentation, as necessary to complete the review.

Concurrent review will occur every 30 days.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Psychiatric Residential Treatment Facility Services

PRTFs provide care for children who have a mental illness or substance abuse/dependency and who are in need of services in a nonacute inpatient facility. This service may be provided when an individual does not require acute care but requires supervision and specialized interventions on a 24-hour basis to attain a level of functioning that allows subsequent treatment in a less restrictive setting. This service is available for those under 21 years of age or who are in treatment at age 21. Continued treatment can be provided until the 22nd birthday as long as it is medically necessary. Discharge planning starts on the day of admission.

This is a structured inpatient psychiatric program accredited as a residential treatment facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. In addition, hospital licensure or 122C licensure is required. This program must be provided under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with demonstrated experience in the treatment of children and adolescents. The services must be therapeutically appropriate and meet medical necessity criteria as established by the state. Documentation requirements must meet both the requirements of the accrediting body and Medicaid guidelines.

Certification of Need Process

A CON process is necessary and must be performed by an independent team that includes a physician who has competence in the diagnosis and treatment of mental illness – preferably in child psychiatry – and has knowledge of the individual’s situation (taken from CFR 441.153). An individual comprehensive service plan must be developed, implemented, and managed on an ongoing basis.

For an individual who applies for Medicaid while in the facility or program, the CON must be performed at the time of application by the team responsible for the plan of care. It must cover any period prior to the application date for which the facility is seeking to have Medicaid coverage begin.

The CON for PRTF services must certify that:

1. ambulatory care resources available within the community are insufficient to meet the treatment needs of the recipients;
2. the patient’s condition is such that it requires services on an inpatient basis under the direction of a board-eligible or certified child and adolescent psychiatrist or general psychiatrist with experience in treating children and adolescents; and
3. the services can reasonably be expected to improve the recipient’s presenting condition or prevent further regression so that the services will no longer be needed.

It should be noted that adolescents who appropriately require this level of care may have demonstrated unlawful or criminal behaviors. Therefore, this level of care may be court-ordered as an alternative to incarceration. This court order does not automatically certify that the medical necessity criteria must be met for certification.

Criteria for Admission

1. Must meet Level D in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' (MH/DD/SAS) level of care document.
2. The need for this level of treatment arises from a mental health or substance abuse diagnosis (DSM IV) which requires and can be reasonably expected to respond to therapeutic interventions.

AND

The child/adolescent's condition is not amenable to treatment outside a highly specialized secured therapeutic environment under daily supervision of a treatment team directed by and with 24-hour access to a board-eligible or certified psychiatrist or general psychiatrist with experience in treating children and adolescents.

OR

Less restrictive levels of care (Levels I through IV) have been attempted within the last three months and have failed or been ineffective with history of poor treatment compliance.

AND

The child is not at an acute level but is in need of extended diagnostic evaluation to determine appropriate treatment.

AND

The child/adolescent can reasonably be expected to respond favorably to the specialized therapeutic interventions/modalities employed by the PRTF.

Continued Stay Criteria

Spectrum of symptoms leading to admission have not remitted sufficiently to allow discharge to a lower level of care or the client has manifested new symptoms or maladaptive behaviors which meet initial authorization criteria and the treatment plan has been revised to incorporate new goals.

AND

Patient shows continued progress towards goals as reflected in documentation and treatment plans must be adjusted to reflect progress.

AND

The patient's family, legal guardian, or home community is actively engaged in treatment and ongoing discharge planning.

OR

Indicated therapeutic interventions have not yet been employed.

Discharge Criteria

1. The patient's needs can now be met at a less restrictive level of care.
2. A community placement or supportive services package exists that is able to adequately meet the needs of the recipient.
3. Treatment goals related to problems leading to admission have been adequately met.
4. The legal guardian has withdrawn consent for treatment.
5. There is no evidence of progress towards treatment goals and the treatment team has no expectation of progress at this level of care.

This program will not be used when the primary problems are social or economic (placement issues) alone. Medical necessity must be evident. Utilization review will be performed by an independent utilization review contractor every 30 days by a telephonic review. All denials will be based on physician review decisions.

LEVEL II, III, AND IV RESIDENTIAL TREATMENT

Prior Approval Process

The prior approval process for Levels II, III, and IV residential treatment (in facilities of four beds or more) begins when the area mental health program becomes aware that a recipient is in need of services. An assessment is conducted jointly by the area mental health program and the child and family team to determine medical necessity and the appropriate level of care. Once the level of care is established, the case manager will then contact the independent utilization review contractor for Medicaid. The case manager will provide pertinent recipient information by telephone to the utilization reviewer. At the time of admission, the case manager will give the authorization form to the residential facility to submit to EDS.

The following is the minimum data required from the facility representative in order to complete a preadmission certification review:

1. a DSM-IV diagnosis on Axis I through V
2. a description of the initial plan of care relating to the admitting symptoms
3. the current symptoms and precipitating factors requiring inpatient treatment
4. medication history
5. prior hospitalization
6. prior alternative treatment
7. appropriate medical, social, and family histories
8. proposed aftercare placement/community-based treatment
9. the recipient's Medicaid identification (MID) number
10. the recipient's name, date of birth, county of eligibility, and sex
11. the residential facility name, provider number, and planned date of admission

Reviewers will request the transmittal of appropriate medical records or additional written documentation as necessary to complete the review.

Concurrent review by ValueOptions for Levels II and III will begin after the first 120 days.

Concurrent review by ValueOptions for Level IV begins after the first 30 days.

DEFINITIONS OF SERVICE FOR LEVELS II THROUGH IV RESIDENTIAL TREATMENT SERVICES

The following service definitions for Levels II through IV have been approved by both the Division of Medical Assistance and the Division of Mental Health and have been in effect since July 1, 1999.

Definition of Service – Level IV

Residential Treatment – Secure

Therapeutic Relationship

This service provides all elements of Residential Treatment – High plus ability to manage intensive levels of aggressiveness.

Structure of Daily Living

Daily living is structured to provide all elements of Residential Treatment – High in a physically secure, locked setting including, typically but not always, locked time-out rooms (used only for the safe management of out of control behaviors).

Cognitive/Behavioral Skill Acquisition

Treatment provides all Residential Treatment – High elements plus intensive focus on assisting consumers acquiring disability management skills and significantly increased onsite interventions from qualified professionals including psychologists and physicians.

General Characteristics

Additionally, most other service needs are met in the context of Residential Treatment – Secure setting including school, psychological and psychiatric consultation, nurse practitioner services, vocational training, recreational activity, etc. Typically, the treatment needs of consumers at this level are so extreme that these activities can only be undertaken in a therapeutic context. These services are conducted in a manner that is fully integrated into ongoing treatment.

Program Type

Staff is awake during sleep hours and supervision is continuous.

This service includes all Residential Treatment – High elements plus the following activities:

1. **Medically supervised secure treatment including physical restraints and containment in time-out room.** Locked and secure to ensure safety for consumers who are involved in a wide range of dangerous behaviors which are manageable outside of the hospital setting.
2. Continual and intensive interventions designed to assist the consumer in acquiring control over acute behaviors.

Note: Periodic services may not be used to augment residential services.

Program Type

Treatment is provided in a structured program setting with staff employed by, or contracted by, an area program. Staff is present and available at all times of the day, including overnight awake.

A minimum of two direct care staff are required per six consumers at all times. Additionally, consultative and treatment services at a qualified professional level shall be available no less than eight hours per week. Staffing provisions apply as with Residential Treatment – High.

In addition to meeting Residential Treatment – High medical necessity criteria, the following must be satisfied:

1. Consumer is medically stable, but may need significant intervention to comply with medical treatment
2. Meets Level D criteria/NCSNAP (developmental disabilities assessment tool).

AND

Consumer’s needs cannot be met with Residential Treatment – High services.

AND

The consumer is experiencing any one of the following:

1. Frequent and severe aggression including verbal aggression and property damage or harm to self or others and unmet needs for safety, containment of aggressive or dangerous behaviors.
2. Severe functional problems as defined in Residential Treatment – High coupled with demonstrated inability to maintain treatment in an unlocked setting as evidenced by, but not limited to, history of eloping from unlocked facilities, or inability to become stabilized in anything but a locked facility.
3. Medication administration and monitoring has alleviated limited or no symptoms and other treatment interventions are needed to control severe symptoms or to ensure safety.

May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays or disabilities.

In addition to meeting Residential Treatment – High medical necessity criteria, the following must be satisfied:

1. Consumer is medically stable but may need significant intervention to comply with medical treatment.

A sex offender specific evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE, and a level of risk shall be established (low, moderate, high) through the use of at least three risk assessment tools.

2. Meets Level D criteria/NCSNAP.

AND

Consumer’s needs cannot be met with Residential Treatment – High services.

AND

The consumer is experiencing any one of the following:

1. Frequent and severe aggression including verbal aggression and property damage or harm to self or others and unmet needs for safety, containment of aggressive or dangerous behaviors.

Risk of offending or predatory sexual behavior is high with inadequate supervision that puts the community at high risk for victimization.

2. Severe functional problems as defined in Residential Treatment – High coupled with demonstrated inability to maintain treatment in an unlocked setting as evidenced by, but not limited to, history of eloping from unlocked facilities, or inability to become stabilized in anything but a locked facility.
3. Medication administration and monitoring has alleviated limited or no symptoms and other treatment interventions are needed to control severe symptoms or to ensure safety.

May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays or disabilities.

High risk for sexual reoffense.

4. Experiences severe limitations in ability to independently access or participate in other human services and requires intensive, active support, supervision and onsite access to all routinely needed services.
5. Has severe deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

To include sexual behaviors.

6. Severe aggressive and dangerous episodes may be without provocation or predictable, identifiable triggers.

Has deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems.

Service Order Requirement

Services orders for Residential Treatment – Secure must be completed on DMA's standardized service order form by a physician or a licensed practicing psychologist prior to or on the day that services are to be provided.

Continuation

Consumer continues to have the need and continues to benefit as outlined in their service plan.

Utilization review must be conducted at a minimal of every 30 days and so documented in the service record.

Discharge Criteria

The consumer shall be discharged from this level of care if any one of the following is true:

The level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment.

OR

The consumer no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Discharge or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured.

Service Maintenance Criteria

If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

1. There is a past history of regression in the absence of residential treatment or a lower level of residential treatment.
2. There are current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.
3. The presence of traditional psychiatric diagnoses, which would necessitate a “disability management”, approach. In this event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Provider Requirements – Program Type (Family type is not applicable)

The minimal requirements are a high school diploma or GED, associate degree with one year of experience or a four-year degree in the human service field or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider must be at a level that include structured interventions in a contained setting to assist consumer in acquiring control over acute behaviors.

In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment.

Implementation of therapeutic gains is the goal of the placement setting.

OR

Must meet requirements established by state personnel system or equivalent for job classifications. Weekly supervision is provided by a qualified professional for 60 minutes.

Supervision provided by a qualified professional with sex offender specific expertise, is onsite per shift.

Documentation Requirements

The minimal documentation standard is a full service note per shift on DMA's standardized forms. Documentation is directly related to the consumer's identified needs, preferences or choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining their level of functioning.

Documentation includes the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.

Definitions of Service – Level III

Residential Treatment – High

Therapeutic Relationship

This service provides all Family/Program Residential Treatment elements plus relationship which is structured to remain therapeutically positive in response to grossly inappropriate and provocative interpersonal consumer behaviors including verbal and some physical aggression.

Structure of Daily Living

Daily living is structured to provide all elements of Family/Program Residential Treatment plus intensified structure, supervision, and containment of frequent and highly inappropriate behavior. This setting is typically defined as being "staff secure."

Cognitive/Behavioral Skill Acquisition

Treatment provides all Family/Program Residential Treatment elements plus active "unlearning" of grossly inappropriate behaviors with intensive skill acquisition. Includes specialized, onsite interventions from qualified professionals.

General Characteristics

Residential Treatment – High service is responsive to the need for intensive, active therapeutic intervention, which requires a staff secure treatment setting in order to be successfully implemented. This setting has a higher level of consultative and direct service from psychologists, psychiatrists, medical professionals, etc.

Program Type

Staff is awake during sleep hours and supervision is continuous.

This service includes all Family/Program Residential Treatment elements and the following activities:

1. Individualized, intensive, and constant supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits, to ensure safety and contain out-of-control behaviors including intensive and frequent crisis management with or without physical restraint or to maintain optimum level of functioning.

2. Includes active efforts to contain and actively confront inappropriate behaviors and assist consumers in unlearning maladaptive behaviors. Includes relationship support to assist the consumer in managing the stress and discomfort associated with the process of change and maintenance of gains achieved earlier and specifically planned and implemented therapeutically focused interactions designed to assist the consumer in correcting various patterns of grossly inappropriate interpersonal behavior, as needed. Additionally, providers require significant skill in maintaining positive relationship in interpersonal dynamics, which typically provoke rejection, hostility, anger, and avoidance.

Periodic services may not be used to augment residential services.

Program Type

Treatment is provided in a structured program setting with staff employed by, or contracted by, an area program. Staff is present and available at all times of the day, including overnight awake. **A minimum of one staff is required per four consumers at all times. Additionally, consultative and treatment services at a qualified professional level shall be available no less than four hours per week.** This staff time may be contributed by a variety of individuals. For example, a social worker may conduct group treatment or activity; a psychologist may consult on behavioral management; or, a psychiatrist may provide evaluation and treatment services. These services must be provided at the facility site. Group therapy or activity time may be included as total time per consumer (i.e., if there are six members in a group for 90 minutes, this may be counted as 90 minutes per consumer).

In addition to meeting Family/Program Residential Treatment medical necessity criteria, the following must be satisfied:

1. Consumer is medically stable but may need significant intervention to comply with medical treatment.
2. Meets Levels D criteria/NCSNAP.

AND

The consumer's identified needs cannot be met with Family/Program Residential Treatment service.

AND

The consumer is experiencing any of the following:

1. Severe difficulty maintaining in the naturally available family setting or lower level treatment setting as evidenced by, but not limited to, frequent and severe conflict in the setting; or frequently and severely limited acceptance of behavioral expectations and other structure; or frequently and severely limited involvement in support or impaired ability to form trusting relationships with caretakers; or a pervasive and severe inability to form trusting relationships with caretakers or family members; or an inability to consider the effect of inappropriate personal conduct on others.
2. Frequent physical aggression including severe property damage or moderate to severe aggression toward self or others.

3. Severe functional problems in school or vocational setting or other community setting as evidenced by failure in school or vocational setting because of frequent and severely disruptive behavioral problems in school or vocational setting; or frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings; or severe and pervasive inability to accept age appropriate direction and supervision from caretakers or family members coupled with involvement in potentially life-threatening, high-risk behaviors.

May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays or disabilities.

4. Medication administration and monitoring has alleviated some symptoms but other treatment interventions are needed to control severe symptoms.
5. Experiences significant limitations in ability to independently access or participate in other human services and requires intensive, active support and supervision to stay involved in other services.
6. Has significant deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

In addition to meeting Family/Program Residential Treatment medical necessity criteria, the following must be satisfied:

1. Consumer is medically stable but may need significant intervention to comply with medical treatment.

A sex offender specific evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE, and a level of risk shall be established (low, moderate, high) through the use of at least three risk assessment tools.

2. Meets Level D criteria/NCSNAP.

AND

The consumer’s identified needs cannot be met with Family/Program Residential Treatment service.

A sex offender specific evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE, and a level of risk shall be established (low, moderate, high) through the use of at least three risk assessment tools

AND

The consumer is experiencing any of the following:

1. Severe difficulty maintaining in the naturally available family setting or lower level treatment setting as evidenced by, but not limited to, frequent and severe conflict in the setting; or frequently and severely limited acceptance of behavioral expectations and other structure; or frequently and severely limited involvement in support or impaired ability to form trusting relationships with caretakers; or a pervasive and severe inability to form trusting relationships with caretakers or family members; or an inability to consider the effect of inappropriate personal conduct on others.

The parent or caregiver is unable to provide the supervision of the sex offender required for community safety. Moderate to high risk for reoffending.

2. Frequent physical aggression including severe property damage or moderate to severe aggression toward self or others.
3. Severe functional problems in school or vocational setting or other community setting as evidenced by failure in school or vocational setting because of frequent and severely disruptive behavioral problems in school or vocational setting; or frequent and severely disruptive difficulty in maintaining appropriate conduct in community settings; or severe and pervasive inability to accept age appropriate direction and supervision from caretakers or family members coupled with involvement in potentially life-threatening, high-risk behaviors.

May be related to the presence of severe affective, cognitive, or behavioral problems or developmental delays/disabilities.

Moderate to high risk for sexually victimizing others.

4. Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control severe symptoms.
5. Experiences significant limitations in ability to independently access or participate in other human services and requires intensive, active support and supervision to stay involved in other services.
6. Has significant deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

Has deficits that put the community at risk for victimization unless specifically treated for sexual aggression problems.

Service Order Requirement

Services orders for Residential Treatment – High must be completed on DMA’s standardized service order form by a physician or a licensed practicing psychologist prior to or on the day that services are to be provided.

Continuation/Utilization Review

The consumer continues to have the need or can benefit from this level of care as documented in their service plan.

Utilization review must be conducted at a minimal of every 30 days and so documented in the service record.

Discharge Criteria

The consumer shall be discharged from this level of care if any one of the following is true:

The level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment.

OR

The consumer no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Discharge or step-down services can be considered when in a less restrictive environment the safety of the consumer around sexual behavior and the safety of the community can reasonably be assured.

Service Maintenance Criteria

If consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn. This decision should be based on at least one of the following:

1. There is a past history of regression in the absence of residential treatment or a lower level of residential treatment.
2. There are current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.
3. The presence of traditional psychiatric diagnoses, which would necessitate a “disability management”, approach. In this event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Provider Requirements – Program Type (Family Type is not applicable)

The minimal requirements are a high school diploma or GED, associate degree with one year of experience or a four-year degree in the human service, or a combination of experience, skills, and competencies that is equivalent. Skills and competencies of this service provider must be at a level that offers psychoeducational, relational support, and behavioral modeling interventions and supervision. These preplanned, therapeutically structured interventions occur as required and outlined in the consumer’s service plan.

In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment.

Implementation of therapeutic gains is the goal of the placement setting.

OR

Must meet requirements established by state personnel system or equivalent for job classifications. Weekly supervision is provided by a qualified professional for 60 minutes.

Supervision provided by a qualified professional with sex offender-specific treatment expertise is available per shift.

Documentation Requirements

The minimal documentation standard is a full service note per shift on DMA's standardized forms. Documentation is directly related to the consumer's identified needs, preferences or choices, specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining their level of functioning.

Documentation includes the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.

Definitions of Service – Level II

Family/Program Type Residential Treatment

Therapeutic Relationship

This treatment provides all Family/Program Type Residential Treatment elements plus provision of a more intensive corrective relationship in which therapeutic interactions are dominant. Focus is broadened to include assisting consumer in improving relationships at school or work and other community settings.

Structure of Daily Living

Daily living is structured to provide all elements of Family/Program Type Residential Treatment with a higher level of structure and supervision.

Cognitive/Behavioral Skill Acquisition

Treatment provides all Family/Program Type Residential Treatment elements with a complete emphasis on individualized interventions for specific skill acquisition that enable the consumer to achieve or maintain the highest level of independent functioning.

General Characteristics

This level of service is responsive to the need for intensive, interactive, therapeutic interventions, which still fall below the level of staff secure/24-hour supervision or secure treatment settings. The staffing structure may include family and program type settings.

Program Type

The staff is not necessarily awake during sleep time, but must be constantly available to respond to consumer needs, while consumers are involved in educational, vocational, and social activities or other activities except for periods of planned respite.

Family Type

The provider is not necessarily awake during sleep time but must be constantly available to respond to consumer needs, while consumers are involved in educational, vocational and social activities or other activities except for periods of planned respite. This service in the family or program settings includes Family Type Residential Treatment elements and the following activities:

- Individualized and intensive supervision and structure of daily living designed to minimize the occurrence of behaviors related to functional deficits to ensure safety during the presentation of out of control consumer behaviors or to maintain optimum level of functioning.
- Specific and individualized psychoeducational and therapeutic interventions including development or maintenance of daily living skills; anger management; social skills; family living skills; communication skills; stress management; relational support; or comparable activity and intensive crisis or near crisis management including de-escalation interventions and occasional physical restraints.
- Direct and active intervention in assisting consumers in the process of being involved in and maintaining in naturally occurring community support systems and supporting the development of personal resources (assets, protective factors, etc).

Periodic services may not be used to augment residential services.

Family Type

This treatment may be provided in a natural family setting with one or two surrogate family members providing services to one or two consumers per home.

Program Type

Treatment is provided in a structured program setting with staff employed by, or contracted by, an area program. Staff is present and available at all times of the day. **A minimum of one staff is required per four consumers at all times.**

In addition to meeting Family Type Residential Treatment medical necessity criteria, the following must be satisfied:

1. The consumer is medically stable, but may need some intervention to comply with medical treatment.
2. Meets Level C criteria/NCSNAP.

AND

The consumer's needs cannot be met with Family Type Residential Treatment services.

AND

The consumer is experiencing any one of the following:

1. Moderate to severe difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, severe conflict in the setting; or severely limited acceptance of behavioral expectations and other structure; or severely limited involvement in support or impaired ability to form trusting relationships with caretakers; or limited ability to consider the effect of inappropriate personal conduct on others.
2. Frequent and severely disruptive verbal aggression or frequent and moderate property damage or occasional, moderate aggression toward self or others.
3. Moderate to severe functional problems in school or vocational setting or other community setting as evidenced by failure in school or vocational setting; or frequent and disruptive behavioral problems in school or vocational setting; or frequent and disruptive difficulty in maintaining appropriate conduct in community setting or pervasive inability to accept age appropriate direction and supervision, in significant areas, from caretakers or family members.

May be related to the presence of moderate to severe affective, cognitive, or behavioral problems or developmental delays or disabilities.

4. Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control moderate symptoms.
5. Experiences limitations in ability to independently access or participate in other human services and requires active support and supervision to stay involved in other services.
6. Has deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

In addition to meeting Family Type Residential Treatment medical necessity criteria, the following must be satisfied:

1. The consumer is medically stable, but may need some intervention to comply with medical treatment.

A Sex Offender Specific Evaluation (SOSE) shall be provided by a trained professional in conducting the SOSE, and a level of risk shall be established (low, moderate, high) through the use of at least three risk assessment tools.

2. Meets Level C criteria/NCSNAP.

AND

The consumer's needs cannot be met with Family Type Residential Treatment services.

AND

The consumer is experiencing any one of the following:

1. Moderate to severe difficulty maintaining in the naturally available family or lower level treatment setting as evidenced by, but not limited to, severe conflict in the setting; or severely limited acceptance of behavioral expectations and other structure; or severely limited involvement in support or impaired ability to form trusting relationships with caretakers; or limited ability to consider the effect of inappropriate personal conduct on others.

2. Frequent and severely disruptive verbal aggression or frequent and moderate property damage or occasional, moderate aggression toward self or others.

There has been at least one incident of inappropriate sexual behavior; risk for offending/re-offending is low to moderate.

3. Moderate to severe functional problems in school or vocational setting or other community setting as evidenced by failure in school or vocational setting; or frequent and disruptive behavioral problems in school or vocational setting; or frequent and disruptive difficulty in maintaining appropriate conduct in community setting or pervasive inability to accept age appropriate direction and supervision, in significant areas, from caretakers or family members.

May be related to the presence of moderate to severe affective, cognitive, or behavioral problems or developmental delays or disabilities.

Low to moderate risk for sexual victimizing.

4. Medication administration and monitoring has alleviated some symptoms, but other treatment interventions are needed to control moderate symptoms.
5. Experiences limitations in ability to independently access or participate in other human services and requires active support and supervision to stay involved in other services.
6. Has deficits in ability to manage personal health, welfare, and safety without intense support and supervision.

Has deficits that put the community at risk unless specifically treated for sexual aggression problems.

Service Order Requirement

Services orders for Family/Program Type Residential Treatment must be completed on DMA’s standardized service order form by a physician or a licensed practicing psychologist prior to or on the day that services are to be provided.

Continuation/Utilization Service Review

The consumer continues to have the need and continues to benefit as outlined in their service plan.

Utilization review must be conducted at a minimal of every 30 days and so documented in the service record.

Discharge Criteria/Review

The consumer shall be discharged from this level of care if any one of the following is true:

The level of functioning has improved with respect to the goals outlined in the service plan and can reasonably be expected to maintain these gains at a lower level of treatment.

OR

The consumer no longer benefits from service as evidenced by absence of progress toward service plan goals and more appropriate service(s) is available.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Discharge or step-down services can be considered when in a less restrictive environment, the safety of the consumer around sexual behavior, and the safety of the community can reasonably be assured.

Service Maintenance Criteria

If the consumer is functioning effectively at this level of treatment and discharge would otherwise be indicated, this level of service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service were to be withdrawn.

This decision should be based on at least one of the following:

1. There is a past history of regression in the absence of residential treatment or a lower level of residential treatment.
2. There are current indications that consumer requires this residential service to maintain level of functioning as evidenced by difficulties experienced on therapeutic visits or stays in a nontreatment residential setting or in a lower level of residential treatment.
3. The presence of traditional psychiatric diagnoses, which would necessitate a “disability management” approach. In this event, there are epidemiological sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain functional gains.

Any denial, reduction, suspension or termination of services requires notification to the consumer about their appeal rights.

Provider Requirements – Family Type

The minimal requirements are a high school diploma or GED with experience in the human service field.

Provider Requirements – Program Type

The minimal requirements are a high school diploma or GED or associate degree with one year of experience or four-year degree in the human service field. Skills and competencies of this service provider must be at a level that offers psychoeducational, relational support, and behavioral modeling interventions and supervision. These preplanned, therapeutically structured interventions occur as required and outlined in the consumer’s service plan

In addition to the above, special training of the caregiver is required in all aspects of sex offender specific treatment.

Implementation of therapeutic gains are to be the goal of the placement setting.

OR

Must meet requirements established by state personnel system or equivalent for job classifications. Weekly supervision is provided by a qualified professional for 60 minutes.

Supervision provided by a qualified professional with sex offender-specific treatment expertise, is available for a total of at least 60 minutes. On-call and back-up plan with a qualified professional is also available.

Documentation Requirement

The minimal documentation standard includes a daily head-count and a monthly summary with description of staff's interventions and activities on DMA's standardized forms. The summary of interventions and activities are directly related to identified needs, preferences or choices, and specifies goals, services, and interventions, along with frequency which assists in restoring, improving, or maintaining, the consumer's level of functioning. Documentation of critical events, significant events, or changes of status in the course of treatment shall be evidenced in the consumer's medical record as appropriate. Documentation includes the specific goals of sex offender treatment as supported and carried out through the therapeutic milieu and interventions outlined in the service plan.

**BILLING INSTRUCTIONS FOR DIRECT ENROLLED
RESIDENTIAL SERVICES AND
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES
PROVIDERS**

Psychiatric Residential Treatment Facility providers should bill for this service on a UB-92 claim form. This service will be coded in form locator 42 with the Revenue Center Code (RCC) 911. It is to be billed as one unit per day for a span of days.

Levels II through IV should be billed on the UB-92 claim form as well. For Level II, the RCC 902 is entered in form locator 42. A corresponding Y2346 is entered in form locator 44. It is to be billed as one unit per day for a span of days.

For Level III, the RCC 902 is entered in form locator 42. A corresponding Y2345 is entered in form locator 44. It is to be billed as one unit per day for a span of days.

For Level IV, the RCC 902 is entered in form locator 42. A corresponding Y2344 is entered in form locator 44. It is to be billed as one unit per day for a span of days.

42 Rev Code	43 Description	44 HCPCS/Ra tes	45 Serv Date	46 Serv Units	47 Total Charges	48 Noncovered Charges

CURRENT PROCEDURAL TERMINOLOGY

Mental Health Procedure Codes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), also referred to as the Kennedy-Kassesbaum Act, is a federal law, which was signed by President Clinton on August 21, 1996. The purpose of the Act is to protect health insurance coverage for workers and their families when they change or lose their jobs. In order for transitional insurance coverage to be provided, administrative reforms were instituted. Standardization of billing across the nation is one such reform, which is now mandated. The mandate for standardized billing necessitates uniform health care identifiers and requires codes to be recognizable, and consistent.

Current Procedure Terminology (CPT) is a listing of descriptive medical, surgical, and diagnostic services, which are assigned an identifying five-digit code. The purpose of the CPT codes is to simplify the reporting of services through standardization. Previous billing codes should be converted to the corresponding CPT codes.

The transition from state-created codes to CPT codes or some other national code must be completed by August, 2002. The first stage of this transition for mental health Y codes is as follows:

The Mental Health codes Y2305 (outpatient individual) and Y2306 (outpatient group) are to be broken out and billed separately. The services provided under the old Y2305 and Y2306 are as follows:

- therapy for mental health and substance abuse issues
- medication administration and monitoring
- behavioral counseling contracts programming, etc.
- PT, OT, speech and language therapy
- psychoeducational activities.
- education to client and collaterals about mental health and substance abuse issues, medication, wellness, etc., both in individual and group forums
- methadone treatment and outpatient detoxification
- clinical in-home services
- providing consultation to caregivers, service providers, and others who have a legitimate role in addressing the needs identified in the service plan
- outpatient treatment activities while a client resides in an acute hospital setting, which are professional services not covered by the cost of acute care (e.g., sex offender evaluations, forensic screenings)

The following specified disciplines are to bill the new conversion codes 90801, 90802 through 90829 as appropriate instead of the old Y 2305 code for individual therapy for MH/SA: LCSW, CCSW, CNS, MD, Ph.D., and MA psychologist.

The following CPT codes are physician codes only: 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829, 90862, 99202, 99203, 99204, 99205, 99212, 99213, 99214, and 99215.

Licensed OT, PT, and speech therapists can now bill OT, PT, and speech therapy separately. This was previously a part of outpatient therapy, and was coded Y2305 and Y2306.

Psychological and developmental testing should be billed by psychologists using CPT codes 96100 through 96117.

There is also evaluations in management codes available, these CPT codes are 99202 through 99215. These codes can be used, if this better describe the service rendered, and specified documentation requirements are met. The required documentation consists of a history, physical and medical decision process.

All other area program staff, not mentioned above should continue to bill Y2305 and Y2306 when providing any outpatient service as they currently do. These outpatient services consist of the following:

- case consultation telephone only
- screening after hours – telephone referrals
- individual therapy for MH/SA
- behavioral counseling
- psychoeducational activities
- education to consumers and collaterals regarding MH/SA both in individual and group forums
- methadone treatment and outpatient detox
- OT,PT, and speech therapy

If any service that did not convert to the CPT crosswalk are provided by an MD, LCSW, CNS or licensed therapist, they should use Y2305 or Y2306. However, they are not to use a Y code if the service can be converted.

Removal of Limits to CPT Code 90862

Effective with dates of service May 1, 2001, edits have been removed that limit the billing of CPT code 90862 (pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy) to once every 30 days. Beginning May 1, 2001, this code will not have any limitations nor will it be subject to prior approval. It will not count in the 26 unmanaged visits for the under 21 population but does count in the 24 annual visits for adults.



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Medical Policy

1985 Umstead Drive – 2511 Mail Service Center - Raleigh, N.C. 27699-2511
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Buell, Secretary

Nina M. Yeager, Director

Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21

Recipient Name: Hospital:

Medicaid ID # Provider #

Date of Birth: Admission Date:

Type of Certification: (check 1 item)

- Pre-admission/elective
Emergency admission

Medicaid Eligibility Status: (check 1 item)

- Medicaid eligible on admission
Pending Medicaid on admission
No evidence of Medicaid on admission
Applied for Medicaid during stay
Applied for Medicaid after discharge

At the time of admission, the interdisciplinary team certifies the following:

- 1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The acute inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

Physician Team Member Signature Print name/Title Date (Mo/Day/Yr)
Other Team Member Signature Print name/Title Date (Mo/Day/Yr)

FOR Independent Contractor USE ONLY:

Date: Reviewer: Results: Start Date:



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Department of Health and Human Services
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Psychiatric Residential Treatment Facility (PRTF)
Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21

Recipient Name: _____ Facility Name: _____

Medicaid ID #: _____ Provider #: _____

Date of Birth: _____ Admission Date: _____

Type of Certification: (check 1 item)

Medicaid Eligibility Status: (check 1 item)

_____ Pre-admission/elective

_____ Medicaid eligible on admission

_____ Pending Medicaid on admission

_____ No evidence of Medicaid on admission

At the time of admission, the interdisciplinary team certifies the following:

- 1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.
2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.
3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

Physician Team Member Signature

Print Name/Title

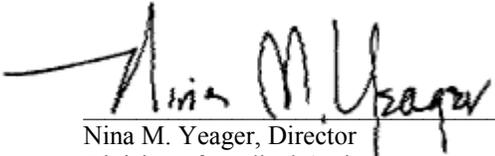
Date (Mo/Day/Yr)

Other Team Member Signature

Print Name/Title

Date (Mo/Day/Yr)

Revised 11/01


Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services


Ricky Pope
Executive Director
EDS



P.O. Box 30001
Raleigh, North Carolina 27622

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