CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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PROVIDERS OF SERVICE

In the mental health and substance abuse field, physicians, psychiatrists, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists, clinical nurse specialists-psychiatric, , community mental health clinics, and general hospitals (including outpatient departments) may be enrolled as providers billing for psychiatric services. In addition, Licensed Substance Abuse Treatment Practitioners may provide substance abuse services. Freestanding psychiatric hospitals including state mental hospitals are enrolled as a special type of facility rendering medical care only for those 65 years and older or those under 21 participating in Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Medicaid policy includes the reimbursement of psychiatric services offered in mental health clinics by employees of the clinic who are licensed clinical social workers, licensed professional counselors, licensed clinical nurse specialists-psychiatric, and marriage and family therapists when billed by the physician-directed clinic. The clinic is required to maintain personnel files that include a copy of credentials for all staff who provide Medicaid-reimbursed services.

Psychiatric and Substance Abuse Services may be provided by:

- A psychiatrist who is a licensed physician who has completed at least three years of postgraduate residency training in psychiatry;
- A licensed clinical psychologist licensed by the Department of Health Professions, Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Department of Health Professions, Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Virginia Board of Counseling; or
- A psychiatric clinical nurse specialist- (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A psychiatric nurse practitioner, licensed by the Board of Nursing;
- A marriage and family therapist licensed by the Virginia Board of Counseling;
- An individual who has completed his or her graduate degree and is under the direct personal supervision of an individual licensed under state law. The individual must be working towards licensure and supervised by the appropriate licensed professional in accordance with the requirements of the individual profession.

Substance Abuse Services (**only)** may be provided by an individual who is licensed as a substance abuse treatment practitioner by the Virginia Board of Counseling.

Direct Supervision for Persons Working Towards Licensure

- Both the unlicensed individual and the licensed professional must be employed by the same public clinic.

- The plan of care must be approved and signed by the licensed professional. It must state the need for psychiatric and/or substance abuse treatment, state the objectives or goals of the psychotherapy which fall within the parameters of Medicaid-covered services and are congruent with the diagnosis and initial evaluation of the client; and include a treatment regimen, projected schedule, and schedule for reevaluation. Documentation in the client's record should include written records of client contracts, services rendered, the role of the service to the care plan, and updates of the client's progress. The medical record must contain the notes that are countersigned or signed by the licensed individual to show that he or she personally reviewed the patient's medical history and confirmed the plan of care.

- The licensed supervisor does not have to be present in the room during the session, but must be in the clinic during the session and meet regularly with the professional to discuss the client's plan of care and review the record. The record should indicate that the patient's progress and plan of care are reviewed, at least after every six sessions, by the supervising licensed professional. All progress notes and plan of care reviews must contain the dated signature of both the supervisor and supervisee. Progress notes are required to be completed on the date of service

Physician Direction of Mental Health Clinics

Federal law requires that each mental health clinic be physician-directed. The physician does not have to be a psychiatrist. Under this policy, licensed clinical psychologists, licensed clinical social workers, licensed professional counselors, and clinical nurse specialists-psychiatric may render reimbursable services without the direct personal supervision of a physician present. In public clinics, these licensed practitioners may supervise the work of unlicensed professional social workers or counselors. However, each mental health clinic must ensure that the federal requirement for the physician direction of the clinic is fully met. Failure to do so could result in the recovery of funds. In addition, DMAS may terminate the Medicaid provider contract when the service provider did not meet his or her requirements.

The State Medicaid Manual § 4320B, published by the Health Care Financing Administration, summarizes the federal requirements for physician direction.

The requirement for physician supervision of all patient care in the mental health clinic is a condition of participation in Medicaid as a mental health clinic. The physician must have a face-to-face visit with the recipient, prescribe the type of care provided, and if services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when his or her patient is receiving covered services, the physician must assume professional responsibility for the services provided and ensure that the services are medically appropriate. Thus, physicians who are

affiliated with the clinic must spend as much time in the facility as is necessary to ensure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. For a physician to be affiliated with a clinic, there must be a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients. Some clinics will require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement.

The patient care protocols for treatment of Medicaid recipients must reflect the role of the physician. The patient's medical records must document that the physician personally reviewed the patient's medical history, conducted a thorough assessment, confirmed or revised the diagnosis, saw the patient face-to-face, reviewed and signed the plan of care, and is periodically reviewing the need for continued care. The licensed professional must conduct an intake interview with the patient, record the medical history, conduct the intake assessment, record a diagnosis, and develop the plan of care. If the plan of care is implemented, there must be no more than three sessions or no more than thirty days, which ever is least, before the face-to-face interview with the physician. If the recipient is an existing patient of the physician and the physician has had a face-to-face interview within the past 30 days, the face-to-face meeting may be waived. However, the physician must still review the medical history and intake assessment, confirm the diagnosis, and review and sign the plan of care. The physician must document a review of progress and need for continued care every six months. This requirement must be met for all mental health clinic services billed to Medicaid.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management program that enables Medicaid recipients to select their personal Primary Care Physician (PCP) who will be responsible for providing and coordinating services necessary to meet all health care needs. MEDALLION promotes the physician/patient relationship, preventive care, and patient education while reducing the inappropriate use of medical services. The PCP serves as a gatekeeper for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide a referral for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. Refer to the MEDALLION supplement to this manual for further details on the program.

Psychiatric/psychological services (limited sessions of outpatient treatment) are exempt from the referral requirements of MEDALLION. While reimbursement for these services does not require a referral from the PCP, the PCP must be forwarded a summary of services so the PCP may track and document them to ensure the continuity of care.

MEDALLION II

In areas where the Medallion II program is available, the majority of Medicaid recipients receive primary and acute care through mandatory enrollment in Health Maintenance Organizations (HMOs). There are at least two HMOs per area that have contracts to serve Medicaid recipients. Effective January 1, 1996, the program initially covered Medicaid populations located in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Poquoson, and Virginia Beach. Effective November 1, 1997, Medallion II expanded to cover populations located in the counties of York, James City, Gloucester, and Isle of Wight and the cities of Williamsburg and Suffolk. Effective April 1, 1999, populations located in the Richmond metropolitan area, Eastern Shore, and Southwest Tidewater regions were covered.

COVERED SERVICES

Outpatient Psychiatric and Substance Abuse Services

Outpatient psychiatric and substance abuse services are covered by the Virginia Medicaid Program subject to certain specific exclusions. A separate plan is required for psychiatric services and SA services when prior authorization is requested separately. The primary diagnosis should indicate the focus of treatment. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed with the expectation the clinician will bill for the primary presenting problem. The requirements for outpatient psychiatric and substance abuse services provided in mental health clinics are:

Criteria for Participation

In order for a recipient to qualify to receive outpatient psychiatric and substance abuse services, the recipient must meet ALL of the following criteria:

A. Requires treatment in order to sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired;

B. Exhibits deficits in peer relations, deficits in dealing with authority, hyperactivity, poor impulse control, clinical depression, or demonstrates other dysfunctional symptoms having an adverse impact on attention and concentration, the ability to learn, or the ability to participate in employment, educational, or social activities;

C. Is at risk for developing or requires treatment for maladaptive coping strategies; and

D. Presents a reduction in individual adaptive and coping mechanism or demonstrates extreme increase in personal distress.

Documentation Required (what must be in the medical record)

- History, to include:

- The onset of the diagnosis and functional limitations;
- Family dynamics; ability/desire of the family/caretakers to participate and follow through with treatment;
- Reasons that may require consideration (foster care, dysfunctional family);
- Previous treatment and outcomes;
- Medications, current and history of;
- Medical history if relative to current treatment;
- Treatment received through other programs (Department of Rehabilitative Services, day treatment, Special Education, Community Services Board, or the Department of Mental Health, Mental Retardation and Substance Abuse Services clinics.

- Functional limitations.

- Plan(s) of Care, and review of the plan of care signed and dated by the qualified provider.

- Medical Evaluation (evidence of coordination with the PCP, if applicable, or documentation that it is not applicable). The purpose of the evaluation is to rule out any underlying medical condition as causing the symptoms, and to ensure that any underlying medical conditions are being treated.

- Results of a Diagnostic Evaluation done within the past year. The chief complaint should relate to the psychiatric or substance use diagnosis that is current, within the past year.

- For SA services, individuals must meet the Diagnostic Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) diagnostic criteria for an Axis I Substance Use Disorder, with the exception of nicotine or caffeine abuse or dependence. A diagnosis of nicotine or caffeine abuse or dependence alone shall not be sufficient for approval of these services. American Society of Addiction Medicine (ASAM) criteria will be used to determine the appropriate level of treatment.

- Progress Notes for each session (must describe how the activities of the session relate to the client-specific goals, the length of the session, the level of participation in treatment, the modalities of treatment, the type of session [group, individual], the progress or lack thereof toward the goals, and the plan for the next treatment and must contain the dated signatures of the providers).

- Evidence of Discharge Planning.

- Discharge Summary (including the reason for the discharge and any follow-up needed).

Plan of Care (elements of the initial and ongoing plan of care)

- *Focus of the Plan* must be related to the diagnosis.

Must have a DSM-IV-TR psychiatric or SA diagnosis including current mental status documented in the medical progress notes.

- Must indicate client-specific goals related to symptoms and behaviors.
- Must indicate treatment modalities used and documentation specific to the appropriateness of the modalities (why the modality was chosen for this individual; all modalities will be considered with appropriate documentation).
- Must indicate estimated length that treatment will be needed.
- Must indicate frequency of the treatments/duration of the treatment.
- Must indicate documentation of the family/caregiver participation.
- Qualified provider must sign and date the plan of care.
- The Plan of Care must be reviewed by the provider every 90 days or every sixth session, whichever time frame is shorter, from the date of the provider's signature.
    - Has there been a relapse?
    - Has there been a significant change in the environment?
    - Is the individual at risk for moving to a higher level of care?
    - Positive/negative changes relative to the symptoms.
    - Documented review of the plan of care by a qualified therapist/personnel (the provider)

Specific Service Limits

The following psychotherapy and substance abuse services are limited to no more than three visits in a seven-day period when performed as an outpatient service:

- Individual therapy coverage is limited to once per day.
- Medical evaluation and management codes (90805, 90807, 90809, 90811, 90813, or 90815, including services with modifier HF) may be billed, but evaluation and management cannot also be billed separately.
- Interpretation of examinations, procedures and data, and the preparation of reports are non-covered services. This includes CPT code 90885 (psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes). Review of records or reports

are included in the interview examination. A psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medial interpretation of laboratory, or other medical diagnostic studies.

- Group therapy coverage is limited to once per day. Services for sensory stimulation, recreational activities, art classes, excursions, or eating together are not included as group therapy sessions. There is a maximum of ten individuals per group session.

- Family therapy is limited to once per day.

- Multiple-family group therapy is a non-covered service.

- Medical hypnotherapy; environmental intervention; interpretation of examinations, procedures, and data; and the preparation of reports remain non-covered services.

- Psychological and neuropsychological testing are allowed when done for purposes other than educational diagnosis, school admission, evaluation of an individual with mental retardation prior to admission to a nursing facility, or any placement issue. Medical records must document the medical necessity for these tests. DMAS allows one per six-month period and up to seven hours of units. Should the testing exceed the limits of frequency or units, the provider must provide the documentation with the bill as to the medical necessity for the testing and a list of the specific tests conducted.

- Separate payment will be allowed for the attending physician and the anesthesiologist involved in electroconvulsive therapy.

<u>Non-Covered Psychiatric Services</u>

The following services are non-covered services:

- Broken appointments;

- Remedial education;

- Day care;

- Psychological testing done for purposes of educational diagnosis or school admission or placement;

- Occupational therapy;

- Teaching “grooming” skills, monitoring activities of daily living, bibliotherapy, reminiscence therapy, or social interaction are not considered psychotherapy and remain non-covered;

- Telephone consultations;

- Mail order prescriptions;
- Psycho-education for the purpose of educating the recipient's guardian about the diagnosis and any related symptoms/treatment; and
- Teaching parenting skills.

REIMBURSEMENT

Payment for covered services on Medicaid invoices submitted by a mental health clinic is based on the mental health clinic's usual and customary charge to the public within Medicaid limitations.

Client Medical Management Program

As described in Chapters I, III and VI of this manual, the state may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for services to these recipients only:

- In a medical emergency situation in which a delay in treatment may cause death or result in lasting injury or harm to the recipient; or
- On written referral from the primary physician. This also applies to covering physicians.

The primary care physician must complete a Practitioner Referral Form (DMAS-70 4/89) when making a referral to another physician or clinic. (See "Exhibits" at the end of the chapter for a sample of the form.) Appropriate billing instructions for these situations are covered in Chapter V of this manual. See "Client Medical Management Program "in "Exhibits" in Chapter I for exceptions to the referral requirement.

Copayment

Copayments are a portion of the allowed Medicaid charges for which a recipient is responsible. Copayments must be paid directly to the provider by the recipient.

The Virginia Medical Assistance Program requires copayment from recipients for each visit to a community mental health clinic. This copayment is $1.00 per visit.

The Virginia Medicaid Program prohibits imposition of copayment requirements for any services rendered to children age 20 and under. Other copayment limitations include:

- No copayment is to be collected for any service which is pregnancy-related.
- There are no copayments for services rendered to individuals who are residents

of intermediate care facilities, intermediate care facilities for the mentally retarded, skilled nursing facilities, or tuberculosis or mental hospitals.

- Services to a recipient cannot be denied solely because of his or her inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

- Copayment does not apply to an emergency or life-threatening condition and will not be deducted from the calculated payment.

Remittance Voucher

The amount of copayment determined by the Medicaid Program will be reflected on the remittance voucher under the columnar heading "Paid by Patient."

EXHIBITS

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY