Chapter 22

Behavioral Health Services
(Mental Health and Substance Use Disorder)

Definitions

Adult Diagnostic Assessment Update: For adults 18 years old and over, use an adult DA update to revise a standard or extended DA that has occurred:

- within the past 12 months;
- within the past 24 months, when a previous adult diagnostic assessment update has occurred within the past 12 months.

An adult DA update must include:

- review of the member's life situation;
- significant new or changed information; or document where there has not been significant change;
- screenings for substance use, abuse or dependency;
- mental status exam;
- an assessment of the member's needs based on:
    - baseline measurements
    - symptoms
    - behavior
    - skills
    - abilities
    - resources
    - vulnerabilities
- safety;
- clinical summary;
- clinical summary, including recommendations and prioritization of needed mental health or other services;
- involvement of the member and member's family in the assessment and his or her preferences or referrals to services;
- diagnosis on all axes of the current DSM;
- documentation of covered services;
- Medical Necessity, Individual Treatment Plan and Progress Note criteria the same as standard diagnostic.

Assessment: a test or other way of measuring something, such as a person's mental health, or goals, or needs; often the first test in a series of tests or a test given before treatment starts.

Assessor: a person qualified under Rule 25 to perform an assessment of chemical use.

Behavioral Health Care: an encompassing term including assessment and treatment of mental and/or psychoactive substance abuse disorders.

Brief Diagnostic Assessment: A brief diagnostic assessment may be used for:

- a new member;

- an existing member who had less than 10 sessions of psychotherapy in previous 12 months and is projected to need 10 or fewer psychotherapy sessions in the next 12 months;
- an existing member who only needs medication management;
- an annual assessment, if the member's treatment history and provider's clinical judgment suggest the member will need 10 or fewer mental health sessions in the next 12 months.

A brief diagnostic assessment may not be used for:

- when a member or member's family requires a language interpreter to participate, unless the member:
    - had fewer than 10 sessions of psychotherapy in the previous 12 months and is projected to need fewer than 10 sessions in the following 12 months
    - receives only medication management
    - when a member is expected to need more than 10 sessions of mental health services in a 12-month period
    - documentation of Covered Services
    - Medical Necessity, Individual Treatment Plan and Progress Note criteria the same as standard diagnostic

A brief DA includes:

- sufficient information to apply a provisional clinical hypothesis; the clinical hypothesis may be used to address the member's immediate needs or presenting problem;
- the member's current life situation, including the following:
    - age
    - current living situation (including household membership and housing status)
    - basic needs status including economic status
    - education level and employment status
    - significant personal relationships (including member's evaluation of relationship quality)
    - strengths and resources (including extent and quality of social networks)
    - belief system
    - contextual non-personal factors contributing to the member's presenting concerns
    - general physical health and relationship to member's culture
    - current medications
- member's description of symptoms (including reason for referral);
- a mental status exam;
- screenings used to determine a member's substance use, abuse or dependency, and other standardized screening instruments;
- a clinical summary that explains the provisional diagnostic hypothesis.

Care Coordination: services designed to ensure access to and integration of the delivery of all Medicare and Medicaid preventive, acute, post-acute, rehabilitative, mental health, and long-term supports and services including home care (e.g. skilled nurse visits and home health aide).

Chemical Health Services: a planned program of care for the treatment of chemical dependency or chemical abuse to minimize or prevent further chemical abuse.

Chemical Abuse: a pattern of inappropriate and harmful chemical use which could be linked to specific situations in a member's life such as loss of a job, death of a loved one, or sudden change in life. Chemical abuse does not involve a pattern of pathological use, but it may progress toward it.

Chemical Dependency: a pattern of pathological use, accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use.

Chemical Use Assessment: an interview and written list of the member's specific problems related to chemical use and risk description that will enable the assessor to determine an appropriate treatment planning decision according to the Minnesota Matrix.

Community Intervention Services: a series of strategies that help to reduce a member's barriers to integration in the community or to independent living. These strategies minimize the risk of hospitalization or other restrictive living arrangements. A community intervention may involve a member's relatives, friends, landlord, employer, teachers, neighbors and providers among others. Community intervention:

- must be aimed exclusively for the client and his/her treatment;
- must be provided on an individual basis;
- may be conducted in person or by phone;
- can be conducted without the client being present if the strategy is shown to be more effective without the client's presence.

Community Mental Health System: a system intended to provide public mental health services directly to those in need of assistance in the communities where they reside. Intended to provide a community-based alternative to institutional care for many people with mental illness, implementation of the community mental health system rested on expansion of outpatient services in the community, particularly in federally funded community mental health centers.

Comprehensive Assessment: determines intensity and duration of member placement in substance use disorder treatment services.

Co-occurring Program: a chemical dependency treatment program serving members with co-occurring mental health conditions.

Crisis Assessment: an immediate, face-to-face assessment by a physician, mental health professional or mental health practitioner under clinical supervision by a mental health professional. It follows a screening that suggests a mental health crisis or emergency exists. A crisis assessment evaluates any immediate need for emergency services and as time permits, the member's:

- current life situation;
- sources of stress;
- mental health problems and symptoms;
- strengths;
- cultural considerations;
- support network;
- vulnerabilities;
- current functioning.

Crisis Assistance: a service for the child, the child's family and all providers of services to the child to:

- recognize factors precipitating a mental health crisis;
- identify behaviors related to the crisis;

- be informed of available resources to resolve the crisis.

Crisis assistance requires the development of a plan that addresses prevention and intervention strategies in a potential crisis, including plans for:

- arranging admission to acute care hospital inpatient treatment;
- crisis placement;
- community resources for follow-up;
- emotional support to the family during crisis.

Crisis Intervention: a face-to-face, short-term, intensive mental health service. It is initiated during a mental health crisis or emergency. The purpose is to help the member:

- cope with immediate stressors;
- identify strengths and available resources and begin to use them;
- avoid unnecessary hospitalization and loss of independent living;
- develop action plans;
- begin to return to his/her baseline level of functioning.

Crisis Stabilization Services: mental health services provided to a member after crisis intervention to help the member obtain his/her functional level as it was before the crisis. Provide stabilization services in the community, based on the crisis assessment and crisis plan.

Explanation of Findings: to discuss the results of the diagnostic assessment, psychological tests and other accumulated data to make recommendations in regard to the member's treatment plan.

Extended Diagnostic Assessment: an extended DA includes all components of a standard DA, gathered over three or more appointments. The member requires significant additional assessment time due to complex needs, caused by:

- Acuity of psychotic disorder
- Cognitive or neurocognitive impairment
- A need to consider past diagnoses and determine their current applicability
- Co-occurring substance abuse use disorder
- Disruptive or changing environments
- Communication barriers
- Cultural considerations

For child members:
appointments may be conducted outside the office, with or without the child present, for face-to-face consultation and information gathering with:

- Family members
- Doctors
- Caregivers
- Teachers
- Other providers
- May involve directly observing the child in various settings that the child frequents (home, school, care settings)

For children under age 5:

- utilize the DC:0-5R diagnostic system for young children

• early childhood mental status exam that assesses the child's developmental, social, and emotional functioning and style with the family and with the examiner. The exam includes:
    - physical appearance including dysmorphic features
    - reaction to new setting and people and adaptation during evaluation
    - self-regulation, including sensory regulation, unusual behaviors, activity level, attention span, and frustration tolerance
    - physical aspects, including motor function, muscle tone, coordination, tics, abnormal movements, and seizure activity
    - vocalization and speech production, including expressive and receptive language
    - thought, including fears, nightmares, dissociative states, and hallucinations
    - affect and mood, including modes of expression, range, responsiveness, duration, and intensity
    - play, including structure, content, symbolic functioning, and modulation of aggression
    - cognitive functioning
    - relatedness to parents, other caregivers, and examiner
    - other assessment tools as determined and periodically revised by the commissioner.

A new extended DA must be completed for a child:

- at least annually following the initial DA if additional services are needed;
- when a child does not meet the criteria for a brief or standard DA;
- when the child's mental health condition has changed markedly since the child's most recent DA;
- when the child's current mental health condition does not meet criteria of the child's current diagnosis.

For adult members:

- appointments may be conducted outside the office for face-to-face assessment with the adult;
- may involve directly observing the adult in various settings that the adult frequents (home, school, job, service settings, community settings);
- may include face-to-face meetings with:
    - The adult and family members
    - Doctors
    - Caregivers
    - Teachers
    - Social support network members
    - Recovery support resource representatives
    - Other providers
    - Completion of other assessment standards for adults.

A new extended DA must be completed for an adult:
• when the adult does not meet the criteria for a brief or standard DA;
• who has complex needs and requires at least three diagnostic appointments to complete the assessment, which allows further mental health services for one year;
• when the adult's mental health condition has changed markedly since the adult's most recent diagnostic assessment;
• when the adult's current mental health condition does not meet criteria of the adult's current diagnosis;
• documentation of Covered Services;

• Medical Necessity, Individual Treatment Plan and Progress Note criteria the same as standard diagnostic assessment.

Hospital Based Treatment Services: a licensed chemical dependency treatment program provided within a facility licensed as a hospital.

Health and Behavior Assessment / Intervention: a behavioral assessment or follow-up service is provided under physician order for information concerning a member's psychological status in relation to a medical diagnosis. This is NOT a mental health diagnostic assessment.

Individual Treatment Plan (ITP): focuses on the member's vision of recovery, their priority treatment goals and objectives and the interventions that will help meet those goals and objectives.The members on an ITP must be:

- based on the information and outcome of the diagnostic assessment;
- involve the member in the development, review and revision of the ITP;
- developed by the mental health professional who provides the psychotherapy, no later than the end of the first psychotherapy session, or five days, if the member is in a day treatment program;
- signed by the member (including revisions), unless the request is not appropriate to the member's mental health status. In the case of a child, the child's parent, primary caregiver, or other authorized person must sign the ITP. If a member refuses to sign the ITP or his/her mental health status contraindicates the request, the mental health professional must document the circumstances in the ITP;
- reviewed and updated as required by Minnesota Statute.

Medical Necessity: the member must have a primary DSM-V diagnosis (major mental disorder or emotional disturbance) based on the results of a diagnostic assessment. The mental health service provided should be consistent with the diagnosis and recognized as the prevailing standard or current practice. For mental health rehabilitation services (adult/children) to be medically necessary, the member's functional impairment must be due to their mental health diagnosis and the impairment will be expected to improve as a result of the rehab service.

Medical Services: services delivered by appropriately credentialed medical staff to assess the member's health care needs. The required intensity of medical care will be calculated at a minimum of two hours per week per member. Any one member will get the amount of care he or she needs.

Medication Assisted Therapy (MAT): combines behavioral therapy and medications to treat substance use disorders.

Mental Health Behavioral Aide (**MHBA):** a paraprofessional working under the clinical supervision of mental health professionals

Mental Health Crisis: a behavioral, emotional, or psychiatric situation that would likely result in significantly reduced levels of functioning in primary activities of daily living or in the placement of the member in a more restrictive setting.

Mental Health Emergency: a behavioral, emotional, or psychiatric situation which causes an immediate need for mental health services (ie: 911 call, emergency department visit or inpatient hospitalization).

Methadone Maintenance Treatment: is the use of methadone, a synthetic, habit forming drug used as a substitute, administered over a prolonged period of time (can be indefinite), as treatment for someone who is addicted to opioids (such as heroin), where detoxification has been unsuccessful and/or admittance to a substance abuse treatment facility requires complete abstinence.

Mental Health Medication Management: determines the need for, or the effectiveness of, the medication prescribed for the treatment of a member's symptoms of mental illness.

Neuropsychological Services: used to identify the internal and external restrictions of a member's cognitive, emotional, behavioral and social impairments. They are skills-based interventions.

Non-Residential Treatment Services: a licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license that does not require members to reside in the same facility.

Placing Authority: If member is on Medicaid / MNCare South Country plan, the responsible placing authority is South Country Health Alliance and / or the county or tribe residence.

Psychotherapy for Crisis: services to assist in reducing a member's mental health crisis through immediate assessment and psychotherapeutic interventions. An intervention of psychotherapy for crisis will diminish the suffering of the member in crisis and help restore life functioning.

Residential Treatment Program: a licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license, and provides at least:

- 30 hours of treatment services per week and room and board to members - High Intensity;
- 15 hours of treatment services per week and room and board to members - Medium Intensity;
- 5 hours of treatment services per week and room and board to members - Low Intensity.

For purposes of placement, decisions may also include room and board provided by a facility with a contract with the Commissioner in conjunction with non-residential treatment services providing at least 30 hours of treatment.

Room and Board: a facility that provides meals and a place to reside for members who are participating in chemical dependency treatment.

Rule 24: CCDTF rule regulates county and provider responsibilities, as well as member eligibility.

Rule 25: an interview and written list of the member's specific problems related to chemical use and risk description that will enable the assessor to determine an appropriate treatment planning decision according to the Minnesota Matrix.

Rule 31: residential treatment licensing.

Rule 32: regulates detoxification provider licensing.

Serious Mental Illness (SMI): A mental, behavioral or emotional disorder (excluding developmental and substance use disorders);

- diagnosable currently or within the past year;

- of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) and;
- resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

Serious and Persistent Mental Illness (SPMI): a condition with a diagnosis of mental illness that meets at least one of the following criteria:

- member had two or more episodes of inpatient care for mental illness within the preceding 24 months;
- member had continuous psychiatric hospitalization or residential treatment exceeding six months duration within the preceding 12 months;
- member has been treated by a crisis team two or more times within the preceding 24 months;
- member has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder or borderline personality disorder, evidences a significant impairment in functioning, and has a written opinion from a mental health professional stating he/she is likely to have future episodes requiring inpatient or residential treatment unless community support program services are provided;
- member has, in the last three years, been committed by a court as a mentally ill person under Minnesota statutes, or the adult's commitment as a mentally ill person has been stayed or continued;
- member was eligible under one of the above criteria, but the specified time period has expired and has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment unless ongoing case management or community support services are provided;
- member was eligible as a child with severe emotional disturbance and is age 21 or younger.

Service Coordination: helping the member obtain services and support the member needs to establish a lifestyle free from the harmful effects of substance abuse disorder. The placing authority must not duplicate service coordination activity that is already in place for the member:

- Rule 25 assessor should indicate service coordination that is already in place for the member on the Rule 25 Assessment and Placement Summary;
- Third Party Administrator (TPA) or a treating provider could also provide this service.

Severe Emotional Disturbance (SED): a child with severe emotional disturbance:

- has been admitted to inpatient/residential treatment within the last three years or is at risk of being admitted for an emotional disturbance;
- is a MN resident and receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact;
- has been determined by a mental health professional to meet one of the following criteria:
    - have psychosis or clinical depression;
    - be at risk of harming self or others as a result of emotional disturbance;
    - has psychopathological symptoms as a result of being a victim of physical/sexual abuse or psychic trauma within the past year;
- has significantly impaired home, school or community functioning lasting at least one year or presents a risk of lasting at least one year, as a result of emotional disturbance, as determined by a mental health professional.

Skills Training: is medically necessary when the child has lost behavioral skills or failed to develop behavioral skills compared to others of similar age as a result of their diagnosed mental health disorder. Skills training may also be delivered to help the youth to self-monitor, compensate for, cope with, counteract or replace skills deficits or maladaptive skills acquired during the course of a psychiatric illness. Unlike a thought, feeling or perception, a skill is observable by others. It is an activity that must be practiced in order to be mastered and maintained. There are right ways and wrong ways to perform the skill. Typically, a skill is performed for a reason and a skill can be generalized and adapted to many different situations

Special Populations: this category of programs is:

- designed to address the unique needs of members who share a common language, racial, ethnic, or social background;
- governed with significant input from members of that specific background;
- employ individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except that programs serving members with physical disabilities are exempt from this requirement.

Substance Use Disorder Services: a planned program of care for the treatment of chemical dependency or chemical abuse to minimize or prevent further chemical abuse.

Mental Health Services

****South Country follows all DHS Medicaid requirements**

Assertive Community Treatment (ACT)

a team-based approach to the provision of treatment, rehabilitation, and support services. ACT models of treatment are built around a self-contained multidisciplinary team that serves as the fixed point of responsibility for all member care for a fixed group of members. In this approach, normally used with members with severe and persistent mental illness, the treatment team typically provides all member services using a highly integrated approach to care.

Eligible Providers

- have a contract with a host county;
- be certified by DHS to provide ARMHS;
- meet specific fidelity standards, as detailed in the MN Assertive Community Standards;
- team includes the following specialists:
    - Psychiatrist (or provisionally, a psychiatric NP or CNS-MH);
    - Mental Health Professional, with supervisory experience, acting as team lead;
    - Registered Nurse (RN), for medication management;
    - Mental Health practitioner or rehabilitation worker, including a substance abuse specialist with at least one year of training or supervised experience in substance abuse treatment and a vocational specialist with at least one year training and experience in vocational rehabilitation and supported employment.

Eligible Members

A person who is eligible to receive ACT services:

- must be eligible for medical assistance (Medicaid);
- age 18+;
- have a primary diagnosis of serious mental illness as determined by a Diagnostic Assessment;

- be a member of the target population the ACT team serves;
- have a LOCUS assessment with a Level 4 indication;
- have a completed Functional Assessment following the domains specified by statute with three or more areas of significant impairment in functioning.

Covered services

- case management that supports the member's access to services such as:
  - Medical and dental services
  - Social services
  - Transportation
  - Legal advocacy
- support and skills training in:
  - Activities of daily living (self-care, home making, financial management, use of transportation and health and social services);
  - Social and interpersonal relationships;
  - Leisure time activities (including social, recreational and educational activities).
- illness education and medication management
- assistance in locating and maintaining safe, affordable housing, with an emphasis on member choice and independent community housing;
- psycho education to family members
- discharge:
  - supports are reduced as the member demonstrates increasing independence;
  - members have easy access to ACT team after graduating;
  - members can return to ACT team if necessary.

Non-Covered Services

- See table below

Authorization

Notification is required (Form SCHA #2281)

- Service limitations apply when ACT services are provided with other concurrent services.

Service Thresholds

- None.

Billing

ACT & Other Concurrent Services

The ACT team must coordinate all services provided concurrently with ACT services.

*when requesting authorization, clearly document medical necessity for the additional service(s), including reasons ACT does not/cannot meet member's needs (i.e.: specialty service, transitional service, etc.)

Other Service	Is service included in ACT?	Can service be provided in addition to ACT?	Service Limitations
MH-TCM	Yes	No	Case management functions are bundled in the ACT rate.

			MH-TCM is covered only in the month of admission or discharge from ACT. MH-TCM must request authorization for coverage other than month of admission/discharge.
Day Treatment	No	Yes	Day Treatment program must request authorization. If ACT team approves Day Treatment, ACT team must provide a statement to Day Treatment provider for authorization request purposes.
Partial Hospitalization	No	Yes	Partial hospitalization thresholds and limitations apply.
IRTS	No	Yes	ACT and IRTS may be provided concurrently without authorization.
ARMHS	Yes	Yes	ARMHS provider must request authorization. If ACT team approves ARMHS, ACT team must provide a statement to ARMHS provider for authorization request purposes.
Crisis Assessment and Intervention (mobile)	Usually	If separately contracted	A component of ACT. Cannot be billed separately. No authorization required.
Crisis Stabilization – Non-residential	Yes	No	A component of ACT. Cannot be billed separately. No authorization required.
Crisis Stabilization – Residential	No	Yes	Service limits apply. Services must be coordinated between the ACT and residential crisis providers.
Psychiatric Physician Services	Sometimes	Yes	May be provided by physician, psychiatric NP, CNS-MH, or a physician extender (e.g., RN). Bill separately only if not included in ACT rate.
Outpatient Psychotherapy	Sometimes	Yes	Outpatient psychotherapy limits apply. May bill separately if not provided by ACT team.
Inpatient Hospitalization	No	Yes	Inpatient hospitalization services are reimbursed separately from ACT. ACT claims: enter POS code 21.
Waivered Services	No	Yes	County must approve concurrent care.
Other medical services (e.g., PCA)	No	Yes	Service limits apply to each service.

*****Forensic Assertive Community Treatment (FACT)***

Although similar to traditional ACT teams, includes the additional following elements:

- Goal of preventing arrest;
- Receiving referrals from criminal justice providers such as Department of Corrections transition release planners, local jails and mental health courts; and
- Integration of probation personnel in treatment.

Adult Rehabilitative Mental Health Services (ARMHS)

services that enable members to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment and independent living and community skills when these abilities are impaired by the symptoms of mental illness. Services are designed to enable a member to retain

stability and functioning if the member is at risk of losing significant functionality or being admitted to a more restrictive service setting without these services. Typically, these services are provided as a one-to-one skills service but are at times taught in a group setting allowing each participant to benefit from a group modality. All services must be deemed as a medically necessary intervention.

Eligible Providers

The following individual mental health professional providers are eligible to provide ARMHS:

- clinical nurse specialist in mental health;
- licensed independent clinical social worker (LICSW);
- licensed marriage and family therapist (LMFT);
- licensed psychologist (LP);
- licensed professional clinical counselor (LPCC);
- mental health rehabilitation professional;
- nurse practitioner with psychiatric specialty (NP);
- psychiatrist;
- mental health practitioner;
- mental health rehabilitation worker;
- certified peer specialist.

* each ARMHS provider must be certified to provide this service, re-certification must be completed every three years.

Eligible Members

A person who is eligible to receive ARMHS:

- must be eligible for medical assistance (Medicaid);
- age 18+;
- primary diagnosis of a serious mental illness as determined by a Diagnostic Assessment;
- have a completed LOCUS assessment that indicates a Level 3 or a Level 2;
- have a significant impairment in functioning in three or more areas of the Functional Assessment domains specified in statute.

Covered Services

The following seven services are billable as ARMHS:

- basic living and social skills;
- certified peer specialist services;
- community intervention;
- functional assessment;
- individual treatment plan;
- medication education;
- parenting skills services;
- transition to community living services.

*all covered services are provided face-to-face except community intervention. Documentation of activities is included in the covered service and must not be billed separately.

ARMHS services may be provided in the following settings:

- member's home;
- home of a relative or significant other;
- member's job site;
- community setting such as: clubhouse, drop in center, social setting, classroom, other places in the community.

Non-Covered Services

Do not provide ARMHS to a recipient residing in any of the following:

- regional treatment centers;
- nursing facilities;
- acute-care settings (inpatient hospital);
- sub-acute settings (Intensive Residential Treatment Services [IRTS] program).

Authorization

Prior authorization is required (Form SCHA #2285)

- after the threshold is met;
- if provided concurrently with ACT services.

Service Thresholds

- 1200 Units cumulative.

*all ARMHS codes combined per year

Billing

Adult Rehabilitative Mental Health Services (ARMHS) Billing		
Code	**Service Description**	**Unit**
H2017	Basic living and social skills – individual; MH professional or practitioner	15 min
H2017 HM	Basic living and social skills – individual; rehabilitation worker	15 min
H2017 HQ	Basic living and social skills – group; MH professional, practitioner or rehabilitation worker	15 min
H2017 U3	Basic living and social skills, transitioning to community living, MH professional or practitioner	15 min
H2017 U3 HM	Basic skills, transitioning to community living by a MH rehabilitation worker, less than bachelor's degree level	15 min
90882	Environmental or community intervention, MH professional or practitioner	1 session *authorization required for more than 10 sessions / month or 72 sessions / year
90882 HM	Environmental or community intervention, mental health rehabilitation worker	1 session *authorization required for more than 10 sessions / month or 72 sessions / year
90882 U3	Environmental or community intervention, transition to community living intervention	1 session *authorization required, cannot be done concurrently with other ARMHS services, no threshold
90882 U3 HM	Environmental or community intervention, transition to community living intervention, less than bachelor's degree level, MH rehabilitation worker	1 session *authorization required, cannot be done concurrently with other

			ARMHS services, no threshold
H0031	UD	MH Assessment by non-physician	15 min *authorization required for more than 24 units per calendar year
H0031 T5	UD	MH Assessment by non-physician, follow up service (review or update)	15 min *authorization required for more than 24 units per calendar year
H0032	UD	MH service plan development by non-physician	15 min *authorization required for more than 14 units per calendar year
H0032 T5	UD	MH service plan development by non-physician	15 min *authorization required for more than 14 units per calendar year
H0034		Medication education, individual; MD, RN, PA or pharmacist	15 min *authorization required for more than 26 hours per calendar year
H0034	HQ	Medication education, group setting	15 min *authorization required for more than 26 hours per calendar year

Behavioral Health Homes (BHH) Services

a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of care by better meeting the needs of members experiencing serious mental illness and their families by addressing the member's physical, mental, substance use and wellness goals. BHH services offer a person-centered approach and engage and respect the member and family in their health care recovery and resiliency.

Eligible Providers

- be certified by DHS to deliver BHH services;
- be enrolled as a Medicaid provider and meet federal and state standards to become certified as a BHH provider;
- serve as a central point of contact for BHH members and ensure person centered development of a health action plan.

*provider must ensure that member has current MA coverage

**provider must review and explain the Behavioral Health Home Services Rights, Responsibilities and Consent form to the member

***provider must explain to member if they are receiving a duplicative service they must select which service they want to receive

BHH Team members can be:

- member;
- team leader;
- Integration Specialist (case management);
- BHH Systems Navigator (case management/care coordination);

- qualified Health Home Specialist (peer specialist, community health worker);
- consulting physicians;
- external professionals.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- eligibility for BHH services is determined by a MH Professional employed or under contract with a state certified BHH;
- have a condition that meets the definition of serious mental illness or emotional disturbance;
- have a current Diagnostic Assessment as performed or reviewed by a mental health professional employed by or under contract with the behavioral health home.

Covered Services

- case management;
- care coordination;
- health and wellness;
- comprehensive transitional care;
- individual and family supports;
- referral to community supports.

Non-Covered Services

- duplicative services, some examples are:
    - Adult Mental Health Targeted Case Management;
    - Children's Mental Health Targeted Case Management;
    - Assertive Community Treatment / Assertive Community Treatment for Youth;
    - Vulnerable Adult / Developmental Disability Targeted Case Management;
    - Relocation Services Coordination Targeted Case Management;
    - Health Care Home care coordination services

Authorization

Notification is required (Behavioral Health Home Service Eligibility Notification Form)

- to track enhanced rate.

Service Thresholds

- six-month lifetime per member - member engagement for enhanced rate.

Billing

Behavioral Health Home (BHH) Services Billing		
Code	**Service Description**	**Unit**
S0280 U5	BHH services care engagement, initial plan	PMPM
S0281 U5	BHH services ongoing standard care, maintenance of plan	PMPM
Limitations on engagement rate – lifetime limit of six payments in member's lifetime. No payment if prior payment for duplicative service was made in same calendar month.		

Certified Community Behavioral Health Clinics (CCBHC)

a service delivery model that aims to coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health and social services, increase consistent use of evidence-based practices and improve access to high-quality care.

Eligible Providers

Certified Community Behavioral Health Clinics beginning July 2017:

- Amherst H. Wilder Foundation serving Ramsey County;
- Northern Pines Mental Health Center in the northcentral part of the state;
- Northwestern Mental Health Center serving six northwest counties;
- People Incorporated serving Anoka, Dakota, Hennepin and Ramsey counties;
- Ramsey County Mental Health Center serving Ramsey County;
- Zumbro Valley Health Center in Olmstead and Fillmore Counties in the southeast.

*during the federal demonstration program period (July 2017-June 2019), additional organizations cannot be added to the state's demonstration.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- be receiving at least one of the required services from one of the six identified CCBHCs;
- if new to receiving services from one of the six identified CCBHCs, must have received a preliminary screening and risk assessment and receive at least one CCBHC service from the CCBHC.

Covered Services

- outpatient mental health and substance use disorder services;
- primary care screening and monitoring;
- screening, assessment and diagnosis, including risk management;
- psychiatric rehabilitation services, including ARMHS and CTSS;
- crisis mental health services, including 24-mobile crisis teams, emergency crisis intervention services and crisis stabilization;
- patient-centered treatment planning;
- targeted case management;
- peer and family support;
- services for members of the armed forces and veterans;
- connections with other providers and systems.

*regardless of how the service is provided, the CCBHC retains the responsibility to coordinate care. CCBHCs are expected to perform care coordination across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral need.

Authorization

Notification is required –

- if the member is not referred by a MCO care coordinator the CCBHC will notify and communicate to the MCO that the member is receiving CCBHC services;
- provider will notify the MCO when a member's casefile has been closed;
- if the member receiving CCBHC services has been assigned a MCO care coordinator by MCO, the CCBHC provider must record the MCO care coordinator's name and contact information in the member's CCBHC records and a schedule for how frequently the CCBHC provider will check in with the MCO care coordinator;

- if the CCBHC provider learns that the member is or has been hospitalized, the CCBHC provider must notify the MCO in a timely manner;
- if the CCBHC learns that the member was treated in the emergency department, the CCBHC provider must notify the MCO in a timely manner;
- the CCBHC provider must contact the MCO if the member requires assistance to ensure access to needed treatment or services upon discharge;
- the CCBHC provider is responsible for having contact with the member, member's family, or other identified supports to ensure that the member is able to access all needed services and supports at the time of discharge or other transition.

Billing

Certified Community Behavioral Health Clinic (CCBHC) Services Billing
CCBHCs will be paid a daily encounter rate for all qualified services provided to South Country Health Alliance members. The daily encounter rate supports high quality, evidence based services, outreach, trust building, and supports needed by individuals served. CCBHC services that qualify for a daily encounter rate are listed on the DHS Website. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-294813#bill

Certified Peer Specialist Services (CPSS)

specific rehabilitative services emphasizing the acquisition, development and enhancement of skills needed by a member with mental illness to move forward in their recovery. These services are self-directed and person-centered with a focus on recovery. CPSS are identified in a treatment plan or an Individualized Service Plan and are characterized by a partnering approach between the CPS and the member who receives the services (peer). The CPSS works as a member of the team to address feelings of stigma, social isolation, personal loss and systemic power dynamics that can be common when accessing mental health services. This is accomplished through a mutual shared experience of utilizing mental health services and includes modeling wellness and demonstrating personal responsibility, self-advocacy and hopefulness through appropriate sharing of the recovery journey.

CPSS incorporate elements of motivational interviewing and strengths-based psychosocial service approaches. These services:

- are mental health rehabilitative services provided by a CPS;
- must be identified in a member's individual service plan or treatment plan;
- are characterized by a partnering approach between the CPS and the member who receives the services.

Eligible Providers

Certified Peer Specialist Level I:

- age 21+;
- have a high school diploma, GED or equivalent;
- have a primary diagnosis of mental illness;
- is a current or former consumer of mental health services;
- demonstrates leadership and advocacy skills;

- successfully completes the DHS approved Certified Peer Specialist training and certification exam.

Certified Peer Specialist Level II:
Must meet all requirements of a Level I CPS and one or more of the following criteria:

- is qualified as a mental health practitioner;
- has at least 6,000 hours of supervised experience in the delivery of peer services to people with mental illness;
- has at least 4,000 hours of supervised experience in the delivery of services to people with mental illness and an additional 2,000 hours of supervised experience in the delivery of peer services to people with mental illness.

Eligible Members
A member must be:

- must be eligible for medical assistance (Medicaid);
- age 18+;
- receive ACT, ARMHS, IRTS or Crisis Services.

Covered services

- education and skill-building, including but not limited to the following:
    - wellness planning
    - crisis planning
    - advanced Psychiatric Directives
    - self-advocacy skills including connecting to professional services when appropriate
- services that help recipients to do the following:
    - identify their strengths and to use their strengths to reach their treatment goals
    - identify and overcome barriers to participation in community resources
    - connect with resources, including:
        - ✓ Visiting community resources to assist them in becoming familiar with potential opportunities
        - ✓ teaching and modeling the skills needed to successfully utilize community resources
- building relationships and encouraging community-based activities, such as:
    - work
    - relationships
    - physical activity
    - self-directed hobbies
- Transition to Community Living (TCL) services when working for a certified Adult Rehabilitative Mental Health Service (ARMHS) provider.

Non-Covered Services

- transportation;
- services that are performed by volunteers;
- household tasks, chores, or related activities such as laundering clothes, moving, housekeeping, and grocery shopping;
- time spent “on call” and not delivering services to clients;
- job-specific skills services, such as on-the-job training;
- case management;
- outreach to potential clients;

- room and board;
- service by providers that are not approved to provide CPSS as part of their ARMHS, ACT, IRTS or crisis stabilization services.

Authorization

Prior authorization is required (Form SCHA #2285)

- after threshold is met.

Service Thresholds

- 300 hours per calendar year combined total of H0038, H0038 U5, and H0038 HQ.

Billing

Certified Peer Specialist Services (CPSS) Billing		
Code	**Service Description**	**Unit**
H0038	Self-help / peer services by Level I Certified Peer Specialist	15 min
H0038 U5	Self-help / peer services by Level II Certified Peer Specialist	15 min
H0038 HQ	Self-help / peer services in a group setting	15 min

Children's Mental Health Residential Treatment Services (CMHRTS)- Rule 5

a 24 hour per day program provided under the clinical supervision of a mental health professional and provided in a community setting other than an acute care hospital or regional treatment center.

CMHRTS are designed to:

- prevent placement in settings that are more intensive, costly or restrictive than necessary and appropriate to meet the child's needs;
- help the child improve family living and social interaction skills;
- help the child gain necessary skills to return to the community;
- stabilize crisis admissions;
- work with families throughout the placement to improve the ability of families to care for children with severe emotional disturbance in the home.

Eligible Providers:

- licensed by the state of MN to provide children's mental health residential treatment services;
- under clinical supervision of a mental health professional;
- under contract with a lead county; and
- enrolled as MHCP provider.

Eligible Members

A member must be:

- must be eligible for medical assistance (Medicaid);
- under age 18;
- meet criteria for severe emotional disturbance; and
- have been screened by the county, managed care organization or tribe, as applicable to the specific member, before placement in the facility as needing residential treatment services.

*children may receive mental health treatment in residential settings in other states. State law provides, for a portion of the costs for residential services furnished to children with severe emotional disturbance in facilities located in states that boarder Minnesota, to be covered in certain circumstances. The placement must be made by the county, the facility must be located nearest to the child's home and appropriate to the child's level of care, and the facility must be located in Wisconsin, Iowa, North Dakota, or South Dakota. The facility must be inspected by the Licensing Division of the Department of Human Services and be certified to substantially meet the standards applicable to children's residential mental health treatment programs.

**facilities with certified children's mental health programs located in a state that borders Minnesota and that have met all the requirements of Minnesota Statute, Section 256B.0945, are eligible to receive both Title IV-E and MA reimbursement.

***out-of-state facilities that do not appear on the list located on the MN Department of Human Services website are not eligible for MA reimbursement for Minnesota counties and the placement will not be covered.

Authorization

Notification is required (Form SCHA #2324)

The county must notify MMSI Behavioral Health of any placement in a Rule 5 facility **within 24 hours of admission**.

Counties shall provide notification of pending placement to South Country Health Alliance Provider Services (South Country Health Alliance's Third-Party Administrator, MMSI Behavioral Health) at 1-800-645-6296; Fax number 1-888-889-7822. South Country Provider Services will coordinate the admission and continuing stay criteria on behalf of South Country Health Alliance.

*for children enrolled in pre-paid Medical Assistance or Minnesota Care plans, counties are responsible for costs associated with these placements except to the extent medically necessary treatment and rehabilitative services provided in those programs are the responsibility of the pre-paid plan.

**both South Country Health Alliance and the county have a role in authorizing, paying for and monitoring children's residential mental health treatment services.

The following procedures will apply for Children's Residential / Rule 5 placement:

Process for Coordination of Admission:

Counties are required to conduct a level of care determination (using a validated tool such as CASII or ECSII) under M.S. 245.4885 prior to admission for residential treatment.

South Country Health Alliance or its Third-Party Administrator, MMSI, is required to respond with an authorization or denial to member requests for services **within 10 business days or within 72 hours** if an expedited request was made.

- Request for placement can come to:
  - MMSI Behavioral Health, by calling 1-800-645-6296;
  - to the member's county intake worker;

If the county receives request for placement, the county will immediately notify South Country Health Alliance Provider Services of request for placement.

- if questions, calls may also go to South Country Health Alliance member services at 1-866-567-7242.

MMSI Behavioral Health staff will collaborate with the member's county and coordinate benefits with member's county placement screening team/children's mental health services unit.

MMSI Behavioral Health staff will contact the enrolled child's county to arrange for a validated level of care determination / placement screening (**up to 10 days**) under M.S. 245.4885 to determine if placement in a residential treatment program is authorized.

MMSI Behavioral Health staff will send out an approval letter to the member's authorized representative and to the county stating the member meets criteria for placement.

MMSI Behavioral Health will respond **within 72 hours** of its decision to authorize or deny coverage for mental health services in a residential setting if an expedited response was requested. If inadequate information is available to determine medical necessity for placement, the decision may be denied.

- Prior to convening the level of care determination / placement screening team, MMSI Behavioral Health and the county should identify whether they need additional information to make an informed decision.

If the enrolled child is not currently receiving mental health case management services, the county should assess for eligibility for mental health case management and if eligible, begin case management services now.

The county convenes the placement screening team, including a representative from South Country Health Alliance's Third-Party Administrator, MMSI Behavioral Health**,** either in person or by teleconference.

The joint team makes a recommendation for the necessary level of care, which includes a review of past/current services, CASII functional assessment findings, diagnostic assessment, etc.
MMSI Behavioral Health and the county inform the family, caregiver and child's treating mental health professional of the joint decision for placement and treatment in a Rule 5 facility and of any applicable appeal rights.

The county provides MMSI Behavioral Health with the name and phone numbers of the facilities being considered. The county should also provide the Facility Tax ID Number and Address if known.

Court ordered admissions
A copy of the court order is required to be faxed to South Country Health Alliance /MMSI Behavioral Health at 1-888-889-7822.

Notification is required (Form SCHA #2324)
Providers are required to notify South Country Health Alliance/MMSI Behavioral Health of member placement **within 24 hours of admission**, to ensure payment.

Coordination of Continued Stay and Discharge Plans:
All parties should work for agreement between the child's family/legal representative, county, South Country Health Alliance/MMSI Behavioral Health and facility staff on global goals related to the child's treatment.

South Country will be responsible for case management of members placed in Rule 5 facilities, this includes being in contact with the facility as well as the member's county case manager to assure that:

- a plan has been created for what will occur when the goals are achieved;

- alternate plans have been discussed that may be pursued if the child doesn't respond as expected in treatment.

The facility, county and South Country Health Alliance / MMSI Behavioral Health should communicate before acting unilaterally.

To see a list of children's residential facilities that have been inspected by the Minnesota Department of Human Services and certified by the Minnesota Department of Corrections, click on: http://www.dhs.state.mn.us/main/pub/dhs16_145920.pdf. Facilities and programs that do not appear on this list are not eligible for MA reimbursement for Minnesota Counties.
**** NOTE: Counties remain responsible for the non-treatment portion of the child when enrolled in managed care.**

Clinical Care Consultation - Children's Mental Health

communication between a treating mental health professional and other providers or educators, who are working with the same member. These professionals use the consultation to discuss the following:

- issues about the member's symptoms;
- strategies for effective engagement, care and intervention needs;
- treatment expectations across service settings;
- clinical service components provided to the member and family.

Eligible Providers

- Clinical Nurse Specialist in mental health (CNS);
- Licensed Independent Clinical Social Worker (LICSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Professional Clinical Counselor (LPCC);
- Licensed Psychologist (LP);
- Psychiatric Nurse Practitioner (NP);
- Psychiatrist or Osteopathic Physician;
- Tribal Mental Health Professional;
- Mental Health Practitioners working as clinical trainees.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- between the ages of 0-21;
- have a diagnosis of a mental illness determined by a diagnostic assessment.

Covered Services

clinical care consultation between the treating mental health professional and another provider or educator. Examples of appropriate providers and educators who may receive a consultation include the following:

- home health care agencies;
- child care providers;
- children's mental health case managers;
- educators;
- probation agents;
- adoption or guardianship workers;

- guardians ad litem;
- child protection workers;
- pediatricians;
- nurses;
- after school program staff;
- mentors.

*Two mental health professionals treating the same member may consult; however, they need to split the time into two billable amounts comprising the total amount of time. Clinical care consultation may be done by telephone or face to face.

Authorization

Prior Authorization is required (Form – DHS – 4695 – ENG)

- after threshold is met

Service Threshold

- 15 hours / calendar year

Billing

Clinical Care Consultation Services Billing			
Code		**Service Description**	**Unit**
90899	U8	Clinical care consultation, face to face	5-10 min
90899	U9	Clinical care consultation; face to face	11-20 min
90899	UB	Clinical care consultation; face to face	21-30 min
90899	UC	Clinical care consultation; face to face	31+ min

Crisis Services - Adult

community based services provided by a county, tribe or other contracted agency to members age 18 or older who are experiencing a mental health crisis or emergency. It includes those members with a co-occurring substance abuse and mental health disorders who do not need the level of a detoxification facility.

Eligible Providers

- a county or country-contracted mental health professional, practitioner, or rehabilitation worker;
- a mobile crisis intervention team which consists of two or more mental health professionals or at least one mental health professional and one mental health practitioner.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- age 18+;
- experiencing a mental health crisis or emergency.

Covered Services

Adult Crisis Services may include a number of services:

- crisis/Emergency screening;
- mobile mental health crisis assessment, intervention and stabilization;
- residential crisis stabilization;

- community intervention;
- rapid access to a psychiatrist or other medication prescriber;
- health care and benefit navigator;
- assistance in purchasing medications.

*A crisis assessment, as described here, can be used in lieu of a brief diagnostic assessment to allow 10 sessions of out-patient mental health service to someone who has not had mental health services in the past or to an existing client who should not need more than 10 sessions during the year.

Non-Covered Services

Community intervention services do not include:

- member transporting services
- crisis response services performed by volunteers;
- provider performance of household tasks, chores or related activities such as laundering clothes, moving the recipient's household, housekeeping and grocery shopping for the member;
- time spent "on call" and not delivering services to member;
- activities primarily social or recreational in nature, rather than rehabilitative;
- job specific skills services such as on the job training;
- case management;
- routine communication among members of the treatment team, routine staffing or a care conference;
- telephone contacts that do not conform to the definition of this service or that are not properly documented;
- clinical supervision or consultation with other professionals;
- developing a treatment plan;
- outreach services to potential members;
- crisis response services provided by a hospital, board and lodging or residential facility to a recipient of that facility;
- room and board.

Authorization

Prior Authorization is required (Form SCHA #2285):

- after threshold is met
    - Service Thresholds
        - Community Crisis Response, NONE.
        - Residential Crisis Stabilization; required for more than 10 days in a calendar month.
        - Community Intervention; limited basis and must follow ARMHS billing instructions/thresholds.

Billing

Crisis Response Service - Adult Billing		
Code	**Service Description**	**Unit**
S9484	Adult crisis assessment, intervention and stabilization – individual by a mental health professional	60 minutes
S9484 HN	Adult crisis assessment, intervention and stabilization – individual practitioner	60 minutes

S9484 HM	Adult crisis stabilization – individual by mental health rehabilitation worker	60 minutes
S9484 HQ	Adult crisis stabilization - group	60 minutes
H0018	Adult crisis stabilization, residential	1 day
90882 HK	Community Intervention	1 session
90882 HK HM	Community Intervention by a mental health rehabilitation worker	1 session

Crisis Services - Children

intensive face-to-face, short-term mental health services initiated during a crisis to help the child return to the child's baseline level of functioning.

Eligible Providers

- a county or country-contracted mental health professional, practitioner, or rehabilitation worker;
- a mobile crisis intervention team which consists of two or more mental health professionals or at least one mental health professional and one mental health practitioner.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- under age 21;
- experiencing a mental health crisis or emergency;
- meet criteria for emotional disturbance (age 0-18) or mental illness (age 18-21).

Covered Services

- crisis assessment;
- crisis intervention;
- crisis stabilization.

Non-Covered Services

- recipient transporting services
- crisis response services performed by volunteers;
- provider performance of household tasks, chores or related activities such as laundering clothes, moving the recipient's household, housekeeping and grocery shopping for the recipient;
- time spent "on call" and not delivering services to recipients;
- activities primarily social or recreational in nature, rather than rehabilitative;
- job specific skills services such as on the job training;
- case management;
- outreach services to potential recipients;
- crisis response services provided by a hospital, board and lodging or residential facility to a recipient of that facility;
- room and board.

Authorization

Notification is required (Form SCHA #2281)

Service Thresholds

- None

Billing

Crisis Response Service - Children Billing		
Code	**Service Description**	**Unit**
S9484 UA	Crisis Intervention Mental Health Service - Eligible Providers: CNS-MH, LICSW, LMFT, LP, LPCC, Psychiatrist	60 minutes
S9484 UA HN	Health Services	60 minutes

Children's Therapeutic Services and Supports (CTSS)

a flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. CTSS services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcome, identified in the individual treatment plan (ITP).

CTSS ranges from limited community based services that resemble traditional office-based practice to services that are more structured and intensive, such as day treatment and those requiring more extensive collaboration between a number of providers or agencies.

Eligible Providers

Must be enrolled MHCP provider certified to provide CTSS mental health rehabilitation services. The following entities may request MHCP certification as CTSS providers:

- county-operated entities;
- community Mental Health Centers (CMHCs);
- hospital-based providers;
- Indian health services/638 facilities;
- non-county mental health rehabilitative providers;
- school districts.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- under age 18 diagnosed with an Emotional Disturbance (ED) or Severe Emotional Disturbance (SED);
- adults ages 18 through 20 diagnosed with mental illness (MI) or Serious and Persistent Mental Illness (SPMI).

*the Diagnostic Assessment used to establish eligibility must be done by a mental health professional or qualified mental health practitioner within 180 days before the start of any CTSS services.

Covered Services

CTSS providers must provide or ensure the following services, as prescribed in the child's ITP:

- psychotherapy - with patient and/or family member, family, and group;
- skills training - individual, family, or groups;
- crisis assistance;
- MHBA services, including direction of a mental health behavioral aide.

Psychotherapy and skills training service components may be combined to constitute therapeutic programs, including day treatment and therapeutic preschool programs. These programs have specific recipient and provider eligibility requirements.

Non-Covered Services

CTSS does not cover services that are:

- the responsibility of a residential or program license holder, including foster care;
- in violation of medical assistance policy;
- treatment by multiple providers within the same agency at the same clock time;
- MHBA services provided by a personal care assistant who is not qualified as MHBA and employed by a certified CTSS provider entity;
- primarily recreation oriented or provided in a setting that is not medically; supervised (such as sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours);
- a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child's emotional disturbance;
- consultation with other providers or service agency staff about the care or progress of a child;
- prevention or education programs provided to the community;
- treatment for recipients with primary diagnoses of alcohol or other drug abuse.

Authorization

Prior Authorization is required (Form SCHA #2286)

- after threshold is met.

Service Thresholds

- 200 Cumulative hours per calendar year for any combination of: psychotherapy, skills training, crisis assistance, therapeutic components of preschool program and Mental Health Behavioral Aide (MHBA) services;
- 52 cumulative sessions per calendar year of group psychotherapy, including outpatient group psychotherapy services;
- 26 cumulative sessions per calendar year of family psychotherapy, including outpatient family psychotherapy services;
- 10 cumulative sessions per calendar year of multiple family group psychotherapy;
- 200 cumulative hours per calendar year (units vary by 30, 45 or 60 minutes);
- 200 cumulative hours per calendar year for any combination of psychotherapy, skills training, crisis assistance, therapeutic components of preschool program and Mental Health Behavioral Aide Services.

Billing

Children's Therapeutic Services and Supports (CTSS) Billing		
Code	**Service Description**	**Unit**
90832 UA	Psychotherapy (with member / family member / both)	30 min
90834 UA	Psychotherapy (with member / family member / both)	45 min
90837 UA	Psychotherapy (with member / family member / both)	60 min
Appropriate E/M and 90833 UA	E/M with psychotherapy added on (with member / family member / both)	30 min

Appropriate E/M and 90836 UA	E/M with psychotherapy added on (with member / family member / both)	45 min
Appropriate E/M and 90838 UA	E/M with psychotherapy added on (with member / family member / both)	60 min
90875 UA	Individual psychophysiological therapy incorporating biofeedback, with psychotherapy	30 min
90876 UA	Individual psychophysiological therapy incorporating biofeedback, with psychotherapy	45 min
90846 UA	Family psychotherapy without member present	1 session
90847 UA	Family psychotherapy with member present	1 session
90849 UA	Multiple family group psychotherapy	10 sessions
90853 UA	Group psychotherapy	1 session
90839 UA	Psychotherapy for crisis	60 min
90840 (add on to 90839) UA	Psychotherapy for crisis, clinical trainee	30 min
H0031 UA UD	Administering and reporting standardized measures	15 min
H0032 UA UD	Treatment plan development and review	15 min
H2014 UA	Skills training & development – individual	15 min
H2014 UA HQ	Skills training & development – group	15 min
H2014 UA HR	Skills training & development – family	15 min
H2015 UA	Comp community support services – crisis assistance	15 min
H2012 UA	Behavioral health day treatment – therapeutic components of preschool program	60 min
H2019 UA	Therapeutic behavioral services – Level I MHBA	15 min
H2019 UA HM	Therapeutic behavioral services – Level II MHBA	15 min
H2019 UA HE	Therapeutic behavioral services – direction of MHBA	15 min

*See DHS provider manual for service limitations

Day Treatment - Adult

intensive psychotherapeutic treatment. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the member to live in the community.

Eligible Providers

- licensed outpatient hospitals with JCAHO accreditation;
- MHCP-enrolled community mental health centers;
- entities under contract with a county to operate a day treatment program.

Eligible Members

Eligible recipients of adult day treatment must:

- must be eligible for medical assistance (Medicaid);
- be age 18 years or older (recipients age 18 - 20 years may receive adult day treatment, CTSS, or both, depending on medical necessity);
- meet all criteria for admission or continuing stay, below:
    - Admission Criteria:

        - have a primary diagnosis of mental illness as determined by a Diagnostic Assessment, excluding dementia and other organic conditions;
        - have three or more areas of significant impairment in functioning as determined by a Functional Assessment;
        - have a completed LOCUS assessment with a Level 3 indication;
        - be experiencing symptoms impairing thought, mood, behavior or perception that interfere with the ability to function with a lesser level of service;
        - have the cognitive capacity to engage in and benefit from this level of treatment;
        - reasonably be expected to benefit in improved functioning at work, school, or social relationships;
        - need a highly structured, focused treatment approach to accomplish improvement and to avoid relapse requiring higher level of treatment.
    - Continuing Stay Criteria:
        - condition continues to meet admission criteria as evidenced by active psychiatric symptoms and continued functional impairment;
        - treatment plan contains specific goals and documented measurable progress toward goals;
        - active discharge plan is in place;
        - attempts to coordinate care and transition to other services are documented, as clinically indicated.
    - Discharge Criteria:
        - treatment plan goals and objectives have been met;
        - no longer meets continuing stay criteria;
        - mental health disorder has decreased and lesser level of service is appropriate;
        - voluntarily involved in treatment and no longer agrees to attend day treatment;
        - exhibits severe exacerbation of symptoms or disruptive or dangerous behaviors requiring more intensive level of service. Do not close chart if individual is expected to return to day treatment;
        - does not participate despite multiple attempts to engage the person and address nonparticipation issues;
        - does not make progress toward treatment goals and no reasonable expectation that progress will be made;
        - no longer meets the criteria for a LOCUS Level 3;
        - does not have or ceases to have the cognitive capacity to benefit fromd ay treatment services.

<u>Covered Services</u>

Adult day treatment consists of:

- at least one hour of group psychotherapy (maximum of two hours);
- group time focused on rehabilitative interventions, or other intensive therapeutic services, provided by a multidisciplinary staff;
- a group of at least 3, but not more than 12, recipients.

The services must:

- stabilize the member's mental health status;
- develop and improve the member's independent living and socialization skills;
- be included in the member's individual treatment plan (ITP).

The ITP must:

- be completed before the first session;

- include attainable, measurable goals as they relate to day treatment services;
- be reviewed by the provider and updated with member progress at least every 30 days, until discharge;
- include an attainable discharge plan for the member.

Non-Covered Services

- services provided to members residing in an inpatient or residential facility (except when following the discharge plan guidelines, listed under Admission Criteria);
- primarily recreation-oriented, non-medically supervised services or activities, including, but not limited to:
    - sports activities
    - exercise groups
    - craft hours
    - leisure time
    - social hours
    - meal or snack time or preparation
    - trips to community activities
    - tours
- social or educational services that do not have or cannot reasonably be expected to have therapeutic outcomes related to the member's mental health condition;
- consultations with other providers or service agency staff about the care or progress of a member;
- prevention or education programs provided to the community;
- day treatment for members with a primary diagnosis of alcohol or other drug abuse;
- day treatment provided in the member's home;
- psychotherapy for more than two hours daily;
- participation in meal preparation and eating that is not part of a clinical treatment plan to address a member's eating disorder;
- services not included in the member's treatment plan as medically necessary and appropriate;
- less intensive services, such as a "club-house" or social program not covered by MHCP.

Authorization

Prior Authorization is required (Form SCHA #2285)

- after threshold is met;
- when receiving concurrent DBT services (regardless of whether the 115 hours was met);
- to provide concurrent partial hospitalization or adult day treatment and residential crisis stabilization services concurrently.

Service Thresholds

- 115 hours per calendar year without authorization;
- Max 15 hours per week; may not obtain authorization for more day treatment hours in a week;
- Provide adult day treatment services concurrent with other services.

Billing

Day Treatment Services - Adult Billing		
Code	**Service Description**	**Unit**
H2012	Behavioral Health Day Treatment	1 hour

Day Treatment - Child

a site-based structured mental health treatment program consisting of psychotherapy and skills training services provided by a multidisciplinary team, under the clinical supervision of a mental health professional and available twelve months of the year.

Day treatment services stabilize the child's mental health status while developing and restoring the child's independent living and socialization skills. The goal is to reduce or relieve the effects of mental illness and provide training to enable the child to live in the community.

Eligible Providers

- licensed outpatient hospitals with JCAHO accreditation;
- MHCP-enrolled community mental health centers;
- county agencies;
- HIS / 638 facilities;
- entities under contract with a county to operate a day treatment program.

Eligible Members

Eligible recipients of adult day treatment must:

- must be eligible for medical assistance (Medicaid);
- under age 18 and diagnosed with an emotional disturbance or meet severe emotional disturbance criteria;
- between the ages 18 and 21 and diagnosed with a mental illness or meet serious and persistent mental illness criteria;
- need intensity level of day treatment as identified in the diagnostic assessment.

Covered Services

- psychotherapy provided by a mental health professional or a mental health practitioner qualified as a clinical trainee;
- skills training – individual or group, provided by a mental health professional or a mental health practitioner;
- follow the guidelines below:
    - Day treatment program must be available:
        - No less than one day per week, two hours per day;
        - No more than three hours per day, 15 hours per week.
    - Psychotherapy must be provided for:
        - No less than one hour;
        - No more than two hours, with the remaining time including skills training.

Non-Covered Services

- services that are the responsibility of a residential or program license holder, including foster care;
- services in violation of medical assistance policy;

- treatment by multiple providers within the same agency at the same clock time;
- MHBA services provided by a personal care assistant who is not qualified as a MHBA and employed by a certified CTSS provider entity;
- Primarily recreation oriented or provided in a setting that is not medically supervised, such as:
    - sports activities
    - exercise groups
    - craft hours
    - leisure time
    - social hours
    - meal or snack time
    - trips to community activities
    - tours
- social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child's emotional disturbance;
- consultation with other providers or service agency staff about the care or progress of a child;
- prevention or education programs provided to the community;
- treatment for recipients with primary diagnoses of alcohol or other drug abuse or traumatic brain injury.

*CTSS Day Treatment does not cover Mental Health Behavioral Aide (MHBA) services. MHBA's are not an eligible provider of CTSS day treatment services.

Authorization

Prior Authorization is required (Form SCHA #2285)

- after threshold is met.

Service Thresholds

- 150 hours / calendar year

Billing

Day Treatment Services - Children Billing		
Code	**Service Description**	**Unit**
H2012 UA HK	Behavioral Health Day Treatment	1 hour
H2012 UA HK U6	Behavioral Health Day Treatment (interactive)	1 hour

Diagnostic Assessment (DA)

a written summary of the history, diagnosis, strengths, vulnerabilities and general service needs of a member with a mental illness using diagnostic, interview and other relevant mental health techniques provided by a mental health professional used in developing an individual treatment plan or individual community support plan.

Eligible Providers

- Clinical Nurse Specialist (CNS);
- Licensed Independent Clinical Social Worker (LICSW);
- Licensed Marriage and Family Therapist (LMFT);

- Licensed Professional Clinical Counselor (LPCC);
- Licensed Psychologist (LP);
- Psychiatric Nurse Practitioner (NP);
- Psychiatrist.

* in addition, an individual certified by tribal council as a mental health professional, serving a federally recognized tribe and a mental health practitioner who qualifies as a clinical trainee.
**please see Diagnostic Assessment template on South Country Health Alliance website

Eligible Members

- must be eligible for medical assistance (Medicaid).

Covered Services

- to be eligible for payment a diagnostic assessment must:
    - Identify a mental health diagnosis and recommend services or determine the member does not meet criteria for a mental health disorder;
    - Include a face to face interview with the member and a written evaluation (may be conducted using telemedicine technology when appropriate);
    - Meet the conditions of one of the following fourt types of diagnostic assessment and include in the description which type of diagnostic assessment is used in the written report:
        - Standard Diagnostic Assessment
        - Extended Diagnostic Assessment
        - Adult Diagnostic Assessment Update
        - Brief Diagnostic Assessment

*see definitions section for more information on assessments

Non-Covered Services

A Diagnostic Assessment cannot be performed by providers who are allied mental health professionals or adult mental health rehabilitation professionals.

Authorization

- after threshold is met (Form SCHA #2289)

Service Thresholds

- two sessions per calendar year, maximum of four assessments per year

Billing

Diagnostic Assessment CPT Codes			
Code		**Service Description**	**Unit**
90791		Standard Diagnostic Assessment	1 session
90791	52	Brief Diagnostic Assessment	1 session
90791	TG	Extended Diagnostic Assessment	1 session
90791	TS	Adult Update Diagnostic Assessment	1 session
90792		Standard Diagnostic Assessment with medical services	1 session
90792	52	Brief Diagnostic Assessment with medical services	1 session
90792	TG	Extended Diagnostic Assessment with medical services	1 session
90792	TS	Adult Update Diagnostic Assessment with medical services	1 session

** teaching hospitals may enter the GC modifier for services performed under the direction of a supervising physician.

Dialectical Behavior Therapy (DBT)

a treatment approach provided in an intensive outpatient treatment program using a combination of individualized rehabilitative and psychotherapeutic interventions. A dialectical behavior therapy program involves individual therapy, group skills training, telephone coaching and consultation team meetings.

Eligible Providers

Certified DBT IOP teams and their affiliated individual DBT IOP providers.
At minimum, each team must be comprised of:

- A team leader who is an enrolled mental health professional with a specialty in DBT IOP;
- Other individual treating providers trained in DBT.

A team leader must meet all the following requirements:

- be an enrolled mental health professional;
- be employed by, affiliated with or contracted by a DHS-certified DBT program;
- have competencies and working knowledge of DBT principles and practices;
- have knowledge of and the ability to apply the principles and DBT practices that are consistent with evidence-based practices.

A team member must be one of the following:

- be an enrolled mental health professional;
- a mental health practitioner clinical trainee;
- a mental health practitioner.

A team member must meet all the following requirements:

- be employed by, affiliated with or contracted by a DHS-certified DBT program;
- have appropriate competencies and knowledge of DBT principles and practice or obtain these competencies and knowledge within the first six months of becoming part of a DBT program;
- have knowledge of and the ability to apply the principles and practices of DBT consistent with evidence-based practices, or obtain the knowledge and ability within the first six months of becoming part of a DBT program;
- participate in DBT consultation team meetings for the recommended duration of 90 minutes per week;
- if the team member is a mental health practitioner or mental health practitioner clinical trainee, receive ongoing clinical supervision from a qualified clinical supervisor who has appropriate competencies and working knowledge of DBT principles and practices

Eligible Members

Members must meet all the following admission criteria:

- must be eligible for medical assistance (Medicaid);
- be age 18+;
- meet one of the following two criteria:
    - have a diagnosis of borderline personality disorder;
    - have multiple mental health diagnoses; exhibit behaviors characterized by impulsivity, intentional self-harm behavior or both; and be at significant risk of death, morbidity, disability or severe dysfunction across multiple life areas;

- have mental health needs that can't be met with other available community-based services or that need services provided concurrently with other community-based services;
- be at risk of one of the following:
    - a need for a higher level of care
    - intentional self-harm or risky impulsive behavior or be currently having chronic self-harm thoughts or urges
    - a mental health crisis
    - decompensation of mental health symptoms (a change in LOCUS score)
- understand and be cognitively capable of participating in DBT as an intensive therapy program;
- be able and willing to follow program policies and rules assuring the safety of self and others.

Members must meet all the following continued - stay criteria:

- be actively participating and engaged in the DBT program, its treatment components and its guidelines in accordance with treatment team expectations;
- have made demonstrable progress as measured against the member's baseline level of functioning before the DBT intervention;
- continue to make progress toward goals but have not fully demonstrated an internalized ability to self - manage and use learned skills effectively;
- be actively working toward discharge, including concrete planning for transition and discharge;
- have a continued need for treatment as indicated in the above criteria and by ongoing documented evidence in the member's record;

Members must meet the following criteria for appropriate discharge:

- member's individual treatment plan goals and objectives have been met, or the member no longer meets continuing - stay criteria;
- member's thought, mood, behavior or perception has improved to a level for which a lesser level of service is indicated;
- member chooses to discontinue the treatment contract;
- provider concludes the member will no longer benefit from DBT services after clinical assessment;
- provider will complete paperwork and refer member to needed services.

Covered Services

- Individual DBT Therapy Intensive Outpatient Program;
- DBT Group Skills Training.

Authorization

Prior Authorization is required (Form SCHA #2287 and Form SCHA #2288)

- Authorization is required for initial DBT services as well as a separate authorization required when requesting additional DBT, following the initial six months. Form SCHA #2287 must be completed for initial request and Form SCHA #2288 must be completed when requesting additional DBT services.

Service Thresholds

- Up to 26 hours (104 units) per six months for individual skills training;
- Up to 78 hours (312 units) per six months for group skills training.

Billing

Dialectical Behavior Therapy Services Billing		
Code	**Service Description**	**Unit**
H2019 U1	Individual DBT therapy	15 min
H2019 U1 HN	Individual DBT therapy by clinical trainee	15 min
H2019 U1 HQ	Group DBT skills training	15 min
H2019 U1 HQ HN	Group DBT skills training by clinical trainee	15 min

Eating Disorders

includes Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder Not Otherwise Specified.

Services Covered

- residential
- non-residential

Prior Authorization is required (Form SCHA #2290)

- for residential and non-residential treatment.

Service Thresholds

- none.

Early Intensive Developmental and Behavioral Intervention (EIDBI)

services that offer early intensive intervention medically necessary to members less than 21 years old on Medical Assistance with Autism Spectrum Disorder (ASD) or related conditions.

Eligible Providers

EIDBI providers must:

- be an enrolled Minnesota Health Care Programs (MHCP) provider;
- meet all provider qualifications on the EIDBI assurance statement for your provider type;
- have a DHS approved service authorization to provide services for the member.

Eligible Members

- have a diagnosis of Autism Spectrum Disorder (ASD) or other related condition;
- had a comprehensive multi-disciplinary evaluation (CMDE) that establishes his/her medical need for EIDBI services;
- is eligible for Medicaid;
- is medically stable and not need 24-hour medical monitoring or procedures;
- is under age 21.

Covered Services

- Comprehensive Multi-Disciplinary Evaluation (CMDE);
- Individual Treatment Plan (ITP) development and monitoring;
- Observation and Direction;
- Family/Caregiver Training and Counseling
- Coordinated Care Conference
- travel time.

Non-Covered Services

- conducted over the telephone, or via mail or email;
- for purposes of reporting, charting or record keeping (except when this is integral to a covered CMDE or ITP service);
- not documented in member's health service record or ITP in the manner outlined by this policy manual or MN Rules Part 9505.2175;
- primarily custodial, day care or respite;
- primarily recreational and not supervised by a medical professional, such as:
    - sports activities
    - craft activities
    - meal or snack time
    - trips to community activities
    - tours
- services that are the responsibility of a residential or program license holder (foster care providers) per a service agreement or administrative licensing ruling;

EIDBI benefit does not cover services that:

- have not been approved by the state's medical review agent;
- include or replace academic goals that are otherwise included in the member's IEP or FSP, as required under the Individual with Disabilities Education Improvement Act of 2004.

EIDBI benefit does not cover services that are provided:

- by a parent, legal guardian or another person legally responsible for the member;
- by a person who does not meet the provider qualifications;
- in violation of Medical Assistance policy as outlined in MN Rules 9505.0220;
- to the general community, such as prevention and education;
- when the member is sleeping or napping;
- without the required supervision.

EIDBI benefit also does not cover services that are not provided (no-shows) or not provided directly to a member who is present, either physically or via interactive video with the exception of the following services:

- coordinated care conference;
- family / caregiver training and counseling;
- ITP development.

EIDBI benefit does not cover:

- Provider training activities that do not meet the criteria for observation and direction;
- Transportation of the member;
- Intervention services delivered to one member by two or more EIDBI providers (of any level) at the same time.

Authorization

Prior Authorization is required for the following services:

- EIDBI Intervention - member;
- EIDBI Intervention - group;

- family/caregiver training and counseling;
- 60-day temporary increase of EIDBI intervention services – DHS – 7109D (PDF)
- Individual Treatment Plan progress monitoring (ongoing);
- intervention, observation and direction;
- travel time.

NO Prior Authorization is required for the following services:

- initial ITP;
- annual CMDE;
- one coordinated care conference per year.

Service Thresholds

- See EIDBI Benefit Grid here: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_195657

Billing

- See EIDBI Benefit Grid here: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_195657

Healthy Pathways Program (HPP)

a program to assist South Country members in preventing mental health deterioration through early intervention and education.

Eligible Providers

- must be a qualified mental health professional to oversee goals/objectives.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- be 18+;
- present with a suspected mental health disorder.

Authorization

Prior Authorization is required (Form - Healthy Pathways Communication Form)
Authorization is required at separate stages of service:

- initial;
- 60+ days;
- 6 months;
- annually.

Service Thresholds

- none

Billing

Healthy Pathways Program Billing		
Code	**Service Description**	**Unit**

G9006	Healthy Pathways Case Management Services • Face to Face Contact • Telephone Contact with member • Telephone Contact with providers / resources	per member per month (PMPM)

Inpatient Visits

- are covered for hospitalized South Country Health Alliance members if provided by a Clinical Nurse Specialist-Mental Health (CNS-MH); licensed psychologist (LP) (with a physician's order); Physicians; Psychiatric Nurse Practitioner (NP); and Psychiatrists.

Institute of Mental Disease (IMD)

Prior Authorization is required (Form SCHA #2324)

Intensive Outpatient Mental Health Treatment

Prior Authorization is required (Form SCHA #2285)

- after threshold is met.

Service Thresholds

- 10 days per episode.

Intensive Residential Treatment Services (IRTS)

time-limited mental health services provided in a residential setting to members in need of more restrictive settings (versus community settings) and at risk of significant functional deterioration if they do not receive these services. IRTS are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.

Eligible Providers

IRTS providers must comply with the following:

- be licensed with the Rule 36 Variance;
- not exceed 16 beds;
- have a contract with the host county agency;
- have a rate approved by DHS.

Members of the IRTS interdisciplinary team must be qualified in one of the following roles:

- mental health professional;
- mental health practitioner;
- Certified Peer Specialist;
- mental health rehabilitation worker;
- registered nurse who is also qualified as a mental health practitioner.

IRTS providers must have:

- sufficient staff for 24-hour delivery of mental health services, as described in the member's individual treatment plan (ITP);

- staff available to safely monitor and assist with activities of members;
- the capacity to respond to emergent needs and make staffing adjustments to assure the health and safety of members. This includes providing medical services directly (through its own medical staff) or indirectly (through referral to medical professionals).

Eligible Members

- must be eligible for medical assistance (Medicaid);
- age 18+;
- meet the IRTS admission criteria.

*members who are 17 years old and transitioning to adult mental health services may be considered for IRTS if the service is determined to best meet their needs. IRTS providers must secure a licensing variance in this situation
*members may receive IRTS instead of hospitalization, if appropriate.

Covered Services

- supervision and direction;
- individualized assessment and treatment planning;
- crisis assistance, development of health care directives and crisis prevention plans;
- nursing services;
- interagency case coordination;
- transition and discharge planning;
- living skills development, including:
    - medication self-administration;
    - healthy living;
    - household management;
    - cooking and nutrition;
    - budgeting and shopping;
    - using transportation;
    - employment-related skills.
- integrated dual diagnosis treatment (mental health and substance abuse screening and assessment, with a team approach. Assesses treatment readiness, uses motivational interviewing and a non-confrontational approach)
- illness management and recovery (educating about mental illness and treatment including characteristic symptoms and early warning signs of relapse, managing stress and developing relapse prevention plans, developing coping skills and strategies for coping with symptoms, developing social skills to improve effectiveness in interactions across a range of settings and situations, and identifying therapeutic and rehabilitative approaches available to recipients, such as DBT or treatment for OCD)
- family education (services to educate, inform, assist, and support family members in mental health illness and treatment, coping mechanisms, medication, community resources).

Non-Covered Services

- Room and Board costs are **not** covered though IRTS service.

Authorization

Notification is required (Form – SCHA#2281)

- upon admission

Prior Authorization is required (Form – SCHA#2285)

- after threshold is met.

Service Thresholds

- maximum 90 days;
- readmission within 15 days counts toward 90-day limit;
- request authorization for more than 90 days.

Billing

Intensive Residential Treatment Services (IRTS) Billing		
Code	**Service Description**	**Unit**
H0019	• Behavioral health; long term residential (non-medical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem	per diem

IRTS & Other Concurrent Services

*all services provided concurrently with IRTS must be coordinated with IRTS.
*when requesting authorization, clearly document medical necessity for the additional service (s), including reasons IRTS does not or cannot meet member's needs.

Other Service	Is service included in IRTS?	Can service be provided in addition to IRTS?	Service Limitations
MH-TCM	No	Yes	• Rule 79 applies • IRTS must coordinate with member's case manager
Day Treatment	No	Only with authorization	Day treatment provider must coordinate the plan of care with the IRTS provider and seek authorization for any day treatment services provided on the same day
Partial Hospitalization	No	Only with authorization	• IRTS provider must coordinate the plan of care with the partial hospitalization provider and seek authorization for any IRT services provided on the same day • Partial hospitalization thresholds and limitations apply.
ACT	No	Yes	• ACT rate may be adjusted • ACT and IRTS may be provided concurrently without authorization
ARMHS	Yes	Only with authorization	• ARMHS thresholds and limits apply to each service • For Transition to Community Living (TCL) services, follow Authorization Requirements for TCL Services
Crisis response services (assessment or intervention only – mobile)	No	Yes	• May be billed separately • No authorization required

Crisis Stabilization – Non-residential	Yes	No	• A component of IRTS • Cannot be billed separately
Crisis Stabilization – Residential	Yes	No	• A component of IRTS • Be aware of member transfers • If member is approved for IRTS and residential crisis stabilization, bill only one approved daily rate. Only one of these two services can be billed for a member per day
Psychiatric Physician Services	Sometimes	Yes	• May be provided by physician, psychiatric NP, CNS-MH, or physician extender if a member of the treatment staff • Bill separately only if not included in IRTS rate • This service component is not excluded from Telemedicine Delivery
Outpatient Psychotherapy	No	Yes	• outpatient psychotherapy limits apply
Inpatient Hospitalization	No	No	• Inpatient hospitalization services are reimbursed separately from IRTS • IRTS may not be reimbursed for members admitted to an inpatient hospital
Interpreter Services	Sometimes	Yes	• Bill separately only if not included in IRTS rate
Waivered Services	No	No	• County must approve concurrent care
Other medical services	No	Yes	• Service limits apply to each service

Intensive Treatment in Foster Care

Eligible Provider

- include ITFC certified agencies and their qualified employees enrolled as MHCP providers;
- services provided to MHCP enrollees must be by a qualified mental health professional or a clinical trainee working under the supervision of a licensed mental health professional:
    - Clinical Nurse Specialist (CNS)
    - Licensed Independent Clinical Social Worker (LICSW)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Professional Clinical Counselor (LPCC)
    - Licensed Psychologist (LP)
    - Psychiatric Nurse Practitioner (NP)
    - Psychiatry or an osteopathic physician
    - Tribal certified professionals

**Refer to DHS Provider Manual for additional practitioner requirements.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- age 21 and under;
- have an individual treatment plan that clearly documents the necessity for the type of mental health service requested, including intensity of treatment and medical necessity;
- have a documented diagnosis of mental illness;
- be living in a family foster care setting;

- have a level of care evaluation indicating that intensive intervention without 24-hour medical monitoring is required to treat the mental illness.

*A mental health professional or clinical trainee must do the diagnostic assessment establishing eligibility for ITFC within the 180 days prior to the ITFC services beginning.

Covered Services

- psychotherapy (individual, family and group);
- psychoeducation (individual, family and group);
- crisis assistance;
- clinical care consultation.

Non-Covered Services

Services that are not covered in ITFC but may be billed separately:

- inpatient psychiatric hospital treatment;
- mental health targeted case management;
- partial hospitalization;
- medication management;
- children's mental health day treatment services;
- crisis response services;
- transportation.

Services that are not covered in ITFC and are not billable while a child is receiving ITFC services:

- CTSS;
- mental health behavioral aide services;
- home and community based waiver services;
- mental health residential treatment;
- room and board costs.

Authorization

Prior Authorization is required (Form – SCHA#2285)

- after threshold is met.

Service Thresholds

- 78 units of service.

Billing

- **Intensive Treatment in Foster Care & Other Concurrent Service**
- **ITFC certified agency must provide all the covered services.**
  When requesting authorization, clearly document medical necessity for the additional service(s), including reasons ITFC does not or cannot meet member's needs (e.g., specialty service, transitional service, etc.)

Other Service	Is service included in ITFC?	Can service be provided in addition to ITFC?	Service Limitations
MH-TCM	No	Yes	

Children's Mental Health Day Treatment	No	Yes	Day treatment program must request authorization.
Children's Residential Treatment Services	No	No	Cannot be billed separately. No authorization required.
Partial Hospitalization	No	Yes	Partial hospitalization thresholds and limitations apply.
IRTS	No	Yes	ITFC and IRTS may be provided concurrently without authorization.
CTSS and ARMHS	No	No	Rehabilitative skills training is a not a component of ITFC services and cannot be billed separately.
Mental Health Behavioral Aide Services	No	No	Cannot be billed separately. No authorization required.
Crisis Assessment and Intervention (mobile)	No	No	Can be billed separately. No authorization required.
Crisis Stabilization – Non-residential	No	No	Cannot be billed separately. No authorization required.
Crisis Stabilization – Residential	No	Yes	Service limits apply. Services must be provided with ITFC and residential provider.
Medication Management	No	Yes	May be provided by physician or advance practice registered nurse with mental health certification.
Outpatient Psychotherapy	Yes	No	A component of ITFC. Cannot be billed separately. No authorization required.
Inpatient Hospitalization	No	Yes	Inpatient hospitalization services are reimbursed separately from ITFC. ITFC claims: enter POS code 21.
Waivered Services	No	No	Cannot be billed separately. No authorization required.
Other medical services (e.g., PCA)	No	Yes	Service limits apply to each service.

Intensive Treatment in Foster Care			
Proc. Code	**Brief Description**	**Unit**	**Service Limitation**
S5145 HE	Intensive treatment in foster care (performed by mental health professional)	Per diem	78 Units before Authorization is required.
S5145 HE HN	Intensive treatment in foster care (performed by clinical trainee)		

Mental Health Targeted Case Management (MH-TCM)

services that help adults with a serious and persistent mental illness (SPMI) and children with a severe emotional disturbance (SED) gain access to needed medical, social, educational, vocational, financial and other necessary services as they relate to the member's mental health needs.

Eligible Provider

- must be employed by a county or under contract with a county agency or tribe to provide services and be:
    - case management mentors - qualified, practicing case manager or case manager supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates
    - case management supervisors - must be a mental health professional
      case manager associates - at least 21 years of age, have at least a high school diploma or its equivalent, work under the direction of a case manager or case management supervisor and:
        - have an associate of arts degree in one of the behavioral sciences or human services;
        - be a RN without bachelor's degree;
        - within the previous 10 years, had:
            1.Three years' life experience with SPMI; or
            2. SED as a child; or
            3. Three years' life experience as a primary caregiver to an adult with SPMI, if providing case management to adults; or three years life experience as a primary caregiver to a child with SED if providing case management to children;
        - have 6,000 hours work experience as a state hospital technician (no degree); or
        - be a mental health practitioner.
    - case managers - have a bachelor's degree in one of the behavioral sciences or related fields, including but not limited to social work, psychology, or nursing from an accredited college or university; or, if without a degree, must:
        - have three or four years' experience as a case manager associate;
        - be a registered nurse without a bachelor's degree and have a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or
        - be a person who qualified as a case manager under the 1998 DHS waiver provision and meet the continuing education and mentoring requirements
    - immigrant case managers.

The provider will:

- work with the hospitals, pre-petition screening teams, family members and current providers to assess the member and develop an individual care plan that includes alternatives consistent with the Commitment Act. This may include:
    - testifying in court;
    - preparing and providing requested documentation to the court.
- report to the court within the court required time lines regarding the member's care plan status and recommendations for continued commitment, including as needed, requests to the court for revocation, of a provisional discharge;

- provide input only for pre-petition screening, court appointed independent examiners, substitute decision makers or court reports for members who remain in the facility to which they were committed;
- provide mental health case management coverage, which includes discharge planning for up to 180 days prior to a member's discharge from an inpatient hospitalization in a manner that works with, but does not duplicate, the facility's discharge planning services;
- ensure continuity of health care and case management coverage for members in transition due to a change in benefits or a change in residence;
- staffing ratios must be provided as specified in Minnesota Rules;
- provide a copy of Diagnostic Assessment and certification of SPMI or SED (upon request);
- provide a copy of Functional Assessment (upon request);
- provide a copy of Individual Community Support Plan (ICSP) or the Individual Family Community Support Plan (IFCSP) (upon request);
- follow Denial, Termination or Reduction (DTR) of services guidelines listed under the following section:

South Country Health Alliance has 24-hour telephone access that the provider may call to get an expeditious response to situations where the member has court ordered treatment and disability certification: South Country Health Alliance Member Services M-F from 8:00 am to 8:00 pm (866) 567-7242.

The provider will notify South Country Health Alliance of appeals and grievances **within one business day or within three hours** of an expedited appeal.

The provider will follow the Procedures for MH-TCM with a Civil Commitment.

The county will notify South Country Health Alliance Provider Services (MMSI) at1-800-995-4543 within 72 hours when a member is the subject of a pre-petition screening investigation.

The provider will provide an expedited determination of eligibility for MH-TCM for members referred.

The provider will assign MH-TCM as court ordered services for members with mental illness who are committed or for members whose commitment is stayed or continued.

The provider will submit a copy of the court order and pre-petition screening report, along with the completed MHTCM Eligibility Notification form to South Country Health Alliance at 507-431-6329 Attn: Behavioral Health Program Manager.

*****Authorization for Civil Commitment cases will be for the six months that are court ordered, not the 36 months that are typically given for duration of Diagnostic Assessment validity.***

Denial, Termination, or Reduction of MH-TCM Services

The provider will fax the MH-TCM Recommendation for Action – DTR (Denial, Reduction, or Termination of Service (SCHA #1922v3) form and include the following in the notification to South Country Health Alliance **within 5 days**:

- specify the reason for closing case management services;
    i. member is found to be ineligible for MH-TCM services;
    ii. member has requested to discontinue MH-TCM services (refusal or termination of services);

iii. member has had no Face to Face (F2F) contact with the case manager for:
- 90 days (children only)
- 180 days (adults only)

- member information (name, address, date of birth, PMI, Prior Authorization (PA)#, dates of PA, dates of MH-TCM service, date of most recent diagnostic assessment;
- case manager name, agency and contact information, Provider name, agency and contact information;
- date of discussion regarding potential denial, termination or reduction of service;
- DO NOT ENTER A Date of Action, this date comes from South Country based on the date the letter is sent out to member giving notification of appeal rights;
- the reason and description.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- age 18+ (for adult);
- age 21 and under (for child)
- diagnosed with a serious and persistent mental illness (SPMI);
- determined eligible by the county;
- appears to be eligible for case management but due to the member's initial refusal to participate in diagnostic assessment process, eligibility determination cannot be completed (these services are limited to four months from the day member begins case management services);
- adolescent who has received children's MH-TCM services within 90 days of turning 18 years old and upon turning 18 seeks adult MH-TCM services.

*transition aged youth maintain eligibility for AMH – TCM for up to 36 months and based upon the most recent diagnostic assessment when the youth transitioned to adulthood

Covered Services

- assessment
- planning
- referral and linkage
- monitoring and coordination

Non-Covered Services

MHTCM services are not:

- treatment, therapy or rehabilitation services;
- other types of case management (for example: Community Alternative Care [CAC]; Community Alternatives for Disabled Individuals [CADI]; Brain Injury [BI]; Developmental Disability [DD]);
- legal advocacy;
- conducting a diagnostic assessment;
- determining eligibility for MHTCM;
- administration or management of member's medications;
- services that are integral components of another service or direct delivery of an underlying medical, educational, social, or other service;
- transportation services.

Authorization
Notification is required (MHTCM Eligibility Notification Form) **within 60 days of opening MHTCM services.**

Billing

Mental Health Targeted Case Management Services Billing			
Code		**Service Description**	**Unit**
T2023	HE	Face to Face Contact	1 unit / month
T2023	HE U4	Telephone Contact, including Telemedicine	1 unit / month

Neuropsychological Services

Eligible Members
- Members with neurological disorders that result in cerebral dysfunction.

Covered Services
- assessment;
- testing;
- rehabilitation.

Prior Authorization is required (Form SCHA#2292)
- after threshold is met.

Service Thresholds
- 15 cumulative hours of assessment and neuropsychological testing in a calendar year;
- Five sessions of neuropsychological testing in a calendar year.

Billing

Neuropsychological Services				
Procedure Code	**Modifier**	**Brief Description**	**Unit**	**Service Limitations**
96116		Neuropsychological assessment by a qualified neuropsychologist	1 hour	• Authorization is required for more than 15 cumulative hours of 96116, 96118 and 96119 in a calendar year • The date of service for 96116 must be the date all components of the assessment are complete,
96118		Neuropsychological testing administered by a qualified neuropsychologist, interpretation, analysis, report	1 hour	

96119		Neuropsychological testing administered by a clinically supervised technician, interpretation and report by a qualified neuropsychologist	1 hour	including interpretation of test results and preparing the report • Authorization is required for more than five sessions of 96120 in a calendar year
96120		Neuropsychological testing administered by computer, interpretation and report by a qualified neuropsychologist	1 session	
H2012	HK	Cognitive rehabilitation *Behavioral Health Day Treatment*	1 hour	• Authorization is required before you provide service • Services may be reauthorized every 90 days with demonstration of medical necessity and progress • An eligible recipient may receive up to four hours per day and 390 hours per calendar year • Services must be provided by a specialized cognitive rehabilitation program located in an outpatient hospital, a comprehensive outpatient rehabilitation facility or a rehabilitation agency
You must be an MHCP-enrolled provider to provide and bill for neuropsychological services.				

Partial Hospitalization Program

a time limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team, as defined by Medicare, and provided in an outpatient hospital facility or Community Mental Health Center (CMHC) that meets Medicare requirements to provide partial hospitalization programs services. The goal of the partial hospitalization program is to resolve or stabilize an acute episode of mental illness.

Eligible Providers

- certification by Medicare to provide partial hospitalization
- receive approval from DHS

Eligible Members

- must be eligible for medical assistance (Medicaid);
- be experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission;
- have appropriate famiy or community resources needed to support and enable the member to benefit from less than 24-hour care;
- be referred for partial hospitalization by a physician for an outpatient hospital program, or by a physician, LICSW or LP for a community mental health center program;
- have a completed LOCUS assessment with a Level 4 indication for adults age 18+.

*partial hospitalization may be used as a step down from an inpatient mental health stay or in lieu of an inpatient psychiatric stay, when medically appropriate.

Covered Services

- at minimum, one session of individual, group or family psychotherapy and two or more other services (such as activity therapy or training and education);
- provide at least 4 days but not more than 5 out of 7 calendar days of partial hospitalization program services;
- ensure a minimum of 20 service components and a minimum of 20 hours in a 7-calendar day period;
- provide a minimum of 5 to 6 hours of services per day for an adult age 18+;
- provide a minimum of 4 to 5 hours of services per day for a child under age 18.

Authorization

Prior Authorization is required (Form SCHA#2285)

- after threshold is met.

Service Thresholds

- 10 days per episode.

Psychiatric Consultation to Primary Care Providers

communication between a psychiatrist and a primary care provider, for consultation or medical management of a member.

Eligible Providers

- Psychiatrist;
- Licensed Psychologist;
- Licensed Independent Clinical Social Worker;
- Licensed Marriage and Family Therapist;
- Psychiatric Nurse Practitioner;
- Clinical Nurse Specialist.

Eligible Members

- must be eligible for medical assistance (Medicaid).

Covered Services

- communication between a consulting professional and a primary care provider for the purpose of medical management, behavioral health care and treatment of a member;

- a psychologist, independent clinical social worker and marriage and family therapists may provide consultation about alternatives to medication, medication combined with psychosocial treatment potential results of medication usage.

*provider may conduct the consultation without the member present

Psychiatric Consultation to PCP Services Billing				
Code			**Service Description**	**Unit**
99499	HE	AG	Communication between a consulting professional and PCP, for consultation or medical management or behavioral health care and treatment of member. (Primary Care Provider)	1 session
99499	HE	AM	Communication between a consulting professional and PCP, for consultation or medical management or behavioral health care and treatment of member. (Consulting Professionals)	1 session

Psychiatric Residential Treatment Facility (PRTF)

active treatment to children and youth under age 21 with complex mental health conditions. This is an inpatient level of care provided in a residential facility rather than a hospital. PRTFs deliver services under the direction of a physician, seven days per week, to residents and their families, which may include individual, family and group therapy. A resident's plan of care may also include arranged services or specialty therapies, such as occupational therapy, physical therapy or speech therapy. This is a per diem benefit.

Upon notice by the state, PRTF will become a Covered Service for Children.

PRTF services must be provided under the direction of a physician, and include the following services:

- Psychiatric assessment;
- Individual, family and group therapy;
- Psychotropic medication; and
- Other specialty services that are person centered, trauma informed and culturally responsive.

Eligible Providers

- must be contracted with and certified by the Department of Human Services as a PRTF provider.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- under age 21 at time of admission;
- has a mental health diagnosis as defined in most recent edition of Diagnostic and Statistical Manual for Mental Disorders;
- clinical evidence of severe aggression or a finding that individual is a risk to self / others;
- functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job, an inability to adequately care for one's physical needs or caregivers/guardians are unable to safely fulfill the individual's needs;

- services must be medically necessary according to Code of Federal Regulations, title 42, section 441.152;
- requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;
- utilized and exhausted other community based mental health services or clinical evidence indicates that such services cannot provide the level of care needed; and
- was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional.

Covered Services

- development of the individual plan of care, review of the individual plan of care every 30 days and discharge planning by required members of the treatment team;
- any services provided by a psychiatrist or physician for development of an individual plan of care conducting a review of the individual plan of care every 30 days and discharge planning by required members of the treatment team;
- active treatment seven days per week that may include individual, family or group therapy as determined by the individual care plan;
- individual therapy, provided at a minimum of twice per week;
- family engagement activities, provided at a minimum of once per week;
- consultation with other professionals, including case managers, primary care professionals, community based mental health providers, school staff and other support planners;
- coordination of educational services between local and resident school districts and the facility;
- 24-hour nursing; and
- Direct care and supervision, supportive services for daily living and safety, and positive behavior management.

Authorization

- **Prior Authorization is required**

Psychoeducation - Family

planned, structured and face to face interventions that involve presenting or demonstrating information. The goal of family psychoeducation is to help prevent relapse or development of comorbid disorders and to achieve optimal mental health and long-term resilience. It supports the member and family in understanding these factors:

- member's symptoms of mental illness
- impact on member's development;
- needed components of treatment;
- skill development.

Eligible Providers

- Clinical Nurse Specialist;
- Licensed Independent Clinical Social Worker;
- Licensed Marriage and Family Therapist;
- Licensed Professional Clinical Counselor;
- Licensed Psychologist;
- Psychiatric Nurse Practitioner;
- Psychiatrist;

- Tribal Certified Professional.

Eligible Members
- must be eligible for medical assistance (Medicaid);
- under age 21;
- diagnosis of emotional disturbance or mental illness as determined by a diagnostic assessment.

Covered Services
- psychoeducation services for any of the following in outpatient settings when directed toward meeting the identified treatment needs of each participating member as indicated in member's treatment plan:
    - the member (individual)
    - member's family (with or without the member present)
    - group of members (peer group)
    - multiple families (family group)

*these services may be provided via telemedicine

Non-Covered Services
- communication between the treating mental health professional and a person under the clinical supervision of the treating mental health professional;
- written communication between providers;
- reporting, charting, and record keeping;
- mental health services not related to the member's diagnosis or treatment for mental illness;
- communication provided while performing any of the following mental health services:
    - mental health case management
    - in reach services
    - Youth ACT
    - Intensive treatment services in foster care

Authorization
Prior Authorization is required (Form SCHA#2285)
- after threshold is met.

Service Thresholds
- Individual - 26 hours / calendar year
- Group – 52 sessions / calendar year
- Member and Family – 26 sessions / calendar year
- Family – 26 sessions / calendar year
- Family Group with member– 10 sessions / calendar year
- Family Group without member – 10 sessions / calendar year

Billing

Family Psychoeducation Services Billing		
Code	**Service Description**	**Unit**
H2027	Family Psychoeducation - Individual	15 min
H2027 HQ	Family Psychoeducation – Group	15 min
H2027 HR	Family Psychoeducation – Family with Member Present	15 min

H2027 HS	Family Psychoeducation – Family without Member Present	15 min
H2027 HQ HR	Family Psychoeducation – Multiple Families with Members Present	15 min
H2027 HQ HS	Family Psychoeducation – Multiple Families without Members Present	15 min

Psychological Testing

used to determine the status of a member's mental, intellectual and emotional functioning. Tests are listed in the most recent Buros' *Mental Assessments* Handbook edition. Tests must meet psychological standards for reliability and validity and be suitable for the diagnostic purposes for which they are used.

Eligible Providers

- Licensed Psychologist with competence in psychological testing;
- Mental health practitioner working as a clinical psychology trainee under the clinical supervision of a LP;
- Psychological technicians, psychometrists or psychological assistants may administer or score psychological tests under clinical supervision of a LP.

Covered Services

- A face to face interview to validate the test;
- Administration and scoring;
- Interpretation of results;
- A written report to document results of the test

Authorization

Prior Authorization is required (Form SCHA #2292)

- after threshold is met.

Service Thresholds:

4 hours / 8 hours' max per member / calendar year.

Billing

Psychological Testing Billing		
Code	**Service Description**	**Unit**
96101	Psychological Testing (LP or LP clinically supervised clinical psychology trainee, administered tests, interpretation and report)	1 hour
96102	Psychological Testing (technician administered tests, with LP or clinical psychology trainee interpretation and report)	1 hour
96103	Psychological Testing (computer administered, with LP or clinical psychology trainee interpretation and report)	1 session

Psychotherapy

planned and structured, face-to-face treatment of a member's mental illness, provided using the psychological, psychiatric or interpersonal method most appropriate to the needs of the member according to current community standards of mental health practice.

Eligible Providers

- Clinical Nurse Specialist;
- Licensed Independent Clinical Social Worker;
- Licensed Marriage and Family Therapist;
- Licensed Professional Clinical Counselor;
- Licensed Psychologist;
- Psychiatric Nurse Practitioner;
- Psychiatrist;
- Tribal Certified Professional;
- Mental health practitioners working as clinical trainees.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- must have a diagnosis of mental illness as determined by a diagnostic assessment;

*a new member may receive one session of psychotherapy prior to completing the diagnostic assessment.

Covered Services

- psychotherapy – with member, family or both
- evaluation and management with psychotherapy – with member, family or both
- family psychotherapy
- multiple family group psychotherapy
- group psychotherapy

Authorization

Prior Authorization is required (Form SCHA #2285)

- after threshold is met.

Service Thresholds

- Individual – 26 hours / calendar year
- Group – 52 sessions / calendar year;
- Family – 26 sessions / calendar year;
- Family Group – 10 sessions / calendar year.

Billing

Psychoeducation Services - Family Billing		
Code	**Service Description**	**Unit**
90832	Psychotherapy – with member, family or both	30 min
90834	Psychotherapy – with member, family or both	45 min
90837	Psychotherapy – with member, family or both	60 min
Appropriate E/M and 90833	E/M and psychotherapy – with member, family or both	30 min
Appropriate E/M and 90836	E/M and psychotherapy – with member, family or both	45 min
Appropriate E/M and 90838	E/M and psychotherapy – with member, family or both	60 min

90875	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	30 min
90876	Individual psychophysiological therapy incorporating biofeedback with psychotherapy	45 min
90846	Family psychotherapy without member present	50 min
90847	Family psychotherapy with member present	50 min
90849	Multiple family group psychotherapy	1 session
90853	Group psychotherapy	1 sesssion

Psychotherapy for Crisis

services to assist in reducing a member's mental health crisis through immediate assessment and psychotherapeutic interventions. An intervention of psychotherapy for crisis will diminish the suffering of the member in crisis and help restore life functioning.

Psychotherapy for crisis services must include:

- emergency assessment of the crisis situation;
- mental status exam;
- psychotherapeutic interventions to reduce the crisis;
- development of a post-crisis plan that addresses the member's coping skills and community resources.

Eligible Providers

- Clinical Nurse Specialist;
- Licensed Independent Clinical Social Worker;
- Licensed Marriage and Family Therapist;
- Licensed Professional Clinical Counselor;
- Licensed Psychologist;
- Psychiatric Nurse Practitioner;
- Psychiatrist;
- Tribal Certified Professional;
- Mental health practitioners working as clinical trainees.

Eligible Members

- must be eligible for medical assistance (Medicaid);
- must have a diagnosis of mental illness as determined by a diagnostic assessment;
- be in need of immediate response, due to an increase of mental illness symptoms that put the member at risk of one of the following:
    - experiencing a life threatening mental health crisis;
    - needing a higher level of care;
    - worsening of symptoms without mental health intervention;
    - harm to self, others, or property damage;
    - significant disruption of normal functioning in at least one life area such as self-care or housing.

Covered Services

- emergency assessment of the crisis situation (does not take the place of a diagnostic assessment);

- mental status exam;
- psychotherapeutic interventions to reduce the crisis;
- development of a post crisis plan that addresses the member's coping skills and community resources.

Authorization

Prior Authorization is required (Form SCHA #2285)

- after threshold is met.

Service Thresholds

- 3 occurrences / calendar month
- 10 occurrences / calendar year

*total time billed for psychotherapy for crisis is also included in the:

- 26 hours / year benefit limit
- 200 hour CTSS benefit limit

Billing

Family Psychoeducation Services Billing		
Code	**Service Description**	**Unit**
90839	Psychotherapy for Crisis	60 min
90840	Psychotherapy for Crisis (each additional 30 minutes)	30 min

Youth Assertive Community Treatment (Youth ACT)

an intensive, comprehensive, non-residential rehabilitative mental health services team model. Services are consistent with Children's Therapeutic Services and Supports (CTSS), except Youth ACT services are:

- provided by multidisciplinary, qualified staff, who have the capacity to provide most mental health services necessary to meet the member's needs, using a total team approach;
- directed to eligible members who require intensive services;
- available 24 hours per day, 7 days per week, for if the member requires this level of service.

Eligible Providers

- have a contract with a host county;
- be certified to provide ARMHS or CTSS;

A Youth ACT team must include the following staff:

- mental health professional;
- licensed alcohol and drug counselor trained in mental health interventions;
- Certified Peer Specialist level I or II;
- one of the following, credentialed to prescribe medications:
    - Advanced Practice Registered Nurse certified in psychiatric or mental health care;
    - board-certified child and adolescent psychiatrist.

Based on member needs, the team may include:

- additional mental health professionals;
- a vocational specialist;

- an educational specialist;
- a child and adolescent psychiatrist retained on a consultant basis;
- mental health practitioners;
- mental health case manager;
- a housing access specialist.

Eligible Members

To be eligible for Youth ACT, members must be 16-20 years old and have:

- must be eligible for medical assistance (Medicaid);
- diagnosis of serious mental illness or co-occurring mental illness and substance abuse addiction;
- CASII level of care determination of level 4 or above;
- functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home or job;
- probable need for services from the adult mental health system within the next two years;
- have a current diagnostic assessment indicating the need for intensive nonresidential rehabilitative mental health services.

Covered services

- individual, family, and group psychotherapy;
- individual, family, and group skills training;
- crisis assistance;
- medication management;
- mental health case management;
- medication education;
- care coordination with other care providers;
- psychoeducation to, and consultation and coordination with, the member's support network (with or without member present);
- clinical consultation to the member's employer or school;
- coordination with, or performance of, crisis intervention and stabilization services;
- assessment of member's treatment progress and effectiveness of services using outcome measurements;
- transition services;
- integrated dual disorders treatment;
- housing access support.

*members and/or family members must receive at least 3 face-to-face contacts per week, totaling a minimum of 85 minutes of service.

Non-Covered services

Intensive nonresidential rehabilitative mental health services and supports such as:

- inpatient psychiatric hospital treatment;
- mental health residential treatment;
- partial hospitalization;
- physician services outside of care provided by a psychiatrist serving as a member of the treatment team;
- room and board costs;
- children's mental health day treatment services; and
- mental health behavioral aide services.

Authorization

Notification is required (Form SCHA #2281)

- after threshold is met.

Service Thresholds

- 75 units of service in a calendar year.

Billing

Youth ACT & Other Concurrent Services **The Youth ACT team must coordinate all services provided concurrently with ACT services.** *when requesting authorization, clearly document medical necessity for the additional service(s). *include the reasons Youth ACT does not/cannot meet member's needs (specialty service, transitional service, etc.)			
Other Service	**Is service included in Youth ACT?**	**Can service be provided in addition to Youth ACT?**	**Service Limitations**
MH-TCM	Yes	No	Case management functions are bundled in the Youth ACT rate. CMH-TCM is covered only in the month of admission or discharge from Youth ACT. CMH-TCM must request authorization for coverage other than month of admission/discharge.
CMH Day Treatment	No	When authorized	Day Treatment program must request authorization. If Youth ACT team approves Day Treatment, Youth ACT team must provide a statement to Day Treatment provider for authorization request purposes. Day Treatment providers may not be additional Youth ACT team members. Day Treatment providers must accept clinical direction from the Youth ACT team.
Children's Residential Treatment Services	No	No	Cannot be billed separately. No authorization required.
Partial Hospitalization	No	Yes	Partial hospitalization thresholds and limitations apply.
IRTS	No	Yes	Youth ACT and IRTS may be provided concurrently without authorization.
CTSS and ARMHS	Yes	No	Rehabilitative skills training is a component of Youth ACT services, cannot be billed separately.
Mental Health Behavioral Aide Services	No	No	Cannot be billed separately.

Crisis Assessment and Intervention (mobile)	Yes	No	A component of Youth ACT. Team must provide or contract with a Crisis provider for this service. Cannot be billed separately. No authorization required.
Crisis Stabilization – Non-residential	Yes	No	A component of Youth ACT. Cannot be billed separately. No authorization required.
Crisis Stabilization – Residential	No	Yes	Service limits apply. Services must be coordinated between the Youth ACT and residential crisis providers.
Medication Management	Yes	No	Provided by physician or advanced practice registered nurse team members.
Outpatient Psychotherapy	Yes	No	A component of Youth ACT. Cannot be billed separately. No authorization required.
Inpatient Hospitalization	No	Yes	Inpatient hospitalization services are reimbursed separately from Youth ACT.
Waivered Services	No	Yes	County must approve concurrent care.
Other medical services (PCA)	No	Yes	Service limits apply to each service.

Non-covered Mental Health Services

The following mental health services are NOT covered by South Country Health Alliance:

- mental health services provided by a non-psychiatrist, except psychological testing, to a member who is inpatient and has a mental illness diagnosis (these services are included in the hospital's payment);
- mileage (provider travel time is not the same as mileage);
- transporting a member, except for case managers;
- telephone calls, unless otherwise specified in service coverage sections (example: adult MH-TCM);
- written communication between provider and member;
- reporting, charting and record keeping;
- community planning or consultation, program consultation/monitoring/evaluation, public information, training and education activities, resource development, and training activities;
- fund-raising;
- court-ordered services for legal purposes;
- mental health service not related to the member's diagnosis or treatment for mental illness;
- services dealing with external, social, or environmental factors not directly addressing the member's physical or mental health;
- staff training;
- mental health case management for members receiving similar services through the Veterans Administration (VA);
- duplicate services (for example, mental health case management for members receiving case management services through a home and community-based services);

- mental health services provided by a school or local education agency, unless the school or agency is an MHCP enrolled provider and the services are medically necessary and prescribed in the child's ITP;
- mental health services provided by an entity whose purpose is not health service related (for example, services provided by the Division of Vocational Rehabilitation or Jobs and Training);
- legal services, including legal advocacy, for the member;
- information and referral services included in the county's community social service plan;
- outreach services through the community support services program;
- assistance in locating respite care, special needs day care and assistance in obtaining financial resources, except when these services are provided as part of case management;
- client outreach;
- recreational services, including sports activities, exercise groups, craft hours, leisure time, social hours, meal or snack times, trips to community activities, etc.

****Contact information for all Managed Care Organizations on the DHS website**:

- Greater Minnesota Residents (DHS-4484)
- Metro Area Residents (DHS-4485)
- Mental Health Service Coverage Charts for MinnesotaCare and by Major Program

For additional information on:

Mental Health Services

Case Manager – Minnesota Statutes 245.462m subds,4 and 4(a) and Minnesota Rules 9520.0912.
Staffing ratios - Minnesota Rules 9520.0903, subp.2.
Children's residential mental health treatment program standards - Minnesota Rules, Chapter 2960 and by the Department of Corrections, in accordance with Minnesota Statues, section 260B.198, subd. 11 (a).
Out of state facilities - Minnesota Statute, Section 256B.0945 (in a state that borders Minnesota and that have met all of the requirements are eligible to receive both Title IV-E and MA reimbursement)

Substance Use Disorder Services

****South Country follows all DHS Medicaid requirements**

Eligible Providers

the following enrollment criteria must be met for residential and non-residential substance use disorder treatment programs to be eligible for payment:

- enroll and maintain a provider agreement with MHCP;
- enroll and participate in the Drug and Alcohol Abuse Normative Evaluation System (DAANES);
- continually comply with the standards in the provider agreement;
- possess an acceptable license to provide SUD treatment services, room and board services or both types of services;
- submit an annual financial statement that reports functional expenses of SUD treatment costs in a form approved by the commissioner.

Acceptable licenses:

- Rule 31 substance use disorder treatment provider;
- Children's Residential Facility with substance use disorder certification;
- appropriate tribal license, for providers located on tribe-owned reservation property;
- appropriate room and board license;
- for out of state providers, an appropriate SUD treatment license for their state.

*if provider has more than one service delivery location, provider must obtain a separate license for and enroll each service delivery location

Eligible Members

- assessments are covered for South Country members on any South Country product;
- clinical eligibility is based on the results of a Rule 25 chemical health assessment. Members who score a severity rating of 2, 3, or 4 in Dimensions IV, V, or VI meet clinical eligibility for treatment;
- to qualify for residential level of care, a severity rating of 4 in either Dimension IV, V, or VI is required;
- a Rule 25 assessment using the Rule 25 Assessment Tool and Minnesota Matrix, is required for any member seeking public payment for SUD treatment services, whether the member is assessed by the county, tribe of residence or through South Country.

Covered Services

- Detoxification – Inpatient / Outpatient;
- Rule 25 Chemical Use Assessments;
- Methadone Maintenance Treatment (Suboxone, Methadone, Injectable);
- Non-Residential Treatment Services;
- Residential Treatment Services (Low, Moderate and High Intensity Rule 31);

Authorization

Notification is required (Form SCHA #2291) for an inpatient detoxification placement:

- if an **inpatient** hospitalization is medically necessary due to conditions in addition to, or resulting from, withdrawal. For example, conditions resulting from injury, accident or medical complications during detoxification, such as delirium, which requires constant availability of a physician or complex medical equipment found only in hospital settings would be covered;

- **outpatient** detoxification services are not covered.

Prior Authorization is required

- SUD Request Form along with completed Rule 25 – (Assessor - Form SCHA #1762);
- Form SCHA #1762v3 must be completed by the assessor when there are no recommendations for treatment;
- SUD Admission form for all Levels of Care (Form SCHA #1761)- Treating Facility at time of admission;
- South Country SUD Complexities Grid (Form SCHA #1763)- provider at time of admission;
- Rule 25 Assessment and Placement Summary (DHS-2794), provider when requesting continued stay.

*South Country will no longer accept Rule 25 assessments from providers affiliated with or employed by the Methadone clinics or Opiate Treatment Programs (OTP) for members needing methadone maintenance treatment.

** For South Country members who are in the Minnesota Restricted Recipient Program (MRRP) and in need of Medicated Assisted Therapy (MAT) services, effective August 1, 2014 the primary care provider (PCP) must submit a medical referral form.

*** If a member is receiving a per diem rate for medication-assisted therapy services or medication-assisted therapy plus enhanced treatment services, the member must not receive a rate for hours of individual and group non-residential counseling services or a residential treatment per diem rate concurrently from the same licensed program location. The member may receive additional services at a different licensed location including nonresidential and residential services.

Additional Substance Use Disorder Information

*Civil Commitment

a Rule 25 assessment does not need to be completed for a member being committed as a chemically dependent person and for the duration of a civil commitment

* Coordination of placement

- as stated in Rule 25, counties, tribes, and MCO's are all "placing authorities;"
- Rule 25 assessors are responsible for coordination of individual placement and treatment based upon member need. Prior authorization is required to request SUD placement;
- the Placing Authority must provide service coordination for individuals receiving treatment and who have a risk description of 3 or 4 in Dimension IV, V or VI;
- for members requiring **urgent** placement, assessors may call South Country.

**Screening for Co-Occurring Mental Health and Substance Use Disorder

- individuals who perform chemical dependency assessments or mental health diagnostic assessments must use standardized screening tools approved by the commissioner of the Department of Human Services to identify whether an individual who is the subject of the assessment screens positive for a co-occurring mental health or substance use disorder. Screening for substance use disorders is a required component of a diagnostic assessment for Medicaid payment.
- Approved screening tools are:
    - CAGE – Adapted to Include Drugs (CAGE-AID)
    - Global Appraisal of Individual Needs – Short Screener (GAIN-SS)

Provider Reminder: when a member is hospitalized for more than 23 hours during an authorized episode of Substance Use Disorder Treatment South Country will not continue to pay the treatment provider for the same dates of hospitalization services.

For additional information on:

Substance Use Disorder Services:

Access to Consolidated Chemical Dependency Treatment Funds – Minnesota Statute 254B.04
Adolescent Program – Minnesota Rules 9530.6485
Appropriate Level of Care - Minnesota Rules 9530.6600-9530.6655
Chemical Dependency Licensing – Minnesota Rules 9530.6405-6505
Chemical Dependency Services – Minnesota Statutes 254B, Subd. 2a and 254B.05 subd. 1; as well as 42 CFR 8.12
Civil Commitment – Minnesota Statutes 253B.02, 253B.065, 253B.09 or 253B.095
Clients with Children – Minnesota Rules 9530.6490
Documentation Requirements – Minnesota Rules 9505.2175 and 9505.2180
Qualified Rule 25 Assessor Requirements – Minnesota Rules 9530.6615
Residential Treatment Licensing – Minnesota Rules 9530.6405-6505
Risk Descriptions – Minnesota Rules 9530.6622 subparts 3,4,5 and 6
Rule 25 – Minnesota Rules 9530.6600-9530.6655
Rule 31 – Minnesota Rules 9530.6405-9530.6485
Screening for Co Occurring Mental Health and Substance Use – Minnesota Rule 9505.0372 subpart 1

Prior Authorization or notification forms are located on the South Country website at:http://mnscha.org/Providers/ChemicalDependency.aspx

See the Prior Authorization grid for additional detail at: http://mnscha.org/Providers/PriorAuth.aspx